

DOP Session 5 - Recent advances in epidemiology

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Large differences in IBD care and education across Europe, first results of the pan-European VIPER survey

J. Král* PhD¹, R. Nakov², V. Lanska³, B. Barberio⁴, N. Benech⁵, A. Blesl⁶, E. Brunet⁷, T.L. Capela⁸, L.A.A.P. Derikx⁹, G. Dragoni¹⁰, A. Eek¹¹, C. Frias-Gomes¹², G.E. Gilcă-Blanariu¹³, L. Gilroy¹⁴, P.R. Harvey¹⁵, A. Kagramanova¹⁶, H.T. Kani¹⁷, T. Konikoff¹⁸, M. Lessing¹⁹, G.R. Madsen²⁰, V. Maksimaityte²¹, M. Miasnikova²², I. Mikolasevic²³, V. Milivojevic²⁴, D. Noviello²⁵, D. Oliinyk²⁶, A. Patai²⁷, A.A. Protopoulos²⁸, I. Rodríguez-Lago²⁹, P. Schreiber³⁰, V. Skuja³¹, F. Tran¹⁹, M. Truysens³², M. Włodarczyk³³, H. Zatorski³⁴, B. Verstockt³⁵, J.P. Segal³⁶

¹Institute for Clinical and Experimental Medicine, Department of Hepatogastroenterology, Prague, Czech Republic, ²Tsaritsa Yoanna University Hospital- Medical University of Sofia, Department of Gastroenterology, Sofia, Bulgaria, ³Institute for Clinical and Experimental Medicine, IT Department, Prague, Czech Republic, ⁴Gastroenterology Unit- University of Padova-Azienda Ospedaliera di Padova, Department of Surgery- Oncology and Gastroenterology DISCOG, Padova, Italy, ⁵Saint Antoine Hospital- AP-HP, Department of Gastroenterology, Paris, France, ⁶Medical University of Graz, Department of Internal Medicine- Division of Gastroenterology and Hepatology, Graz, Austria, ⁷Hospital Parc Tauli, Department of Gastroenterology, Sabadell, Spain, ⁸Hospital Senhora da Oliveira, Gastroenterology Department, Guimarães, Portugal, ⁹Inflammatory Bowel Disease Center- Radboud University Medical Center, Department of Gastroenterology and Hepatology, Nijmegen, The Netherlands, ¹⁰IBD Referral Center- Careggi University Hospital, Department of Gastroenterology, Florence, Italy, ¹¹Tartu University hospital, Department of Gastroenterology, Tartu, Estonia, ¹²Hospital Beatriz Ângelo, Gastroenterology division- Surgery department, Loures, Portugal, ¹³Grigore T Popa University of Medicine and Pharmacy, Gastroenterology Department, Iași, Romania, ¹⁴Royal Victoria Hospital, Department of Gastroenterology, Belfast, United Kingdom, ¹⁵Harvey PR- Russells Hall Hospital, Department of Gastroenterology, Dudley, United Kingdom, ¹⁶Moscow Clinical Scientific Centre n.a. A.S. Loginov, IBD department, Moscow, Russian Federation, ¹⁷Marmara University- School of Medicine, Department of Gastroenterology, Istanbul, Turkey, ¹⁸Rabin Medical Center- Sackler Faculty of Medicine, Division of Gastroenterology, Tel-Aviv, Israel, ¹⁹University Medical Center Schleswig-Holstein, Department of Internal Medicine I, Kiel, Germany, ²⁰Copenhagen University Hospital Hvidovre, Gastroenterology, Copenhagen, Denmark, ²¹Institute of Clinical Medicine- Faculty of Medicine- Vilnius University, Clinic of Gastroenterology- Nephrology- and Surgery, Vilnius, Lithuania, ²²Medical Center Medeor, Out-patient department, Chelyabinsk, Russian Federation, ²³UHC Rijeka and UH Merkur, Department of Gastroenterology, Rijeka, Croatia, ²⁴Clinical center of Serbia- School of medicine, Clinic for gastroenterology and hepatology, Belgrade, Serbia, ²⁵University of Milan, Department of Pathophysiology and Transplantation, Milan, Italy, ²⁶Bogomolets

National Medical University, Department of surgery №1, Kyiv, Ukraine, ²⁷Semmelweis University, Department of Internal Medicine and Hematology, Budapest, Hungary, ²⁸Aristotle University of Thessaloniki- AHEPA Hospital, First Propedeutic Department of Internal Medicine, Thessaloniki, Greece, ²⁹Hospital de Galdakao, Department of Gastroenterology, Galdakao, Spain, ³⁰University Hospital Zurich, Department of Gastroenterology & Hepatology, Zurich, Switzerland, ³¹Riga Stradins University, Gastroenterology- Hepatology and Nutrition Clinic, Riga, Latvia, ³²Ghent University, Department of Internal Medicine and Pediatrics, Ghent, Belgium, ³³Faculty of Medicine- Medical University of Lodz, Department of General and Colorectal Surgery- Department of Biochemistry, Lodz, Poland, ³⁴Faculty of Medicine- Medical University of Lodz, Department of Digestive Tract Diseases, Lodz, Poland, ³⁵University Hospitals Leuven, Department of Gastroenterology and Hepatology, Leuven, Belgium, ³⁶Hillingdon Hospital, Department of Gastroenterology, Uxbridge, United Kingdom

Background: More than 2.5 million people in Europe suffer from inflammatory bowel diseases (IBD). IBD affects the quality of life, but also has important consequences for health systems. As IBD care and education might differ and might be linked to Gross Domestic Product (GDP), we conducted this European Variation In ibd PracticE suRvey (VIPER) to study potential differences.

Methods: This trainee-initiated survey, run through SurveyMonkey®, consisted of 47 questions inquiring basic demographics, IBD training and clinical care. The survey was distributed through social media and national GI societies from December 2020 - January 2021. Results were compared according to GDP per capita, for which countries were divided into 2 groups (low/high income, according to the World Bank). Differences between groups were calculated using the chi2 statistic.

Results: The online survey was completed by 1268 participants from 39 European countries (Figure 1). Most of the participants are specialists (65.3 %), followed by fellows in training (>< 3 years, 19.1%, 15.6 %). Majority of the responders are working in academic institutions (50.4 %), others in public/district hospitals (33.3 %) or private practices (16.3 %).

Despite significant differences in access to IBD-specific training between high (56.4%) and low (38.5%) GDP countries (p<0.001), majority of clinicians feels comfortable in treating IBD (77.2% vs 72.0%, p=0.04). Interestingly, a difference in availability of dedicated IBD units could be observed (58.5% vs 39.7%, p<0.001), as well as an inequality in multidisciplinary meetings (72.6% vs 40.2%, p<0.001), which often take place on a weekly basis (53.0%) (Figure 2). In high GDP countries, IBD nurses are more common (86.2%) than in low GDP countries (36.0%, p<0.001), which is mirrored by differences in nurse-led IBD clinics (40.6% vs 13.8%, p<0.001). IBD dietitians (32.4% vs 16.6%) and psychologists (16.7% vs 7.5%) are mainly present in high GDP countries (p<0.001).

In the current COVID era, telemedicine is available in 58.4% vs 21.4% of the high/low GDP countries respectively (p<0.001), as well as urgent flare clinics (58.6% vs 38.7%, p<0.001) and endoscopy within 24 hours if needed (83.0% vs 86.7% p=0.1). Treat-to-target approaches are implemented everywhere (85.0%), though access to biologicals and small molecules differs significantly (Figure 3). Almost all (94.7%) use faecal calprotectin for routine monitoring, whereas half also use intestinal ultrasound (47.9%).

Figure 1 Visual representation of all participants across Europe

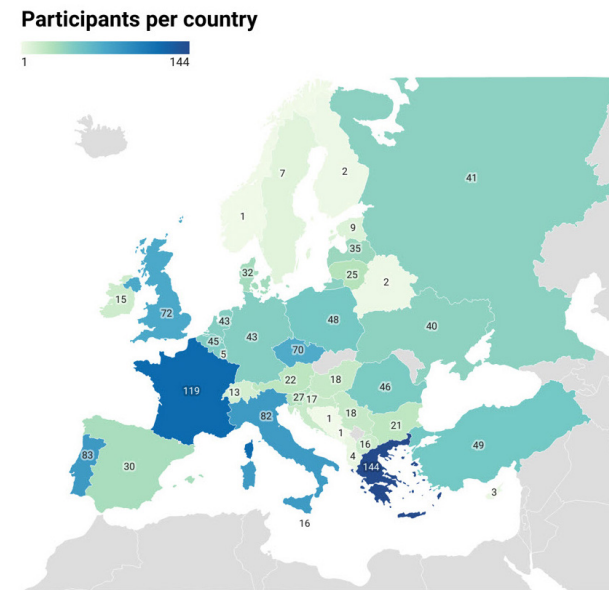


Figure 2 Composition of the multidisciplinary IBD meetings across Europe

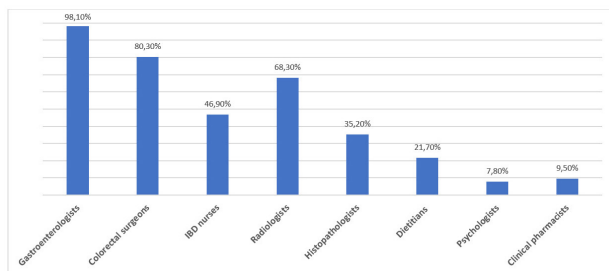
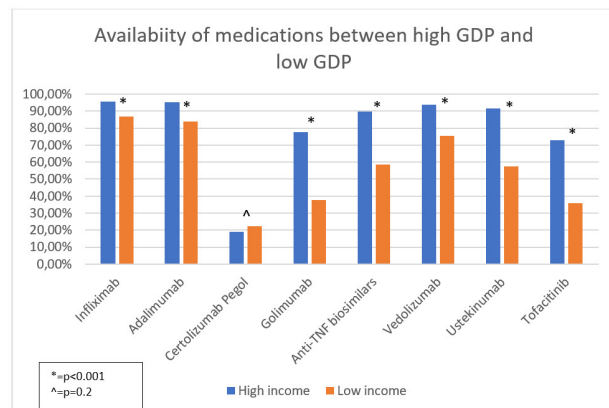


Figure 3. Availability of medications split per high and low income GDP



Conclusion: A lot of variability in IBD practice exists across Europe, with marked differences between high vs low GDP countries. Further work is required to help address some of these inequalities, aiming to improve and standardise IBD care across Europe.

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An observational study to evaluate the burden of illness in patients with Crohn's Disease with and without perianal fistulas in the USA

J. Jiang¹, S.E. Cazzetta², A. Athavale³, M. Kuharic^{1,4}, T. Fan¹, A. Silber⁵, A. Vijay³, N. Hadker⁵, E. Sharpe⁵, P.P. Nazarey²

¹Takeda Pharmaceuticals USA- Inc., Health Economics and Outcomes Research, Lexington, United States, ²Takeda Pharmaceuticals USA- Inc., Medical Affairs, Lexington, United States, ³Trinity Partners-LLC, Quantitative Research, Waltham, United States, ⁴University of Illinois, Department of Pharmacy Systems- Outcomes and Policy- College of Pharmacy, Chicago, United States, ⁵Trinity Partners- LLC, Health Economics and Outcomes Research, Waltham, United States

Background: Crohn's disease (CD) is a chronic inflammatory condition of the gastrointestinal tract that can lead to complications such as perianal fistulas (PAFs). This study compared disease burden, experiences and health-related quality of life between patients who have CD with PAFs (CPF) and those who have CD without PAFs (non-PAF CD).

Methods: This cross-sectional, observational study was conducted in three cohorts of US patients aged 18–89 years with self-reported physician-diagnosed CD: (1) non-PAF CD; (2) CPF without PAF-related surgery; and (3) CPF with PAF-related surgery. Data on medical and surgical interventions, CD-specific symptoms and Fecal Incontinence Quality of Life (FIQL) were collected via a web-enabled questionnaire. Statistical comparisons were assessed at the 0.05 level.

Results: The mean (standard deviation) age of patients in cohorts 1 (n = 300), 2 (n = 51) and 3 (n = 52) was 47 (16.4), 40 (12.2) and 39 (13.1) years, respectively. In patients with CPF (cohort 2 + 3), 59 (57%) reported multiple fistulas and 48 (47%) reported fistula recurrence/persistence. Compared with cohort 1 (non-PAF CD), more patients with CPF reported currently receiving biologic treatment or immunomodulators for CD (58% vs 43% and 23% vs 15%, respectively; both $p = 0.01$). More patients with CPF also reported undergoing ≥ 1 CD-related surgery and experiencing ≥ 1 failures of CD-related surgery (79% and 20%, respectively) versus cohort 1 (53% and 9%, respectively; both $p < 0.001$). In cohort 3, 63% of patients had ≥ 3 PAF-related surgeries, and in those receiving seton placement (n = 37), 8% reported placement failure. Post-surgical/seton placement complications were common; the most frequently reported were worsening of pain and swelling around the anus (33%) and fever/infection (29%).

CD-specific symptom frequency and severity results indicated a high symptom burden across cohorts; fatigue was reported with the highest frequency and severity. Faecal incontinence (FI) and leakage-related symptoms affected greater proportions of patients in cohorts 2 and 3, often with greater severity and frequency, compared with cohort 1 (Fig.1). Across all cohorts, 58% of patients (cohort 1/2/3, n = 158/35/40) reported experiencing FI and completed the FIQL questionnaire: cohorts 2 and 3 reported lower (worse) FIQL scores across domains than cohort 1 (Fig.2).

Conclusion: The burden of illness in patients with CPF is substantial, with medical and surgical intervention rates, and symptom severity and frequency greater than for those with non-PAF CD. Higher disease burden, including FI, was noted in patients with CPF compared with the non-PAF CD cohort. An unmet need remains for improved management and outcomes of CPF.

Sponsor: Takeda Pharmaceuticals USA, Inc.