LETTER

Challenges in chronic paediatric disease during the COVID-19 pandemic: diagnosis and management of inflammatory bowel disease in children

Many paediatric healthcare professionals are increasingly concerned about the long-term secondary impact of the COVID-19 pandemic on the care of children and young people (CYP) with chronic conditions. Those of us working in paediatric gastroenterology now lack the ability to provide the same level of diagnostic care and ongoing management to our patients, particularly the large number with inflammatory bowel disease (IBD). With all elective endoscopy cancelled, difficulty in obtaining day-case infusions and telemedicine becoming the norm, many professionals are justifiably uncomfortable. There is little known about the impact of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) on those CYP with IBD, or on patients with systemic immunosuppression, although the small amount of data derived thus far indicates mild disease in those <18 years.1, 2 Whilst the pressures for paediatric services are different to adult networks, and to date we have not seen a surge in COVID-19 patients, we face the same anxieties in diagnosing and treating IBD patients without diagnostic endoscopy.1

In the new and changed environment the main aim is to avoid harm, whilst still providing adequate treatment. In Southampton, since the cancellation of elective endoscopy, we have diagnosed 10 CYP with ‘presumed’ IBD, using a combination of blood results, ultrasound imaging, faecal calprotectin and multidisciplinary discussion and started them on treatment including exclusive enteral nutrition (EEN) and corticosteroids. Anecdotally this is now occurring in almost all sites around the UK. Starting systemic immunosuppression in those without a confirmed endoscopic or histological diagnosis is extremely challenging and requires a careful risk benefit discussion. The potential risk of SARS-CoV-2 infection in patients on high dose corticosteroids must be considered in the treatment choices for patients.1 In Crohn’s disease, CYP patients have long been started on EEN as a first-line induction therapy. This strategy now appears to offer further benefits; not exposing patients to systemic immunosuppression while offering the potential of buying 4–8 weeks prior to consideration of immunosuppression or biologic therapy.

The risks of stopping treatment in CYP is considerable. The Chinese Society of Gastroenterology guidelines instructed clinicians to stop IBD immunosuppressant maintenance therapy during the initial COVID-19 outbreak. This guideline is polar opposite to recommendations from the UK, where the risk of disease flare is considered to be greater than that of infection with SARS-CoV-2.3 Interestingly, recent survey data from the ESPGHAN PORTO group reports monoclonal treatment was delayed in 79 children in China and South Korea, with 22% having relapse.4

We will be living with the direct, and indirect, effects of the SARS-CoV-2 virus for some time. The limited publications to date do not suggest an increased risk of COVID-19 in those with paediatric inflammatory bowel disease, however these are extremely preliminary and must be interpreted with caution.2 These problems in IBD will be echoed in many other chronic medical disorders of childhood where there is potential for secondary morbidity to exceed the primary morbidity from COVID-19. Highlighting these issues is highly relevant. Timely resourcing, consideration and action in the next phase of the pandemic response will minimise long-term harm to vulnerable CYP.

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