IBD patients in Lebanon and (2) determine the impact of patient knowledge on anxiety, depression, and quality life while controlling for disease activity.

METHODS: We prospectively recruited adult IBD patients from the GI clinic at a tertiary referral center in Beirut, Lebanon. Demographic data was collected and patients were asked to fill in the following questionnaires: (1) Short IBD Questionnaire (SIBDQ) as a measure of quality of life (QoL), (2) Harvey-Bradshaw Index (HBI) for Crohn’s disease (CD) or Ulcerative Colitis (UC) Activity Index (UCAI) for UC patients as a measure of disease activity, (3) Hospital Anxiety and Depression Scale (HADS), as a measure for anxiety and depression, and (4) the Crohn’s and Colitis Knowledge (CCKnow) questionnaire as a measure of IBD-specific patient knowledge. Pearson Chi-square, student’s t-test and multivariate analysis was used for statistical analyses.

RESULTS: A total of 95 patients were included; 55.8% males, 18 years of age, mean age 34.5 ± 12.0. Over half (53.7%) of patients had CD, 44.2% UC, and 2.1% IBD-unclassified. The majority of patients (31.6%) were unmarried and had a university degree (77.9%). The mean CCKnow score amongst patients was 8 ± 4, with 53.7% scoring ≥ 8. Of all patients, 43.2% had anxiety, 22.1% had depression, mean SIBDQ score was 49 ± 15, with 49.5% having a poor QoL. The 51 CD patients had a mean CCKnow of 8 ± 4, with 43.5% scoring ≥ 8. These patients had a mean HBI of 5 ± 4. The 29 UC patients had a mean CCKnow of 8 ± 4, with 61.9% scoring ≥ 8. The mean UCAI for these patients was 5 ± 4. Patients with a university degree had more disease specific knowledge (CCKnow score ≥ 8). Comparing patients with CCKnow ≥ 8 to those with less knowledge (CCKnow < 8), there was no significant difference in anxiety, depression or quality of life; however, being female with CD was associated with increased levels of anxiety.

CONCLUSION(S): IBD patients in Lebanon knew less about their IBD compared to values reported in the literature. There were no differences between patients who knew about their disease compared to those who did not. There was a trend towards significant difference in anxiety amongst CD patients who knew more about their disease.

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Colonic Histoplasmosis Mimicking Metastatic Colon Cancer in a Patient With Ulcerative Colitis


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BACKGROUND: Histoplasma capsulatum is a dimorphic fungus that may cause a self-limited respiratory infection in immunocompetent individuals. Immunosuppressed individuals, however, are at increased risk for disseminated disease. We report a case of a patient presenting with ulcerative colitis on chronic anti-TNF therapy, presenting with sinister-appearing colonic ulcers and abnormal radiologic data.

CASE SUMMARY: A 43 year old man with a 12 year history of ulcerative colitis was referred to the university medical center with progressive abdominal pain and distension. He had undergone a previous colectomy for colorectal cancer showing segmental inflammation in the ascending colon with a discrete ulceration. Biopsies were non-diagnostic. Cross-sectional imaging demonstrated multiple enlarged mesenteric lymph nodes and omental soft tissue thickening, suggestive of possible omental epithelioid granulomas. There was no evidence of malignancy or dysplasia. Viral inclusions were absent of abnormal chest imaging, which is estimated to occur in 70% of immunocompromised patients with dissemination. Additionally, the patient’s known risk factors for GI histoplasmosis as a manifestation of disseminated disease is not well characterized. A subsequent colonoscopy showed complete resolution of the ulcer. He has had no recurrence of his abdominal lymphadenopathy and inflammatory stranding. A subsequent colonoscopy showed complete resolution of the ulcer. He has had no recurrence of his abdominal lymphadenopathy and inflammatory stranding.

RESULTS: A subsequent colonoscopy showed complete resolution of the ulcer. He has had no recurrence of his abdominal lymphadenopathy and inflammatory stranding. As of September 2018, the CD-PRO/SS scores from 479 patients (67.4% aTNF-experienced, cohort 1, n = 215; cohort 2, n = 264) with nonmissing data were analyzed. Mean changes from baseline at week 14 were −2.28 (standard deviation, 2.55) and −2.45 (2.88) for the functional domain and the bowel domain, respectively. Based on a reduction of ≥100 CDAI, the MCID from anchor-based method were 2.7 for the functional domain and 3.1 for the bowel domain regardless of treatment arm. Responder definitions for the CD-PRO/SS were a reduction ≥2.5 for the functional domain and ≥3.0 for the bowel domain that were determined through triangulation. According to these cutoffs, 64% and 40% of patients were responders by week 14 based on the functional domain and the bowel domain, respectively.

CONCLUSION(S): In the pooled analysis, the proposed responder definitions demonstrate that a clinically meaningful response on the CD-PRO/SS are a reduction of ≥2.5 in the functional domain or ≥3.0 in the bowel domain. Similar to the responders defined by the Ulcerative Colitis Patient-Reported Outcomes Signs and Symptoms (CD-PRO/SS) is the first Crohn’s disease-specific PRO tool developed with input from health authorities, patients, and clinical experts and is under review by the US Food and Drug Administration for validation as a clinical outcome measure. In April 2019, the European Medicines Agency released a letter of support for use of the CD-PRO/SS as an endpoint in inflammatory bowel disease clinical trials. The aim of this study was to define responder definitions for the CD-PRO/SS using data from patients with moderate-to-severe CD treated with etrolizumab in the BERGAMOT Phase 3 trial (NCT02394028).

METHODS: In BERGAMOT, anti-tumor necrosis factor (aTNF)-naïve and aTNF-experienced patients with moderate to severe CD were treated with etrolizumab 105 mg, 210 mg, or placebo subcutaneously every 4 weeks during a 14-week induction phase. Cohort 1 (blinded) and cohort 2 (open-label etrolizumab) were analyzed independently; these cohorts included all treatments. Data presented are from all patients regardless of treatment. The CD-PRO/SS consists of 2 separately scored scales: a 3-item functional domain and a 3-item bowel domain. The domain score was calculated as the sum of the item scores, which were derived using the average of ≥4 out of 7 days before week 0 (baseline) and week 14. Minimum clinically important differences (MCIDs) were calculated using distributional-and anchor-based methods on a reduction of ≥16 points in the Inflammatory Bowel Disease Questionnaire and ≥100 points in the Crohn’s Disease Activity Index (CDAI) at week 14.

RESULTS: As of September 2018, the CD-PRO/SS scores from 479 patients (67.4% aTNF-experienced, cohort 1, n = 215; cohort 2, n = 264) with nonmissing data were analyzed. Mean changes from baseline at week 14 were −2.28 (standard deviation, 2.55) and −2.45 (2.88) for the functional domain and the bowel domain, respectively. Based on a reduction of ≥100 CDAI, the MCID from anchor-based method were 2.7 for the functional domain and 3.1 for the bowel domain regardless of treatment arm. Responder definitions for the CD-PRO/SS were a reduction ≥2.5 for the functional domain and ≥3.0 for the bowel domain that were determined through triangulation. According to these cutoffs, 64% and 40% of patients were responders by week 14 based on the functional domain and the bowel domain, respectively.

Socioeconomic Disparities in IBD: Outcomes in Emergency Department Utilization and Outpatient Follow-Up

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BACKGROUND: The association of socioeconomic status, emergency department (ED) utilization, and access to outpatient gastroenterology care in inflammatory bowel disease (IBD) remains understudied. We sought to identify associations between overall socioeconomic deprivation and these outcomes in IBD patients.

METHODS: Our historical cohort included 743 unique IBD patients with a total of 6,066 all-cause ED visits during a 51-month period (January 1, 2015 to April 1, 2019). Detailed demographic variables were recorded for all subjects. Zip codes were used to approximate the level of socioeconomic deprivation via the Area Deprivation Index (ADI), a comprehensive score developed at the University of Wisconsin based on a composite score including 17 different factors related to income, education, employment, and housing quality (1). ADI scores of these IBD patients were divided into quartiles (quartile 4 = most deprived) and then compared with outcomes, including average number of ED visits, average hours spent in ED per visit, acuity level of ED visits (by Emergency Severity Index levels 1–5, with level 1 = highest acuity), admission rates, total outpatient GI visits and IBD-specialist visits, percent attending any outpatient GI visit or IBD specialist visit, and initiation of any outpatient steroid-sparring therapies. Univariate comparisons were performed using analysis of variance (ANOVA) for continuous variables and chi-square tests for categorical variables. Statistical significance was set at P < 0.05.

RESULTS: 743 IBD patients (60% female, age 48 ± 18 yrs, 446 with Crohn’s disease (CD), 297 with ulcerative colitis (UC)) were evaluated. Basic demographics were similar overall, with significant differences noted in race (P < 0.001) and insurance coverage (P < 0.001). Increased ED visits were