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BACKGROUND: The main ophthalmologic extraintestinal manifestations (EIM) in inflammatory bowel disease (IBD) are uveitis, keratitis, and sarcoidosis. Uncommon ophthalmologic complications can occur and may be related to adverse events of anti-TNF therapy. As the signs and symptoms are similar, differentiating these changes becomes a challenge for the physician. The aim of this report is to describe 3 cases of ophthalmologic complications (2 opportunistic infections and 1 adverse effect) during anti-TNF treatment.

METHODS: Data from patients from the IBF Unit of Gastroenterology Division of the Clinics Hospital of the University of São Paulo was retrospectively collected based on medical records.

RESULTS: Case 1: Female, 61 yo, diagnosed with Crohn’s disease (CD) since 2004 (melanoma, atopic dermatitis, and uveitis). The patient showed improvement in visual acuity and skin lesions. Case 2: Female, 51 yo, diagnosed with CD (penetrating) since 2012. Submitted to an albus-rectum anastomosis in 2015. After surgery, she started treatment with infliximab monotherapy. After 1 year, she began to have symptoms of irritated eyes. Her symptoms worsened after infliximab dose optimization for every 4 weeks. The patient had increased visual acuity, conjunctival hyperemia, puritus, photophobia and pain around both eyes. She was evaluated by the ophthalmologist and diagnosed with cornea with punctate keratitis, eyelid edema, diffuse conjunctival hyperemia, decreased eyelashes and blepharitis. Infliximab treatment was discontinued. Eye drops prescribed with dexamethasone and lubricant. Patient had progressive visual improvement.

CONCLUSION(S): Unusual eye involvement may occur in IBD patients during anti-TNF therapy as adverse events. Careful evaluation with a multidisciplinary team (including the ophthalmologist) is required for proper and early diagnosis with suitable treatment in order to reduce ophthalmic morbidity.

P075

Inflammatory Bowel Diseases and Autoimmune Hepatitis: Is Anti-TNF Therapy an Option?

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BACKGROUND: Comorbidities among immune mediated inflammatory disorders are frequently reported (1). Although some physicians are not aware of the potential association between auto-immune hepatitis (AIH) and inflammatory bowel diseases (IBD) it is uncommon (2). As anti-tumor necrosis factor (anti-TNF) therapy has the potential to induce autoimmunity, including AIH (3), the safety of its utilization in this condition is unknown and often avoided by physicians.

METHODS: Data from patients with concomitant diagnosis of IBD and AIH in the IBF unit of the Department of Gastroenterology of the Clinics Hospital of University of São Paulo was retrospectively collected based on medical records.

RESULTS: Two female (28 and 33 years old) and one male (28 years old) patients with concomitant AIH and ulcerative colitis (pancolitis) were identified. These three patients needed to start infliximab because of persistent clinical and endoscopic activity in two of them and gangrenous pyoderma in the other case. All of them were taking azathioprine when anti-TNF was initiated. Two had type 1 AIH and one AIH with no markers. Two were cistic; (Child A/MELD 11 and Child B/MELD 14) with portal hypertension and one did not have signs and symptoms of cirrhosis. After a follow up of an average of 20 months under anti-TNF treatment transaminases slightly reduced (mean ALT prior treatment 50 ± 32 U/L, mean ALT during treatment 27 ± 8 U/L) and immunoglobulin G level slightly decreased (from 1.5 g/L to 1.1 g/L). Clinicaly, cistic or acne patients persisted with compensated liver disease (Child A / MELD 11 and Child B / MELD 15) and the one who was not cistic did not have any clinical deterioration.

CONCLUSION: AIH do not seem to alter the course of liver disease in IBD patients with concomitant diagnosis of AIH. Due to potential side effects it needs to be applied with caution and in a multidisciplinary approach in tertiary centers with special attention to infectious complications.

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BACKGROUND: The decline in the incidence of Tuberculosis (TB) worldwide, this disease still occurs with high rates of morbimortality. It is estimated that TB caused 1.3 million deaths worldwide in 2016. Brazil is an endemic country and it counts nearly 70,000 new cases of TB per year (1). Whether the risk of TB infection in Inflammatory Bowel Disease (IBD) patients is related to immunosuppressants or to the disease itself is controversial. This study aimed to evaluate the incidence of active TB in patients with IBD, and its relationship with immunosuppressive treatment in a tertiary referral center.

METHODS: Patients with active TB were identified among 1040 IBD patients in a regular follow up at Hospital das Clínicas, São Paulo, Brazil, from 2010 to 2017. Data regarding disease phenotype, TB treatment at the time of TB diagnosis and the previous status of TB screening was retrospectively collected. The correlation between tuberculosis and IBD is based on symptoms, tuberculin skin test (TST), sample cultures, images, and endoscopic exams.

RESULTS: Twenty-three patients with active TB were identified (mean age at TB diagnosis 49 [28–69]; 13/23 [56.5%] female). The person-time incidence rate of active TB was 2.21 cases/100 patient-years in our IBD population. The relative incidence of active TB was increased (RR 6.6) compared to general Brazilian population. Fifteen patients (65.2%) had Crohn’s Disease (7 perianal; 4 stercoraceous; 4 non-penetrating non-stercoraceous) and eight (34.7%) had Ulcerative Colitis (7 extensive disease). Regarding IBD treatment, 13/23 [56.5%] patients were under anti-TNF drugs (9 Infliximab, 4 Adalimumab), six of them (46.2%) in monotherapy and seven (33.8%) under combination therapy with thiopurines. Five patients (21.7%), were under AZA monotherapy and one was under steroids. Regarding the interval between anti-TNF use and TB diagnosis, just one case was diagnosed in the first 6 months of treatment. Most patients (14/19, 73.6%) developed active TB after 24 months of exposition to immunosuppressant medications, two (2/19, 10.5%) between 12-24 months of exposure and three (3/19, 15.7%) between 6-12 months. All four of the patients (4/23, 17.4%) that were not under immunosuppressant drugs were smokers, one of them was also an alcoholic and another one treated active TB seven years before the reinfection. The most common TB site was pulmonary (16/23, 69.5%) and no deaths resulted from active TB. One case of TB occurred three years after immunosuppressant medications for latent TB in a patient under cotreatment (anti-TNF and AZA).

CONCLUSION(S): Our patients presented an incidence of TB higher than the general population in Brazil. Immunosuppressive drugs seem to be a major causal factor, especially anti-TNF. Most cases occurred after the first six months of treatment suggesting a new infection. This study reinforced the importance of an accurate screening for TB at IBD diagnosis and prior to initiation of immunosuppressive therapy. Appropriate follow-up is required in immunosuppressed patients living in endemic areas for TB.

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INTRODUCTION: Crohn’s disease (CD) is an Inflammatory Bowel Disease (IBD) may present systemic manifestations as extraintestinal manifestations (EIM). Suppurative Hydradenitis (SH) is a chronic, recurrent and debilitating dermatological disease that causes inflammatory process of the follicular epithelium, which becomes susceptible to secondary bacterial infections. The association of CD and SH is known, but the isolated manifestation of CD in the perianal region associated with manifestation of SH is rare and makes diagnosis and therapy challenging.

METHODS: To describe the clinical case of adolescent with SH and perianal CD by reviewing medical records.

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S20