Ten patients were identified with IBD and restrictive eating patterns. Age at diagnosis was 7–16 years, 8 females and 2 males. 7 had CD, 2 UC, and 1 IBD. Five patients had known mental health conditions at time of IBD diagnosis (anxiety, ADHD, Major Depressive Disorder). 2/10 patients had formal ED diagnosis before their IBD diagnosis. 8/10 patients developed symptoms of ED after IBD diagnosis and met criteria for ED NOS. 6/8 (75%) patients with ED NOS after IBD diagnosis were exposed to diet therapy: 2 EEN, 4 EEN with subsequent SCD. 3/8 had a prior mental health diagnosis. ED NOS appeared within a median of 22 months from diet therapy initiation (range 2 months–3 years). Of the 2 patients with a previous ED diagnosis, 1 was exposed to diet therapy. Both patients had persistent ED symptoms despite remission with biological therapy. Of the 6 patients with ED NOS after IBD diagnosis who were exposed to diet therapy, 4 had persistent ED despite clinical remission with biological therapy. Lastly, both patients who developed ED NOS after IBD diagnosis and were not exposed to diet therapy had persistent ED NOS symptomatology despite remission with biologics.

CONCLUSION: Eight out of 10 children with IBD and ED disorder symptoms diagnosed before or after IBD diagnosis had persistent ED symptoms despite successful IBD therapy with biologics. The overlap between IBD and ED merits further study to outline the incidence of ED in IBD, possible risk factors for persistent ED and understand patient outcomes. In our case series, ED symptoms persisted in patients regardless of whether nutrition therapy was used or not.

Power Calculations in Randomised Controlled Trials of Inflammatory Bowel Disease

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BACKGROUND: Sample size estimation is a vitally important calculation to make when designing a clinical trial. The 25% of randomised controlled trials (RCTs) on interventions for Inflammatory Bowel Disease (IBD) have no power calculation (PC). We set out to systematically review RCTs reporting interventions for the management of IBD and to use the actual clinical data across these comparisons to produce data for minimum sample sizes that would achieve appropriate power.

METHODS: We included RCTs investigating any form of therapy for the treatment of IBD in patients of any age and interventions for either induction or maintenance of remission against control, placebo, or no intervention. The relevant data was extracted, and the studies were grouped according to the intervention used. We recalculated sample size and the achieved difference, as well as minimum sample sizes needed in the future.

RESULTS: A total of 105 trials were included. There was a large discrepancy between the estimated figure for the minimal clinically important difference used for power calculations and the actual differences seen. The minimum sample sizes to use in future trials were proposed based on the calculations made from actual observed clinical differences from previous studies.

CONCLUSION: A third of intervention studies in IBD within the last 25 years are underpowered, with large variations in the calculation of sample sizes. The resource containing sample size estimates constructed on the published evidence base is required for future researchers and key stakeholders within the IBD trial field.

Measuring Patient-Reported Outcomes in Crohn’s Disease Patients During the Outbreak of COVID-19

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BACKGROUND: There are no data regarding the application of Patient-Reported Outcome (PRO) measures under the COVID-19 pandemic. The aim of the present study was to use a specific PRO measure to assess CD patients during the COVID-19 pandemic.

METHODS: We interviewed 67 consecutive CD patients during the COVID-19 quarantine. We measured PROs using an adapted questionnaire that consists of a structured questionnaire evaluating the impact of gastrointestinal symptoms related to COVID-19 are associated with the need of hospitalization in IBD patients with IBD patients are associated with active intestinal disease, comorbidities and older age. The effect of immunosuppressant medications on the severity of COVID-19 disease still unclear. Our aim was to describe the characteristics of patients with IBD and identify risk factors for hospitalization and inpatient care. We then analyzed association between symptomatology, IBD characteristics, therapies IBD and COVID-19 symptoms with the need of hospitalization in Brazil.

METHODS: The Brazilian IBD Study Group (Grupo de Estudos da Doença Inflamatória Intestinal Brasileira - GEDIIB) developed a 19-question online survey for IBD patients with confirmed COVID-19 assessing clinical characteristics, IBD treatment, medications used for COVID-19 as well as the need for hospital admission due to COVID-19. The survey was distributed from February 28, 2020. Data was analyzed and reported in SPSS Statistics 23 (IBM Corporation, Armonk, New York, United States) and a two-tailed P value of 0.05 was used for statistical significance.

RESULTS: Among 74 respondents: 52.3% were male, the mean age was 37.67 (±9.93) years and most participants (77.0%) had no comorbidities considered risk factors for severe COVID-19. Most participants had Crohn’s disease (72.6%) and 46% reported IBD symptoms at the time of COVID-19 diagnosis. Biological therapies were the most common reported treatment (67.7%), 34% of them in combination with immunomodulators. The most common class of biologic medication utilized was TNF-antagonists (72.9%) and followed by IL-17 inhibitors (57.8%) reported frequent IBD treatment (38.7%), followed by aminosalicylates (31.1%) and corticosteroids (28.4%). The proportion of IBD patients who stopped therapy during COVID-19 was 64.0% for biologics, 53.6% for immunomodulators and 9.5% for corticosteroids. Median duration of COVID-19 symptoms was 13.5 (8–20) days. Gastrointestinal symptoms attributable to COVID-19 were reported by 52.7% of participants and the most common symptom was diarrhea (92.3%). Clinical complications from COVID-19, defined as thromboembolic event, gastrointestinal bleeding, renal or cardiac dysfunction and/or other unspeciﬁed complications, were reported by 21.8% of participants. Gastrointestinal bleeding was the most prevalent (43.8%) reported complication. Overall, 30% of participants visited the emergency room and 17.6% required hospitalization. The frequencies of aminosalicylates and corticosteroid treatment were signiﬁcantly higher in patients requiring hospitalization (respectively, 61.5% vs 24.6%, P = 0.009 and 61.5% vs 21.3%, P = 0.003) while no signiﬁcant differences were observed for biologics or immunomodulators. In hospitalized patients the symptoms of COVID-19 were longer (20 days, IC 18–21 vs 10 days, IC 5–15, P = 0.0001) and the frequency of gastrointestinal symptoms attributable to COVID-19 was also higher (100% vs 42.8%, P < 0.001).

CONCLUSION: Corticosteroids, aminosalicylates, prolonged COVID-19 symptoms and gastrointestinal symptoms related to COVID-19 are associated with the need of hospitalization in IBD patients with COVID-19.

Corticosteroids, Aminosalicylates and Gastrointestinal Symptoms Are Associated With the Need of Hospitalization in Patients With Inflammatory Bowel Diseases and COVID-19

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BACKGROUND: Current evidence suggests that patients with inflammatory bowel disease (IBD) do not have increased risk of infection due to SARS-CoV-2 [1]. However, some studies have shown that IBD patients hospitalized with COVID-19 have higher mortality rates than the general population [2]. The aim of this study was to evaluate the association between clinical characteristics, IBD therapies and COVID-19 symptoms with the need of hospitalization in Brazil.

METHODS: The Brazilian IBD Study Group (Grupo de Estudos da Doença Inflamatória Intestinal Brasileira - GEDIIB) developed a 19-question online survey for IBD patients with confirmed COVID-19 assessing clinical characteristics, IBD treatment, medications used for COVID-19 as well as the need for hospital admission due to COVID-19. The survey was distributed from February 28, 2020. Data was analyzed and reported in SPSS Statistics 23 (IBM Corporation, Armonk, New York, United States) and a two-tailed P value of 0.05 was used for statistical significance.

RESULTS: Among 74 respondents: 52.3% were male, the mean age was 37.67 (±9.93) years and most participants (77.0%) had no comorbidities considered risk factors for severe COVID-19. Most participants had Crohn’s disease (72.6%) and 46% reported IBD symptoms at the time of COVID-19 diagnosis. Biological therapies were the most common reported treatment (67.7%), 34% of them in combination with immunomodulators. The most common class of biologic medication utilized was TNF-antagonists (72.9%) and followed by IL-17 inhibitors (57.8%) reported frequent IBD treatment (38.7%), followed by aminosalicylates (31.1%) and corticosteroids (28.4%). The proportion of IBD patients who stopped therapy during COVID-19 was 64.0% for biologics, 53.6% for immunomodulators and 9.5% for corticosteroids. Median duration of COVID-19 symptoms was 13.5 (8–20) days. Gastrointestinal symptoms attributable to COVID-19 were reported by 52.7% of participants and the most common symptom was diarrhea (92.3%). Clinical complications from COVID-19, defined as thromboembolic event, gastrointestinal bleeding, renal or cardiac dysfunction and/or other unspeciﬁed complications, were reported by 21.8% of participants. Gastrointestinal bleeding was the most prevalent (43.8%) reported complication. Overall, 30% of participants visited the emergency room and 17.6% required hospitalization. The frequencies of aminosalicylates and corticosteroid treatment were signiﬁcantly higher in patients requiring hospitalization (respectively, 61.5% vs 24.6%, P = 0.009 and 61.5% vs 21.3%, P = 0.003) while no signiﬁcant differences were observed for biologics or immunomodulators. In hospitalized patients the symptoms of COVID-19 were longer (20 days, IC 18–21 vs 10 days, IC 5–15, P = 0.0001) and the frequency of gastrointestinal symptoms attributable to COVID-19 was also higher (100% vs 42.8%, P < 0.001).

CONCLUSION: Corticosteroids, aminosalicylates, prolonged COVID-19 symptoms and gastrointestinal symptoms related to COVID-19 are associated with the need of hospitalization in IBD patients with COVID-19.
BACKGROUND: Crohn’s disease (CD) patients present characteristic abnormalities in the mesenteric adipose tissue (MAT) near the affected intestinal area. The MAT is thickened and wraps around the bowel circumference (1). Recent evidence indicates that this tissue plays a role in storing memory immune cells and potentially supporting antigen-driven immune responses (2). Therefore, the present study aims to identify the microRNAs (miRs) pattern of CD MAT, as well as to validate a microarray study focused on the analysis of miRs and messenger RNAs (mRNAs) in CD. These miRs may be involved in the risk of opportunistic infections with the progressive use of immunosuppressors and biological therapy in IBD. This study aimed to determine associated pathogenic factors, the role of perianal disease, disease activity and fecal consistency in anorectal disease patient under follow-up treatment. The first 36 postoperative months were considered as patients with inflammatory bowel disease (IBD). The aim of this study is to determine associated pathogenic factors, the role of perianal disease, disease activity and fecal consistency in anorectal disease patients with IBD. The study was approved by the Research Ethics Committee.


P063 Prophylaxis of Hepatitis B Reactivation and Inflammatory Bowel Disease: A case report Basílio Fabiano1, Amarim Cesar2, Carvalho Márcio3, Martins Carolina3, Fonseca Iubali1, Breves Joanna1, Zulmair Cury1.

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BACKGROUND: The risk of opportunistic infections is increasing with the progressive use of immunosuppressors and biological therapy in IBD treatment. In this scenario, screening for hepatitis B virus (HBV) is important in order to prevent viral reactivation. METHODS: CASE REPORT. A 48 year old female with longstanding ulcerative proctitis (diagnosed in 2005) and salivary gland perineum with 3 bowel movements a day with mucus and blood, diffuse abdominal pain, tenesmus, and urgent evacuation. Laboratory tests showed leukocytosis without left shift, normal platelets and liver tests. Flexible sigmoidoscopy showed a severe disease activity (Mayo score 3) in the rectum and sigmoid. The patient was admitted to our hospital and received IV corticosteroids without response to them. They then were prescribed Azathioprin and Infliximab. HBsAg and anti-HBc Ag were positive. In admission HBV DNA was detected (225 IU/mL). Other labs were consistent with chronic hepatitis B (Anti-HBeAg positive, HBeAg negative, Anti-HBsAg positive). Abdominal ultrasonography and ultrasound were normal. Considering the serological profile and the use of high-dose corticosteroids, infliximab, and azathioprine, Entecavir 0.5 mg/day was initiated.

RESULTS: HBV produces stable coDNA mini-chromosome in infected hepatocytes, that can be present even after the loss of the HBsAg and serocconversion to anti-HBs. coDNA serves as a matrix for reactivation even in patients with a remote history of hepatitis B. This fact explains the impossibility of HBV inhibition evaluation. Viral reactivation in chronic inactive patients is defined as a 2-log increase in HBV-DNA. The use of prophylaxis must be based on the patient’s epidemiological profile and the risk of drugs used and their potential for viral reactivation. Higher doses than 20 mg/day of prednisone for 4 weeks or more are considered of moderate risk but the use of immunosuppressors or biological therapy increase this risk (high risk). Azathioprine immunosuppressors are not associated with viral reactivation, unlike what occurs with the sole use of infliximab. Antimicrobial prophylaxis should be done with nucleotide analogues (NA) with high potency (Entecavir, Telbivudine Disoproxil Famatecur or Telbivudine Alafamidine). Lamivudine and other NAs are not recommended because of the risk of selection of resistant strains, but it can be used if it is the only option. Prophylaxis should be maintained for 6–12 months after the suspension of the immunological agent. Pre-emptive therapy with an antiviral can be performed in moderate risk patients with easy access to serial viral load dosage, transaminases and serology.

CONCLUSION: Screening for HBV infection should be a routine in IBD patients mainly at diagnosis, as HBV reactivation can occur in the context of immunosuppressive therapy. As this risk depends on host factors, virological factors, and type and degree of immunosuppression, therapeutic prophylactic strategies must be individualized.

P064 Manometric Study of the Role of the Perianal Region and the Clinical Activity in Anorectal Dysfunction in Crohn’s Disease Codes Lima1, Jesus Ana2, Ferreira Reginaldo2, Sacramento Carolino, Fidelis Flávia3, Cruz Izaiuba4, Matta Marinea5, Alves Cândida6, Tiquino Almeida7, Guimond Viviane1, Codes João1, Santana Gemelle1,1 Universidade Federal de Uberaba - UFU. Brazil; 2 University of Uberlandia - UEB. Brazil; 3 UNESP - Ribeirão Preto - SP. Brazil; 4 Universidade Federal de Minas Gerais - UFMG. Brazil; 5 Universidade Federal de Campina Grande - UFGC. Brazil; 6 Hospital de Clínicas de Porto Alegre - HC. Brazil; 7 Hospital de Clínicas de Porto Alegre - HC. Brazil; 8 Hospital de Clínicas de Porto Alegre - HC. Brazil; 9 Hospital de Clínicas de Porto Alegre - HC. Brazil.

BACKGROUND: Although Crohn’s disease frequently affects the perianal region and its function, studies evaluating anorectal functional complaints in these patients are rare and with conflicting results. The impact of perianal disease on anorectal functional complaints is not clear, other factors such as disease activity, stool consistency and decreased rectal capacity may have a more important role in its pathogenesis. Athanasius et al. found no association between the values of resting and squeeze pressure, anorectal incontinence, and fecal incontinence in Crohn’s disease (CD) patients. According to the authors, this result could be explained by the difference in the pathophysiology of fecal incontinence among patients with inflammatory bowel disease (IBD). The aim of this study is to determine associated pathogenic factors, the role of perianal disease, disease activity and fecal consistency in anorectal dysfunction in CD patients.

METHODS: This is an observational, cross-sectional study. Fifty-six CD patients under patient follow-up, completed a questionnaire and were submitted to a medical record review, and anorectal manometry. Manometric variables studied resting and squeeze pressure, anorectal incontinence (fistula in anorectal disease). The Mann-Whitney U-test was used to compare the patients with CD and controls.

RESULTS: Of the 56 patients evaluated, 53.6% are male, with a mean age of 41.4 years (SD: 12.4). According to the Montreal Classification, most patients have non-penetrating/non-stenosing disease (61.5%). Perianal disease, was present in 44.2% of the patients. Most patients were in remission, according to the Harvey-Bradshaw Index. Among the functional complaints, the most common is fecal incontinence (38%), followed by a sensation of obstructed/incomplete evacuation and fecal urgency (29%). When patients with anorectal functional complaints (fistula incontinence, incomplete/obstructed evacuation, fecal urgency and tenesmus) were compared with patients without anorectal functional complaints, no statistically significant difference was found in relation to perianal disease. On the other hand, a statistically significant difference was found when we compared the patients with any anorectal functional complaint (fistula incontinence, incomplete/obstructed evacuation, fecal urgency and tenesmus) with the patient without any complaints in relation to activity index of the disease and fecal consistency.

CONCLUSION: Our results suggest that functional complaints in patients with Crohn’s disease are more related to disease activity and fecal consistency, among other factors, than structural and functional anorectal-perianal abnormality, including those caused by perianal involvement of the disease. Therefore, the control of the disease activity probably is critical for the management of this function symptoms.

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