Longstanding gastrointestinal symptoms after COVID-19

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To the Editor,

At present the world is engulfed by SARS-CoV-2 and while the situation is fairly controlled in some countries it is still spiralling out of control in many others. We are still learning about the short and long term impact of COVID 19 and its management. We observe that a portion of infected patients report gastrointestinal (GI) symptoms probably because enterocytes are (besides the lungs) rich in angiotensin converting enzyme (ACE)-2 receptors making them an important interaction site (1,2).

I my clinical practice I noticed post COVID 19 patients consulting because of severe and persistent gastro-intestinal symptoms, two of which I will briefly describe to you.

The first case is a 20-year-old male who got infected with SARS-CoV-2 in April. He noticed fever, fatigue, mild upper respiratory symptoms and diarrhoea. He quickly recovered but in the weeks that followed he started complaining of a complete loss of appetite and a severe per- and postprandial sense of fullness leading to a significant weight loss of 6 kilograms. Other symptoms were absent and general work-up by the GP (lab tests, abdominal ultrasound, stool sample) did not reveal any abnormality besides the presence of SARS-CoV-2 antibodies. Upper GI endoscopy was unremarkable with normal gastric and duodenal biopsies. Symptoms were still present 3 months after the infection. He was started on oral nutritional supplements and Mirtazapine 15 mg once daily aiming to reduce postprandial fullness and reverse weight loss.

The second patient is a 38-year-old female who also got infected in April together. She complained of extreme fatigue, cough, shortness of breath and loss of sense of smell and taste. She recovered partially, but in May she developed severe, non-bloody, watery diarrhoea (also at night), cramping abdominal pain with significant weight loss of 7 kilograms. In June the SARS-CoV-2 PCR was still positive and only became negative in July. At presentation, in the middle of July, she complained of exhaustion, postprandial cramping abdominal pain and a pronounced gastro-colic reflex. The diarrhoea was better but not yet completely normalised. She was still losing weight. A course of Otilonium Bromide (40mg tid) started by her GP had no effect. Work-up by means of stool sample, lab tests and upper GI endoscopy did not reveal striking abnormalities besides mild antritis and moderately elevated duodenal intra-epithelial lymphocytes in the absence of celiac auto-antibodies. Colonoscopy was not yet planned (on request of the patient), but will be in case of ongoing symptoms. She was started on supplementary peroral feeding and Nortriptyline 25 mg a day aiming at effect on pain, diarrhoea, weight loss and fatigue.

As we all know, functional GI symptoms can in some cases be triggered by viral infections. This also seems to be the case for SARS-CoV-2. The complete pathophysiology is still to be uncovered but in absence of evidence for alternative pathology and in absence of response to classical therapy (e.g. PPI and prokinetics for upper GI symptoms and antispasmodics and antidiarrheals for lower GI symptoms), it seems reasonable to treat them similarly to other functional GI disorders aiming at symptom control, weight gain and gain in quality of life. The future will tell us if these cases will be a rarity or a genuine upcoming problem.

References

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