Table 1. Values expressed as median (range) or n (%). PC: proctocolitis, PA: perianal; IMM: immunomodulators

<table>
<thead>
<tr>
<th>Variable</th>
<th>Study Cohort</th>
<th>Responders</th>
<th>Non-responders</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age at surgery (yr)</td>
<td>40 (18-84)</td>
<td>44 (19-78)</td>
<td>37 (19-84)</td>
<td>.21</td>
</tr>
<tr>
<td>Gender</td>
<td>50 (51)</td>
<td>31 (31)</td>
<td>19 (19)</td>
<td>.63</td>
</tr>
<tr>
<td>Disease duration (yr)</td>
<td>15 (2-43)</td>
<td>12 (2-43)</td>
<td>14 (2-43)</td>
<td>.03</td>
</tr>
</tbody>
</table>

Indication for surgery:

- PC: 48 (59)
- PA: 34 (35)
- P: 5 (5)
- IMM: 52 (53)
- Active tobacco use: 15 (15)

Values expressed as median (range) or n (%). PC: proctocolitis, PA: perianal; IMM: immunomodulators.

Factors Associated With Ustekinumab Dose Escalation in Patients With Crohn’s Disease

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INTRODUCTION: Ustekinumab (UST) is a monoclonal antibody which inhibits both IL-12 and IL-23 and was approved for treatment of Crohn’s disease (CD) in 2016. The current dosing is an intravenous weight-based loading dose followed by 90 mg subcutaneous maintenance injections every 8 weeks. Yet, patients frequently require dose escalation, most commonly to every 4 or 6 weeks. However, reasons for UST dose escalation and to which interval are poorly understood.

METHODS: Retrospective cohort study of adult CD patients with CD who were treated with UST and underwent dose escalation between 1/1/2016 and 1/31/2019 at a tertiary referral center. Electronic health records were manually reviewed for demographic data, CD history, UST serum concentrations within 3 months prior to escalation and to identify primary reason for dose escalation.

RESULTS: We identified 238 patients on UST for CD. Among these patients, 123 (51.7%) underwent escalation to every 4 (n = 64), 5 (n = 10), 6 (n = 55) or 7 (n = 3) weeks. UST serum concentrations were measured in 18/238 (14.6%) patients within 3 months prior to dose escalation with mean of 2.1 ug/ml and 1.3 ug/ml in patients escalated to 4 or 6 weeks, respectively (P = 0.54). Of the 123 patients, a total of 85 patients (69.1%) were escalated due to persistent clinical disease activity with Harvey Bradshaw Index (HBI) of 5 or greater. Among the 38 patients with HBI <5, primary reasons for escalation were as follows: early symptom recurrence (n = 10), concurrent corticosteroid use (n = 8), evidence of inflammation on endoscopy (n = 8), low UST drug concentrations (n = 3), elevated fecal calprotectin (n = 3), radiographic evidence of inflammation (n = 3), active perianal disease (n = 3) and patient preference (n = 1) (Figure 1).

CONCLUSION: Among patients with CD who undergo UST dose escalation, nearly one fourth are escalated despite achieving remission as defined by HBI <5 without concurrent use of corticosteroids on standard UST dosing. The most common reasons for dose escalation among these patients are early recurrence of symptoms prior to next maintenance dose and evidence of inflammation on endoscopy. UST serum concentrations are uncommonly utilized to guide dose escalation and its utility remains unclear. Larger, prospective studies are needed to determine the long-term benefits and cost effectiveness of dose escalation of UST, as well as to further elucidate effectiveness of dose escalation primarily based on endoscopic findings in the absence of clinical symptoms.

Outcomes Following Inter-Hospital Transfer in Patients Admitted With Inflammatory Bowel Disease in the United States

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INTRODUCTION: Inflammatory bowel disease (IBD) patients who get transferred to new hospitals have not been well described. Using a national dataset, we sought to describe trends and outcomes in IBD transfers in the United States.

METHODS: Adults with IBD (defined with ICD-9 codes for Crohn’s Disease - CD and Ulcerative Colitis - UC) were identified in the 2007–2014 National Inpatient Sample. Trends in inter-hospital IBD transfers, along with patient and hospital-level descriptors were examined. A cohort of patients who received IBD-related surgery at the recipient hospital was also identified (IBD-surgical transfers).

RESULTS: Outcomes including all-cause in-hospital mortality, length of stay (LOS), and total hospital costs (THC) in IBD transfers were then assessed after controlling for confounding variables.

RESULTS: We identified 793,015 IBD discharges of which 519, 598 (65.5%) were for CD and 273,417 (34.5%) for UC. 3.4% of IBD patients (n = 27,005) were transferred to a recipient hospital of these, 15.1% (n = 4,090) underwent an IBD-related surgery at the new hospital. Between 2007–2014, there was a rise in all IBD and IBD-surgical transfers in the US (P = 0.02, Figure 1). In IBD-surgical transfer patients, the mean age at transfer was 41 years with most patients being White (80.6%), on private insurance (52.5%), and living below the median level of income (56.2%) (Table 1). Twenty-three percent of IBD-surgical transfers occurred during the weekends, predominantly to teaching hospitals.

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