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Grupo de Estudos da Doença Inflamatória Intestinal do Brasil

Bem vindos!

Apoio:

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Agenda do nosso webinar

Abertura

Dr. Rogério Saad

Recomendações gerais para pacientes com DII durante a pandemia de COVID-19: a opinião do infectologista

Dr. Guilherme C. Fernandes

Recomendações para o manejo das medicações em DII durante a pandemia de COVID-19

Dra. Liliana A. Chebli

Perguntas e respostas e considerações finais

COVID-19

Dr. Guilherme C. Fernandes
Infectologista

The NEW ENGLAND JOURNAL of MEDICINE

EDITORIAL

Covid-19 — Navigating the Uncharted

Anthony S. Fauci, M.D., H. Clifford Lane, M.D., and Robert R. Redfield, M.D.

The latest threat to global health is the ongoing outbreak of the respiratory disease that was recently given the name Coronavirus Disease 2019 (Covid-19). Covid-19 was recognized in December 2019.[1] It was rapidly shown to be caused by a novel coronavirus that is structurally related to the virus that causes severe acute respiratory syndrome (SARS). As in two preceding instances of emergence of coronavirus disease in the past 18 years[2] — SARS (2002 and 2003) and Middle East respiratory syndrome (MERS) (2012 to the present) — the Covid-19 outbreak has posed critical challenges for the public health, research, and medical communities.

diagnosis of pneumonia, the currently reported case fatality rate is approximately 2%.[4] In another article in the *Journal*, Guan et al.[5] report mortality of 1.4% among 1099 patients with laboratory-confirmed Covid-19; these patients had a wide spectrum of disease severity. If one assumes that the number of asymptomatic or minimally symptomatic cases is several times as high as the number of reported cases, the case fatality rate may be considerably less than 1%. This suggests that the overall clinical consequences of Covid-19 may ultimately be more akin to those of a severe seasonal influenza (which has a case fatality rate of approximately

DOI: 10.1056/NEJMe2002387
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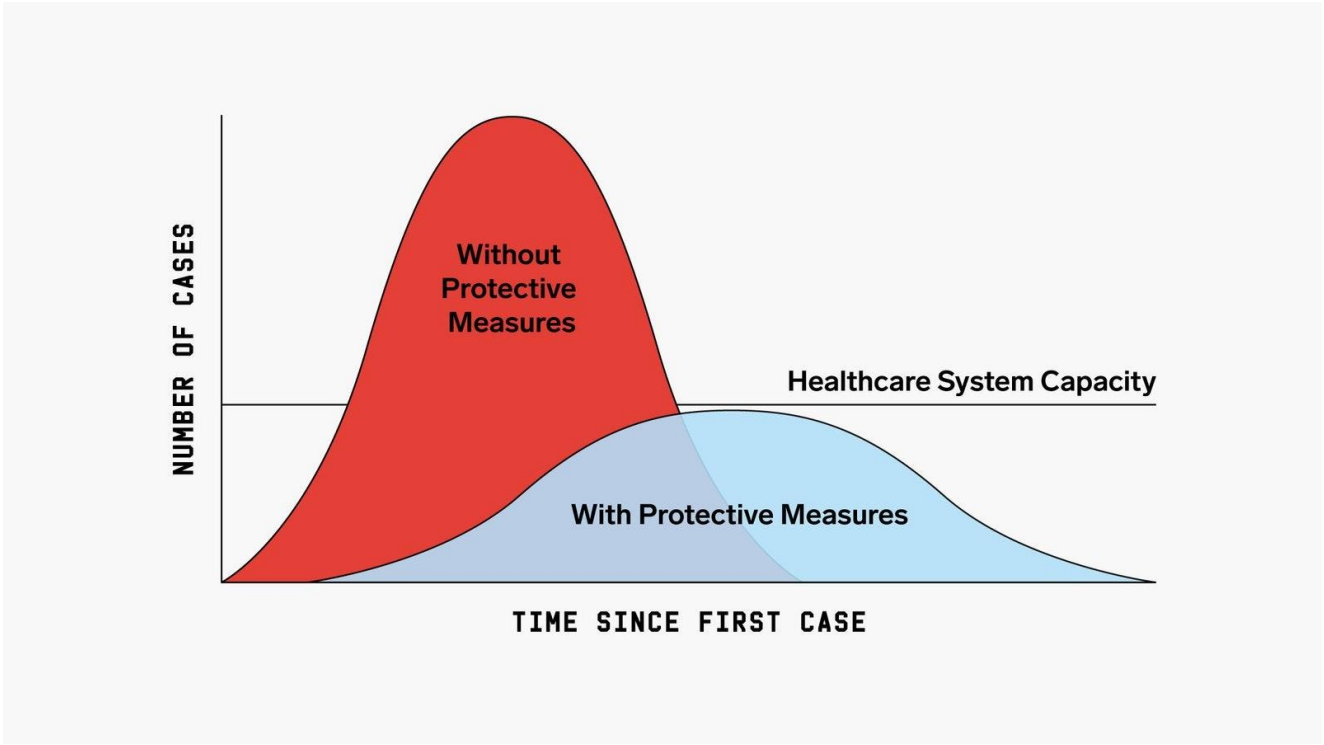

Achatar a curva

- Com medidas de distanciamento social

Critical Supply Shortages — The Need for Ventilators and Personal Protective Equipment during the Covid-19 Pandemic

Megan L. Ranney, M.D., M.P.H., Valerie Griffeth, M.D., Ph.D., and Ashish K. Jha, M.D., M.P.H.

On March 11, 2020, the World Health Organization designated "coronavirus disease 2019" (Covid-19) a global pandemic. As the number of cases in the United States continues to grow, political leaders are encouraging physical (or "social") distancing to slow the rate of transmission. The goal of this practice is to flatten the curve of new infection, thereby avoiding a surge of demand on the health care system, but the effects of physical distancing may take weeks to appear. U.S. hospitals are already reporting shortages of key equipment needed to care for critically ill patients, including ventilators and personal protective equipment (PPE) for medical staff. Adequate production and distribution of both types of equipment are crucial to caring for patients during the pandemic.

There is a broad range of estimates of the number of ventilators we will need to care for U.S. patients with Covid-19, from several hundred thousand to as many as a million.[1] The estimates vary depending on the number, speed, and severity of infections, of course, but even the availability of testing affects the number of ventilators needed: without adequate testing, the number increases because patients who are traditionally treated with noninvasive positive-pressure ventilation (NIPPV) for conditions such as chronic obstructive pulmonary disease exacerbations may need to instead be presumptively intubated while awaiting Covid-19 testing results (using NIPPV is contraindicated for patients with Covid-19 because of aerosolization of the virus under positive pressure). Current estimates of the number of ventilators in the United States range from 60,000 to 160,000, depending on whether those that have only partial functionality are included.[2] The national strategic reserve of ventilators is small and far from sufficient for the projected gap.[2] No matter which estimate we use, there are not enough ventilators for patients with Covid-19 in the upcoming months.

Equally worrisome is the lack of adequate PPE for frontline health care workers, including respirators, gloves, face shields, gowns, and hand sanitizer. In Italy, health care workers experienced high rates of infection and death[3] partly because of inadequate access to PPE. And recent estimates here in the United States suggest that we will need far more respirators and surgical masks than are currently available.[4]

The U.S. shortage has multiple causes, including problems with the global supply chain. Before this pandemic, for instance, China produced approximately half the world's face masks.[5] As the infec-

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SOUNDING BOARD

Fair Allocation of Scarce Medical Resources in the Time of Covid-19

Ezekiel J. Emanuel, M.D., Ph.D., Govind Persad, J.D., Ph.D., Ross Upshur, M.D., Beatriz Thome, M.D., M.P.H., Ph.D., Michael Parker, Ph.D., Aaron Glickman, B.A., Cathy Zhang, B.A., Connor Boyle, B.A., Maxwell Smith, Ph.D., and James P. Phillips, M.D.

DOI: 10.1056/NEJMsb2005114
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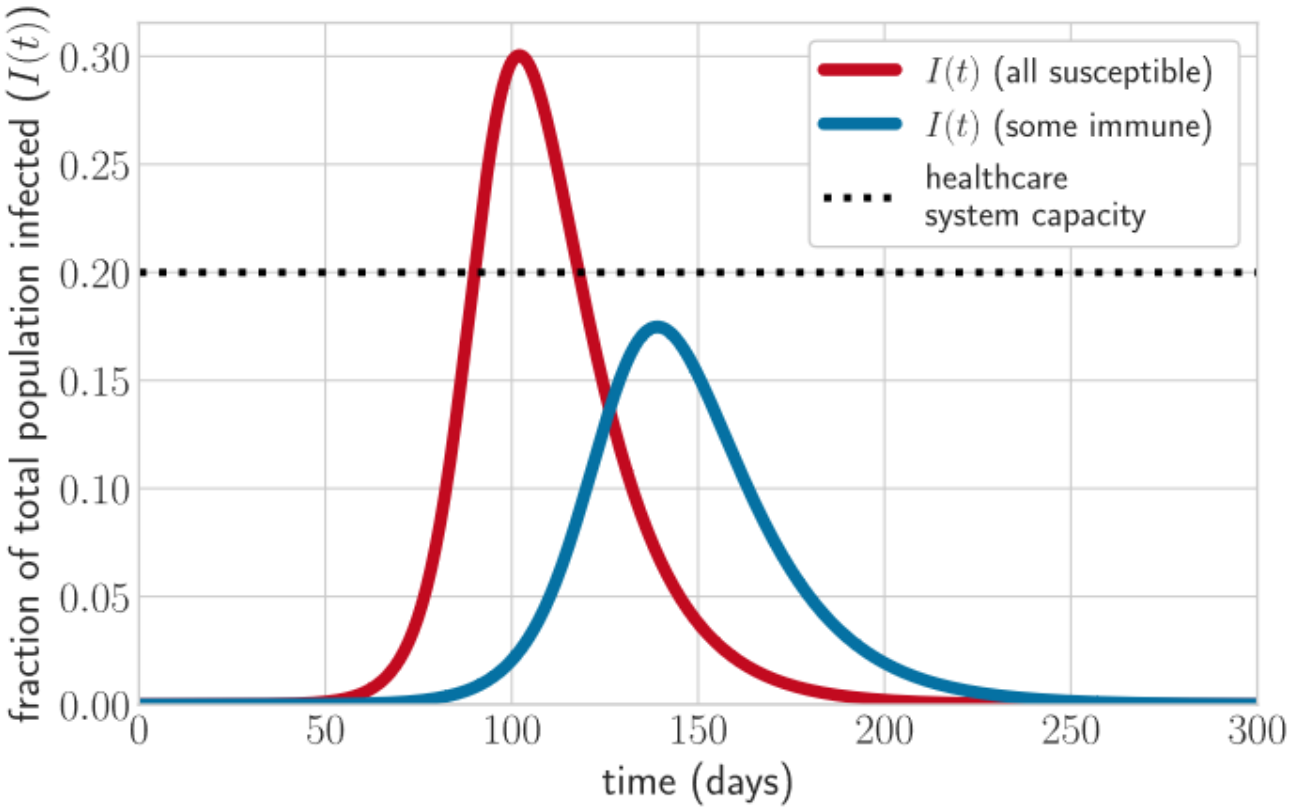


É só uma gripe?

NEJM Catalyst | Innovations in Care Delivery

ARTICLE

At the Epicenter of the Covid-19 Pandemic and Humanitarian Crises in Italy: Changing Perspectives on Preparation and Mitigation

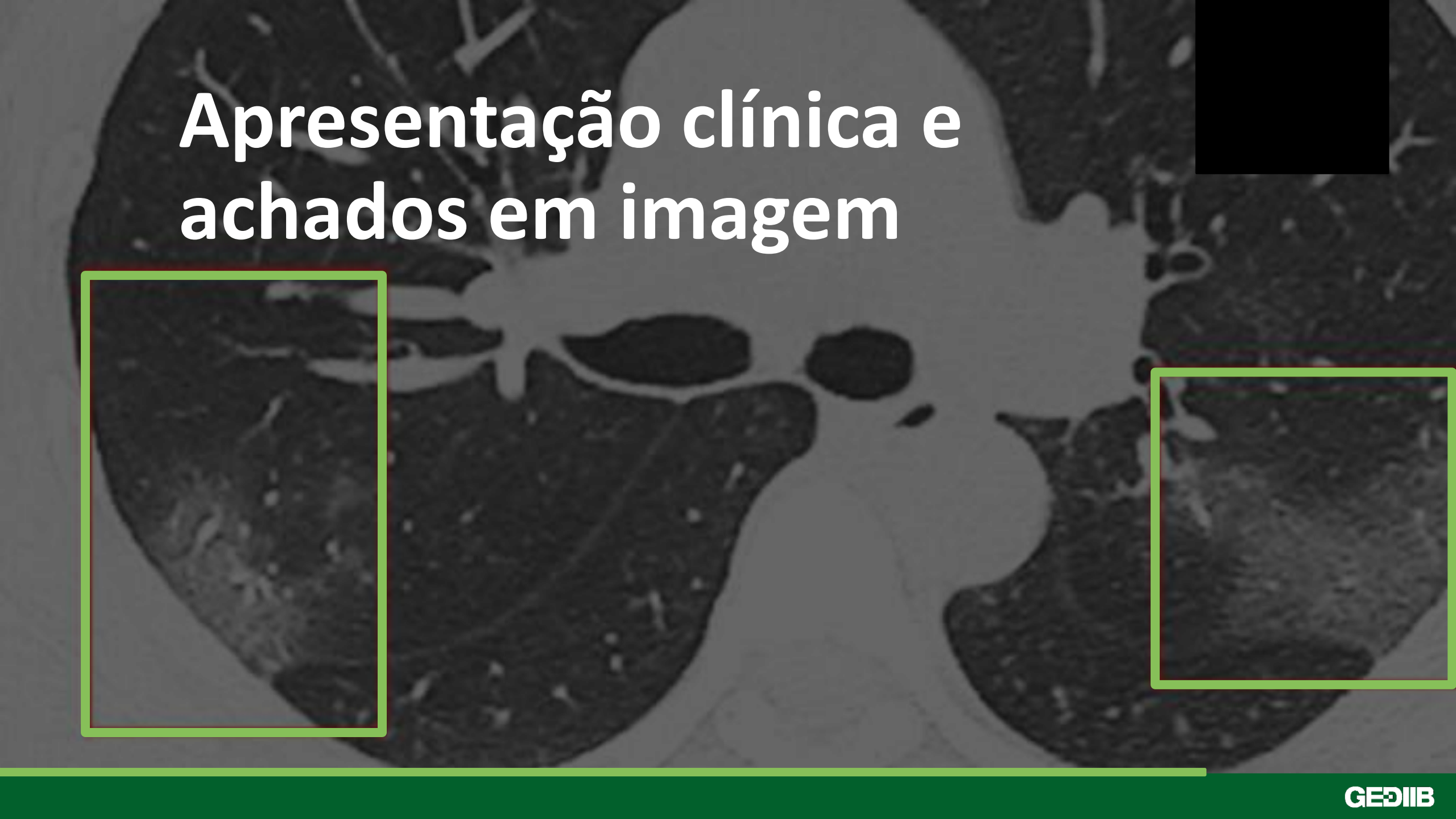
Mirco Nacoti, MD, Andrea Ciocca, MEng, Angelo Giupponi, MD, Pietro Brambillasca, MD, Federico Lussana, MD, Michele Pisano, MD, Giuseppe Goisis, PhD, Daniele Bonacina, MD, Francesco Fazzi, MD, Richard Naspro, MD, Luca Longhi, MD, Maurizio Cereda, MD, Carlo Montaguti, MD

Vol. No. | March 21, 2020

DOI: 10.1056/CAT.20.0080

In a pandemic, patient-centered care is inadequate and must be replaced by community-centered care. Solutions for Covid-19 are required for the entire population, not only for hospitals. The catastrophe unfolding in wealthy Lombardy could happen anywhere.

Apresentação clínica e achados em imagem



Journal Pre-proof

COVID-19 can present with a rash and be mistaken for Dengue

Beuy joob, PhD, Viroj Wiwanitkit, MD

PII: S0190-9622(20)30454-0

DOI: https://doi.org/10.1016/j.jaad.2020.03.036

Reference: YMJD 14342

To appear in: *Journal of the American Academy of Dermatology*

Received Date: 6 March 2020

Revised Date: 13 March 2020

Accepted Date: 17 March 2020

Title: Case report of COVID-19 in a kidney transplant recipient: Does immunosuppression alter the clinical presentation?

Authors: Elena Guillen1, Gaston Julio Pineiro1,3, Ignacio Revuelta1,3, Diana Rodriguez1, Marta Bodro2, Asunción Moreno2, Josep M Campistol1,3, Fritz Diekmann1,3,4, Pedro Ventura-Aguiar1,3

COVID-19 in a patient with chronic lymphocytic leukaemia

Xiang-Hong Jin*, Kenneth I Zheng*, Ke-Hua Pan, Yu-Peng Xie, Ming-Hua Zheng

Since the outbreak of coronavirus disease 2019 (COVID-19) first began in Wuhan, China, in December, 2019, the viral epidemic has quickly engulfed China. Here we describe a case of a patient with chronic lymphocytic leukaemia with COVID-19.

On Feb 16, 2020, a 39-year-old man with a medical history of non-Hodgkin lymphoma and chronic lymphocytic leukaemia attended our clinic in Wenzhou, China, after 4 days of fever, sore throat, productive cough, and dyspnoea. Previous history of treatment for non-Hodgkin lymphoma consisted of six courses of 21 days of R-CHOP chemotherapy in 2007. His previous treatment for chronic lymphocytic leukaemia started in November, 2018, with oral chlorambucil (10 mg/m²) per day. He became non-compliant in December, 2019, stating that improvements derived from treatment did not outweigh the cost and follow-up time required. At admission (Feb 16, 2020), the most relevant clinical findings included body temperature of 38·5°C, white blood cell counts of

changed to low-dose intravenous methylprednisolone (40 mg) every 12 h with oral chlorambucil (2 mg) twice per day for the next 4 days. A follow-up chest CT on March 1, 2020 (figure), showed a substantial improvement with a marked reduction of pulmonary exudative lesions. The patient's temperature also returned to normal with improvement in symptoms. However, repeated real-time RT-PCR test remained positive for COVID-19 infection. He was scheduled for an additional 7 days of observation until all clinical criteria for hospital discharge were met (more than 3 days of normal body temperature, resolved respiratory symptoms, substantially improved acute exudative lesions on chest CT, and two consecutive negative COVID-19 infection tests), at which time he was transferred to the inpatient haematology department for further management.

After the first positive test for COVID-19 infection, the attending physician must, by protocol, verify the source and possible transmission of COVID-19. Initially, the

Lancet Haematol 2020; 7: e351–52

*These authors contributed equally

Department of Hematology (X-H Jin MD), **Department of Hepatology** (K I Zheng MD, M-H Zheng MD), **Department of Radiology** (K-H Pan MD), **and Department of Respiratory and Critical Care Medicine** (Y-P Xie MD), **The First Affiliated Hospital of Wenzhou Medical University, Wenzhou, China**

Correspondence to:
Dr Ming-Hua Zheng, Department of Hepatology, The First Affiliated Hospital of Wenzhou Medical University, Wenzhou 325000, China
zhengmh@wmu.edu.cn

Cancer care in the time of COVID-19

As of March 18, 2020, the number of confirmed cases of coronavirus disease 2019 (COVID-19) had reached 191 127, with 7807 deaths. Europe is now the epicentre of the pandemic. France, Italy, and Spain have imposed lockdowns and as *The Lancet Oncology* went to press, there were rumours that London might take similar action. The EU has introduced stringent border controls and schools have been closed across the continent. It is unclear how long the emergency measures will remain in place.

may mean pausing the set-up of new trials and recruitment to existing trials, but there are still some trials running". The UK Medicines and Healthcare products Regulatory Agency has issued guidance on managing trials during the pandemic. It suggested delivering the medication under investigation to patients' homes to avoid unnecessary trips to the clinic.

Boyd points out that there are no indications that the pandemic is causing drug shortages. "We are confident that Government is putting plans in place

be arranged. "We are doing what we can, but it is not straightforward", said Pearce.

Moreover, the outbreak itself complicates efforts to obtain donations. The process first requires donors to attend hospital for preparation and blood tests. The donation can take a couple of days. "Donors are understandably concerned about travelling, and especially spending so long in a hospital", notes Pearce. "And if the UK goes into lockdown, will we be able to have exemptions for stem-cell

Lancet Oncol 2020

Published Online
March 23, 2020

https://doi.org/10.1016/S1470-2045(20)30201-1

For more on the disruption of stem cells services see https://www.theguardian.com/world/2020/mar/18/cancer-stem-cells-coronavirus-logistical-nightmare

COVID-19: consider cytokine storm syndromes and immunosuppression

As of March 12, 2020, coronavirus disease 2019 (COVID-19) has been confirmed in 125 048 people worldwide, carrying a mortality of approximately 3·7%,[1] compared with a mortality rate of less than 1% from influenza. There is an urgent need in Wuhan, China, included elevated ferritin (mean 1297·6 ng/ml in non-survivors *vs* 614·0 ng/ml in survivors; p<0·001) and IL-6 (p<0·0001),[2] suggesting that mortality might be due to virally driven hyperinflammation.

As during previous pandemics (severe acute respiratory syndrome and Middle East respiratory syndrome), corticosteroids are not routinely recommended and might exacerbate COVID-19-associated lung injury.[7] However, in hyperinflammation, immunosuppression is likely to be beneficial. Re-analysis of data from a phase 3 randomised controlled trial of IL-1 blockade (anakinra) in sepsis, showed significant survival benefit in patients with hyperinflammation, without increased adverse events.[8] A multicentre, randomised controlled trial of tocilizumab (IL-6 receptor blockade, licensed for cytokine release syndrome), has been approved in patients with

Published Online
March 13, 2020
https://doi.org/10.1016/S0140-6736(20)30628-0

Immunosuppression for hyperinflammation in COVID-19: a double-edged sword?

Mehta and colleagues[1] postulate that hyperinflammation in coronavirus disease 2019 (COVID-19) could be a driver of severity that is amenable to therapeutic targeting since retrospective data have shown that systemic inflammation is associated with adverse outcome. However, correlation does not equal causation, and it is equally plausible that increased virus burden (secondary to failure of the immune response to control infection) drives inflammation and consequent severity (as shown for other viruses[2]) rather than augmented inflammation being an inappropriate host response that requires correction.

The decision to pharmacologically immunosuppress a critically unwell patient with COVID-19 remains a difficult one. Possible beneficial effects of reducing inflammation should be carefully weighed up against the potential for deleterious impairment of anti-microbial immunity.

AS reports personal fees for consultancy from AstraZeneca and funds from grants from the Wellcome Trust, the British Lung Foundation, and others, all unrelated to this Correspondence. AIR declares no competing interests.

*Andrew I Ritchie, *Aran Singanayagam*
a.singanayagam@imperial.ac.uk

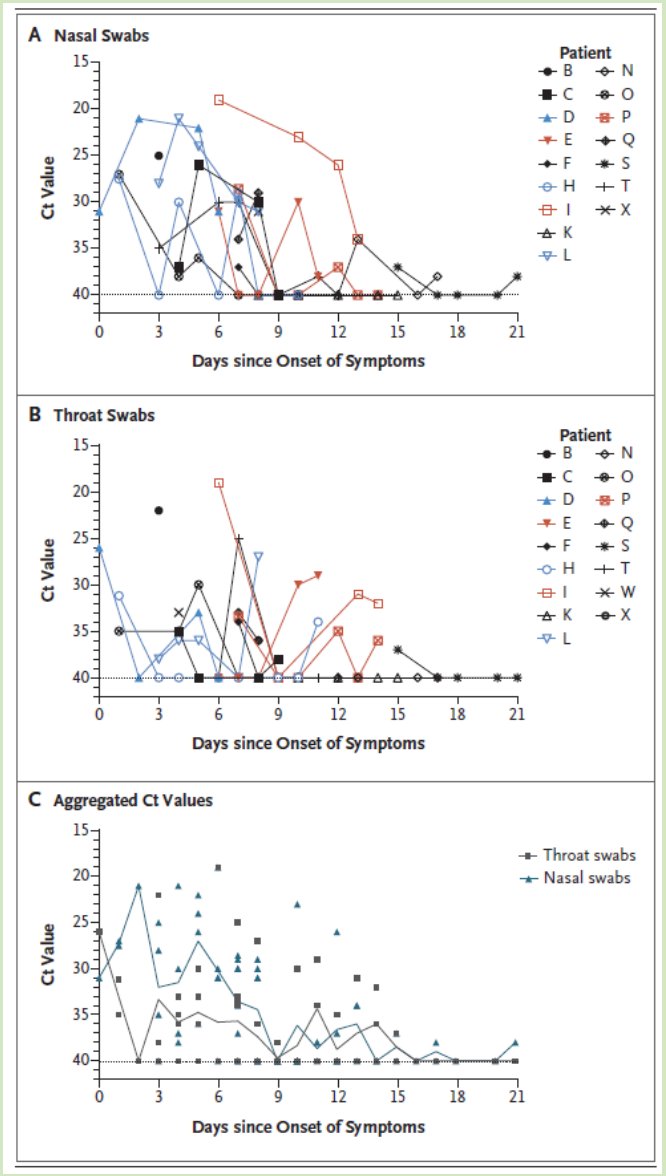
National Heart and Lung Institute, Imperial College London, London SW7 2AZ, UK (AIR, AS); and Royal Brompton and Harefield NHS Trust, London, UK (AS)

1 Mehta PM, McAuley DF, Brown M, Sanchez E, Tattersall RS, Manson JJ. COVID-19: consider cytokine storm syndromes and immunosuppression. *Lancet* 2020; published online March 16. https://doi.org/10.1016/S0140-6736(20)30628-0.
2 Lee N, Chan MC, Lui GC, et al. High viral load and respiratory failure in adults hospitalized

Published Online
March 23, 2020
https://doi.org/10.1016/S0140-6736(20)30691-7

Transmissão / Prevenção

- Gotículas
- Aerossol
- Contato



The NEW ENGLAND JOURNAL of MEDICINE

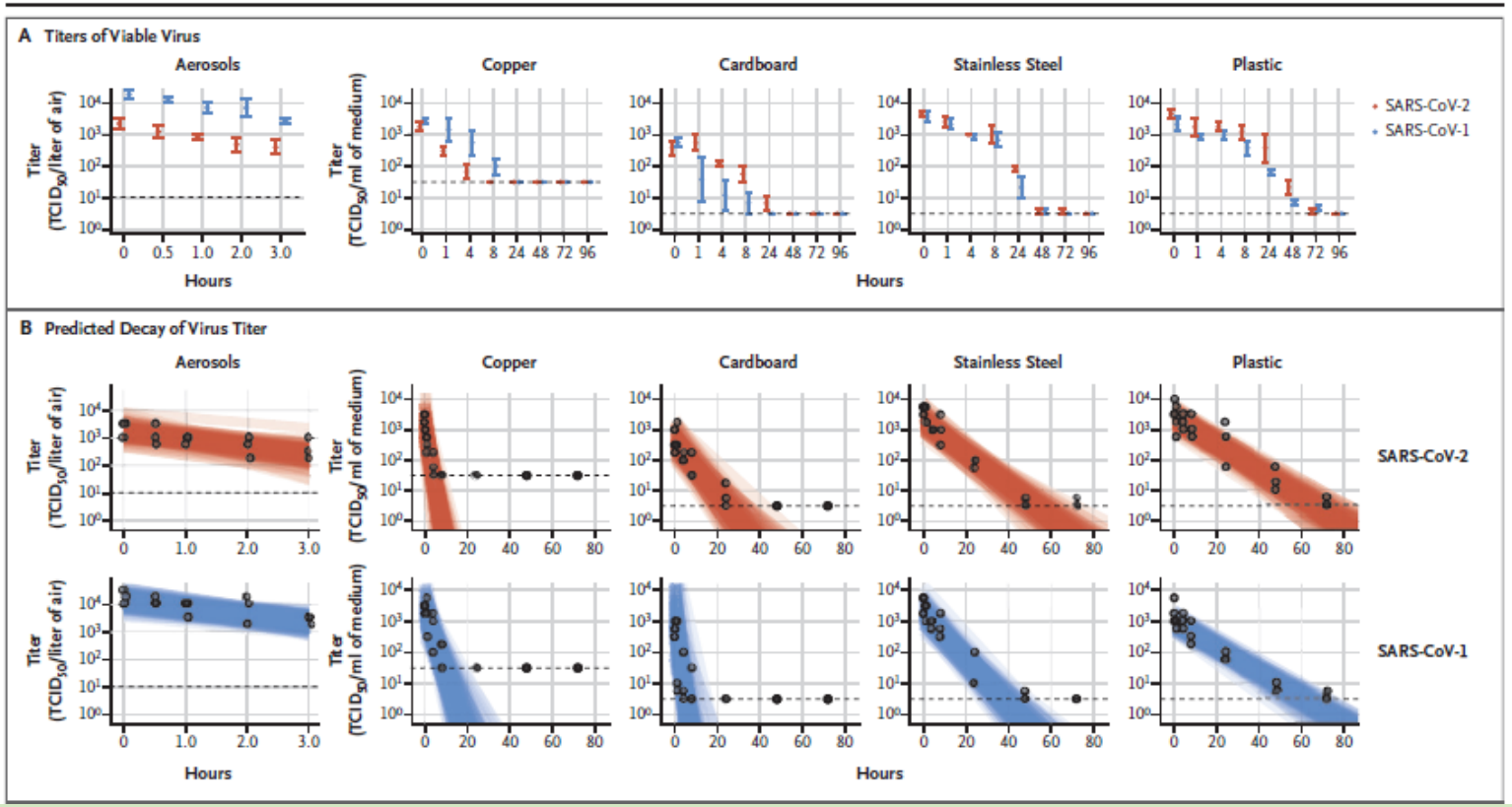
CORRESPONDENCE

SARS-CoV-2 Viral Load in Upper Respiratory Specimens of Infected Patients

The NEW ENGLAND JOURNAL of MEDICINE

CORRESPONDENCE

Aerosol and Surface Stability of SARS-CoV-2 as Compared with SARS-CoV-1

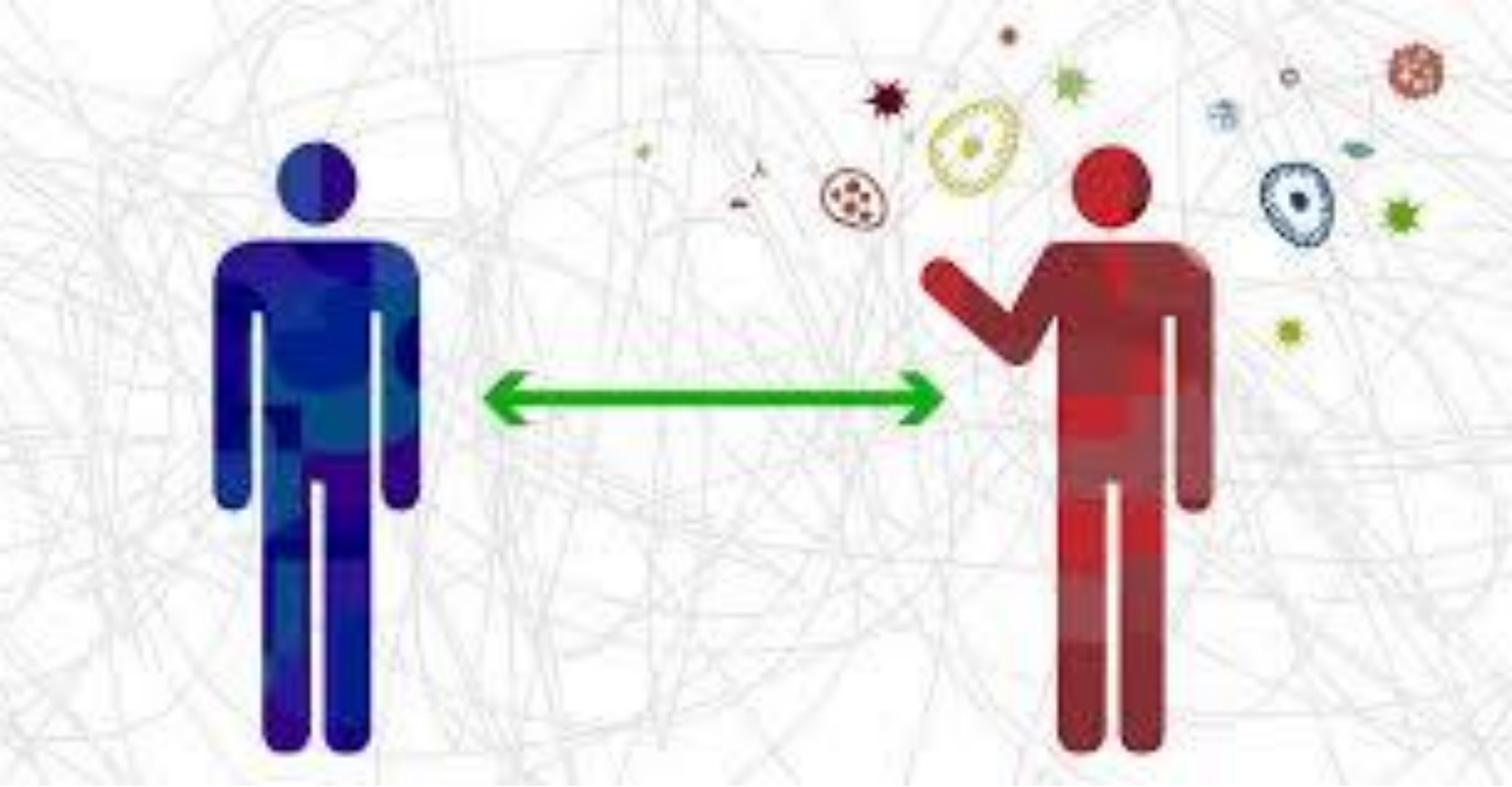


DIÁRIO OFICIAL DA UNIÃO

Publicado em: 23/03/2020 | Edição: 56-C | Seção: 1 - Extra | Página: 5
Órgão: Ministério da Saúde/Agência Nacional de Vigilância Sanitária

RESOLUÇÃO - RDC Nº 356, DE 23 DE MARÇO DE 2020

Dispõe, de forma extraordinária e temporária, sobre os requisitos para a fabricação, importação e aquisição de dispositivos médicos identificados como prioritários para uso em serviços de saúde, em virtude da emergência de saúde pública internacional relacionada ao SARS-CoV-2.



Recomendações para o manejo das medicações em DII durante a pandemia da COVID-19

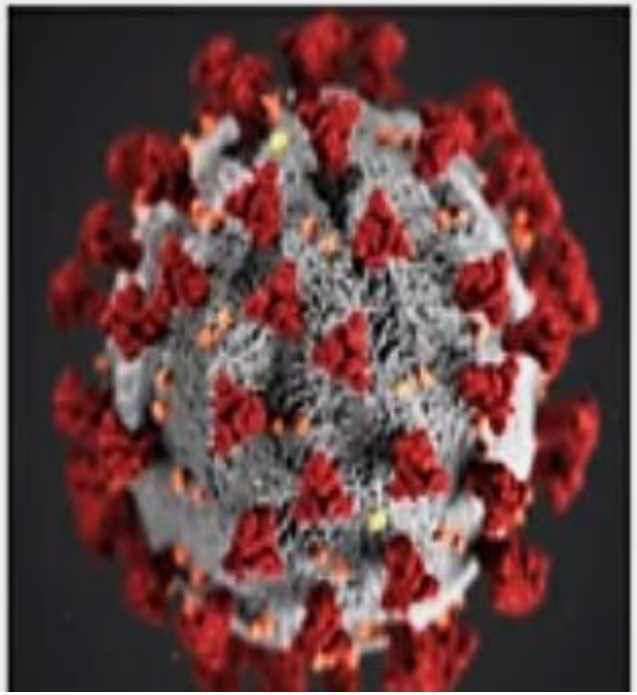
01 de abril de 2020

Dra. Liliana Andrade Chebli
Faculdade de Medicina
Hospital Universitário
Universidade Federal
de Juiz de Fora
Gastroenterologista

Declaro não ter nenhum conflito de interesse nesta apresentação

SARS-CoV-2 / COVID-19 and inflammatory bowel disease

Definitions

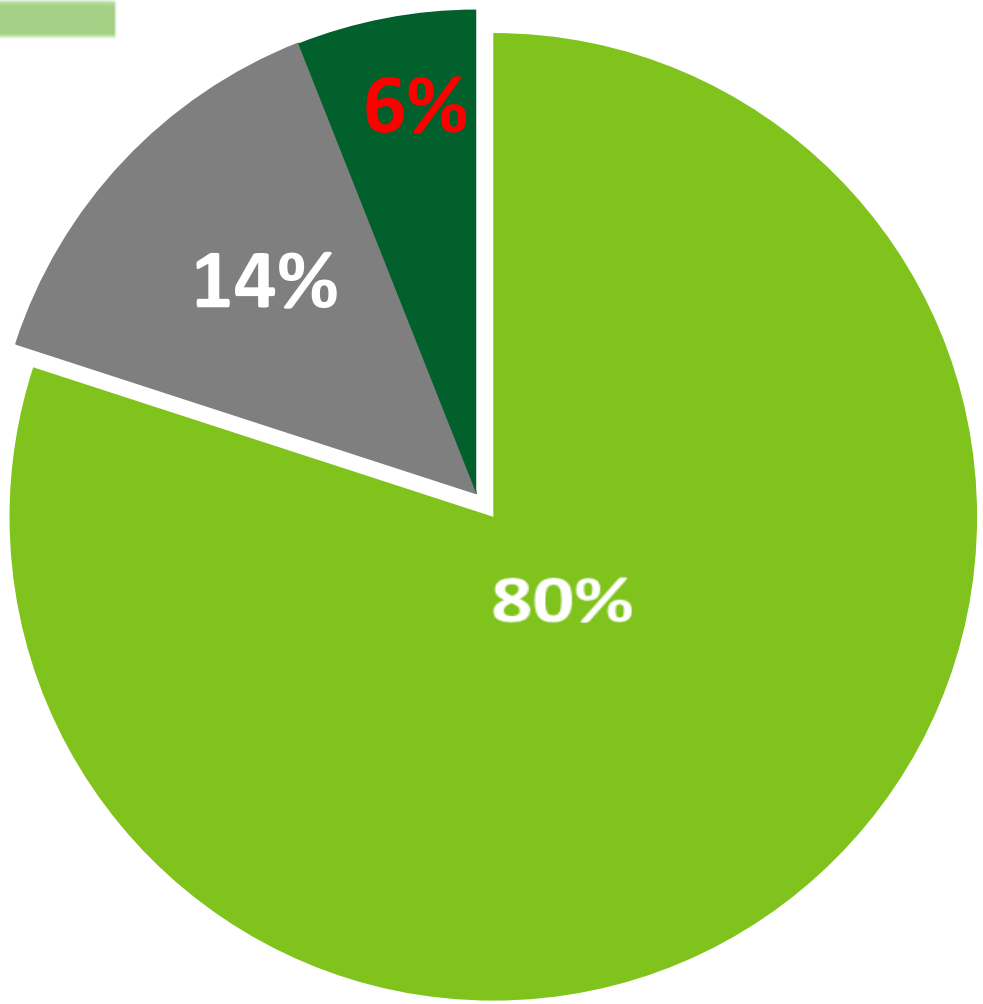


- The SARS-CoV-2 virus causes COVID-19 disease
- Virus enters the nose, mouth or eyes and attaches to cells in the airway that have the ACE2 receptor
- The ACE2 receptor is found on the cells of multiple organs, including the gastrointestinal tract
- IL-6 and TNF upregulate ACE2 receptor expression, as does infection with SARS-CoV-2
- Virus has been found in stool even after respiratory clearance
- Gastrointestinal symptoms are present in some patients affected by COVID-19

Diarreia (2-33%), elevações de ALT/AST (até 35%) e bilirrubinas (10%; em casos + graves)

Mao R et al. Lancet Gastroenterol Hepatol, Mar11; doi: 10.1016/S2468-1253(20)30076-5. [Epub ahead of print]

Evolução da COVID-19 baseada no percentual de pacientes sintomáticos



Doença leve

Doença mais grave

Doença crítica

Admite-se que para cada paciente sintomático possa haver até 10 indivíduos assintomáticos

https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports

Secure IBD Registry

https://covidibd.org

Michael Kappelman MD, MPH (University of North Carolina at Chapel Hill)
Erica Brenner, MD (University of North Carolina at Chapel Hill)
Ryan Ungaro, MD (Icahn School of Medicine at Mount Sinai, New York)

CROHN'S & COLITIS FOUNDATION | NASPGHAN | IOIBD | ECCO European Crohn's and Colitis Organisation

Current Data

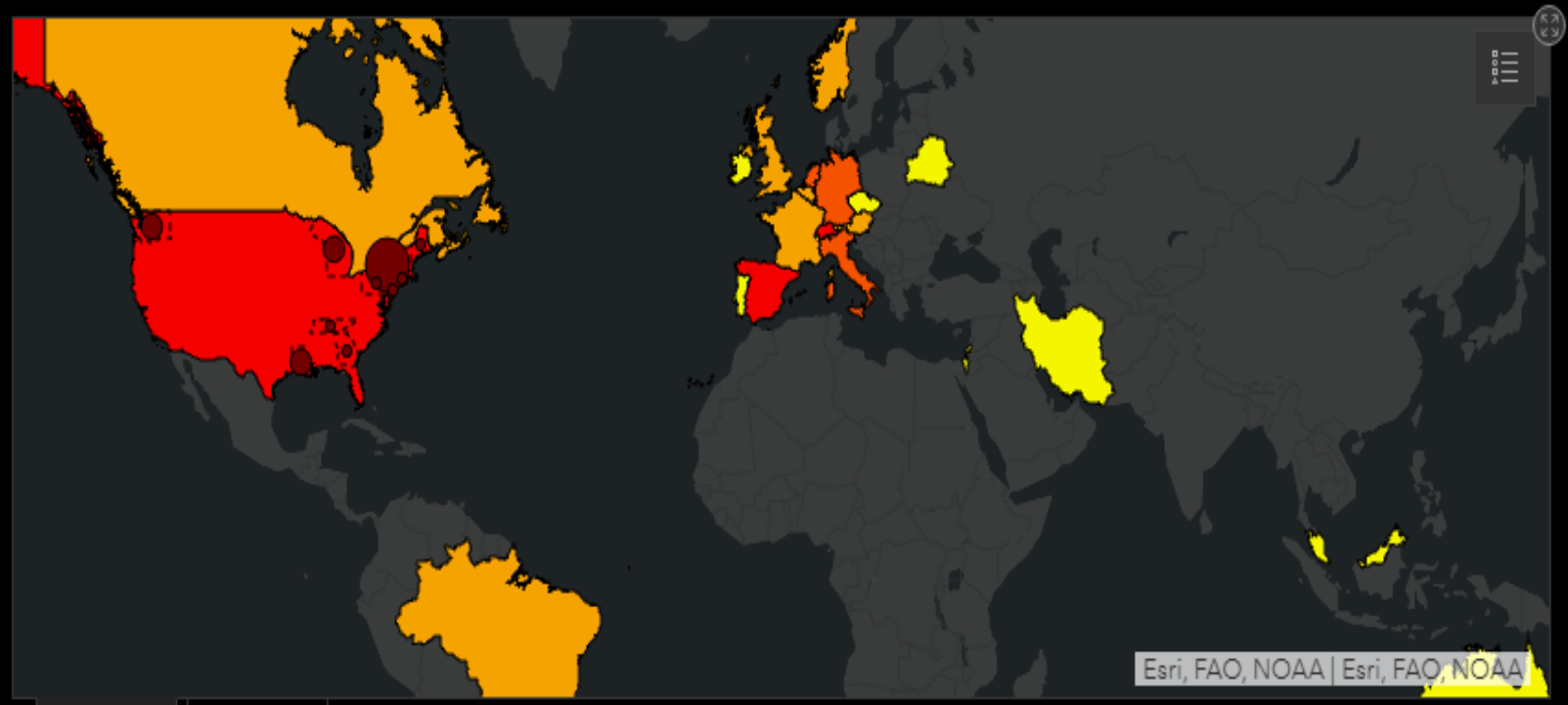
Date last updated: 3/27/2020

COVID-19 in People with Inflammatory Bowel Disease

Surveillance Epidemiology of Coronavirus (COVID-19) Under Research Exclusion. Visuals prepared by Dr. Gilaad G. Kaplan, Cumming School of Medicine, University of Calgary.

We encourage IBD clinicians worldwide to report ALL cases of COVID-19 in their IBD patients, regardless of severity (including asymptomatic patients detected through public health screening). Reporting a case to this Surveillance Epidemiology of Coronavirus Under Research Exclusion (SECURE)-IBD registry should take approximately 5 minutes. Please report only confirmed COVID-19 cases, and *report after sufficient time has passed to observe the disease course through resolution of acute illness and/or death*. **To report a case of coronavirus, click here.**

Dr. Gilaad G. Kaplan is a gastroenterologist and epidemiologist in the Cumming School of Medicine and Department of Community Health Sciences at the University of Calgary. **For more maps of digestive diseases, view our website.**



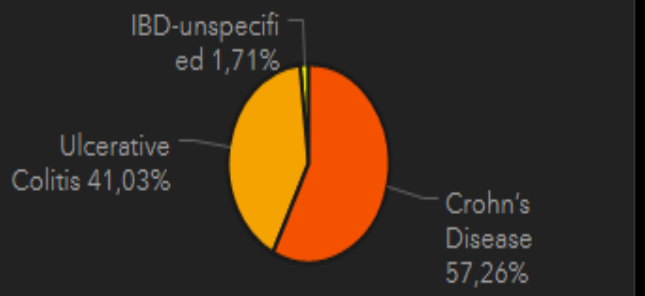
March 27 | March 23

As of March 27th.

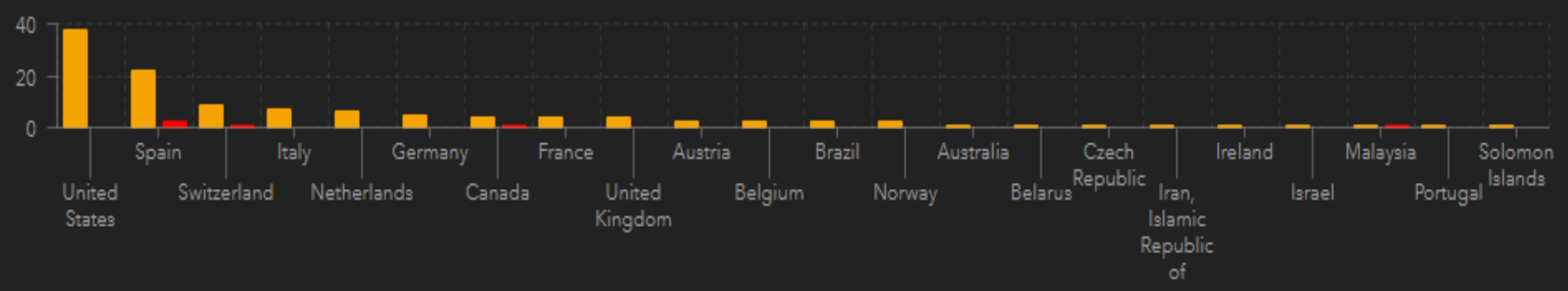
Cases
117

Hospitalized
23

Deaths
5



CD and UC | Sex | Activity



Country | US State | Age | Treatment

Deaths reported to the database

Obs	age	country	sex	diagnosis	Disease activity	IBD medication	Hospitalized	ICU	ventilator support
1	82	Spain	Male	Ulcerative colitis	Mild	Mesalamine	Yes	No	No
2	≥90	Canada	Male	Crohn's disease	Remission	Adalimumab	No	.	.
3	46	Switzerland	Male	Ulcerative colitis	Severe	Prednisone or prednisolone, JAK inhibitor	Yes	Yes	Yes
4	25	Malaysia	Male	Ulcerative colitis	Moderate	Infliximab, Methotrexate	Yes	No	No
5	52	Spain	Male	Crohn's disease	Remission	Adalimumab, Methotrexate	Yes	No	No

Nível de risco para pacientes com DII relacionado à COVID-19

Highest risk Advise SHIELDING (mandatory self-isolation)	Moderate risk Recommend enhanced social distancing	Lowest risk Follow advice for general population
1. IBD patients who **either** have a co-morbidity (respiratory, cardiac, hypertension or diabetes mellitus) **and/or** are ≥70 years old **and*** are on any therapy for IBD (per middle column) except 5ASA, budesonide, beclometasone or rectal therapies 2. IBD patients of any age regardless of co-morbidity and who meet one or more of the following criteria: • On oral or intravenous prednisolone ≥20mg per day (only while on this dose) • New induction therapy with combo therapy (starting biologic within previous 6 weeks) • Moderately to severely active disease despite immunosuppression/biologics • Short gut syndrome requiring nutritional support • Requirement for parenteral nutrition	Patients on the following medications: • Ustekinumab • Vedolizumab • Methotrexate • Anti-TNFα monotherapy (infliximab, adalimumab, golimumab) • Thiopurines (azathioprine, mercaptopurine, tioguanine) • Calcineurin inhibitors (tacrolimus or ciclosporin) • Janus kinase (JAK) inhibitors (tofacitinib) • Combination therapy in stable patients** • Immunosuppressive/biologic trial medication	Patients on the following medications: • 5ASA • Rectal therapies • Orally administered, topically acting steroids (budesonide or beclometasone) • Therapies for bile-acid diarrhoea (colestyramine, colesevelam, colestipol) • Anti-diarrhoeal agents (e.g. loperamide) • Antibiotics for bacterial overgrowth or perianal disease

Education webinar on COVID-19 & Digestive Health, March 24, 2020 https://www.youtube.com/watch?v=w60DVdKkuGw&feature=youtu.be

ueg education

Webinar | COVID-19 & Digestive Health
Experts: James Lindsay and Alessandro Repici
Moderator: Klaartje Bel Kok

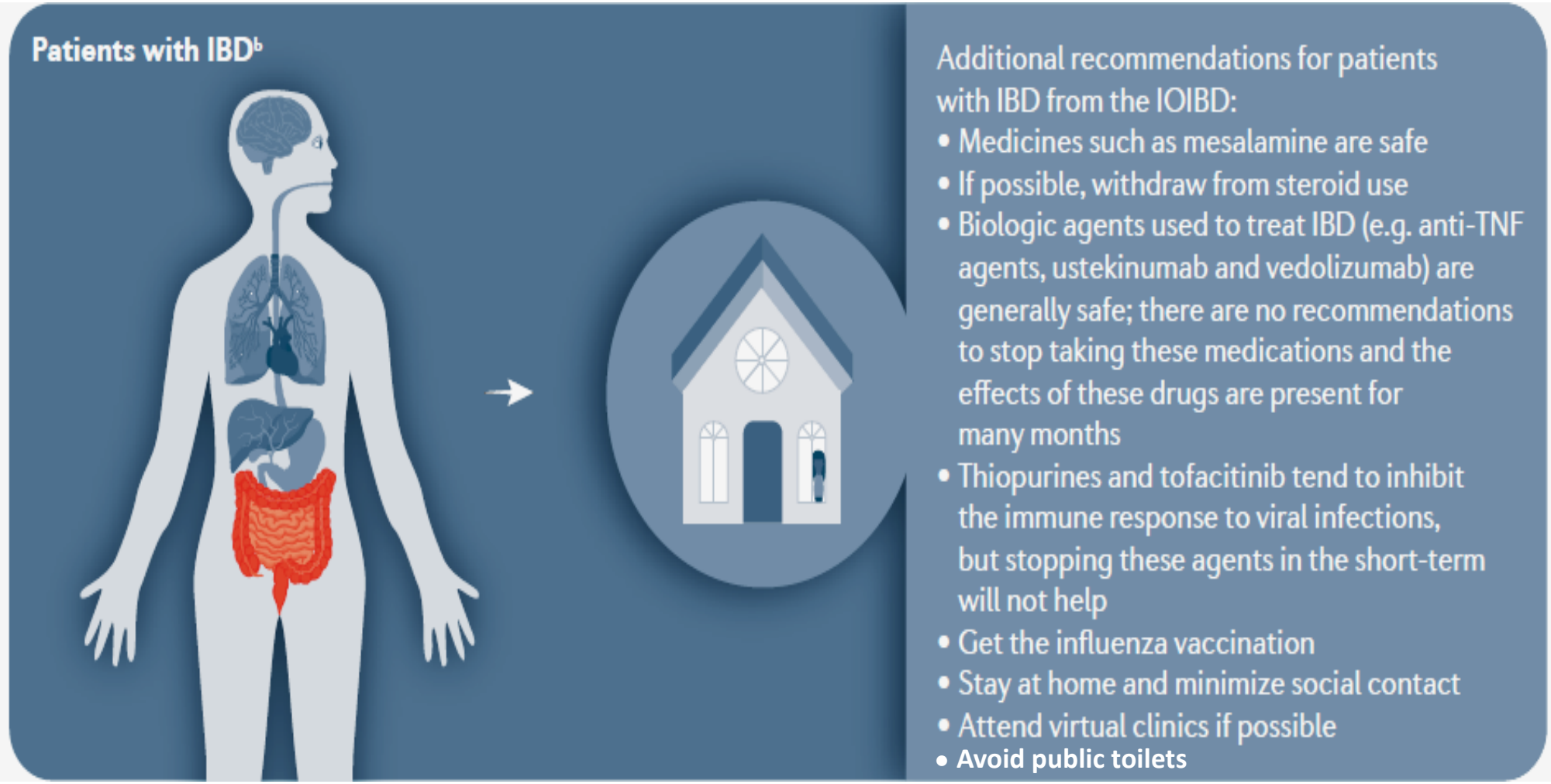
Tuesday, March 24, 2020

What do we tell our IBD patients in the UK?

Top 10 tips for all patients with IBD

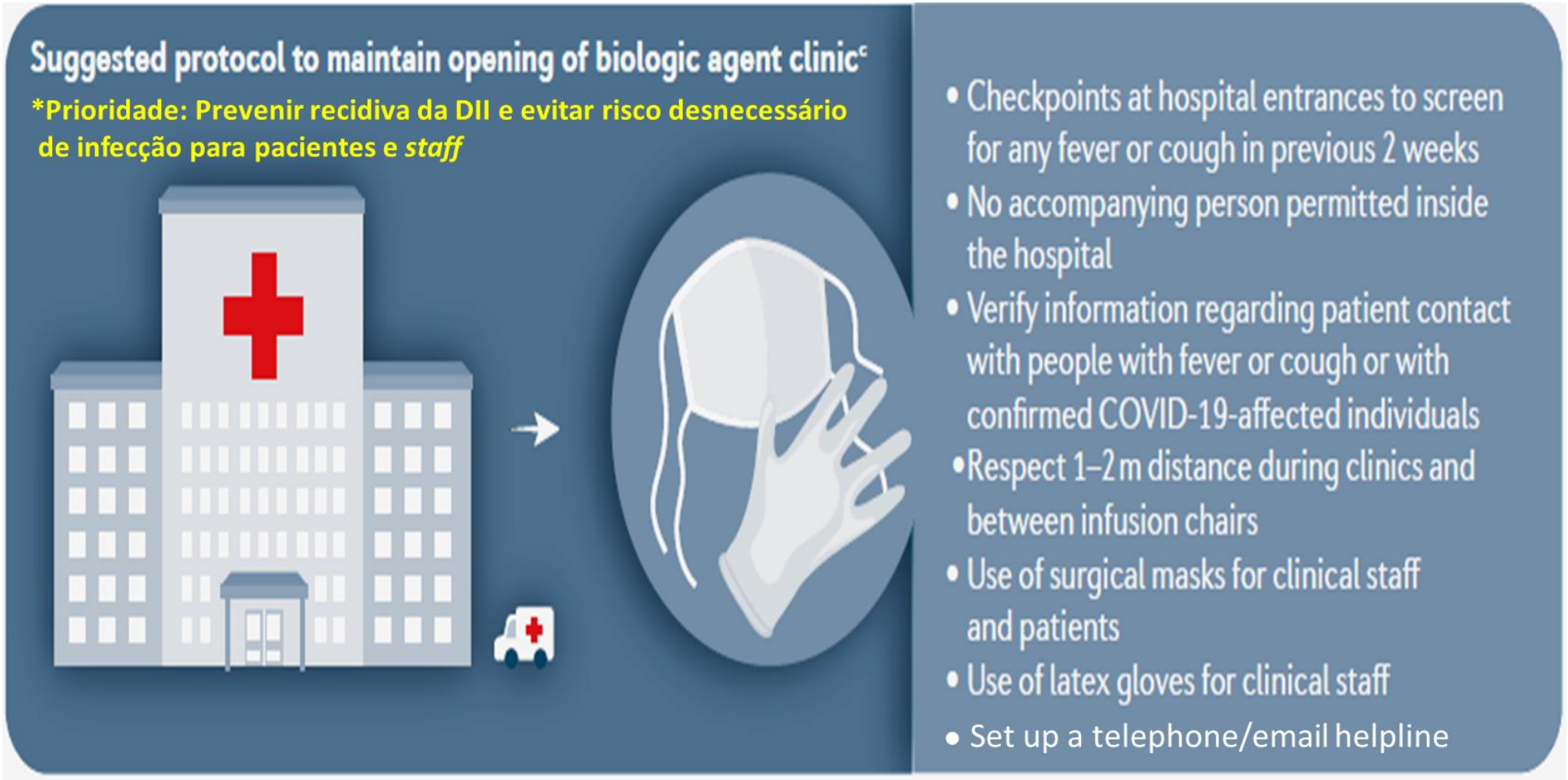
1. Follow current advice on social distancing / self isolation
2. Quit smoking as it increases the risk and severity of SARS-CoV-2 infection
3. Ensure you have a good supply of medication in case you need to self-isolate
4. Wash your hands frequently (20 seconds with soap and warm water)
5. Avoid touching your nose, eyes and mouth
6. The UK Government advises against all non-essential travel overseas
7. If you develop a cough, fever or flu-like symptoms contact **your doctor before coming into the hospital or clinic**
8. Although it does not protect against COVID-19, all patients on immunosuppressants should have an influenza vaccination as seasonal flu is also circulating at the current time
9. Should you develop a fever of 37.8°C or above, we would recommend that you temporarily stop immunosuppressants and biologic medication and contact the IBD helpline for advice
10. Take care of yourself, but also be kind and considerate to others in these difficult times

Recomendações para pacientes com DII relacionada à COVID-19



IOIBD. IOIBD Update on COVID19 for Patients with Crohn's Disease and Ulcerative Colitis. *IOIBD* https://www.ioibd.org/ioibd- update- oncovid19- for- patients- with- crohns- disease- and- ulcerative- colitis/ (2020) Danese S, Cecconi M, Spinelli A. Nat Rev Gastroenterol Hepatol. 2020 Mar 25. doi: 10.1038/s41575-020-0294-8. [Epub ahead of print]

Estratégias sugeridas para serem adotadas em clínicas de administração de biológicos durante a pandemia da COVID-19



Danese S, Cecconi M, Spinelli A. Nat Rev Gastroenterol Hepatol. 2020 Mar 25. doi: 10.1038/s41575-020-0294-8. [Epub ahead of print]

Princípios gerais para o tratamento das DIIs na era da COVID-19

- Os pacientes com DII, usando ou não IS, não parecem apresentar risco aumentado da infecção pelo SARS-Cov2; entretanto, pode haver risco extra de complicações pelo vírus se eles são infectados e estão em uso de IS

- A continuidade do tratamento com imunomoduladores/biológicos é recomendada porque pode evitar recorrências ou complicações da doença e a consequente necessidade de visitas a clínicas ou mesmo hospitalizações, o que tornaria o paciente mais exposto ao coronavírus

- *Flares* de DII devem ser prontamente tratados para evitar hospitalizações e complicações que podem necessitar de cirurgia

- Em pacientes que irão iniciar a terapia biológica, a via subcutânea pode ser preferível nesta ocasião para evitar visitas à clínicas ou hospitais.

- Em caso da ocorrência de sintomas/sinais sugestivos da COVID-19, o paciente deve comunicar imediatamente com seu médico. Neste contexto, recomenda-se suspender a terapia IS ou biológica até que haja resolução da infecção (em 3-4 semanas).

Mao R et al. Lancet Gastroenterol Hepatol, Mar11; doi: 10.1016/S2468-1253(20)30076-5. [Epub ahead of print]
Zhu LR, Mao R, Fiorino G. 2nd Interview COVID-19 ECCO Taskforce, published March 20, 2020
Bass MH, Hachem CY, Greenwald DA. ACG. Updated March 23, 2020.
Monteleone G, Ardizzone S. J Crohns Colitis. 2020 Mar 26. doi: 10.1093/ecco-jcc/jjaa061

Principais recomendações para tratamento e procedimentos endoscópicos em pacientes com DII durante a pandemia da COVID-19, baseado em opinião de experts

	QUEM ESTIVER EM USO	QUEM NÃO ESTIVER EM USO
Mesalazina/Sulfassalazina	Pode ser mantida; Se necessário pode aumentar a dose.	Pode ser iniciada se necessário.
Azatioprina/Metotrexate	Pode ser mantida; Evitar aumentar a dose.	Evitar iniciar.
Corticosteroides	Tentar reduzir gradualmente a dose, se em uso de doses elevadas.	Evitar iniciar; Em caso de *flare*, pode ser usado por um curto período.
Terapia anti-TNF (Infliximabe, Adalimumabe, Certolizumabe pegol)	Pode ser mantido; Considerar aumentar o intervalo entre as doses se houver remissão profunda há mais de 1 ano.	Se atividade moderada a grave, pode ser iniciado em monoterapia. Os demais casos, postergar o início se possível.
Comboterapia (anti-TNF + imunossupressor)	Suspender o imunossupressor se possível.	Evitar iniciar.

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Principais recomendações para tratamento e procedimentos endoscópicos em pacientes com DII durante a pandemia da COVID-19, baseado em opinião de experts

	QUEM ESTIVER EM USO	QUEM NÃO ESTIVER EM USO
Vedolizumabe	Pode ser mantido; Considerar aumentar o intervalo entre as doses se houver remissão profunda há mais de 1 ano.	Se atividade moderada a grave, pode ser iniciado em monoterapia. Os demais casos, postergar o início se possível.
Ustequinumabe	Pode ser mantido; Considerar aumentar o intervalo entre as doses se houver remissão profunda há mais de 1 ano.	Se atividade moderada a grave, pode ser iniciado em monoterapia. Os demais casos, postergar o início se possível.
Tofacitinibe	Pode ser mantido; Evitar aumentar a dose.	Evitar iniciar, exceto se não houver outra alternativa terapêutica.
Terapia nutricional	Pode ser mantida.	Pode ser iniciada.
Cirurgia	Cirurgia de urgência deve ser realizada.	Postergar cirurgia eletiva.
Procedimentos endoscópicos	Procedimento de urgência pode ser realizado, com todas as recomendações de cuidados pertinentes.	Postergar procedimento eletivo.

Mao R et al. Lancet Gastroenterol Hepatol, Mar11; doi: 10.1016/S2468-1253(20)30076-5. [Epub ahead of print]
Zhu LR, Mao R, Fiorino G. 2nd Interview COVID-19 ECCO Taskforce, published March 20, 2020
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DII no idoso e em pacientes com comorbidades em maior risco para COVID-19: Particularidades durante a pandemia da COVID-19

- Estratégias terapêuticas são similares àquelas que adotávamos no mundo pré-COVID-19
- Continuar com a terapia de manutenção: benefício > risco de adquirir a infecção
  - ♦ Evitar "flare" tem 2 potenciais benefícios, além daquele voltado para a própria DII:
    - Pode diminuir o risco de contrair COVID-19
    - Previne o paciente de ter que usar corticosteroides em doses elevadas ou de ir ao hospital, os quais aumentam o risco de adquirir a infecção
- As maiores taxas de fatalidade estão entre pacientes com ≥ 60 anos ou com comorbidades
  - ♦ Para estes grupos de pacientes, além das precauções recomendadas pelo MS, deve-se adotar o distanciamento social mais estrito
  - ♦ Evitar levar estes pacientes ou seus acompanhantes em ambientes hospitalares ou em clínicas- usar telemedicina

Kappelman MD, Ungaro R. 3nd Interview COVID-19 ECCO Taskforce, published March 27, 2020
Monteleone G, Ardizzone S. J Crohns Colitis. 2020 Mar 26. doi: 10.1093/ecco-jcc/jjaa061

Meu paciente com DII testou positivo para SARS-CoV-2 e encontra-se assintomático. Eu optei por suspender temporariamente o IS ou o agente biológico. Quando posso retornar o tratamento?

- ♦ Terapia IS ou agentes biológicos podem ser reiniciados após 14 dias, desde que o paciente não tenha desenvolvido COVID-19

Meu paciente com DII desenvolveu COVID-19. Eu suspendi o IS ou biológico. Quando posso retornar o tratamento?

- ♦ Terapia IS ou agentes biológicos podem ser reiniciados após os sintomas da COVID-19 resolverem (em 3-4 semanas) OU (idealmente)

- ♦ Terapia IS ou agentes biológicos podem ser reiniciados após 2 testes de PCR do swab nasofaríngeo, coletados com≥24 h de intervalo entre eles, serem negativos

IOIBD Update on COVID-19 for Patients with Crohn's Disease and Ulcerative Colitis. Update: 26 March 2020; https://www.ioibd.org/ioibd-update-on-covid19-for-patients-with-crohns-disease-and-ulcerative-colitis/

Mensagens finais

COVID Considerations for Patients with IBD

- If patient is well continue therapy
- Well controlled IBD on an immunosuppressant not a reason to isolate if asymptomatic
- If patient on steroids do what you can to taper or reduce dosing
- If patient flaring then work up as usual for cause and if COVID negative OK to start a biologic
- Would avoid tofacitinib for now

https://webfiles.gi.org/videos/media/covid19.mp4

Obrigado pela atenção!

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Centro de DII – Hospital Universitário/UFJF


Perguntas
e
Respostas

OBRIGADO PELA PRESENÇA DE TODOS!

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