occurring in 53.2% of patients with DC and 59.1% in UC. Recurrent use of corticosteroids (27.7% in CD and 27.9% in UC) followed by treatment de-escalation (29.8% in DC and 22.7% in UC) were also causes of treatment modification. Currently, 21.4% of patients with CD use immunosuppressants as monotherapy and 44.6% use biologicals as monotherapy compared to UC, where 0% and 3% use immunosuppressants as monotherapy or biologicals as monotherapy (P < 0.001). In UC, 30.3% use 5-aminosalicylic acid (5-ASA) as monotherapy, 15.2% require combined therapy with 5-ASA and immunosuppressants and 9.1% require combined therapy with biological, immunosuppressants and 5-ASA. Corticosteroids are still being used in combination with 5-ASA in 24.2% of this sample. Median time until biological prescription was 14 months in CD and UC respectively (P = 0.51).

CONCLUSION: In this study, most patients required treatment modification, most cases due to lack of response. This finding highlights the severity of PIBD, where immunosuppression and combined therapy are often required. Monotherapy was statically more frequent in CD than UC. This probably reflects a misdiagnosis in immunosuppression in UC. Use of corticosteroids was also more frequently seen in UC than CD.

P069
Admission Steroid Use, Serum Albumin and Endoscopic Severity Predict Intravenous Steroid Failure in Patients With Acute Severe Ulcerative Colitis
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BACKGROUND: About 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 day 1 score 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 tests. 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 151 patients with 194 episodes of ASUC included. Seventy-seven (50.3%) female, median disease duration 1.8 years (0–6), 53 (37.3%) were index presentation of UC. 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 (43.6%) episodes required rescue therapy [83 episodes received medical rescue (15 cyclosporin/68 Infliximab) and 5 underwent direct colectomy]. Seventy (87.7%) episodes had a colectomy during the admission for ASUC. On univariate analysis of admission variables, oral steroids (OR 4.21, P < 0.001, CI 8.8-9.7), CRP (OR 1, P = 0.005, CI 1.00-1.01), UCEIS score (OR 2.14, P < 0.005, CI 1.58–2.96) 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 predictors of steroid failure (OR 3.14, CI 1.58–6.91, P < 0.001). The area under ROC curve for predicting steroid failure was 0.803. On multivariate regression analysis oral steroids (OR 4.21, CI 2.76–6.42, P < 0.001), CRP (OR 1.56, CI 1.39–1.75, P < 0.001) and UCEIS (OR 1. 0.70–1.12, P = 0.015, CI 1.00-1.10) were significant predictors of steroid failure. On multivariate regression analysis, UCEIS score and albumin remained significant.

CONCLUSION: In patients ≥ 60 years of age, steroid failure rate, the need for colectomy during the same admission and albumin at 12 months is similar to a population.

P071
Fistula Healing After Fecal Diversion Surgery in Perianal Crohn’s Disease: A Case Series
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BACKGROUND: Perianal fistulas are seen in 25% of patients with Crohn’s disease and are often refractory to medical therapy. Fecal diversion is used to treat perianal fistula, with 63% in clinical improvement, however data on fistula healing rates are often not reported. This case series aims to evaluate the response of complete fistula healing in complex perianal Crohn’s disease after fecal diversion.

METHODS: Patients with perianal Crohn’s disease who underwent fecal diversion surgery from June 1, 2016 to June 1, 2020 with colorectal surgeons at UC Davis were selected through electronic medical record chart extraction using ICD-10 and CPT codes.

RESULTS: 22 patients were selected with refractory perianal fistula undergoing fecal diversion surgery from June 1, 2016 to June 1, 2020. Fistula healing was evaluated through imaging or exam under anes-thesia. One patient was lost to follow up after surgery and not included in the outcomes. Time to follow up ranged from 4 to 24 months, with a mean of 11 months. Patient were aged 22–60 years (5/ 11 females). Ten of 11 patients underwent fecal diversion at time of surgery. 4/10 (40%) had complete fistula healing, 6/10 (60%) had persistent fistula, and 3/10 (30%) were readmitted within 90 days for complications. Most frequent complications observed were peristomal wounds/skin infection (3/10), high ostomy output/dehydration (2/10), bowel obstruction (1/10). Two patients required proctectomy.

CONCLUSION: Fistula healing rates after fecal diversion were low, at 40% and is accompanied by frequent complications such as output high ostomy.

P072
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 and ulcerative colitis are a public health challenge worldwide1. The complexity of the diagnosis and the lack of familiarity of care practitioners with the different IBD phenotypes can cause a delay in IBD recognition, referral to an IBD center, and consequently interrupt patient’s 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 (HUCC-FURJ), 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 between symptoms onset and definitive diagnosis; disease type and phenotype, extra-intestinal manifestations (EMD), number of medical appointments until definitive diagnosis, type of health system unit where the diagnosis occurred, and first treatment. Statistics were performed using SPSSv21 software.

RESULTS: There were 188 patients included, 99 (52.6%) with CD and 89 (47.3%) 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 (39.8%), 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, re- spectively), 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%), diarrhea (70.7%), and weight loss (63.6%); and in UC: rectal bleeding (80.9%), diarrhea (76.4%), and abdominal pain (53.9%). EIM were present in 43.7% UC and 34.6% CD, with a higher frequency of rheumatological manifestations in both diseases (DC 23.2%, UC 23.1%).

CONCLUSION: Despite the predominance of classic initial symptoms, the diagnosis of IBD was complex and mostly made in reference centers with a significative delay, mainly in CD patients. The introduction of treatment during the therapeutic window of opportunity in early disease may progress as a progressive 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 standard referral patterns are necessary to provide an earlier diagnosis and treatment.

P073
Analysis of Dysbiosis in Crohn’s Disease by Next-Generation Sequencing: One Size Does Not Fit All
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