**ADDRESSING PSYCHOLOGICAL NEEDS OF INDIVIDUALS WITH INFLAMMATORY BOWEL DISEASE IS NECESSARY**

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To the Editors,

We thank Drs. Hopkins and Moulton for their letter, which highlights a number of the limitations we report in our systematic review (1).

We agree that the use of ICD-9 coding can be an insufficient proxy for a diagnosis of depression or anxiety. We included the studies because frequently these codes are identified by clinicians and thus would reasonably classify the individuals. However, this is not the case universally, and so their inclusion potentially contributed to less precise estimates.

As identified in the review, we did not undertake a meta-analysis due to the inconsistency of the published data. At the point of registering our protocol, we had anticipated that the data we reviewed would most likely be unsuitable for a meta-analysis, but we would aim to complete one if appropriate. Our decision post-data extraction was not to pool the data using meta-analysis techniques due to the evident heterogeneity. In our opinion, pooling the data in this review would be misleading. However, since no other research group has attempted a relevant systematic review to date, our intention was to move the data synthesis one step closer to a future meta-analysis and thus we presented mean percentages/weighted means where it was possible.

It can be difficult to meaningfully interpret comparisons of anxiety/depression prevalence between IBD and other chronic conditions, given the heterogeneity of the patient samples in the available studies. Certainly, there is limited generalizability, and summary findings should be interpreted with caution, as we aimed to do in our report. The information was reflecting the current state of research and in fact highlights the need for further appropriate and direct comparisons with other types of chronic diseases.

We argue that the conclusions arising from a systematic evaluation of each study are supported by the cited research. Given the high prevalence of mental conditions in IBD and their detrimental impact on disease course (2), we find it surprising that Drs. Hopkins and Moulton question the recommendation to screen and treat anxiety and depression in IBD. This would not be best practice (3, 4) nor in the interest of patient biopsychosocial wellbeing. While we agree better quality studies are needed, our recommendation would be to focus on comparative studies with carefully selected controls rather than recommending population-based studies which are unlikely to be feasible due to associated costs.

**References**

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