values were obtained using univariate logistic regression with $P < 0.05$ significant. True area under the curve (AUC) was estimated to be within 0.7 to 0.9, with 0.8 as a cut point for clinical relevance.

RESULTS: A total of 85 patients (66% Crohn's disease, 34% Ulcerative colitis, 48 male, 37 female) with mean age 42.5 ± 14.6 were included. Eighty-four patients were on at least one medication for IBD, including 52.4% on steroids, 23.8% on immunomodulators, and 23.8% on biologics. Albumin level (OR = 0.52, $P = 0.039$) and biologic use (OR = 5.92, $P = 0.006$) were significantly associated with post-operative complications. The predictive models incorporating sarcopenia, either as a dichotomous variable or PMTH as a continuous variable, were not significantly different from a model with hypoalbuminemia and biologic use ($P = 0.73$). Sarcopenia on univariate analysis was only significantly associated with lower rate of 30-day reoperation ($P = 0.04$).

CONCLUSION: While PMTH as a surrogate marker for sarcopenia was not a predictor of post-operative outcomes, hypoalbuminemia and biologic use were. An unexpected association between sarcopenia and lower 30-day reoperation rates may be due to hesitancy to take sarcopenic patients back to the operating room. Sarcopenia defined by PMTH may have a role in decision making with nutritional markers, however larger studies that compare PMTH with accepted radiographic surrogates for sarcopenia and risk assessment in IBD patients are needed.

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P018

Vitamin D and Related Parameters: A Prospective IBD Patient Cohort with Active vs Remission State and a Healthy Control Group

Akin Hakan[1], Kurt Ramazon[1], Imeryuz Nese[1].
[1]Marmara University, Istanbul, Turkey.

BACKGROUND: Vitamin D deficiency is associated with Inflammatory Bowel Disease (IBD) but the relationship with IBD disease activity with Vitamin D is controversial. The aim of our study is to investigate the relationship between Vitamin D related parameters and disease activity in a prospective IBD cohort by comparing patients' active vs remission period values. The study also looks at data from a healthy control group.

METHODS: The study included a cohort of 88 patients diagnosed with active IBD until they achieved disease remission phase. A group of 87 healthy controls with similar age, gender characteristics were enrolled to the study. Active and remission period was determined by using Crohn's Disease Activity Index and Harvey-Bradshaw Index for Crohn's disease and Mayo Clinic Score for Ulcerative Colitis patients. Active and remission period serum samples from the patient group and samples from the control group were stored at -80Celsius. 25 (OH) D, calcium, phosphorus, parathyroid hormone, albumin, Vitamin D Binding Protein levels were measured by using ELISA method and colorimetric method, then bioavailable vitamin D level was calculated. All demographic, clinical and laboratory results were analyzed using SPSS 20:00. In the patient group each patient's own parameters were used for the comparison of remission and relapse phases of the IBD at statistical analysis. Additionally, patient's data was compared with healthy control group's data separately.

RESULTS: 25(OH)D is significantly higher in the healthy control group (25,86 ng/ml) according to IBD group active period (15,45 ng/ml) and remission period (15,13 ng/ml) (for both $P = 0.000$). Results of the active period and remission period were similar ($P = 0.570$). Bioavailable vitamin D is significantly higher in control group (4,28 pg/ml) compared with IBD active period (2,56 pg/ml) and remission period (2,52 pg/ml) (for both $P = 0,000$). The active and remission period results were similar ($P = 0.608$). Vitamin D Binding Protein (DBP) was significantly lower in control group (206,72 ng/ml) compared with IBD active period (321,86 ng/ml) and remission period (332,68ng/ml) (for both $P = 0.000$). The active and remission periods results were similar ($P = 0.595$). Parathyroid hormone is significantly higher in control group (40,12 pg/ml) compared with IBD group active period (13,85 pg/ml) and remission period (14,86 g/ml) (for both $P = 0,000$). The active and remission period results were similar ($P = 0,280$).

CONCLUSION: The strongest aspect of this study is that it is a prospective cohort study that enabled us to compare the very same patient's own Vitamin D related parameters at active and remission and by excluding most other patient-related confounding factors. Our results showed that Vitamin D deficiency is common in IBD but 25(OH)D levels in active and remission periods of the same patient were similar. This shows that vitamin D has no effect on IBD disease activity. Looking at the bioavailable vitamin D in IBD had no additional benefit, because statistical data was similar as data of 25(OH)D. DBP levels were significantly higher in IBD indicate that DBP may be a marker of inflammation. Further studies are needed.

P019

Covid-19 Infection in a Patient with Crohn's Disease Under Treatment with Ustekinumab - Case Report

Almeida Clarissa[1], Maluf Fauze[1], Fachin Adriano[2], Almeida Maristela[2].
[1]Faculdade de Medicina do ABC, Santo André, Brazil; [2]Professor Edmundo Vasconcelos Hospital, São Paulo, Brazil.

CASE: We report a case of a 44-year-old patient with ileocolonic Crohn's disease, infected with SARS-Cov-2 and, on treatment with ustekinumab for six months. The patient has been treated for Crohn's disease since 2002. Ustekinumab was prescribed after the failure of treatment with infliximab and adalimumab six months ago. In May 2020, she presented headache, coryza, general malaise, and a temperature of 37.7ºC, which persisted for two days. She sought an emergency room for investigation and presented the following lab tests results: Hb = 14.9g/dl; Ht = 44%; Total leucocytes = 8400/mm^3; Lymphocytes = 15% (normal range 20-45%); Platelets count = 357.000/mm^3; CPR = 20mg/L (normal value < 500ng/mL), oxygen saturation = 97%. Chest tomography showed ground-glass peripheral pulmonary opacities with impairment of less than 25%. Given Covid-19 suspicious, rt-PCR for SARS-Cov-2 was collected and the result was positive. She was discharged to her home with symptomatic pills and azithromycin 500mg/day for 5 days. In the following days, she presented diarrhea (8x/day), nausea, vomiting, and returned to the emergency room for intravenous medication and hydration. After this treatment, she was discharged again to her home. There was an improvement in symptoms, but diarrhea persisted for 8 days. The next maintenance dose of ustekinumab was suspended for 15 days. After this period, she collected a control rt-PCR for SARS-Cov-2 that resulted negative and, returned to use biologic therapy without presenting any complication. In this case, there was a good recovery of Covid-19 even during the use of ustekinumab. The possibility of performing rt-PCR and monitoring signs and symptoms of the disease, allowed the period of active infection to be properly controlled. Additionally, biological therapy could also be promptly resumed without jeopardizing the treatment of Crohn's disease.

P020

Incidence of Suboptimal Response to First-Line Anti-TNF Therapy in Patients with IBD in Argentina: Results from the EXPLORE Study

Zubiaurre Ignacio[1], Pedreira Silvia C[2], De Maria Julio[3], Balderramo Domingo C[4], Brion Laura[5], Leonardi Daiana B[5], Guimaraens Patricia N[5], Fadeeva Olga[6], De Paula Juan A[7].
[1]Hospital Britànico de Buenos Aires, Buenos Aires, Argentina; [2]Hospital Alemàn, Buenos Aires, Argentina; [3]Hospital Italiano La Plata, La Plata, Argentina; [4]Hospital Privado Centro Médico de Córdoba & Instituto Universitario de Ciencias Biomédicas de Córdoba, Cordoba, Argentina; [5]Medical Affairs, Takeda Pharma S.A., Buenos Aires, Argentina; [6]Medical Affairs, Takeda Pharmaceutical International AG, Singapore, Singapore; [7]Hospital Italiano Buenos Aires, Buenos Aires, Argentina.

BACKGROUND: While anti-TNFs have long been a mainstay in UC and CD management, a considerable proportion of patients experience treatment failure. The aim of this sub-analysis from the main EXPLORE study (NCT03090139) was to assess suboptimal response to anti-TNFs in Argentina.

METHODS: Patients with Ulcerative Colitis (UC) and Crohn´s Disease (CD) who initiated first-line anti-TNF therapy between March 2010 and March 2015 from 5 centers in Argentina were enrolled. Anti-TNF dose escalation or discontinuation, IBD-related surgery or hospitalizations, and augmentation of non-biological therapy were considered indicators of suboptimal response to anti-TNF therapy. Primary non-response (PNR) was defined as suboptimal response that occurred within 4 months of anti-TNF initiation (index date), and secondary loss of response (SLOR) if this occurred > 4 months after initiation. The cumulative incidence (CI) of suboptimal response to first-line anti-TNF therapy was evaluated within 2 years after treatment initiation.

RESULTS: A total of 78 first-line anti-TNF treated patients were analyzed (n = 40 CD, n = 38 UC). Females represented 45.0% and 52.6% in CD and UC, respectively. At diagnosis, over half of the CD patients had ileocolonic disease involvement (55.0%), while 47.4% and 39.5% of the UC patients showed a left-sided colitis and extensive involvement (including pancolitis), respectively. Median age at diagnosis was 31 years (range 13-67) and 29 years (range 11-80) for CD and UC, respectively. Median age at first-line anti-TNF treatment was 34.5 years (range 22-70 for CD and 19-81 for UC). About 36.9% of CD patients had a disease duration between 0 to < 2 years to index date, 33.3% ≥ 2 to 5 years, 10.3% ≥ 5 to < 8 years and 20.5% ≥ 8 years; the respective proportions were 50.0%, 15.8%, 13.2% and 21.0% in UC.Within 2 years of treatment initiation, PNR was 15.0% in CD (n = 6) and 10.5% in UC (n = 4), while SLOR was 42.5% in CD (n = 17) and 31.6% in UC (n = 12). The CI of suboptimal response for the first anti-TNF agent was 37.9% and 30.0% at 12 months and 49.2% and 44.5% at 24 months for CD and UC, respectively. Augmentation in non-biological therapy and dose escalation of the anti-TNF were the most frequent indicators of suboptimal response in both conditions (30.4% and 26.1% [CD]; 25.0% and 56.3% [UC]).

CONCLUSION: In accordance with other real-world studies, almost half of first-line anti-TNF treated IBD patients evaluated in 5 centers in Argentina experienced suboptimal response to their first-line anti-TNF therapy within 2 years. Determining response-predictive biomarkers and the use of newer therapies may help improve treatment outcomes in IBD.

P021

Characteristics of Patients Treated with Tofacitinib for Ulcerative Colitis in the Real World: Findings from a Large US Claims Database

Chiorean Michael[1], Sharma Puza[2], Chastek Benjamin[3], Salese Leonardo[4], Bell Elizabeth[3], Peterson-Brandt Jesse[3], Cappelleri Joseph[5], Guo Xiang[4], Khan Nabeel[6].
[1]Virginia Mason Hospital, Seattle, United States; [2]Pfizer Inc, New York City, United States; [3]Optum, Eden Prairie, United States; [4]Pfizer, Inc., Collegeville, United States; [5]Pfizer, Inc., Groton, United States; [6]University of Pennsylvania School of Medicine, Philadelphia, United States.

BACKGROUND: Tofacitinib (TOF) is an oral, small molecule Janus kinase inhibitor approved for the treatment of moderate to severe ulcerative colitis (UC). The objective of this study is to describe real-world experience with TOF since emerging real-world data in UC in the US is limited.

METHODS: Commercial and Medicare Advantage plan members from the Optum Research Database with a diagnosis of UC who initiated treatment with TOF between May 2018 and July 2019 were included. Demographic and baseline characteristics including age, gender, comorbidities, insurance type, and prior therapies were evaluated. Drug adherence (proportion of days covered [PDC]) was assessed in the 6-month follow-up period after TOF initiation. Analyses were stratified based on prior biologic drug use (1 or 2+ agents).

RESULTS: Of the 182 patients who initiated TOF, 92 patients (51%) had 1 prior biologic and 90 patients (49%) had 2+ prior biologic use. Mean (SD) age was 45.5(15.4) and 45.2(17.4) years for patients with 1 and 2+ biologics, respectively. 53% of the cohort with 1 biologic was female vs. 47% with 2+ biologics. Most patients had commercial coverage – 84% (1 biologic) and 89% (2+ biologics). Among TOF patients with 1 prior biologic use, 82.6% were previously treated with a tumor necrosis factor inhibitor (TNFi) and 17.4% vedolizumab (VDZ). Among TOF patients with 2+ biologics, 54.4% were treated with VDZ + a TNFi, 16.7% were treated with two TNFis, and the remaining 28.9% were treated with 3 or more biologics prior to baseline. Approximately half of the sample in both cohorts were treated with 5-ASA and one-third were treated with immunomodulators in the 6 months prior to TOF treatment initiation. Mean (SD) 12-month baseline Charlson score was 0.72(1.49) and 0.66(1.16) for patients with 1 and 2+ biologics, respectively. Most patients, 73.9% (1 biologic) and 77.8% (2+ biologics), were treated with an oral corticosteroid (OCS) in the 12 months

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