cal attention or could have tried different attempts to solve the impactation, such as drinking carbonated bevarages. Spending more time at home and having more time to eat could be another reason to explain the reduction of impactions. Probably related to the former reasons the percentage decrease of UGE due to impaction of foreign bodies was higher than the observed for GI bleeding.

On the other hand, decreased demand from hospitalization rooms may be another explanation for the reduction in the number of UGE performed. In fact, during the COVID-19 period, non-urgent surgical activity was lower, therefore the number of post-surgical complications decreased (Table 2).

There is no obvious explanation for the decrease in the treatment of colonic obstruction or volvulus, but it could be related to the probable increase of acute abdomen and peritonitis.

According to our experience, the decrease in UGE was lower on weekdays than on weekends. Perhaps the endoscopy was delayed until the next morning trying to avoid coronavirus infections.

In summary, during the Covid period, an important decrease in the emergency endoscopy and surgery was observed.

Contributions

IG and LB developed the study concept and design and drafted the manuscript. LB, PA, IG, ST, MM, JMN acquired the clinical data, designed and analyzed the database and interpreted the data. LB and IG carried out the statistical analysis of data and contributed to the interpretation of data. All had the opportunity to revise the manuscript.

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Ustekinumab for prevention of postoperative recurrence: Our clinical experience☆

El ustekinumab en la profilaxis de la recurrencia posquirúrgica: nuestra experiencia clínica

In Crohn's disease (CD), postoperative recurrence (POR) is common. Without treatment, 65–90% of patients who have had surgery experience endoscopic recurrence within the first year, and 80–100% at three years.[1]

According to the current European Crohn's and Colitis Organisation (ECCO) guidelines, prophylactic treatment for POR is recommended after surgery in patients with at least one risk factor. The drugs of choice are thiopurines, or anti-TNFs, with salicylates and antibiotics being useful alternatives in isolated cases.[2,3]

We found no evidence or reports in the literature on the use of ustekinumab (USTK) as preventive treatment for POR. We present here our clinical experience on the use of USTK for POR prophylaxis in CD.

Material and methods

We describe a series of three patients treated with ustekinumab as prophylaxis for POR, all with long-standing CD with a stricturing and/or fistulising pattern, having needed one or more surgical resections, and previous treatment with two anti-TNFs and immunosuppressants as common features.

POR was assessed by: endoscopy, MR-enterography and biomarkers (faecal calprotectin, c-reactive protein, ESR and leucocytes).

Case 1

A 50-year-old female smoker, with CD A2L1B2 diagnosed 12 years previously. She required her first surgical resection two years after diagnosis. Six years after surgery, she developed endoscopic and clinical POR, receiving treatment with azathioprine and infliximab, and later with adalimumab, but with subsequent loss of response. Eight years after diagnosis, she developed long symptomatic fibrotic strictures and a new surgical resection was performed, after which the decision was made for prophylactic treatment with ustekinumab 260 mg IV induction plus 90 mg SC every eight weeks as maintenance.

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Case 2

A 60-year-old male patient with Crohn's disease f A2B3L1, with two ileal resections. He received treatment with methotrexate, azathioprine and infliximab prior to his first resection, and adalimumab dose intensification prior to the second. In view of the patient's previous history, it was decided to start treatment with USTK to prevent POR, with induction doses of 260 mg IV and 290 mg SC as maintenance.

Case 3

A 64-year-old male patient with Crohn's disease A2B3L1, operated on three times for fistulising disease and intra-abdominal collections, having received prior treatment with azathioprine, infliximab and adalimumab. After the last resection, it was decided to start prophylactic treatment with ustekinumab 260 mg IV and 90 mg SC every eight weeks, with a good response to date.

Results

In our series, 100% of the patients (3/3) had a good clinical, analytical and endoscopic response in the first year of treatment with ustekinumab as prophylaxis for POR. There have been no treatment-related adverse effects or withdrawals due to poor tolerance.

Discussion

In 2016, the EMA approved the use of ustekinumab in CD. It is a monoclonal antibody which inhibits the activity of human cytokines IL-12 and IL-23, slowing down the inflammatory cascade responsible for the disease.

To date, there are no clinical trials or case series assessing the use of ustekinumab as a preventive treatment for POR in patients undergoing surgical resections, but it does seem reasonable to use new therapeutic targets in patients with risk factors in whom clinical experience has shown the failure of anti-TNFs and thiopurines. In our series of cases, the patients received treatment with ustekinumab as prophylaxis for POR, all showing normal biochemical parameters and clinical and endoscopic remission after one year of treatment.

Although there is a lack of solid scientific evidence to promote its generalised use, ustekinumab is a promising therapeutic option, particularly in patients with CD and a high risk of POR.

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Conflicts of interest

The authors declare that they have no conflicts of interest.

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