P321

Cessation of Anti-Tumour Necrosis Factor Therapy in Patients with Perianal Fistulizing Crohn's Disease: Individual Patient Data Meta-Analysis of 323 patients from 12 studies

S. Ten Bokkel Huinink* MD[1], J. van der Woude[1], M.J. Casanova[2], G. Bouguen[3], J.W.Y. Mak[4], T. Molnar[5], J. Seidelin[6], A. Aurelien[7], G. D'Haens[8], P. Riviere[9], L. Guidi[10], B. Renata[5], W.C. Lin[11], A. de Vries[12]

[1]*Erasmus Medical Center, Gastroenterology and hepatology, Amsterdam, The Netherlands,* [2]*Hospital Universitario de La Princesa- Instituto de Investigación Sanitaria Princesa IIS-IP-Universidad Autónoma de Madrid UAM and Centro de Investigación Biomédica en Red de Enfermedades Hepáticas y Digestivas CIBEREHD, Gastroenterology, Madrid, Spain,* [3]*University Hospital of Pontchaillou, Gastroenterology and Hepatology, Rennes, France,* [4]*Chinese University of Hong, Medicine and Therapeutics, Hong Kong, Hong Kong- China,* [5]*University of Szeged, First department of Medicine, Szeged, Hungary,* [6]*Herlev Hospital, Gastroenterology and Hepatology, Copenhagen, Denmark,* [7]*Henri Mondor Hospital-Assistance Publique-Hôpitaux de Paris APHP- Paris Est Creteil University UPEC, Gastroenterology, Creteil, France,* [8]*Amsterdam UMC- location AMC, Gastroenterology and Hepatology, Amsterdam, The Netherlands,* [9]*Hospitalier Universitaire, Gastroenterology and Hepatology, Bordeaux, France,* [10]*Università Cattolica del Sacro Cuore, Internal medicine, Rome, Italy,* [11]*Mackay Memorial Hospital, Gastroenterology and Hepatology, Taipei, Taiwan- Province Of China,* [12]*Erasmus MC, Gastroenterology and Hepatology, Rotterdam, The Netherlands*

Background: The risk of relapse after anti-tumour necrosis factor [TNF] therapy cessation in Crohn's disease [CD] patients with perianal fistulas is unclear. We aimed to assess the risk of relapse after anti-TNF cessation in a large cohort and to identify risk factors.

Methods: A systemic literature search was conducted to identify cohort studies reporting on the incidence of relapse after cessation of anti-TNF therapy in CD patients. Individual patient data [IPD] were requested from the original study cohorts. Inclusion criteria for IPD-meta-analysis (IPD-MA) included age ³ 18 years, perianal fistulizing CD as indication for start of anti-TNF therapy, minimal treatment duration ³3 doses, and remission of luminal and perianal CD at cessation of anti-TNF therapy. Primary outcome was CD relapse [either perianal or luminal]. Perianal fistula relapse was defined as recurrence of draining perianal fistula related to previous or new fistula tracks, or abscess. Luminal relapse was defined as a clinical, biochemical, endoscopic, or radiological relapse requiring treatment or dose optimization of IBD medication or surgery. In a secondary analysis, risk factors associated with relapse were assessed using multivariate logistic regression analysis.

Results: A total of 307 patients from 12 studies in 9 countries were included in this IPD-MA. The median duration of anti-TNF treatment prior to therapy cessation was 14 months [IQR 6.1 – 29.9]. In 272/307 patients [89%] anti-TNF therapy was started for active perianal fistula and in 34 [11%] for both active perianal fistula and luminal CD. 169 patients [55%] developed a relapse [either perianal or luminal] after a median follow-up after cessation of 25 months [IQR 12 – 54]. Overall cumulative incidence of relapse was 31% and 43% at 1 and 2 years after anti-TNF cessation. Risk factor for CD relapse include upper GI involvement (L4) [HR 1.9], whereas older age [A3 vs A1, HR 0.48] and continuation of concomitant immunomodulators [HR 0.62] were protective factors. For a subgroup of patients with active perianal fistula and in luminal remission at start of anti-TNF, the cumulative incidence relapse rates were 25% and 43% at 1 and 2 years. No considerable differences in risk factors were found within this subgroup regarding risk of recurrence. Of the 179 patients who relapsed, 104 were retreated with anti-TNF with a response rate of 85%.

Conclusion: According to this IPD-MA, approximately two-thirds of CD patients with perianal fistula remain in remission with regard to fistulizing and luminal disease during 2 years after cessation of anti-TNF therapy. Further risk stratification based on perianal fistula characteristics is required.

P322

Hepatitis B reactivation under biologic therapy in patients with HBsAg negative phase of chronic HBV infection

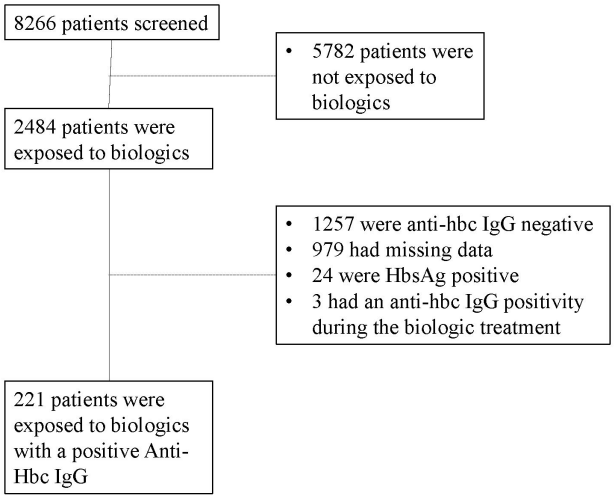
I. Ergenç*[1], H.T. Kani[1], M. Karabacak[2], E. Cömert Özer[3], S. Mehdiyev[1], F. Jafarov[1], K.Y. Abacar[2], S. Kutluğ Ağaçkıran[2], G. Seven Sevik[2], F. Alibaz Öner[2], N. İnanç[2], M.P. Atagündüz[2], D.S. Gençosmanoğlu[3], Y. Özen Alahdab[1], T. Ergun[3], R.H. Direskeneli[2], Ö. Atuğ[1]

[1]*Marmara University School of Medicine, Gastroenterology, istanbul, Turkey,* [2]*Marmara University School of Medicine, Rheumatology, istanbul, Turkey,* [3]*Marmara University School of Medicine, Dermatology, istanbul, Turkey*

Background: Biologic agents are widely used in immune mediated inflammatory diseases (IMID). The risk and consequences of hepatitis B reactivation in hepatitis B surface antigen (HBsAg) negative phase of hepatitis B virus (HBV) exposed patients is not clear. We aim to investigate the reactivation rate in biologic exposed patients within surface antigen negative phase of HBV infection.

Methods: We identified patients followed up at gastroenterology, rheumatology and dermatology out-patient clinics with a diagnosis of IMID from clinical charts. Patients exposed to biologic agents with a negative HBsAg and positive Anti-HBc IgG were included. Primary outcome was HBV reactivation, which was defined as reverse seroconversion of HBsAg.

Figure 1: Patients included the study



Results: We screened 8266 IMID patients and 2484 of them were exposed to biologic agents. A total of 221 patients were included in

the study. The mean age was 54.08 ± 11.69 years and 115 (52.0%) patients were female. The median number of different biologic subtype use was 1 (range: 1 – 6). The mean biologic agent exposure time was 55 (range: 2 – 179) months. One hundred and fifty-two (68.8%) patients were using concomitant immunomodulatory agents and 84 (38.0%) patients were exposed to corticosteroids during biologic use. No hepatitis B reactivation with a reverse seroconversion of HBsAg positivity was observed in the whole cohort. Antiviral prophylaxis for hepatitis B was given to 48 (21.7%) patients with entecavir, tenofovir or lamivudine. HBV-DNA was screened in 56 (25.3%) patients prior to the biologic exposure. Two patients had HBV-DNA reactivation with a negative HBsAg during exposure to the biologic agent.

Table 1: Clinical characteristics of the patients.

Diagnosis (n)	
Rheumatoid arthritis	55 (24.9%)
Spondylarthritis	76 (34.4%)
Inflammatory Bowel Disease	20 (9.0%)
Psoriasis	57 (25.8%)
Behçet's disease	7 (3.2%)
Takayasu arteritis	4 (1.8%)
Still disease	1 (0.5%)
Temporal arteritis	1 (0.5%)
Exposed biological agents n (%)	
Infliximab	41 (18.6%)
Adalimumab	67 (30.3%)
Etanercept	38 (17.2%)
Certolizumab	13 (5.9%)
Golimumab	14 (6.3%)
Ustekinumab	17 (7.7%)
Secukinumab	5 (2.3%)
Abatacept	11 (5.0%)
Ixekizumab	1 (0.5%)
Tocilizumab	4 (1.8%)
Tofacitinib	10 (4.5%)
Hepatitis B DNA screening prior to biologic exposure n (%)	
Screened	56 (25.3%)
Not Screened	165 (74.7%)

Conclusion: Though only 21.7% of our patients used prophylaxis, we found only two reactivations (1%) and no HBsAg seroconversion in our cohort. Our results suggest a re-assessment of antiviral prophylaxis for anti-HBc Ag (+) patients exposed to biologic agents. Current guidelines would be updated in the light of future studies.

P323

Efficacy and safety of tofacitinib treatment for one year in Japanese patients with Ulcerative Colitis in a specialized Inflammatory Bowel Disease center

K. Kojima*[1], K. Yokoyama[1], K. Kaku[1], Y. Takashima[1], T. Sato[1], M. Kawai[1], K. Kamikozuru[1], T. Takagawa[1], Y. Yokoyama[1], K. Watanabe[1]

[1]Hyogo College of Medicine, Center for Inflammatory Bowel Disease- Division of Internal Medicine, Nishinomiya, Japan

Background: Few reports of the real-world efficacy and safety of tofacitinib (TFB) in Asians are available, and potential predictors of the response to therapy are unclear. We investigated the efficacy and safety profiles of TFB treatment for one year in patients with active Ulcerative Colitis (UC) in our specialized Inflammatory Bowel Disease center.

Methods: This study included 111 patients who received TFB between May 2018 and February 2020. We assessed disease activity using the partial Mayo Score (pMS). Clinical remission was defined as pMS ≤2, with no subscore >1 and a rectal bleeding subscore of 0. Clinical response was defined as a decrease in pMS of ≥2 points from baseline with an accompanying decrease in the rectal bleeding subscore of ≥1 point or an absolute rectal bleeding subscore of ≤1 point.

Results: Mean patient age was 35 years (interquartile range [IQR]: 28-47), 60 (59.4%) were men, and mean disease duration was 4.8 years (IQR:1.5-10). The pMS was 6 (IQR:4-7) and C-reactive protein was 0.30 mg/dl (IQR: 0.1-1.0). At baseline, 63 (62.4%) patients received an anti-TNFα agent, 11 (10.9%) received vedolizumab, and 7 (6.9%) received both. Clinical response and clinical remission were, respectively, 66.3% (67/101) and 50.5% (51/101) at week 8, and 47.1% (40/85) and 43.5% (37/85) at week 48. The cumulative remission rate was 61.7% at 1 year and 51.7% at 2 years, and tended to be better in the ≥2 anti-TNFα agents failure group than in the 1 anti-TNFα agent failure and bio-naïve groups (P=0.10). Cumulative colectomy-free survival was 91.9% at 1 year and 89.1% at 2 years. Cumulative drug-free survival in the non-remission group at week 8 was 30.9% at 1 year and 30.9% at 2 years, significantly lower than in the remission-achieving group at week 8 (P<0.01). Baseline pMS was significantly lower in responders vs non-responders at week 8 (odds ratio, 0.61; 95% confidence interval, 0.45-0.82). Relapse occurred in 45.7% of patients after tapering TFB, and 85.7% of patients with re-increased TFB responded by week 4. Herpes zoster occurred in 6 unvaccinated patients (46±16 years old). There were no specific features regarding age, TFB dosage, duration of administration, or lymphocyte count in these patients. No thrombotic adverse events occurred, even though 54.1% patients continued treatment with 10 mg twice daily at week 48.

Conclusion: TFB was more effective in low-activity UC patients and its efficacy was not affected by previous treatment with anti-TNF agents. Most patients in the remission groups at week 8 could continue TFB for one year without severe adverse events, although careful monitoring for herpes zoster is necessary. The risk of thrombotic adverse events might be lower in Japanese UC patients.

P324

Predictors of corticosteroid-free remission after initiation of ustekinumab for ulcerative colitis: a real-world, multicenter cohort study in the United States

R. Dalal*[1], S. Esckilsen[2], E. Barnes[3], E. McClure[1], H. Goodrick[1], J. Allegretti[1]

[1]Brigham and Women's Hospital- Harvard Medical School, Gastroenterology- Hepatology and Endoscopy, Boston, United States, [2]University of North Carolina at Chapel Hill, Medicine, Chapel Hill- NC, United States, [3]University of North Carolina at Chapel Hill, Gastroenterology and Hepatology, Chapel Hill- NC, United States

Background: Clinical trial data has demonstrated the efficacy of ustekinumab (UST) for the treatment of ulcerative colitis (UC), however real-world clinical outcomes data are limited. We therefore