and remains as the first-line drug in induction therapy and maintenance therapy for UC. However, 5-ASA often cause diarrhea, fever, and skin rash, and it is often difficult to maintain remission in these cases. There are few studies about the effect of 5-ASA intolerance on the prognosis of patients with UC. In this study, we aimed to clarify the optimal treatment strategy for patients with 5-ASA intolerance by examining the 5-ASA intolerance using the IBD registry of our hospital.

METHODS: We conducted a multi-center retrospective cohort study of UC patients, who visited our hospital from January 2015 to June 2018, and we enrolled 793 UC patients in IBD registry. We collected the detailed clinical information of enrolled patients in the prior year, and the primary outcome was hospitalization. Risk factors for hospitalization were assessed by binary logistic regression analysis. This study was approved by the ethics committee of Keio University School of Medicine (approval number: 20160038).

RESULTS: We defined 5-ASA intolerance as patients who had at least one in the following symptoms due to 5-ASA administration, headache, gastrointestinal symptoms, cutaneous symptoms, and fever. The rates of 5-ASA intolerance were 28.5% (227/776) in admission group and 5.1% (37/722) in no admission group. Our multivariate analysis showed that the following 3 factors have significant correlations with hospitalization; 5-ASA intolerance (odds ratio (OR) = 5.46, 95% confidence interval (CI) = 2.26–13.5), extent of disease (OR = 9.47, 95% CI = 1.25–71.6), and serum albumin level (OR = 0.122, 95% CI = 0.07–0.20). On the other hand, IM intolerance, age, duration of disease, and 5-ASA non-administration were not significantly correlated with hospitalization. Furthermore, compared with 5-ASA tolerance group, the intolerance group had significantly greater incidences of corticosteroid usage (P < 0.001) and calcium inhibitors usage (P < 0.01).

CONCLUSION(S): It became clear for the first time that 5-ASA intolerance is the risk factor for hospitalization and worsen the prognosis of patients with UC. Therefore, even when we encounter patients with UC who are intolerant to one of the 5-ASAs, switching to another 5-ASA and continuing hospitalization and worsen the prognosis of patients with UC.

PO24

Treatment patterns of biologic therapies used to treat ulcerative colitis: A retrospective database analysis in the United States


BACKGROUND: Treatment goals for ulcerative colitis (UC) focus on inducing a response and maintaining long-term disease remission. The current study sought to document the real-world treatment patterns during the first year of biologic therapy in the United States.

METHODS: This retrospective analysis used the Pharmetrics Plus claims data from January 1, 2013 to October 31, 2015, for patients aged 18 years or older with a diagnosis of UC (ICD9:556.* or ICD10: K51.*) who newly initiated biologic therapy (adalimumab [ADA], infliximab [IFX], vedolizumab [VEDO], golimumab [GOL]) were included. Patients had to have 12 months of continuous enrollment prior to (pre-index) and after (post-index) their first biologic drug claim (index). Patients with Crohn’s disease or a history of biologic therapy were excluded. Treatment patterns were reported: remission induction therapy (frequency of an IM with a biologic), maintenance therapy (frequency of a biologic and a maintenance therapy), persistence (frequency of patients using their index therapy at the end of the 12-month post-index observation period; the fourth (and last) year was the outcomes assessment period). The primary outcome was hospitalization stays. These results suggest an ongoing challenge in managing these patients.

RESULTS: A total of 3,395 patients with UC were included (51.7% male; age = 42.4 years [SD = 13.6]; disease duration = 13.6 years [SD = 13.5]; extent of disease = 13.5); disease duration = 13.6; IFX = 32.10%, GOL = 37.5%, and VEDO = 29.6% and 11.1 total days spent in hospital during the post-index period (SD = 14.1). Unadjusted all-cause hospitalization rates and total days hospitalized by treatment were as follow: ADA = 14.0% were hospitalized with 10.4 total days spent in hospital (SD = 13.6); IFX = 19.5% and 11.1 total days (SD = 14.1); GOL = 14.5% with 6.2 total days (SD = 6.6); VEDO = 11.2% with 8.2 total days (SD = 6.5).

CONCLUSION(S): Almost 60% of UC patients who initiate their first biologic therapy rely on steroids within the first 12 months. A number of patients also experience extended UC-related hospitalization stays. These results suggest an ongoing challenge in managing these patients.

PO25

Real-world effectiveness of biologic therapies among patients with moderate-to-severe ulcerative colitis in the United States


BACKGROUND: Treatment goals for ulcerative colitis (UC) focus on inducing a response and maintaining long-term disease remission. The aim of this study was to describe the real-world effectiveness of biologic therapies, as defined by the need for concomitant steroids and UC-related hospitalizations.

METHODS: This retrospective analysis used the Pharmetrics Plus claims data from January 1, 2013 to October 31, 2017. Patients aged ≥18 years with UC (ICD9:556.* or ICD10: K51.*) who newly initiated biologic therapy (adalimumab [ADA], infliximab [IFX], vedolizumab [VEDO], golimumab [GOL]) were included. Patients had to have at least 12 months of continuous enrollment prior to (pre-index) and after (post-index) their first biologic drug claim (index). Patients with Crohn’s disease or a history of biologic therapy were excluded. The American Journal of GASTROENTEROLOGY

© 2019 by The American College of Gastroenterology

The American Journal of GASTROENTEROLOGY

Downloaded from http://journals.lww.com/ajg by BbDMf5ePHKbH4TTImqenVA+lpWIIBvonhQl60Etgtdnn9T1vLQWJq3kbRMjK/ocEon07/02/2021

© 2019 by The American College of Gastroenterology. Unauthorized reproduction of this article is prohibited.