Cannabis Use and Crohn’s Disease: An Analysis of Online Patient Resources

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BACKGROUND: There is considerable interest surrounding cannabis and cannabinoid derivatives as potential therapeutic option for gastrointestinal disorders. It has been reported that patients with inflammatory bowel disease are increasingly incorporating cannabis products into their treatment regimen. As marijuana has become more widely legalized and available, we sought to determine the potential adverse effects of cannabis use. Method: A Google search using “Crohn’s disease” and “cannabis” was performed to obtain the available websites. Websites were excluded if it was an inappropriate format (i.e. blog posts, general webpages, advertisements), inaccessible, or not specific for Crohn’s disease. Sites were categorized by intended audience: professional or consumer. The validated Flesch-Kincaid Grade Level Calculation determined readability. The validated DISCERN questionnaire determined quality, with scores rated as Good (56–75), Fair (36–55), or Poor (<36). Results: One hundred forty-five websites were included, 100 were for consumers. The average Flesch–Kincaid Grade Level was 12.10 (12.43 for professional sites vs 12.05 for consumer sites). The mean DISCERN quality score was 44.04 (57.17 for professional sites vs 42.31 for consumer sites) with no significant difference between website categories. Consumer sites compared to professional sites were less likely to report potential adverse effects of cannabis use (30.68% vs 75%, P = 0.0024) and less likely to acknowledge areas of uncertainty (47.73% vs 83.33%, P = 0.0009). 34% of the websites mentioned shared decision making with a medical provider, with no significant difference between consumer and professional websites (P = 0.6023).

CONCLUSION: This study illustrates the potential shortcomings of online resources addressing cannabis use in Crohn’s disease, specifically with regards to readability, quality, and bias. The majority of websites were directed toward consumers. However, the average readability of both consumer and professional websites was 12th grade level which exceeds the NIH recommended sixth grade level.

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Inflammatory Bowel Disease or Bowel Endometriosis? Two Cases of Large Bowel Obstruction

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CASE: Endometriosis, endometrial glands and stroma outside of the uterus, may occur in “extra-genital” locations and can present with inflammatory symptoms and/or bowel obstruction similar to inflammatory bowel disease (IBD). We report 2 cases of reproductive-aged women with inflammatory and/or obstructive symptoms secondary to presumed IBD who were found to have who were found to have an inflammatory cecal mass during endoscopic evaluation for IBD. At operation, an inverted appendix was identified and removed. Surgical pathology revealed appendiceal endometriosis. The second patient was diagnosed with fibrostenotic and inflammatory Crohn’s disease of the sigmoid colon. Despite treatment with bio- logics, she suffered obstructive symptoms from a sigmoid stricture that could not be traversed endoscopically. She was taken to the operating room for sigmoid colectomy. Final pathology revealed endometriosis.
Background: Approximately 40% of patients with acute severe ulcerative colitis (ASUC) fail corticosteroid therapy, hence it is important to develop criteria which can predict steroid failure earlier. Our aim was to identify variables (clinical, biochemical and endoscopic) and develop a novel 1-stage model for predicting steroid failure.

Methods: All admissions for ASUC (fulfilling Truelove and Witts Criteria) between January 1, 2015 and July 31, 2020 at GCUH and from January 1, 2018 to July 31, 2020 at LGH were retrospectively analysed. Review of electronic medical records was performed and clinical, endoscopic, laboratory data were collected. Steroid failure was defined as need for rescue therapy (medical or surgical). For comparisons of proportions, we used Pearson’s Chi square test or Fisher’s exact test. Quantitative data were compared using t-test or Wilcoxon rank sum test. To test independent predictive factors, a logistic regression model was constructed with the requirement for rescue therapy as the dependent variable.

Results: There were 131 patients with 194 episodes of ASUC included. Seventy-seven (50.3%) female, median disease duration 1.8 years (0–6), 53 (37.3%) index presentation of UC as ASUC. Forty-three (22.2%) episodes were on biological therapy at presentation (26 episodes on anti-TNF antagonists, 17 on Vedolizumab). Seventy-five (38.6%) episodes were on oral corticosteroids at admission. Eighty-eight (43.5%) episodes required rescue therapy [83 episodes received medical rescue (15 cyclosporine/68 Infliximab) and 5 underwent direct colectomy]. Seventeen (8.7%) episodes had a colectomy during the admission for ASUC. On univariate analysis of admission variables, oral steroids (OR 4.21, P < 0.001, CI 3.08–5.89), C-Reactive Protein (CRP) (OR 1, P = 0.005, CI 1.00–1.01), UCEIS score (OR 2.14, P < 0.001, CI 1.53–2.90) were significant for predicting steroid failure. Fecal calprotectin was not predictive of need for rescue therapy (OR 1, P = 0.803). On multivariate regression analysis oral steroids at admission, albumin and UCEIS remained significant. We developed a novel score (ASUC score) allocating 1 point to each variable (S: albumin ≤ 50 g/L, Steroid use at admission, and UCEIS ≥ 7). The performance of consequently developed score was: Sensitivity 85.6%, Specificity 69.7%, PPV 96.9%, NPV 84.7%, accuracy 74%, 43/132 patients (32.6%) of patients with a score of < 0.001, CI 0.004–0.92, AUROC 0.775 were significant for predicting steroid failure and the risk of colectomy in this group is 3 times higher compared to the whole cohort; this group may benefit from upfront second-line therapy.

Conclusion: A novel score (ASUC score) ≥ 2 at admission (serum Albumin: ≤ 30 g/L, oral Steroid use, UCEIS ≥ 7 score) fail intravenous corticosteroid therapy and the risk of colectomy in patients with ASUC was 3 times higher compared to the whole cohort; this group may benefit from upfront second-line therapy.

The Pathway IBD Care in Rio de Janeiro From a Tertiary Referral Center Point of View

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Background: It’s well-established that both Crohn’s disease and ulcerative colitis are a public health challenge worldwide1. The complexity of the diagnosis and the lack of familiarity of primary care practitioners with the different IBD phenotypes can cause a delay in IBD recognition, referral to an IBD unit and consequently treatment. The aim of this study was to evaluate patient care pathway since first symptoms until attendance in a tertiary IBD outpatient unit.

Methods: Retrospective cohort study involving outpatients from a reference IBD unit from a University Federal Hospital in Rio de Janeiro (HUCFF-UFRJ), from 2015 to 2018. The data collected through structured interviews and medical record review were: sex, age at diagnosis, family history, initial and definitive diagnosis; the interval time between symptoms onset and definitive diagnosis, disease type and phenotype, extra-intestinal manifestations (EM), number of medical appointments until definitive diagnosis, type of health system unit where the diagnosis occurred, and first treatment. Statistics were performed using SPSS©v21 software.

Results: There were 188 patients included, 99 (52.6%) with CD and 89 (47.4%) with UC, the majority female (56.4%) with a predominant age group of 17–40 years in both diseases (72.7% CD, 52.8% UC). Family IBD history was more frequent in CD (21.2% vs 12.1%) (P = 0.08). Predominant initial treatment in the UC was with aminosalicylates (38.9%), whereas in CD, the use of symptomatic treatments (24.2%) prevailed. In both diseases, the presumptive IBD diagnosis was made in the private health system (40.4% CD, 46.1% UC), but the definitive diagnosis occurred mainly at the university public hospital (CD: 60.6% vs 21.2%, UC: 50.6% vs 31.5% UC, respectively), not occurring in basic care units. The earlier diagnosis (less than a year) was more significantly obtained in UC (50.6%) in comparison to CD patients (28.3%) (P = 0.001). The first symptoms in CD were in decrescent order: abdominal pain (78.8%), diarrhoea (70.7%), and weight loss (63.6%); and in UC: rectal bleeding (80.9%), diarrhoea (76.4%), and abdominal pain (53.9%). EIM was present in 43.7% UC and 34.4% CD, with a higher frequency of rheumatological manifestations in both diseases (DC 23.2%; UC 21.3%).

Conclusion: Despite the predominance of classic initial symptoms, the diagnosis of IBD was complex and mostly made in reference centers with a significant delay, mainly in CD patients. The introduction of the therapeutic window of opportunity in early disease could progress more active course of disease, delaying or preventing complications and patient’s quality of life. However, the local expertise, availability of minimal testing resources and an IBD care pathway with standardized referral patterns are necessary to provide an earlier diagnosis and treatment.