12-Month Post Marketing Safety Surveillance Data of Chewable Inulin Fiber

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INTRODUCTION: Most Americans consume only half of the daily fiber recommended by the National Academy of Medicine, which is 25 grams per day of fiber for women and 38 grams per day for men. Fiber has been shown to promote bowel regularity, lower cholesterol, control blood glucose, and maintain body weight. To fill the “fiber gap,” many patients use fiber supplements. There is a perception that fiber supplementation can lead to bloating and excess gas production, among other adverse events. This study aimed to examine whether or not a pattern of adverse events was associated with chewable inulin fiber (CIF).

METHODS: A call-in number for reporting adverse events (AEs) was provided on bottles of a specific brand of CIF. An independent call center with pharmacovigilance-trained health care personnel in accordance with the FDA and global regulatory guidelines on properly reporting AEs was retained to receive and record customer AEs. The AEs for this study were collected and processed from January 1, 2018 to December 31, 2018.

RESULTS: An estimated 809,239 individual patients consumed CIF during the surveillance. An analysis of the data showed that there were no serious AEs reported. Additionally, the self-reporting rate of non-serious AEs was low, with only 23 non-serious events reported by 21 individuals, a rate of 2.4 per 100,000 users. The top reported, non-serious AEs were flatulence, diarrhea, and constipation; however, the rates for these were extremely low (4.9, 5.7, and 1.2 per million, respectively). Two events were reported that were classified as musculoskeletal and connective tissue disorders; however, these were considered to not be related, having no basis for biological plausibility.

CONCLUSION: 12 months of monitoring real-world use of CIF in a population of over 800,000 patients demonstrates an extremely low rate of self-reported AEs. Contrary to conventional thinking, the rate of flatulence was remarkably low (4.9 per million users), and can most likely be considered statistical background noise. These data, combined with previous RCTs, indicate that CIF is a safe and effective option for fiber supplementation.

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Efficacy and Safety of Upadacitinib as an Induction Therapy for Patients With Moderately-to-Severely Active Ulcerative Colitis: Combined Results From 382 Subjects in the Phase 2b Study U-ACHIEVE

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INTRODUCTION: We assessed efficacy/safety of upadacitinib (UPA) in a pb 2b induction study (part 1) in pts with moderately-to-severely active ulcerative colitis (UC). Additional Pts were enrolled in part 2. We present the efficacy and safety of the combined results of part 1 and part 2.

METHODS: Adults with moderately to severely active UC (Adapted Mayo Score 5-9 points and centrally-read endoscopy subscore 2–3) were randomised 1:1:1:1 to receive extended-release UPA 7.5, 15, 30, 45 mg once daily (QD) or placebo for 8 wks. Patience comparisons between UPA and PBO for primary endpoint of clinical remission per Adapted Mayo Score at Week 8 (defined as stool frequency subscore ≤1, rectal bleeding subscore = 0, and endoscopic subscore ≤1) and ranked secondary endpoints were conducted using Cohen’s Maas-Wasserstein test stratified by previous biologic use, BL corticosteroid use, and BL Adapted Mayo score. No multiplicity adjustments were applied. Non-responder imputation was used for missing values in 13% of pts. Treatment emergent adverse events (AEs) were reported from first dose of study drug to up to 30 days after last dose.

RESULTS: A total 382 pts were randomised with mean (SD) age of 42.7 (14.3) yrs and disease duration of 8.4 (7.4) yrs. Primary endpoint of clinical remission, and secondary endpoints of endoscopic remission, clinical response per Adapted Mayo score, clinical response per Partial Mayo score, endoscopic remission, and histologic improvement were significantly higher with UPA doses ≥30 mg QD vs PBO (Table 1). Incidences of AEs were similar across UPA groups and numerically higher in PBO group. Rates of serious AEs were 10.9%, 6%, 4.1%, 4.9% and 4.9% for PBO and UPA 7.5, 15, 30, and 45 mg, respectively. Serious infections occurred in pts receiving PBO (4.3%, n = 2), 15 mg QD (2.0%, n = 1), 30 mg QD (0.9%, n = 1), and 45 mg QD (1.6%, n = 2). One case of herpes zoster and pulmonary embolism (PE) due to venous thrombosis (DVT) with UPA 45 mg QD were reported. PE/DVT was reported 26 days after study drug discontinuation due to UC worsening and hospitalisation. No deaths were reported.

CONCLUSION: In this combined analysis, primary and ranked secondary endpoints consistently met statistical significance with UPA doses ≥30 mg QD vs PBO in pts with moderately-to-severely active UC. These results are consistent with part 1 intention-to-treat analysis.[2] UPA was well-tolerated and no new safety signals were identified.

216 Determinants of Hospital Admission in Patients With Community-Acquired Clostridium difficile Infection (CA-CDI)


INTRODUCTION: Community-acquired Clostridium difficile infection (CA-CDI) is defined as Clostridium difficile infection (CDI) in patients who have not been in inpatient setting within 90 days of being tested positive for Clostridium difficile. The incidence of CA-CDI has been increasing in young individuals with no co-morbidities or recent antibiotic exposure. Recent research shows that up to 40% patients with CA-CDI need hospitalization, however, the risk factors associated with hospitalization of patients who test positive for CDI in outpatient setting has not been studied. The goal of this study is to look at patients diagnosed with CDI initially as outpatients and analyze the risk factors associated with hospitalization in those patients.

METHODS: This study was approved by the Institutional Review Board. This is a retrospective chart review of 524 patients (189 males, 335 females, mean age 60 years) who were seen in the outpatient department from 2015 to 2018 and were tested for CDI. Inclusion criteria was patients over the age of 18 with positive C. difficile by nucleic acid amplification tests (NAATs). Exclusion criteria was prior diagnosis of C. difficile. For patients with positive C. difficile, the two outcomes selected were hospital admission within 2 weeks, and those remaining outpatients. The variables extracted from the electronic medical record included demographics, medications and co-morbidities. Using a machine-learning algorithm, a Bayesian probabilistic predictive tool was constructed that evaluated a series of variables and their association with potential outcomes.

RESULTS: Of the 524 patients that tested positive for CDI, 105 patients required admission within two weeks of diagnosis. The incidence of hospitalization among males and females was not significantly different. There was significant association between use of acid suppression medications (pantoprazole and famotidine) and risk of hospitalization for C. difficile (p-value <0.001 and 0.002 for pantoprazole and famotidine, respectively). There was no association seen between co-morbidities such as coronary or carotid artery disease, peripheral vascular disease, diabetes mellitus and the risk of hospitalization.

CONCLUSION: Although PPIs have been associated with increased risk of developing CDI, our study shows that acid suppression medications may also increase the risk of hospitalization for CDI. Providers should consider the risk versus benefit of continued use of acid suppression medications in patients with CDI.

217 Post Clostridium difficile Colitis: How Common Is It?

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INTRODUCTION: Acute Clostridium difficile (CDI) is an acute cause of hospitalization. Clostridium difficile is a commonly performed outpatient procedure. There is limited data exist regarding post clostridium CDI. There are few single center studies which discuss about post clostridium CDI but larger studies are lacking. Our aim is to evaluate incidence, demographic factors, clinical factors and mortality associated with post clostridium CDI in nationwide patient population.

METHODS: We used Nationwide Readmissions Database (NRRD) of year 2014 to find patients admitted with AD. From that sample, we found patients who had undergone colonoscopy between one and four days prior to admission. AD patients with and without prior colonoscopy were compared. The univariate and multivariate analysis was done for categorical and continuous variables as well. The p-value <0.05 was considered as significant.

RESULTS: There are total 232,416 hospitalized admissions in year 2014 with AD out of which 797 (0.3%) patients had undergone colonoscopy between one and four days prior to admission. Univariate analysis showed that patients who are male and with age above 65 were significantly more