Fogging IBD Management: An Unusual Case of IBD Flare-up During the COVID-19 Outbreak

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To the Editors,

We have read with interest the article by Occhipinti and Pastorelli, with particular reference to the management of inflammatory bowel diseases (IBD) relapse during the COVID-19 outbreak.[1] Diagnostic challenges may arise in the presence of symptoms that overlap between active IBD and COVID-19, and concerns about the use of immunosuppressive drugs, mainly corticosteroids, which potentially lead to an increased risk for infections.[2] Lombardy, in northern Italy where our clinic is located, has been severely hit by COVID-19 since February 2020. We hereby report on a representative case of how COVID-19 has redefined priorities and changed our clinical approach to active IBD patients.

In April 2020, a 29-year-old man with a 1-year history of ulcerative colitis (UC) on maintenance with mesalamine was admitted to our clinic with a 2-week history of fever up to 38.5°C, bloody diarrhea, dry cough, and ageusia. Physical examination revealed tachycardia. Blood tests showed neutrophilia and increased C-reactive protein. Two consecutive nasopharyngeal plus one rectal swabs for SARS-CoV-2 tested negative. A contrast-enhanced chest-abdomen-pelvis CT scan revealed no signs of pneumonia but a widely thickened and hyper-enhancing colonic wall (Fig. 1A). Abdominal imaging and gastrointestinal symptoms were consistent with IBD relapse. However, the persistence of fever, cough, and ageusia made it necessary to definitely rule COVID-19 out. After a multidisciplinary discussion, a bronchoalveolar lavage was performed, which eventually tested negative for SARS-CoV-2. Ileocolonoscopy, performed 2 days later, showed segmental cobblestone appearance and scattered aphthous erosions in the right and left colon (Fig. 1B), as opposed to a relative sparing of the rectum (Fig. 1C). Histological examination was consistent with IBD colitis. A diagnosis of severe flare of IBD-unclassified was made, and corticosteroid therapy was initiated, with the subsequent rapid improvement of both gastrointestinal and respiratory symptoms.

Gastrointestinal manifestations have occurred in about half of COVID-19 patients and may precede respiratory symptoms.[3] Therefore, the differential diagnosis between IBD relapse and SARS-CoV-2 infection has possibly proved challenging at the peak of the COVID-19 outbreak. Currently, ruling out COVD-19 has become a priority for both clinical and public health reasons, and the timing of endoscopic examination, as well as treatment decisions, closely depend on the COVID-19 diagnostic results.[4] Ageusia and anosmia have been reported in about one third of COVID-19 patients,[5] whereas they have rarely been observed in IBD patients. Ageusia, as reported by our patient, contributed to increase the suspicion of SARS-CoV-2 infection and made the differential diagnosis trickier.

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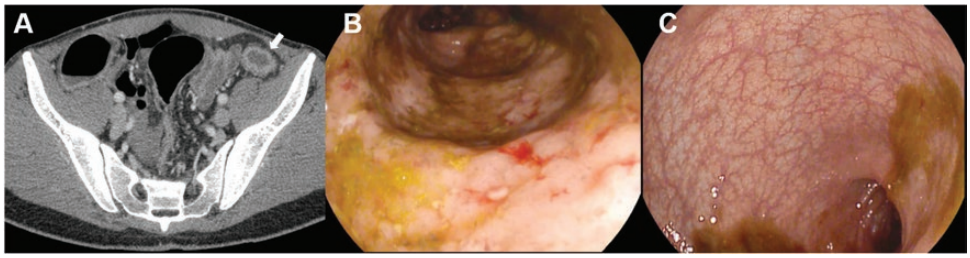

FIGURE 1. A, CT scan image showing a cross-sectioned descending colon (white arrow) with wall thickening and mucosal hyperenhancement. B, Left-colon image showing mucosal oedema, cobblestone appearance, and aphthous erosions. C, Rectum image showing an endoscopically normal appearance of the mucosa.