DISCUSSION: Diverticular Colitis is an endoscopically diagnosed pathology and in a patho-}
gnomonic way the pattern of inflammation of the colon does not affect the diverticular orifices. There are approximately 200 cases reported worldwide. The average age of presentation is 65 years, the male-to-female ratio is 2:3:4. It typically presents with acute lower gastrointestinal bleeding and abdominal pain. The pathogenesis is uncertain, an overlap hypothesis supports a relationship between IBD and DC. One theory describes stress on the intestinal wall as a trigger for both diverticular disease and inflammation of the mucosa, which, in the genetically predisposed patient, can lead to the development of DC. DC is classified into four subtypes: Type A or simianoid fold, type B similar to mild-moderate CUCI, type C similar to Crohn's disease, type D similar to severe CUCI. Gore S, and Shephard N.A reported 57 cases of CD where 6 progressed to UC in 6-24 months. To the best of our knowledge only 20 cases of progression have been reported, the last one in 2014 by Dr. Tatsuiji Maeshiro, and none in Mexican patients.

CONCLUSION: DC is a chronic and segmental inflammatory process of the mucosa associated with a diverticular disease. A physiopathogenetic relationship between DC and DC has been proposed. Reason why reporting and studying these cases could help resolve certain aspects of the physiopathologic route probably taken by this disease in a probable sequence of progression, analogue to the adenoma carcinoma sequence in colon cancer. Therefore, one could consider a closer follow-up in patients with diverticular colitis as they may progress to UC as in the previous case reported. This job has no conflict of interest.

P064

Drug-Induced Liver Injury (DILI) Associated With Anti-tumor Necrosis Factor Alpha (Anti-}
TNFα) Agent

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BACKGROUND: Anti-TNF therapy has become the mainstay in the treatment of Crohn's disease (CD), improving the rates of response and remission in patients. Significant considerations are needed when treating patients with anti-TNF therapy including immunogenicity, duration of treatment, and safety profile. Anti-TNF agents have been associated with drug-induced liver injury (DILI). This case presents a highly suspected association between Remdesivir and DILI.

CASE REPORT: 20 year old with ileocolonic CD started on Remdesivir 5 mg/kg infusions to be given at 0, 2, and 6 weeks, followed by every 8 weeks. Before receiving Remdesivir, tested negative for viral hepatitis with normal liver function tests. Infusions were followed by improvement in clinical symptoms and inflammatory markers. After the fourth infusion, serum liver aminotransferases were slightly elevated and rose higher several weeks after infusion, infusions were discontinued. Extensive serological work up did not find a definitive cause (viral hepatitis and autoimmune antibodies) except for a weakly positive ASMA. Liver biopsy performed that showed a pattern of chronic hepatitis, no fibrosis highly suggestive of DILI. The patient remained asymptomatic, anemic, with rash, or signs of hepatic disease. She was monitored on no IBD therapy and liver aminotransferase tests started to normalized and fell to normal within 12 weeks after infusion discontinuation and budesonide 9 mg daily. This led to a prompt clinical response and serum liver transaminases remained normal during the subsequent following weeks of treatment with bude-
sonide taper dose.

DISCUSSION: Remdesivir is an anti-TNFα antagonist that is biosimilar to Remicade (infliximab) for the treatment of moderately to severe active Crohn's disease. The mechanism of action is highly similar to the originator biologic. Infliximab is a monoclonal antibody genetically engineered chimeric IgG1k (69%), anti-human tumor necrosis factor alpha. It has the ability to fix complement and lyse cells expressing membrane-bound TNF-alpha and induce down-regulation of the inflammatory mechanisms in the entire mucosal layer. Two liver injury issues had been associated with infliximab; reactivation of underlying chronic hepatitis B and direct hepatotoxicity with different antibacterial therapy, acetaminophen, (hepatotoxicity), cholestatics, leading to mild, and acute liver failure. The hepatocellular pattern is marked by isolated or pre-
dominant elevation of serum transaminases. Cholestatic have elevation in serum alkaline phosphatase with normal or mild elevation in serum transaminases and markedly elevated bili-
rubin level. An autoimmune mechanism can present with a hepatocellular pattern if the hep-
atocytes are involved (autoimmune hepatitis) or cholestatic or if the immune mechanism targets the biliary ducts. In this case, the pattern was hepatocellular with elevation of aminotransferases, which generally arise after 2 to 5 infusions. Elevation of transaminases are usually transient and asymptomatic.

CONCLUSION: This case described an association between Remdesivir and DILI. Acute liver injury caused by anti-TNFα antagonist may be a class effect since several agents in this category have been implicated. In this case, the most common presentation occurred as an autoimmune phenotype with marked hepatocellular injury. A possible dual mechanism of immune deregulation on no IBD therapy and liver aminotransferase tests started to normalized and fell to normal within 12 weeks after infusion discontinuation and budesonide 9 mg daily. This led to a prompt clinical response and serum liver transaminases remained normal during the subsequent following weeks of treatment with bude-
sonide taper dose.

P066

A Patient Toolkit for the Transition of Care of Active Duty Patients With IBD to the Veterans Administration Healthcare System

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BACKGROUND: The shift from being an active duty military patient with inflammatory bowel disease (IBD) seen in a military treatment facility (MTF) to being a veteran receiving chronic illness care within the Veterans Administration (VA) is a time of increased vulnerability and risk for loss of continuity of care, and poor disease outcomes. A transitional care program must prioritize the psychosocial growth, self-efficacy and disease-specific knowledge of active military patients who are transitioning to VA care as well as enhance collaborative management between military and VA providers. The Department of Defense (DoD) has established the Transition Assistance Program (TAP) to assist military members to civilian life, but limited preparedness in skills to navigate/ understand medical care. There's currently no available data on transition readiness from active duty military medical care to VA medical care and our objective is to determine the feasibility and acceptability of a self-management intervention.

METHODS: We prospectively measured readiness with the use of the IBD Self-Efficacy Scale (IBD- 
SELF) and Decision Readiness Assessment Questionnaire (TRAQ). All enrolled active duty servicemembers were in disease remission and underwent TAP and 50% were further ran-
domized to undergo TRAQ-based educational and behavioral interventions via mobile applications and clinical consultations.

RESULTS: Servicemembers who underwent further TRAQ-based interventions compared to those only undergoing TAP demonstrated significant improvement in medication/appointment manage-
ment, tracking/managing health issues, and talking with providers (P < 0.001). Furthermore, these servicemembers also demonstrated significant improvement in self-efficacy and self-management which was maintained up to 3 months post military discharge (P < 0.001). Servicemembers had an average VA primary care wait time of 3.5 months and for Gastroenterology specialist of 5.4 months, resulting in >60% of servicemembers having to discontinue therapy due to lapse in care (50% rate of flares) and unnecessary therapy switch.