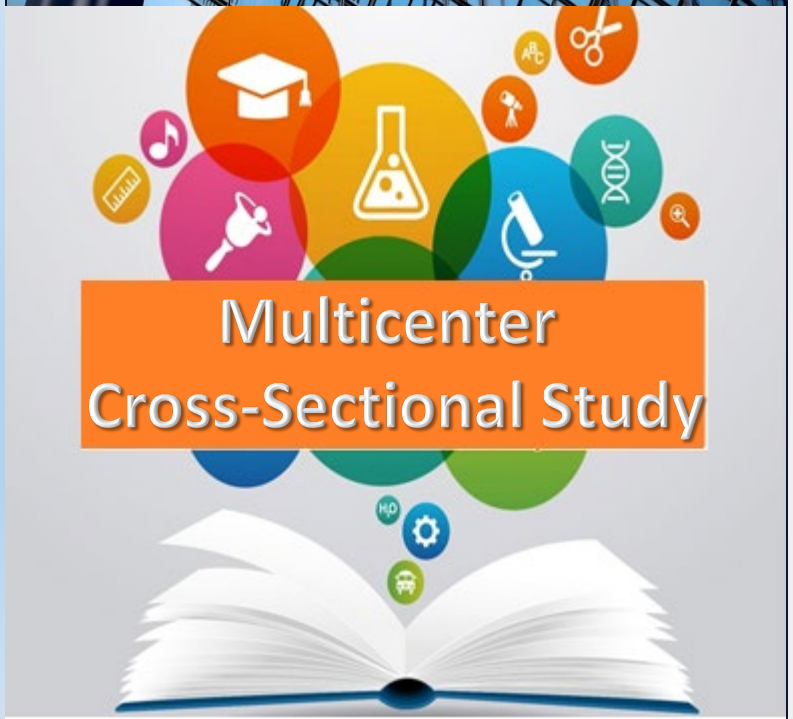
Toward Evidence Based Practice

Prevalence of Oppo Infections in Syrian IBD Patients

MD.Hussam Aldeen Alshiekh



- ♂ ٣٧y إسهالات مزمنة ٣ – ٤ \ يوم ، آلام بطنية ماغصة ، منذ حوالي ٣ سنوات
- اشتدت هذه الهجمات وأصبحت الأعراض مستمرة خلال الـ ٦ أشهر الأخيرة
- فحص سريري ، إيكوبطن ، مخبريات ، تنظير هضمي سفلي مع خزعات ← داء كرون
- كورتيكوستيروئيد + إيميوران ← تحسن ، ولكن مع تخفيض الستيروئيد عاودت الأعراض
- ← مشفى حكومي لتقييم الخطة العلاجية ← علاج بيولوجي ← استجابة جيدة مع هجوع سريري ومخبري
- بعد شهرين من بدء العلاج : إسهالات أشد من السابق ، مدماة ، ألم بطني ، حمى ، اضطراب علامات حيوية
- إعادة تقييم : سريري ، مخبري ، تنظيري ، وأخذ الخزعات المناسبة ← **Acute Severe CMV Colitis**

frontiers | Frontiers in Public Health

TYPE Original Research
PUBLISHED 01 June 2023
DOI 10.3389/fpubh.2023.1174638

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RECEIVED 26 February 2023
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Seroprevalence and trends of hepatitis B virus, hepatitis C virus and human immunodeficiency virus in Syrian blood donors at Damascus University Blood Center between 2004 and 2021

Alia Alassad[1], Mhd Jawad Al Rahwanji[2,3], Amal Yousfan[4,5], Sally Al Moualem[6], Arwa Farhat[6] and Lama A. Youssef[7]*

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Results: Of the total 307,774 donors (82.27% males, median age 27 years), 5,929 (1.93%) had serological evidence of at least one TTVI, and 26 (0.0085%) had multiple infections. The lowest prevalence (1.09%) was detected in donors aged 18–25 years old, and a higher prevalence (2.05%) was evident in males in comparison with females (1.38%). The seroprevalence of HBV, HCV, and HIV was 1.18, 0.52, and 0.23%, respectively. Trend analyses revealed a significant regression in HBV and HIV prevalence from 2011 to 2021. HBV seropositivity depicted a temporal decline by ~80%, from 0.79% in 2011 to 0.16% in 2021 in those born in 1993 and thereafter.

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Review

Hepatitis B and C in the Syrian Arab Republic: a review

H. Bashour [1] and G. Muhjazi [2]

الالتهاب الكبدي الفيروسي B وC في الجمهورية العربية السورية: مراجعة أدبية

هيام بشور، غادة محجازي

الخلاصة: يراجع هذا البحث وبائيات الالتهاب الكبدي الفيروسي B وC ومحدّدات الإصابة بهما في الجمهورية العربية السورية، فضلاً عن معالجتهما والوقاية منهما. فقد أجري بحث منهجي في مواقع Medline، وPubMed وIndex Medicus الخاص بإقليم شرق المتوسط، بالإضافة إلى مراجعة الأدب الرمادي ومجموعات البيانات ذات الصلة في الجمهورية العربية السورية. ولوحظ أن كلا المرضين مُعديين متوطنان على المستوى الوطني بمستويات منخفضة إلى أقل من متوسطة. غير أن وجود فوارق جغرافية لافتة وارتفاع الانتشار بين الفئات عالية الخطورة كان ملحوظاً. وبسبب محدودية البيانات لا بد من إجراء مزيد من البحوث، ومن وضع استراتيجية وطنية لمكافحة الالتهاب الكبدي الفيروسي B وC في الجمهورية العربية السورية، خصوصاً أثناء النزاع الحالي.

ABSTRACT This paper reviews the epidemiology and determinants of hepatitis B and C in the Syrian Arab Republic as well as their treatment and prevention. A systematic search of Medline, PubMed and Index Medicus for the Eastern Mediterranean Region was carried out in addition to a review of grey literature and relevant datasets in the Syrian Arab Republic. Low to low–intermediate levels of endemicity of both infections were noted at the national level. However, striking geographic differences and high prevalence among high-risk groups were noticeable. As a result of data limitations, further research is needed, and a national control strategy to combat hepatitis B and C in the Syrian Arab Republic should be developed, especially during the current conflict.

Hépatites B et C en République arabe syrienne : analyse

RÉSUMÉ La présente étude examine l'épidémiologie et les déterminants des hépatites B et C en République arabe syrienne, ainsi que leur traitement et leur prévention. Une recherche systématique dans Medline, PubMed et dans l'*Index Medicus* de la Région de Méditerranée orientale a été menée, en plus d'un examen de la littérature

Review

Hepatitis B and C in the Syrian Arab Republic: a review

H. Bashour [1] and G. Muhjazi [2]

Epidemiology of hepatitis B and C in the Syrian Arab Republic

Prevalence

In 2004, the Syrian MoH in cooperation with the Central Bureau of Statistics carried out a large serological survey on a random cluster sample with 528 clusters and 3168 individuals (*11*). The seroprevalence of hepatitis C was 2.8% as indicated by HCV antibodies and 5.6% for hepatitis B as indicated by HBV surface antigen (HBsAg). There was a

الالتهاب الكبدي الفيروسي B و

هيام بشور، غادة محجازي

الخلاصة: يراجع هذا البحث وبا
عن معالجتها والوقاية منها. فقا
بالإضافة إلى مراجعة الأدب الرما
متوطنان على المستوى الوطني به
الفئات عالية الخطورة كان ملحوظ
الالتهاب الكبدي الفيروسي B و C

ABSTRACT This paper
Republic as well as their
for the Eastern Mediter
datasets in the Syrian Ara
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B and C in the Syrian Arab
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Hépatites B et C en République arabe syrienne : analyse

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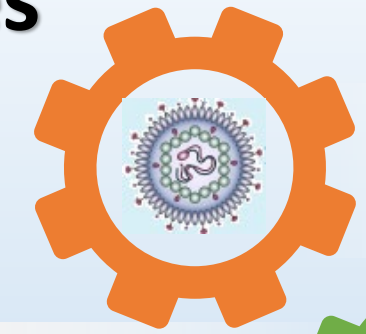
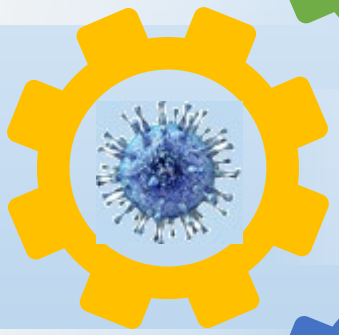
Study Design Outcomes



HBV Prevalence

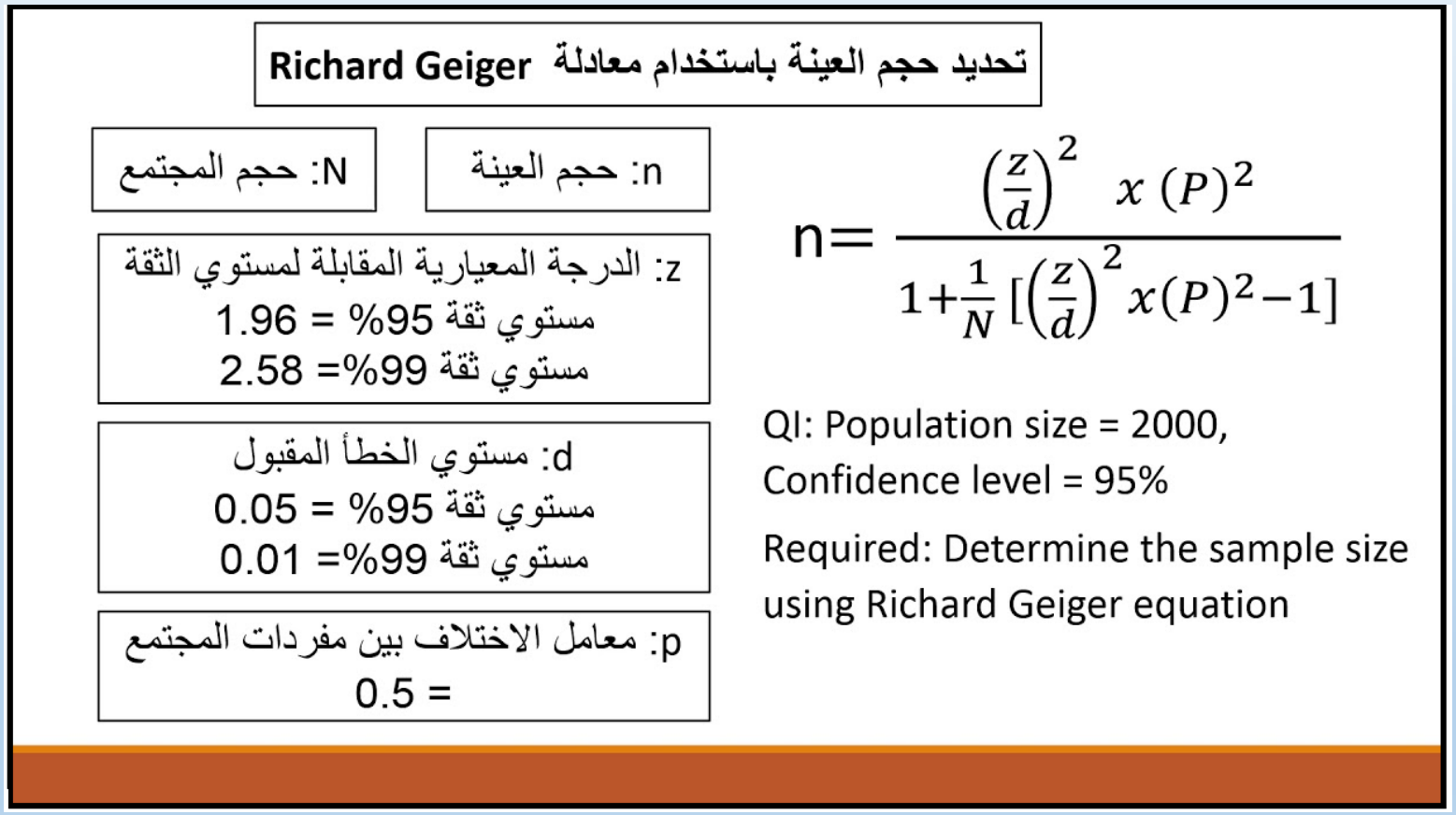
TB Prevalence



CMV Prevalence

HCV Prevalence

Cost Effectiveness Analysis



CMV (90%) → 139

HBV (5,6%) → 82

→

HCV (2,8%) → 42

Sample size = 155

Inclusion And Exclusion

- Confirmed diagnosis of IBD based on:
  - established clinical, endoscopic, and/or histological criteria
- Received treatment at the IBD Unit
- At least, Tow years follow up

IBD & Opportunistic infections

الاسم سنة الميلاد الجنس ذكر ☐ انثى ☐ المحافظة مدخن ☐

IBD ☐ CD ☐ UC HBV Diagnosis date _____ Bio treatment date _____

TST ☐ Not Studied ☐ Negative ☐ Positive IGRA ☐ Not Studied ☐ Negative ☐ Positive

هل حدث تفعيل للسل ☐ علاج في حال حدوث تفعيل للسل

Anti-HCV ☐ Not Studied ☐ Negative ☐ Positive HCV-PCR ☐ Not Studied ☐ Negative ☐ Positive Treatment _____ _____

Anti-CMV ☐ Not Studied ☐ Negative ☐ Positive CMV-Colitis ☐ Not Studied ☐ Negative ☐ Positive Treatment _____

HBsAg ☐ Not Studied ☐ Negative ☐ Positive Anti-HBc ☐ Not Studied ☐ Negative ☐ Positive

Anti-HBs ☐ Not Studied ☐ Negative ☐ Positive HBeAg ☐ Not Studied ☐ Negative ☐ Positive

HBV-PCR ☐ Not Studied ☐ Negative ☐ Positive Anti-HBe _____ Treatment _____

HBVr ☐ Acute HBV _____ Date ☐ ALF _____ Date _____ Date

CD classification
Age ☐ L4:Isolated upper disease ☐ L3:Ileocolonic ☐ L2:colonic ☐ L1: Ileal
☐ p perianal disease ☐ B3 penetrating ☐ B2 stricturing ☐ B1 non-stricturing, non-penetrating

UC classification
☐ Extensive UC ☐ Left sided UC ☐ E1Ulcerative proctitis
☐ S3 ☐ S2 ☐ S1 ☐ S0

العلاجات
☐ Steroide _____ Date ☐ AZA _____ Date
☐ IFX _____ Date ☐ ADA _____ Date ☐ GOLI _____ Date
☐ UST _____ Date

التحاليل المخبرية
ALT _____ AST _____ HGB _____ BIL _____ INR _____ Cr _____

قم باضافة معلومات تفعيل الخمج الانتهازي و تسييره و نتائجه

استطباب البيولوجي ☐ مقاومة على الستيروئيدات ☐ معتمد على الستيروئيدات ☐ داء حول الشرج ☐ فقدان الاستجابة على معدلات المناعة

S0 Asymptomatic
S1 Mild UC passage of four or fewer stools/day (with or without blood), absence of any systemic illness, and normal inflammatory markers (ESR)
S2 Moderate UC passage of more than four stools per day but with minimal signs of systemic toxicity
S3 Severe UC passage of at least six bloody stools daily, pulse rate of at least 90 beats per minute, temperature of at least 37.5°C, haemoglobin of less than 10.5 g/100 ml, and ESR of at least 30 mm/h

IBD & Opportunistic infections

الاسم سنة الميلاد الجنس ذكر انثى المحافظة منغن

IBD CD UC

HBV Diagnosis date Bio treatment date

IGRA Not Studied Negative Positive

TST Not Studied Negative Positive

هل حدث تفعيل للسل علاج في حال حدوث تفعيل للسل

Anti-HCV HCV-PCR Not Studied Negative Positive Treatment Date

Anti-CMV CMV-Colitis Not Studied Negative Positive Treatment Date

HBsAg Anti-HBc Not Studied Negative Positive

Anti-HBs HBeAg Not Studied Negative Positive

HBV-PCR Anti-HBe Not Studied Negative Positive Treatment Date

HBVr Acute HBV Date ALF Date

CD classification L4:Isolated upper disease L3:Ileocolonic L2:colonic L1: Ileal

B3 penetrating B2 stricturing B1 non-stricturing, non-penetrating p perianal disease

UC classification Extensive UC Left sided UC Ulcerative proctitis

S3 S2 S1 S0

Age

العلاجات Steroids Date AZA Date

IFX Date ADA Date GOLI Date

UST Date

التحاليل المخبرية

ALT AST HGB BIL INR Cr

قم باضافة معلومات تفعيل الخمج الانتهازي و تصويره و نتائجه

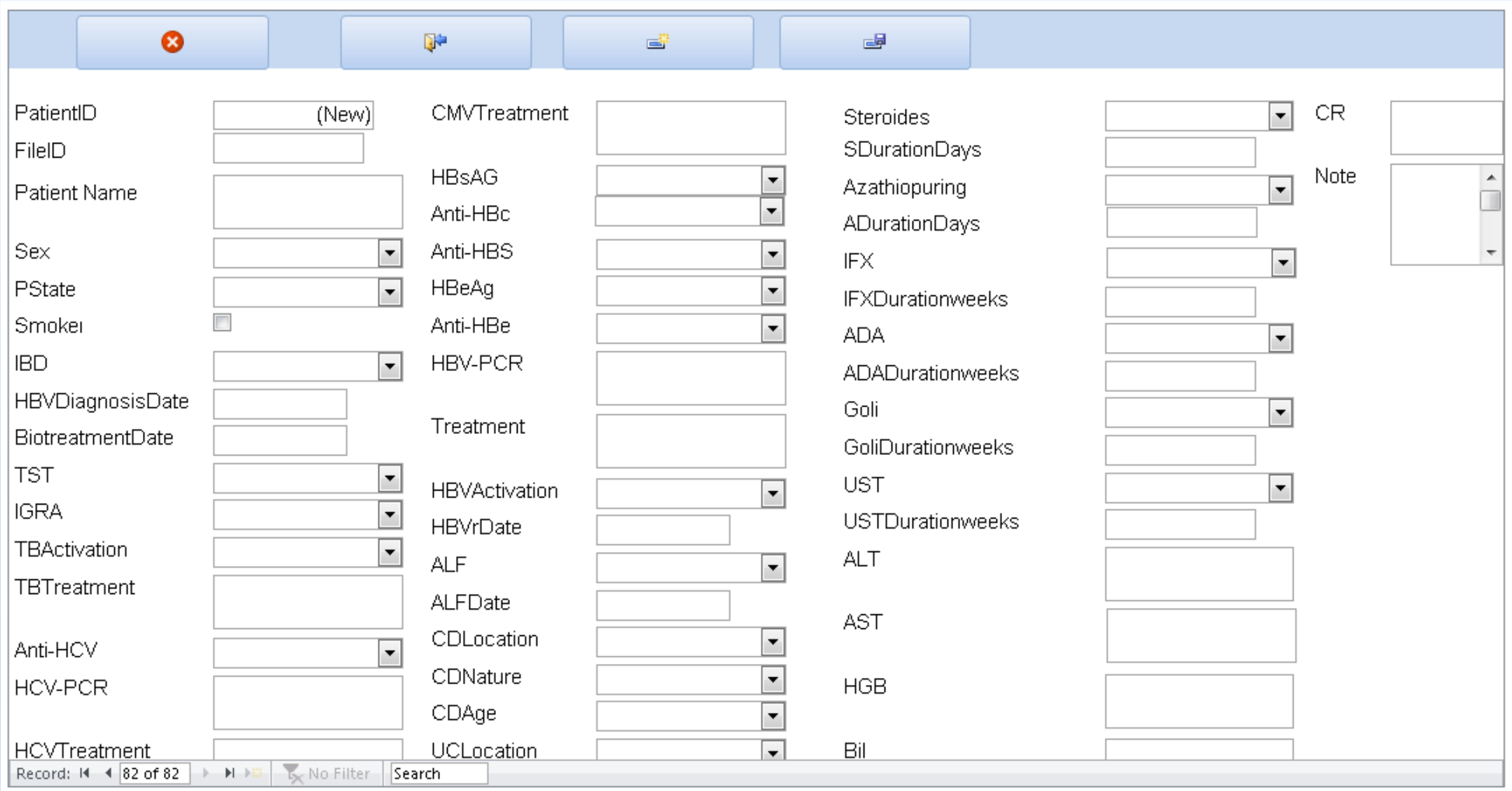
استطباب البيولوجي مضاد على الفيروسيات مضاد على الفيروسيات داء حول الشرج فقدان الاستجابة على معالجات السابقة

S0 Asymptomatic

S1 Mild UC passage of four or fewer stools/day (with or without blood), absence of any systemic illness, and normal inflammatory markers (ESR)

S2 Moderate UC passage of more than four stools per day but with minimal signs of systemic toxicity

S3 Severe UC passage of at least six bloody stools daily, pulse rate of at least 90 beats per minute, temperature of at least 37.5°C, haemoglobin of less than 10.5 g/100 ml, and ESR of at least 30 mm/h


PatientID
(New)
FileID
Patient Name
Sex
PState
Smoker
IBD
HBVDiagnosisDate
BiotreatmentDate
TST
IGRA
TBActivation
TBTreatment
Anti-HCV
HCV-PCR
HCVTreatment
CMVTreatment
HBsAG
Anti-HBc
Anti-HBS
HBeAg
Anti-HBe
HBV-PCR
Treatment
HBVActivation
HBVrDate
ALF
ALFDate
CDLocation
CDNature
CDAge
UCLocation
Steroides
SDurationDays
Azathiopuring
ADurationDays
IFX
IFXDurationweeks
ADA
ADADurationweeks
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ALT
AST
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CR
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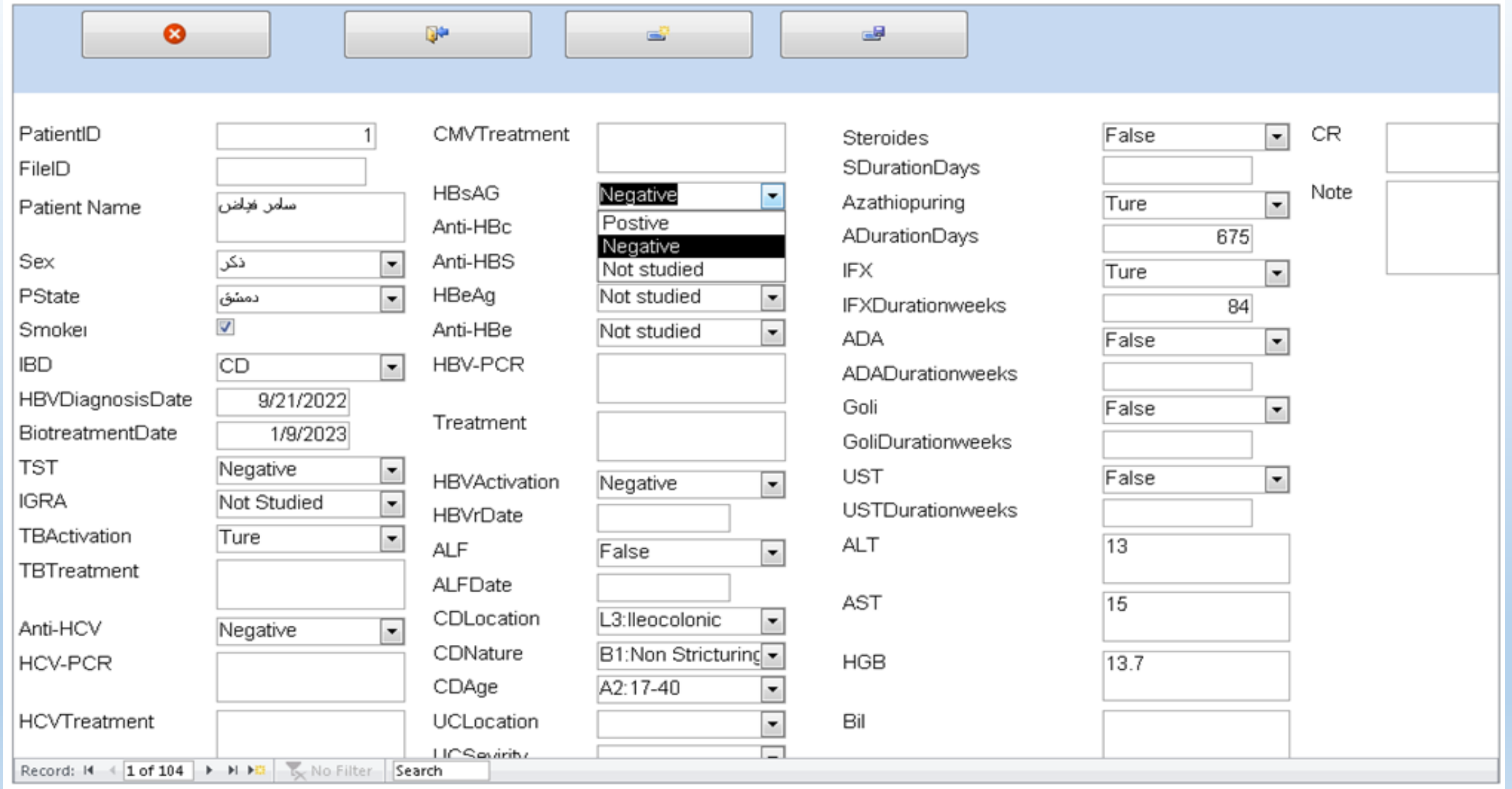

PatientID
1
FileID
Patient Name
سامر فياض
Sex
ذكر
PState
دمشق
Smokeı
IBD
CD
HBVDiagnosisDate
9/21/2022
BiotreatmentDate
1/9/2023
TST
Negative
IGRA
Not Studied
TBActivation
Ture
TBTreatment
Anti-HCV
Negative
HCV-PCR
HCVTreatment
CMVTreatment
HBsAG
Negative
Postive
Negative
Not studied
Anti-HBc
Anti-HBS
HBeAg
Not studied
Anti-HBe
Not studied
HBV-PCR
Treatment
HBVActivation
Negative
HBVrDate
ALF
False
ALFDate
CDLocation
L3:Ileocolonic
CDNature
B1:Non Stricturing
CDAge
A2:17-40
UCLocation
Steroides
False
SDurationDays
Azathiopuring
Ture
ADurationDays
675
IFX
Ture
IFXDurationweeks
84
ADA
False
ADADurationweeks
Goli
False
GoliDurationweeks
UST
False
USTDurationweeks
ALT
13
AST
15
HGB
13.7
Bil
CR
Note
Record:
1 of 104
No Filter
Search

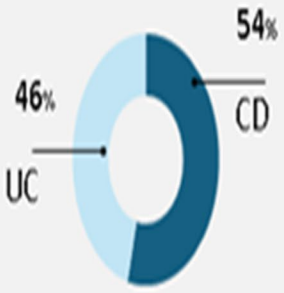
Patients Characteristics

The study evaluated 155 patients consisting of 85 male (55%), 70 female (45%). Among them, 83 patients (54%) were diagnosed with CD, and 72 (46%) with UC, with a median age of 34 years (IQR 24.75-44).

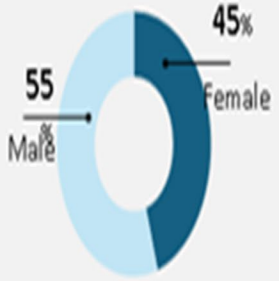
Sample Size

155 IBD Patients

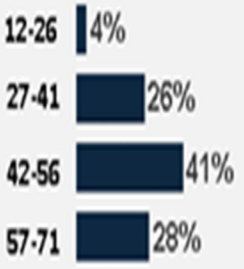
IBD Distribution

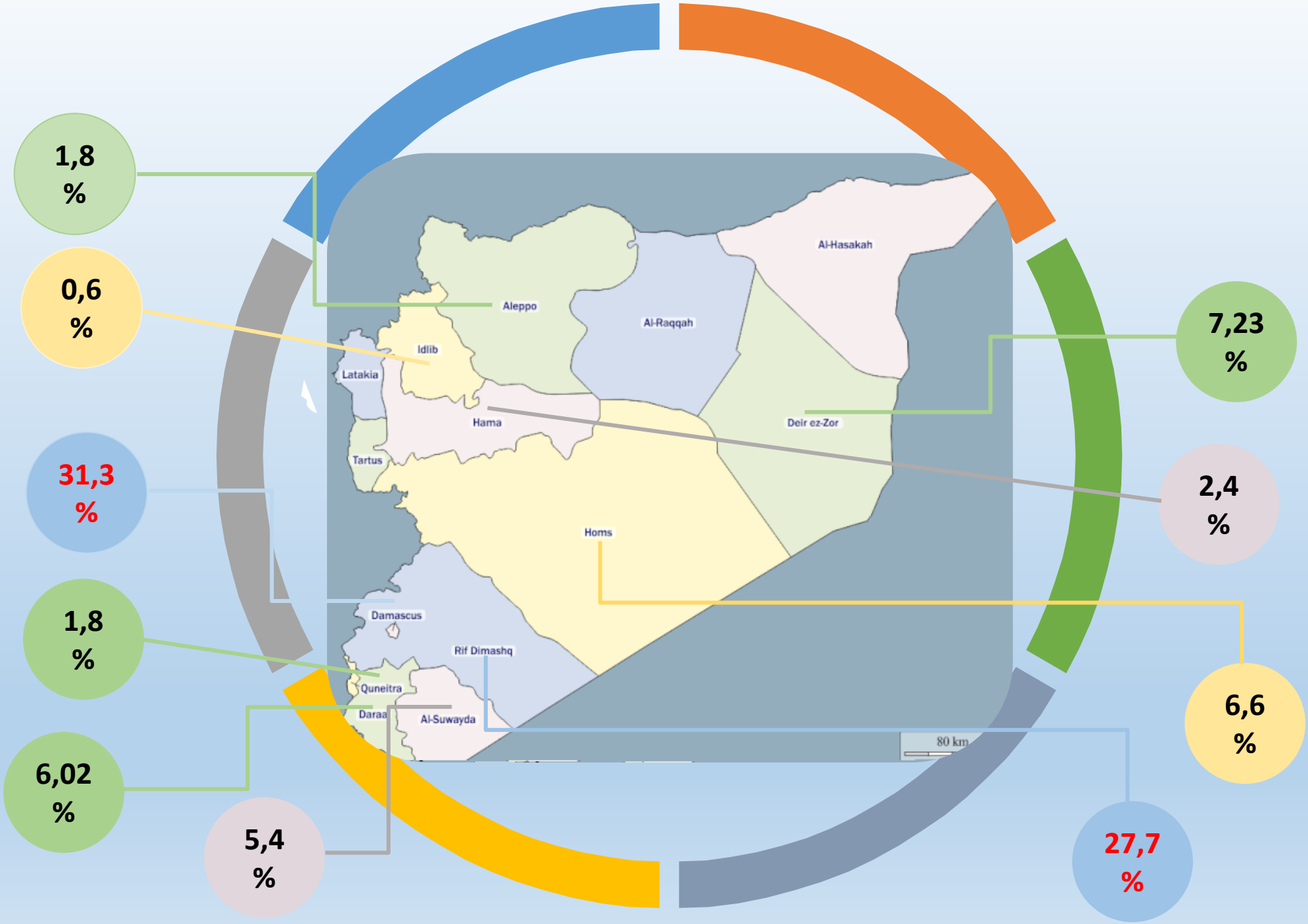


Gender



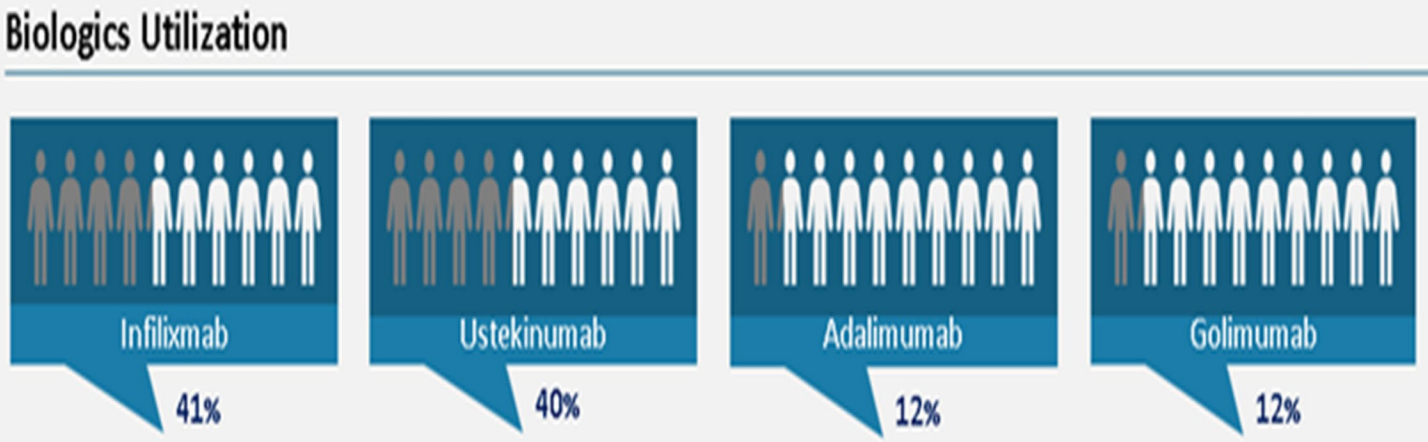
Age



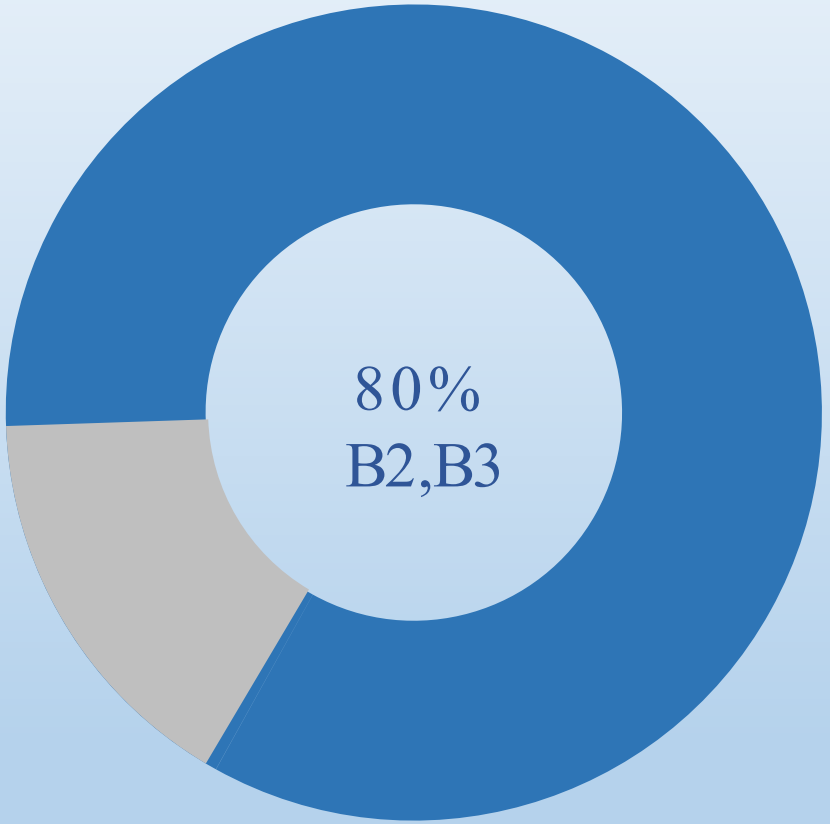

1,8 %
0,6 %
31,3 %
1,8 %
6,02 %
5,4 %
27,7 %
6,6 %
2,4 %
7,23 %
Al-Hasakah
Aleppo
Al-Raqqah
Idlib
Latakia
Hama
Deir ez-Zor
Tartus
Homs
Damascus
Rif Dimashq
Quneitra
Daraa
Al-Suwayda
80 km

Treatment Shares

Infliximab (41%) and Ustekinumab (40%) were the most prescribed biologics, followed by Adalimumab and Golimumab (12% each).

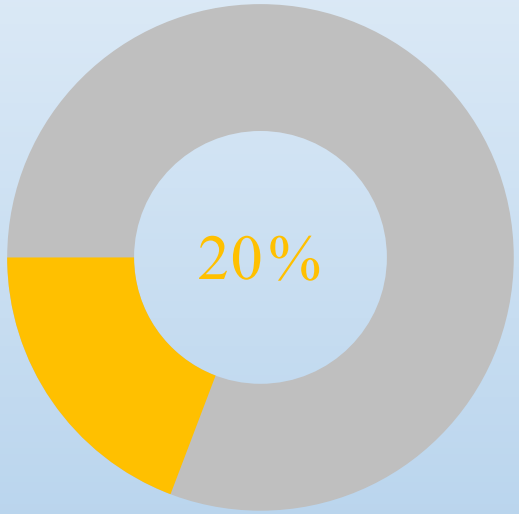


Crohn’s Disease Behavior



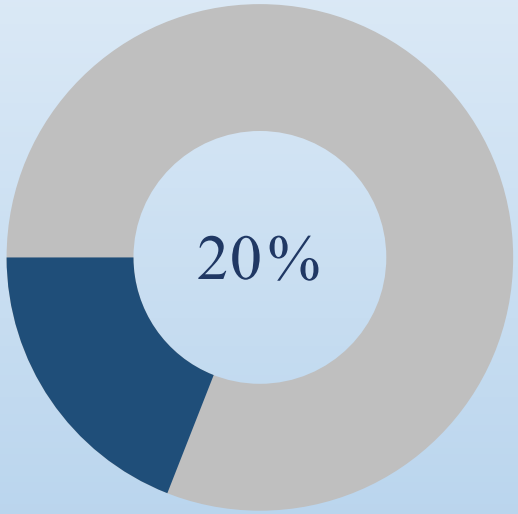
(B2) Stricturing
(B3) Penetrating

Ulcerative Colitis Extent



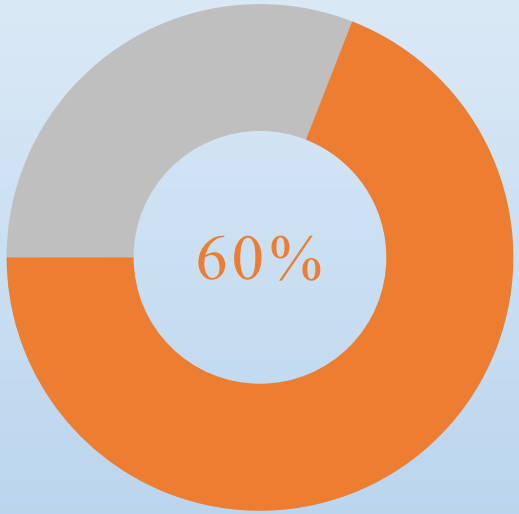
E1

limited to the rectum



E2

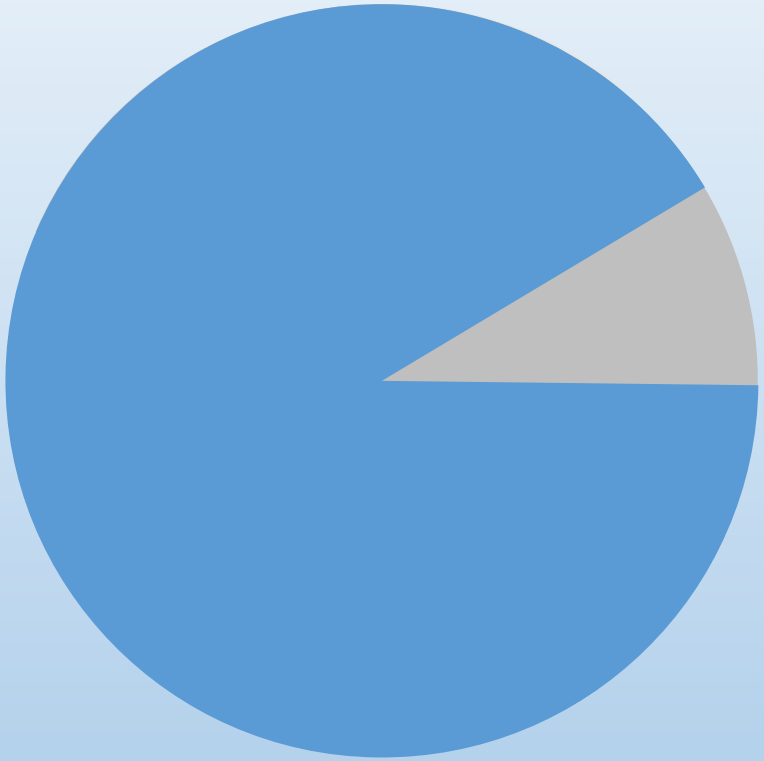
Left-sided UC



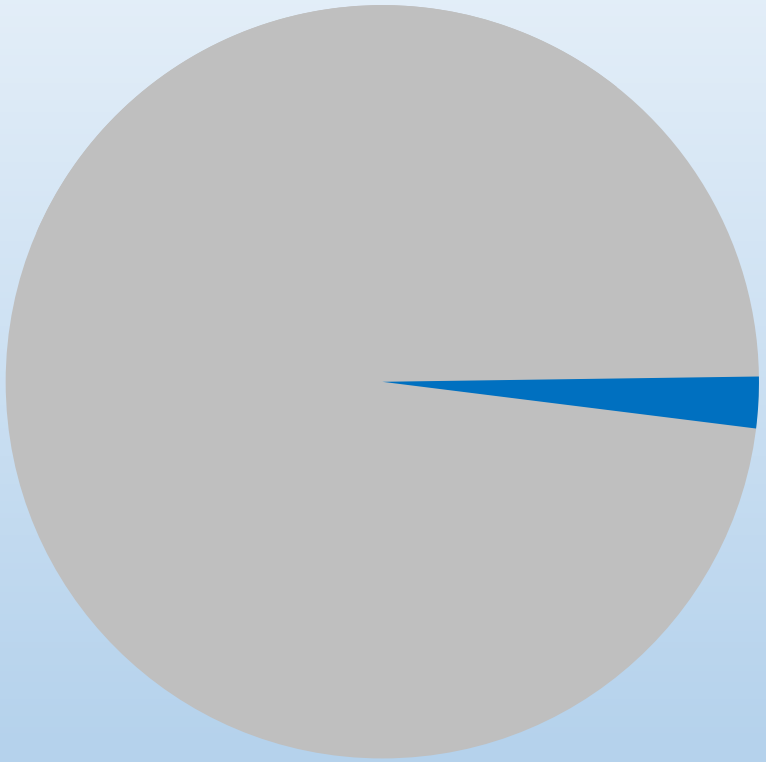
E3

Extensive UC

Cytomegalovirus



Anti CMV IgG
90%



CMV Colitis
1%

Cytomegalovirus

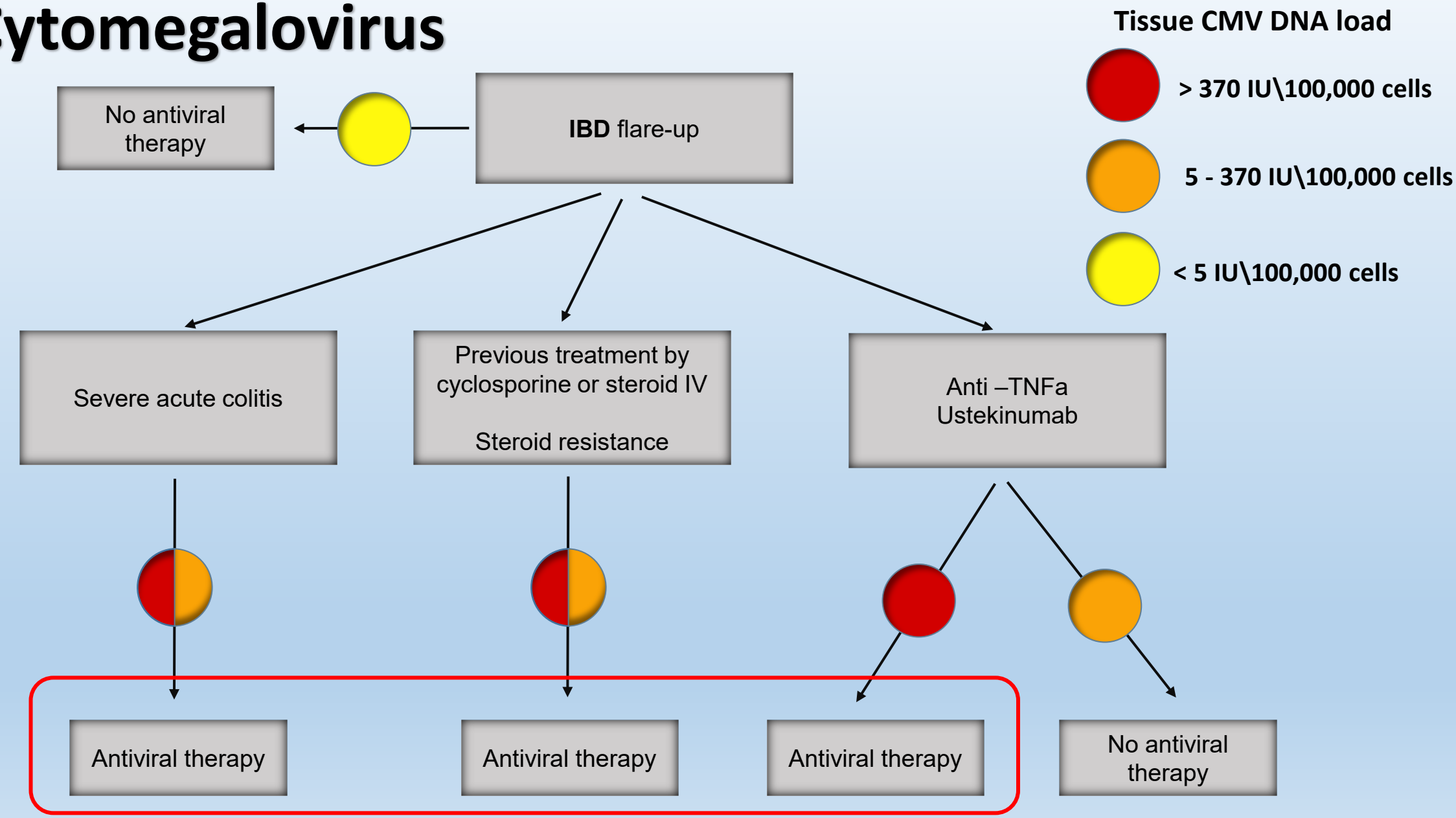
Clinical & Endoscopic Findings

Several Biopsies H&E , IHC Stain

Tissue CMV DNA

More Correct Diagnosis Chance

Cytomegalovirus



Tuberculosis

TST

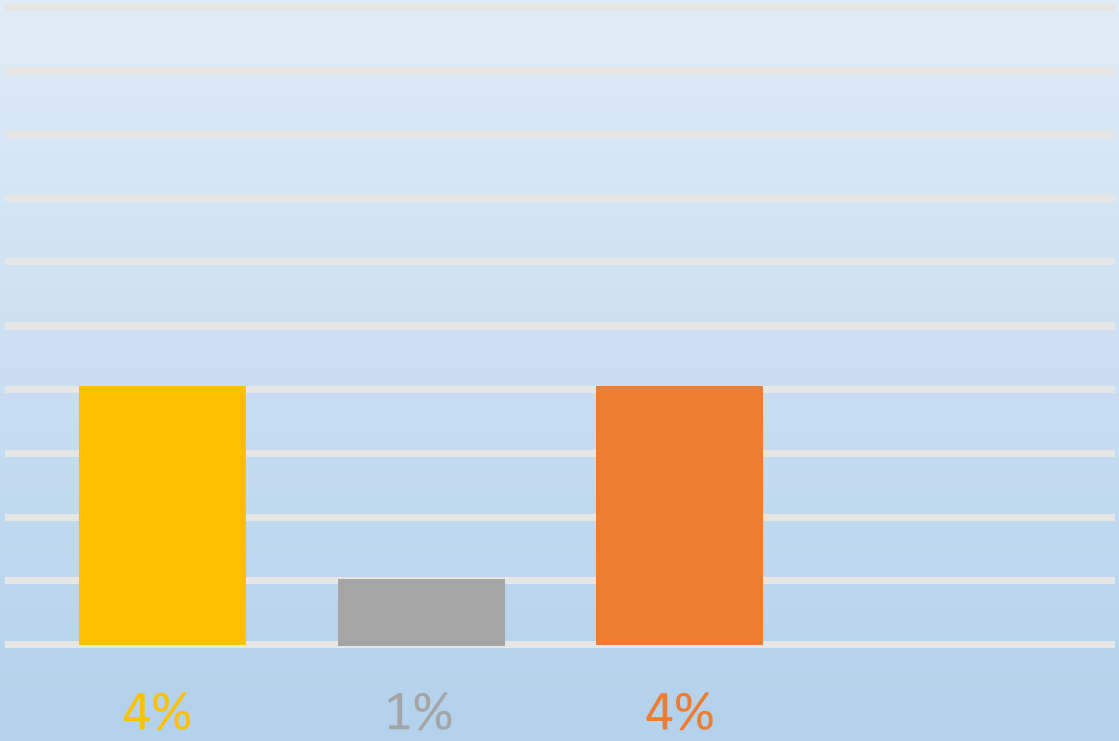
N:(8)

IGRA

N:(2)

Ative TB

N:(7)



Tuberculosis

Open Access Research

BMJ Open

Risk of tuberculosis in patients treated with TNF-α antagonists: a systematic review and meta-analysis of randomised controlled trials

Zheng Zhang,[1] Wei Fan,[1,2] Gui Yang,[3] Zhigao Xu,[2] June Wang,[1] Qingyuan Cheng,[1] Mingxia Yu[1,3]

To cite: Zhang Z, Fan W, Yang G, *et al*. Risk of tuberculosis in patients treated with TNF-α antagonists: a systematic review and meta-analysis of randomised controlled trials. *BMJ Open* 2017;7:e012567. doi:10.1136/bmjopen-2016-012567

► Prepublication history and additional material is available. To view please visit the journal (http://dx.doi.org/10.1136/bmjopen-2016-012567).

Received 9 May 2016
Revised 22 February 2017

ABSTRACT

Objectives: An increased risk of tuberculosis (TB) has been reported in patients treated with TNF-α antagonists, an issue that has been highlighted in a WHO black box warning. This review aimed to assess the risk of TB in patients undergoing TNF-α antagonists treatment.

Methods: A systematic literature search for randomised controlled trials (RCTs) was performed in MEDLINE, Embase and Cochrane library and studies selected for inclusion according to predefined criteria. ORs with 95% CIs were calculated using the random-effect model. Subgroup analyses considered the effects of drug type, disease and TB endemicity. The quality of evidence was assessed using the Grades of Recommendation, Assessment, Development and Evaluation (GRADE) approach.

Results: 29 RCTs involving 11 879 patients were included (14 for infliximab, 9 for adalimumab, 2 for golimumab, 1 for etanercept and 3 for certolizumab

Strengths and limitations of this study

- This meta-analysis evaluated the tuberculosis (TB) risk of all TNF-α antagonists across a variety of conditions in randomised controlled trials (RCTs) with low heterogeneity.
- In addition to the diseases most commonly treated by TNF-α antagonists (rheumatoid arthritis, ulcerative colitis, ankylosing spondylitis and psoriatic arthritis), the review included studies that involved patients with asthma, sarcoidosis and graft-versus-host disease.
- The quality of the evidence was assessed using the GRADE approach, which has been recommended for grading evidence by the *British Medical Journal* since 2006.
- The relatively short follow-up period in the RCTs might have caused an underestimation of the TB rates.

Tuberculosis

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BMJ Open

Risk of tuberculosis in patients treated with TNF-α antagonists: a systematic review and meta-analysis of randomised controlled trials

Conclusions: Findings from our meta-analysis indicate that the risk of TB may be significantly increased in patients treated with TNF-α antagonists. However, further studies are needed to reveal the biological mechanism of the increased TB risk caused by TNF-α antagonists treatment.

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included (14 for infliximab, 9 for adalimumab, 2 for golimumab, 1 for etanercept and 3 for certolizumab

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e RCTs the TB rates.

Tuberculosis

Tuberculin Skin Test Results

Causes of false-negatives

- Acquired immunodeficiency syndrome
- Alcoholism
- Gastrectomy or intestinal bypass
- Hematologic or lymphoreticular disorders
- Inaccurate reading of induration
- Live virus vaccines (measles, mumps, and rubella; poliovirus)*
- Malnutrition
- Patient age older than 45 years
- Renal failure
- Sarcoidosis

Causes of false-negatives *(continued)*

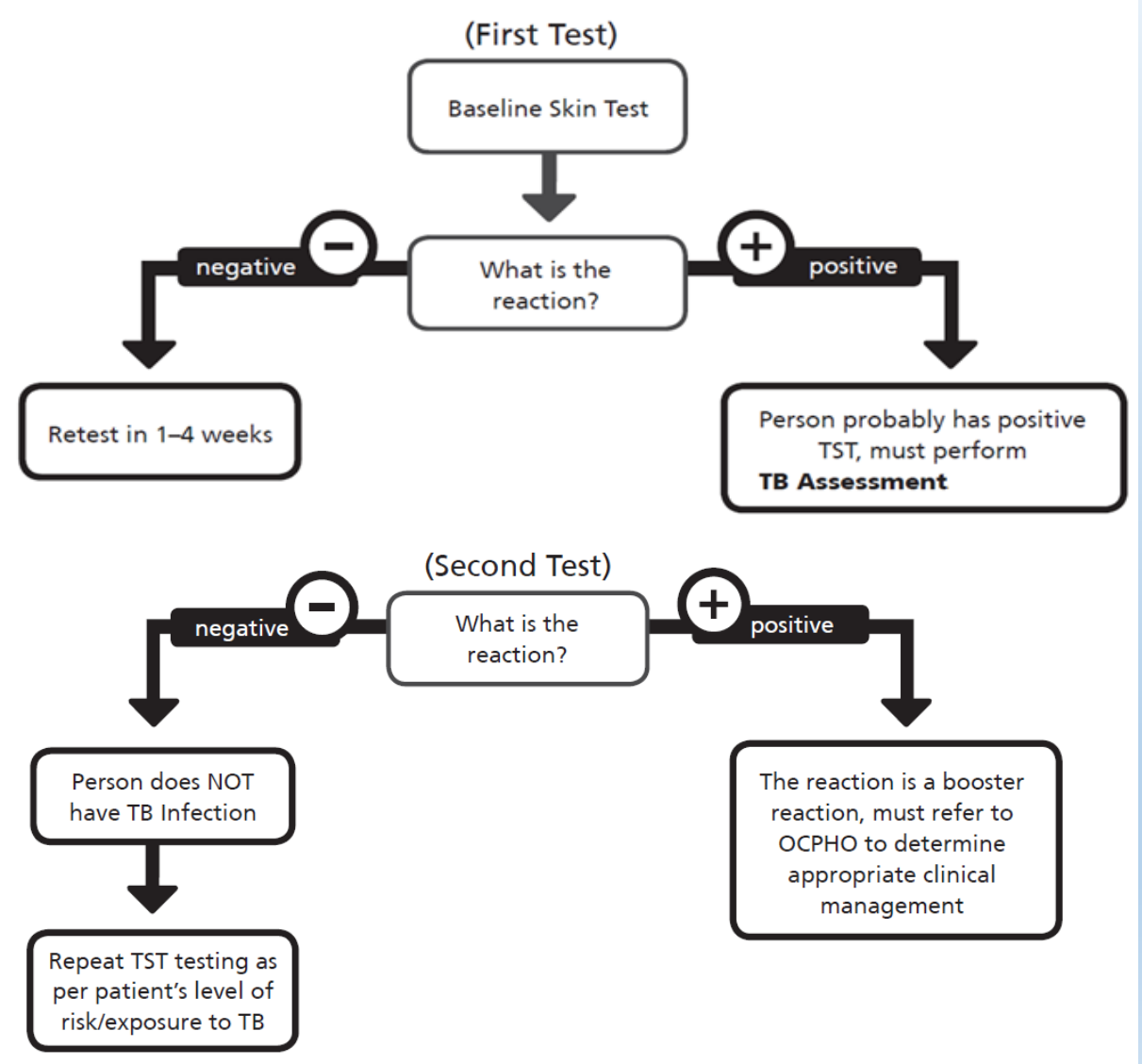
- Systemic viral, bacterial, and fungal infections
- Use of corticosteroids or other immunosuppressant medications
- Zinc deficiency

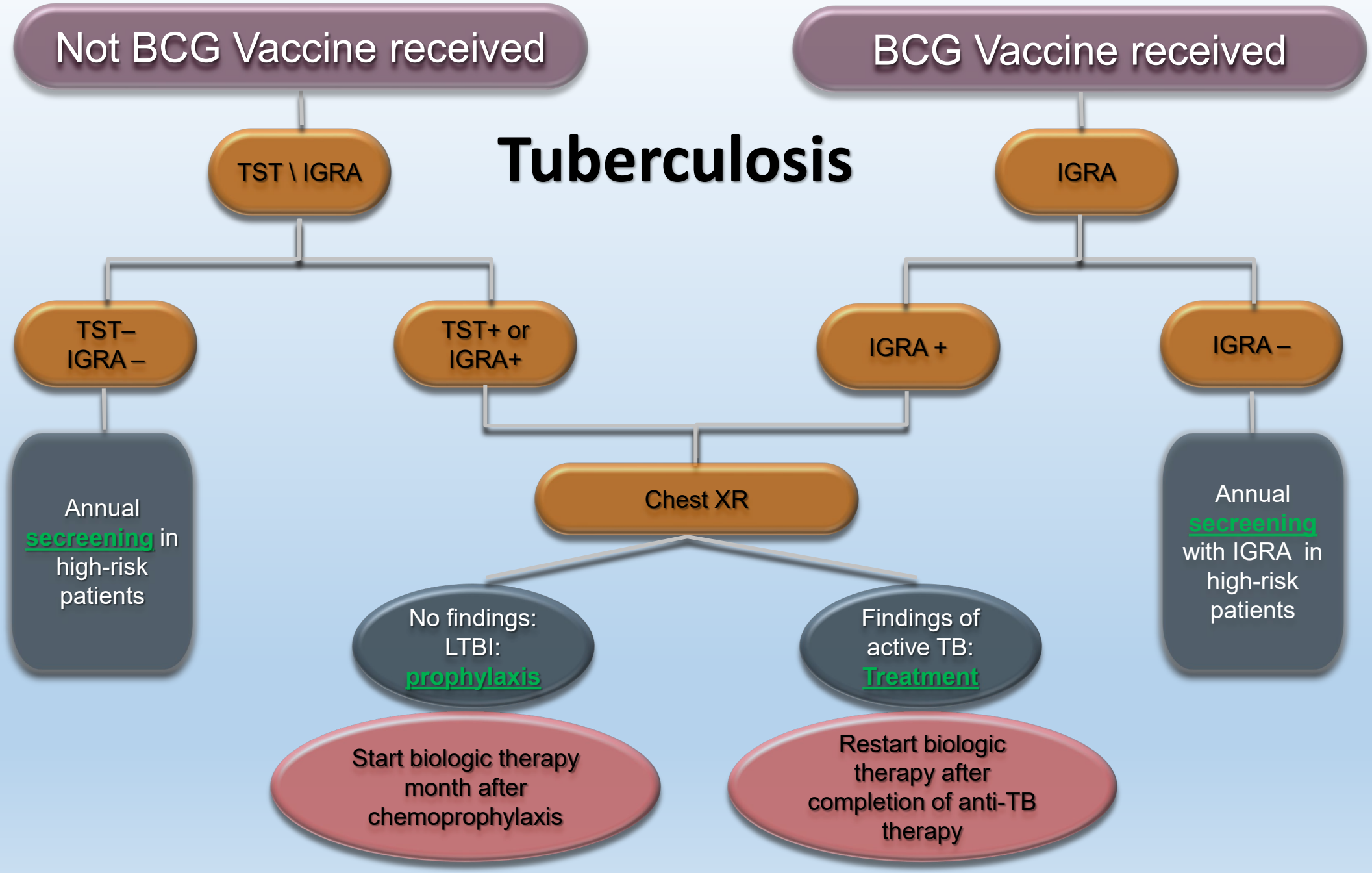
Causes of false-positives

- Boosting phenomenon†
- Cross-reaction with nontuberculous mycobacterial antigens
- Error in administering the test
- Previous bacille Calmette-Guérin vaccination

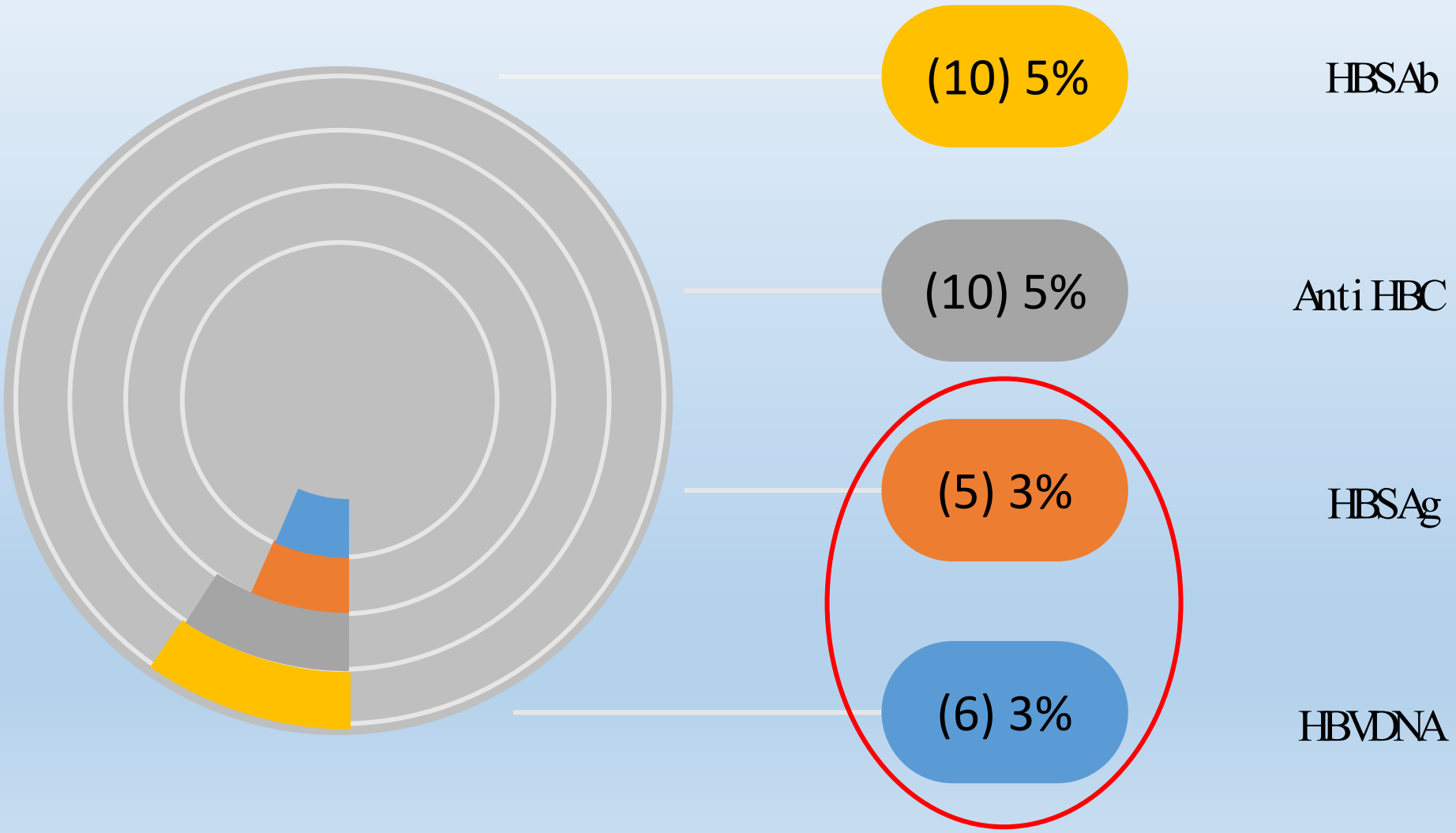
Tuberculosis

Two-step Testing and Boosted Reaction

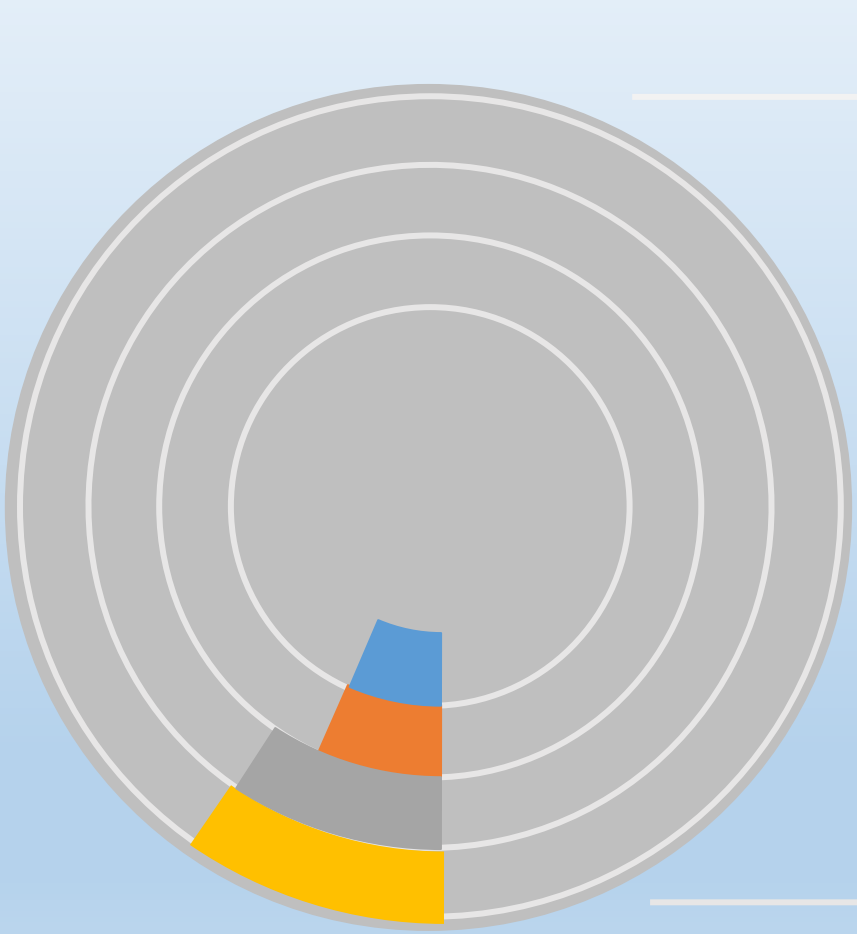



Tuberculosis
Not BCG Vaccine received
BCG Vaccine received
TST \ IGRA
IGRA
TST– IGRA –
TST+ or IGRA+
IGRA +
IGRA –
Annual secreening in high-risk patients
Chest XR
Annual secreening with IGRA in high-risk patients
No findings: LTBI: prophylaxis
Findings of active TB: Treatment
Start biologic therapy month after chemoprophylaxis
Restart biologic therapy after completion of anti-TB therapy

Hepatitis B Virus



Hepatitis B Virus



(10) 5% HBSAb

(10) 5% Anti HBC

(5) 3% HBSAg

(6) 3% HBVDNA

Hepatitis B Virus

	AASLD	APASL	EASL
HBV reactivation	-HBV DNA elevation compared to baseline, or any increase if no baseline available -Previously HBsAg-negative and anti-HBc-positive persons with seroconversion to HBsAg positivity	-HBV DNA ≥ 2 log increase, or newly appearing HBV DNA to a level ≥ 100 IU/mL in previously stable or undetectable persons -HBV DNA at a level ≥ 20,000 IU/mL in a person with no previous baseline level	Not clearly defined
Hepatitis flare	Elevation of ALT 3 times greater than the baseline and at a level > 100 U/L	Elevation of aminotransferase levels > 5 times the upper limit of normal and twice the value at baseline	Not clearly defined

Hepatitis B Virus

(10) 5% HBSAb

(10) 5% Anti HBC

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Rate and Costs of Biologic Treatment Discontinuation in Inflammatory Bowel Disease Patients: A Retrospective Analysis of Governmental Hospital Medical Records in Syria

INTRODUCTION

Inflammatory bowel disease (IBD), which includes Crohn's disease and ulcerative colitis (UC), is a chronic condition that significantly impacts patients' quality of life. Although biologic therapies have transformed the treatment of IBD, their high costs create substantial access barriers, particularly in resource-limited settings like Syria. Treatment discontinuation is common and often attributed to adverse effects, financial constraints, and limited healthcare access. Despite research in other regions, there is limited data on the rate and costs of biologic treatment discontinuation for IBD in Syria.

OBJECTIVES

This study aims to address this gap by analyzing real-world medical records from governmental hospitals to evaluate the rate of biologic treatment discontinuation and the associated costs, defined as the cumulative cost up to the point of discontinuation..

METHOD

An observational, retrospective cross-sectional study analyzed medical records from two governmental hospitals in Syria, Ebn al Nafees and Al-Moujtahed. Patients diagnosed with IBD who received biologic therapy over a two-year period were included. Data collected encompassed age and gender distribution, utilization and costs of biologic treatments, discontinuation rates and the underlying reasons for treatment discontinuation. Mathematical modeling using a bottom-up approach was employed to estimate direct costs of biologic therapy. Costs were collected from hospital administrative centers.

Treatment Dynamics

The analysis revealed that 70% of patients with IBD discontinued biologic treatment, irrespective of the specific biologic agent, within the two-year observation period. The mean time to discontinuation was 55 weeks. Discontinuation was predominantly attributed to medication unavailability (95.7%).

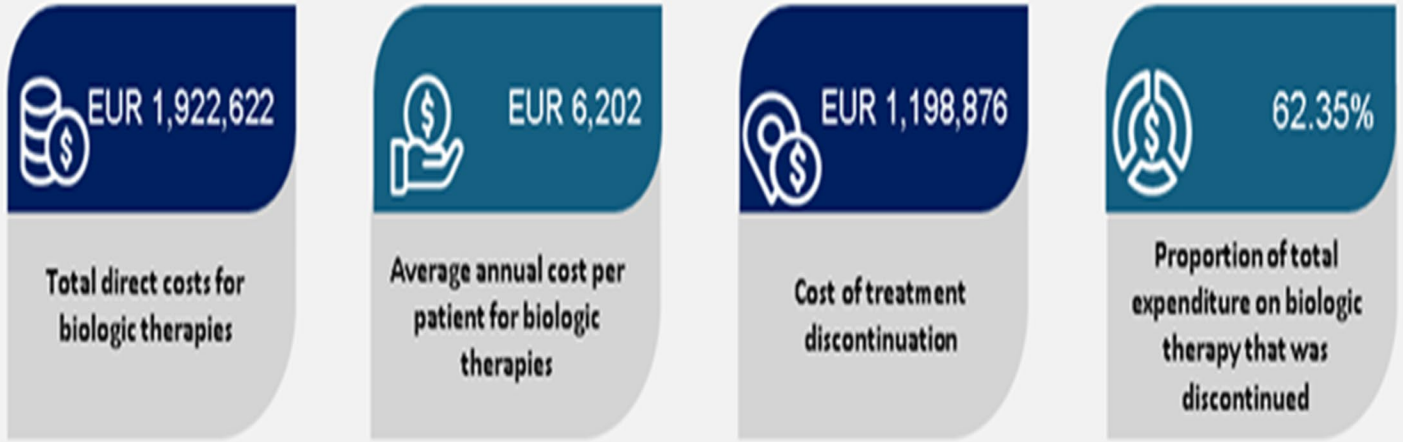
Duration of Therapy

55 weeks (12.6 months)

Missed Doses

Economic Burden

The total direct costs for biologic therapies over the study period amounted to EUR 1,922,622, with an average annual cost of EUR 6,202 per patient. Among patients who discontinued treatment, the cumulative cost up to the point of discontinuation was EUR 1,198,876, accounting for 62.35% of the total expenditure on biologics.



Our Recommendations… CMV

- بسبب الإنتشار الواسع لل CMV والنسبة العالية للخمج الكامن ، يجب التفكير بتشخيص التهاب الكولون الحاد في سياق ال CMV عند كل مريض IBD لديه هجمة معندة

- مع التأكيد على الصعوبة الكبيرة في إثبات التشخيص والذي يتطلب إجتماع عدة معايير سريرية ومخبرية ونسيجية

Our Recommendations... TB

- تعتبر عملية **المسح** لكشف السل الكامن أو الفعال أمراً حاسماً قبل البدء بمثبطات المناعة وحتى أثناء العلاج نفسه خاصة في حالات عدم الإستجابة أو فقدانها

- تشكل كل من : **عوامل الخطر الوبائية ، والفحص السريري ، والتنظير الهضمي مع الخزعات ، صورة الصدر ، و TST or IGRA أو كليهما و البوستر** ، الوسائل المتوفرة لكشف السل الكامن أو الفعال

- في حال السل **الكامن يجب تأجيل العلاج البيولوجي ٤ أسابيع** على الأقل من البدء بعلاج السل ، وتأجيله لما بعد **الإنتهاء من العلاج السلي في حال السل الفعال**

- ننصح بـ **إعادة التقييم السنوي** عند المرضى المتواجدين في المناطق متوسطة إلى عالية الإنتشار

Our Recommendations… HBV

- مثبطات المناعة ومنها العلاجات البيولوجية تشكل خطراً هاما لعودة تفعيل التهاب الكبد ب ، لذلك نؤكد على أهمية المسح قبل بدء العلاج بإجراء : **Alt, Ast, HBSAg, HBSAb, Anti HBC, +\- HBVDNA**

- يعتبر العلاج الوقائي أساسياً عند المرضى إيجابيي الـ HBSAg وبعض حالات إيجابيي الـ Anti HBC قبل البدء بالعلاج البيولوجي وأثناءه

- قد يكون العلاج المضاد للفيروس وقائي وباكر أو عند الحاجة حسب الحالة وخطورتها

- التمنيع هو الطريقة الأنجع للوقاية ، مع أهمية مراقبة مستويات الأضداد أثناء العلاج المثبط

Abstract Page

Assessing the prevalence of opportunistic infections in Syrian inflammatory bowel disease patients on biological therapy: A multicenter cross-sectional study.

Background:

Hepatitis B virus, hepatitis C virus, cytomegalovirus, and tuberculosis pose significant risks of morbidity and mortality, particularly as opportunistic infections in inflammatory bowel disease patients receiving biological therapy. However, data regarding the prevalence of these infections in this vulnerable population within Syria are currently lacking.

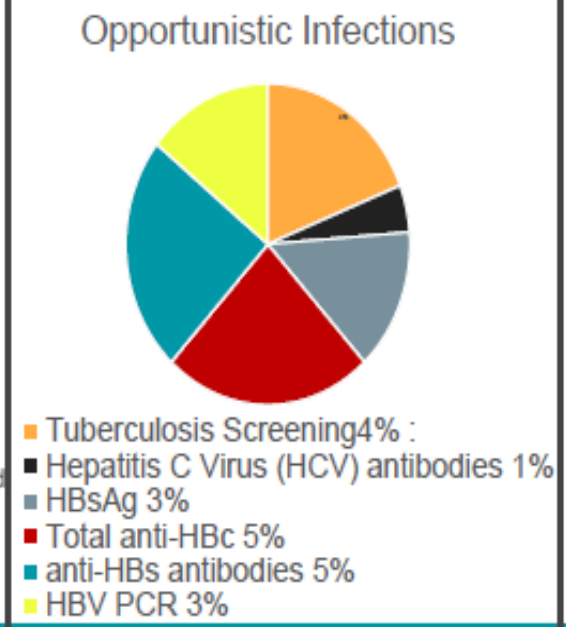
Methods

To determine the prevalence of hepatitis B, hepatitis C, cytomegalovirus, and tuberculosis infections among Syrian individuals treated for inflammatory bowel disease at two hospitals which are major public hospitals in Damascus, the capital of Syria, and are affiliated with the Ministry of Health.. We conducted a retrospective chart review. Using a sample size calculation based on a 95% confidence level, a 5% margin of error, and expected prevalence rates, we determined a minimum required sample size of 139 medical records. However, to enhance precision, we evaluated the records of all patients treated with biologics in the IBD units, exceeding the projected minimum.

Results

In this multicenter cross-sectional study evaluating the prevalence of opportunistic infections among Syrian patients diagnosed with inflammatory bowel disease (IBD) and receiving biological therapy, we observed several demographic and clinical characteristics. A total of 155 patients were enrolled comprising males were (45.95%). Among these participants, (46%) were diagnosed with ulcerative colitis (UC).

Opportunistic Infections		
The Tuberculin Skin Test (TST) was positive in (4%) of patients	the Interferon Gamma Release Assay (IGRA) demonstrated positive results in (1%) of patients	Tuberculosis activation was documented in (4%) patients.
Hepatitis C Virus (HCV) antibodies were detected in (1%) of patients	Cytomegalovirus (CMV) infection was identified in (90%) of patietns, including 2 cases of CMV colitis (1%).	
Hepatitis B Virus (HBV) Screening: HBsAg was positive in (3%) of patietns.	Total anti-HBc antibodies were present in (5%) of patietns and anti-HBs antibodies were detected in an additional (5%) patietns	HBV PCR testing was positive (3%) of patients
Azathioprine (AZA) was administered to (83%) of patients	Infliximab (IFX) to (41%) of patietns	Adalimumab (ADA) (12%).
Golimumab (GOLI) (12%).	Ustekinumab (UST) (40%).	



Conclusions:

Despite consensus on HBV reactivation risk assessment, there are differences amongst guidelines in particular risk thresholds and management options. Antiviral prophylaxis is essential for people with positive HBsAg or anti-HBc levels before beginning biological treatment. Antiviral therapy might be preemptive or on-demand, depending on the scenario. Vaccination remains the most effective way to prevent HBV. Screening for LTBI is required before commencing immunosuppression, which may be followed by therapy depending on the circumstances. Immunosuppression can reduce the accuracy of diagnostic testing, emphasizing the necessity of early detection. While some studies suggest that some drugs may not increase the incidence of tuberculosis, others raise concerns about long-term usage. Overall, thorough monitoring and personalized treatment are critical for IBD patients receiving immunosuppressive medication.