

Exploring Vaccination in Patients With Inflammatory Bowel Disease



Vaccination has become a polarizing issue in the United States, as Dr Francis A. Farraye notes in this month's issue of *Gastroenterology & Hepatology*. Two of our articles this month explore vaccination in patients with inflammatory bowel disease (IBD). In our Advances in IBD column, Dr Farraye provides a comprehensive overview of recommendations for vaccination, along with other health care maintenance, in this patient population. He outlines the latest recommendations for vaccines for influenza, respiratory syncytial virus, COVID-19, and other diseases for patients who have IBD, and shares what he does in his own practice. He also discusses screening for cancers, osteoporosis, and mental health in the setting of IBD. Other topics of discussion include the effect of immunosuppression on vaccine efficacy, the role of the gastroenterologist in promoting health care maintenance and vaccination, and how to try to overcome challenges such as time constraints and reluctant patients.

Our vaccine-related content continues with a review article on COVID-19 vaccination in patients with IBD. Dr Trevor L. Schell and Dr Freddy Caldera recall how the COVID-19 pandemic brought up many questions regarding the care of patients with IBD, a population that is often managed with immunosuppressive therapies. The authors review the literature on COVID-19 and IBD, including the incidence and severity of the virus in this patient population. They also examine studies on COVID-19 vaccine safety, humoral immunity, and cell-mediated immunity, as well as data on the real-world effectiveness and uptake of these vaccines. Finally, the authors review the most recent recommendations for COVID-19 vaccination in patients with IBD.

Another review article this month spotlights the latest concepts of iron overload disorders. Dr Aalam Sohal and Dr Kris V. Kowdley review the metabolism of iron as well as genetic iron overload disorders such as *HFE* and non-*HFE* hemochromatosis. The authors also examine the diagnosis of hereditary hemochromatosis, which previously focused on liver biopsy but is increasingly moving toward other measures such as genetic testing and imaging techniques. Also covered are disease staging and

noninvasive assessment of fibrosis, along with a number of different treatment strategies, including phlebotomy, erythrocytapheresis, iron chelation therapy, liver transplantation, and novel therapies in development.

Our third review article this month highlights the evolving diagnosis of esophagogastric junction outflow obstruction (EGJOO). Dr Kristle Lee Lynch, Dr Joan Chen, Dr Anand Jain, and Dr Rena Yadlapati recount the definition of EGJOO according to the Chicago Classification version 3.0 and how the definition has changed in the fourth version. The authors also review the literature on other manometric considerations as well as timed barium esophagram and the functional lumen imaging probe. Finally, the authors cover EGJOO management, ranging from pharmacologic therapies and esophageal dilations to surgical myotomies.

Finally, our issue includes 2 columns involving hepatology. The drug sofosbuvir was approved by the US Food and Drug Administration with ribavirin or pegylated interferon plus ribavirin just over 10 years ago for the management of patients with hepatitis C virus (HCV) infection. In our Advances in Hepatology column, Dr Ira M. Jacobson discusses how sofosbuvir changed HCV treatment, its use with agents such as ledipasvir and velpatasvir, and its safety in patients with chronic kidney disease and other groups, among other issues. In our HCC in Focus column, Dr Robin Kate Kelley reviews data supporting the use of durvalumab plus tremelimumab as first-line therapy in patients who have hepatocellular carcinoma. She examines the combination's key efficacy data, dosing regimen, and most common toxicities, and discusses its current position in the medical armamentarium for hepatocellular carcinoma, along with related topics.

I hope that this issue provides valuable insights for your clinical practice.

Sincerely,

A handwritten signature in black ink that reads "Gary R. Lichtenstein". The signature is fluid and cursive, with the first name being the most prominent.

Gary R. Lichtenstein, MD, AGAF, FACP, FACG