the participating gastroenterologists include basic demographics, prescribing behavior, and attitudinal survey responses. Data were collected in April 2020. Responding gastroenterologists were required to predominantly treat adult patients, have at least 50 IBD patients under their management, and spend at least half of their professional time in clinical practice.

RESULTS: 64% of gastroenterologists reported awareness of the guideline change recommending the prescribing of infliximab or vedolizumab rather than adalimumab for induction of remission in adult, moderate to severe ulcerative colitis patients who are new to biologic therapy. Using a five point scale, 51% of physicians indicated the guideline change would have some impact (four out of five rating) or a large impact (five out of five rating) on their prescribing of vedolizumab in moderate to severe ulcerative colitis patients. 54% of gastroenterologists reported awareness of the guideline change recommending the prescribing of ustekinumab or tocilizumab rather than vedolizumab or adalimumab for induction of remission in adult, moderate to severe ulcerative colitis patients who have been exposed to infliximab and who were not responsive. Using a five point scale, 63% of physicians indicated the guideline change would have some impact (four out of five rating) or a large impact (five out of five rating) on their prescribing of ustekinumab in these patients. We will also present data showing trends in adherence to new recommendations.

CONCLUSION: A majority of gastroenterologists have awareness of the AAGA guideline changes relative to adult, moderate to severe ulcerative colitis patients new to biologic therapies and that there has been a positive effect on prescribing of vedolizumab in these patients. Approximately one-half of gastroenterologists are aware of the AAGA guideline change relative to adult moderate to severe ulcerative colitis patients who have been exposed to infliximab and who were not responsive. This awareness also had a positive effect on prescribing of ustekinumab, and to a lesser extent, tocilizumab, in these patients.

METHODS: This is a retrospective single-institution chart review of IBD and non-IBD patients with a history of intestinal resection. All adult patients, >18 years of age, who underwent an intestinal resection surgery between January 1, 2010 and December 31, 2017 were included in this study. Patients who had a cholecystectomy or presence of gallstones prior to intestinal resection were excluded from this study. For patients meeting inclusion criteria, demographic characteristics, as well as presence of IBD, and subtype of IBD were included from the patient’s medical records. Development of subsequent biliary disease, after intestinal resection, was identified via review of the medical records with special attention to abdominal imaging reports and operative reports.

RESULTS: A total of 370 patients with intestinal resection were identified and included in the study. Of those patients, 20 (5.4%) had IBD. 6 with UC and 14 with CD. The 6 UC patients underwent intestinal surgery due to medically refractory disease. Of the 14 CD patients, 12 (86%) had surgery for inflammatory complications (including inflammatory masses, strictures and fistulas), only 1 patient (7%) underwent surgery for medically refractory disease and another patient (7%) had surgery due to a right colonic adenocarcinoma. The majority of our IBD patients were males (85% of CD, 66% of UC). The majority of CD patients (85%) underwent ileal/ileocolic resection, with only 2 patients (14%) had a right hemicolectomy, whereas most UC patients (86%) underwent subtotal colectomy, with only 1 patient (16%) who underwent a total colectomy. Two out of the 20 IBD patients (10%) and 42 out of the 350 non-IBD patients (12%) developed gallstones after intestinal resection (P = 1.0). None of the IBD patients developed post-intestinal resection cholecystitis, cholangitis, cholecholithiasis or biliary pancreatitis compared to the ten, four, and four non-IBD patients who did develop these complications respectively. There was no difference in numbers of cholecystectomy post-intestinal resection between non-IBD and IBD patients [3(9.7%) vs 2 (10%)]. Post resection cholecystectomy rate was 3% and 2% for IBD and non-IBD respectively.

CONCLUSION: Although our numbers are small, presence of IBD was not a significant risk factor for the development of biliary complications after intestinal resection. Our data shows that performing a cholecystectomy at the time of intestinal surgery is not warranted.

METHODS: Trends in physical activity and sleep quality in IBD patients measured with wearable biosensors during the COVID-19 pandemic were assessed. This was a cross-sectional study that included adult IBD patients from a tertiary care referral center of the state (UERJ). The participants were recruited through the biosensor during both the stay-at-home period and the preceding period. The median duration of reported stay-at-home period, and the pre-stay-at-home period was 40 days o 2018 in RJ state. Demographic characteristics included sex, age, work status, geographic region, days off work, average monthly benefit, and ICD-10 K50 with all subdivisions. A sub-analysis was performed on CD patients from UERJ during the same study period using prospectively collected data from the database, analyzed retrospectively to investigate potential risk factors associated with absence from work among CD patients. Additional demographic and clinical characteristics including sex, age, disease duration, disease location, predominant disease phenotype, perianal disease, extraintestinal manifestations, smoking history, prior medications (steroids, immunosuppressants and biologics), duration of biologic use, history of abdominal surgery (defined as the need for bowel resection), prior spontaneous abdominal abscess, previous appendectomy, and Montreux classification were analyzed.

RESULTS: In RJ state, the estimated prevalence of CD was 26.5% per 100,000 inhabitants, while the associated work disability was 16.6%, with indirect costs (focusing on losses related to employment) of US$ 8,562,195.86. Permanent disability occurred more frequently in CD patients aged 40 to 49 years. In UERJ, the prevalence of work disability was 16.7% and the risk factors for absence from work were predominantly disease duration, the A2 profile of the Montreux classification, abdominal surgery and resectional fistulas. Mood disorders were observed in 19% of these UERJ patients, with a mean interval of 3 years between diagnosis of CD and the first benefit.

CONCLUSION: The prevalence of work disability in UERJ CD patients is similar to RJ state and may reflect other regions from Brazil. The risk factors are associated with disease duration and complications of disability. The prevalence of psychiatric manifestations has called attention to potentially neglected aspects of CD, and the need to incorporate specialized multidisciplinary care. Rehabilitation programs are still deficient in the country. The increase in the prevalence of CD in Brazil and the resultant socioeconomic impact of a chronic disease affecting relatively young patients, emphasizes the importance of providing quality medical care in order to mitigate the burden of CD. Early diagnosis and full medical therapy might prevent some of the complications that lead to repeated hospitalizations and surgical interventions and the consequent incremental direct and indirect costs associated with CD.

Should the Gallbladder be Emotionally Removed at Time of Intestinal Resection in Inflammatory Bowel Disease Patients?

Mbah et al.

BACKGROUND: Inflammatory bowel diseases (IBD) are chronic inflammatory diseases of the gastrointestinal tract, which include Crohn’s disease (CD) and ulcerative colitis (UC). Biliary complications are common amongst IBD patients. Up to 25% of patients with UC undergo colectomy and 50-75% of those with ileocolonic CD undergo intestinal resection. In this study, we aim to assess the prevalence of cholecystectomy, including cholecystitis, cholecystectomy, choledocholithiasis, cholangitis, and biliary pancreatitis in IBD patients who have had intestinal resection compared to non-IBD patients who also had intestinal resection. Our study may inform clinical practice in the need to empirically perform a cholecystectomy in IBD patients who undergo intestinal resection.

METHODS: This is a prospective single-institution chart review of IBD and non-IBD patients with a history of intestinal resection. All adult patients, >18 years of age, who underwent an intestinal resection surgery between January 1, 2010 and December 31, 2017 were included in this study. Patients who had a cholecystectomy or presence of gallstones prior to intestinal resection were excluded from this study. For patients meeting inclusion criteria, demographic characteristics, as well as presence of IBD, and subtype of IBD were included from the patient’s medical records. Development of subsequent biliary disease, after intestinal resection, was identified via review of the medical records with special attention to abdominal imaging reports and operative reports.

RESULTS: A total of 370 patients with intestinal resection were identified and included in the study. Of those patients, 20 (5.4%) had IBD. 6 with UC and 14 with CD. The 6 UC patients underwent intestinal surgery due to medically refractory disease. Of the 14 CD patients, 12 (86%) had surgery for inflammatory complications (including inflammatory masses, strictures and fistulas), only 1 patient (7%) underwent surgery for medically refractory disease and another patient (7%) had surgery due to a right colonic adenocarcinoma. The majority of our IBD patients were males (85% of CD, 66% of UC). The majority of CD patients (85%) underwent ileal/ileocolic resection, with only 2 patients (14%) had a right hemicolectomy, whereas most UC patients (86%) underwent subtotal colectomy, with only 1 patient (16%) who underwent a total colectomy. Two out of the 20 IBD patients (10%) and 42 out of the 350 non-IBD patients (12%) developed gallstones after intestinal resection (P = 1.0). None of the IBD patients developed post-intestinal resection cholecystitis, cholangitis, cholecholithiasis or biliary pancreatitis compared to the ten, four, and four non-IBD patients who did develop these complications respectively. There was no difference in numbers of cholecystectomy post-intestinal resection between non-IBD and IBD patients [3(9.7%) vs 2 (10%)]. Post resection cholecystectomy rate was 3% and 2% for IBD and non-IBD respectively.

CONCLUSION: Although our numbers are small, presence of IBD was not a significant risk factor for the development of biliary complications after intestinal resection. Our data shows that performing a cholecystectomy at the time of intestinal surgery is not warranted.

Proton Pump Inhibitors are Associated with Less Severe Periodontal Disease: Considerations for IBD Patients

Verke et al.

BACKGROUND: Proton pump inhibitors (PPI) are frequently used for treatment of gastrointestinal symptoms, including Crohn’s disease patients. It has been suggested that PPI might experience an increased risk of disease complications with use of PPI. GI and oral microbiota, as well as bone metabolism, also are affected by use of PPI. IBD has been associated with an inflammatory host response to bacterial infection that shares many characteristics of periodontal disease (PD). We