

postal codes at the date of IBD diagnosis. Study outcomes were measured from IBD diagnosis to the end of the study period or end of health care coverage. Cox proportional regression models were used to evaluate the associations between rural-urban residence and each study outcome. Models were adjusted by sex, age, neighbourhood income quintile at IBD diagnosis, and disease type (Crohn's disease and ulcerative colitis). Adjusted hazard ratios (HR) and 95% confidence intervals (95%CI) were reported.

Results: We identified 5,173 IBD incident cases in SK between 1999 and 2016; 1,544 (29.8%) individuals were living in rural locations at the date of diagnosis. Compared to urban dwellers, rural residents had lower gastroenterology visits (HR=0.82, 95%CI 0.77–0.88) and higher 5-aminosalicylic acid (5-ASA) claims (HR=1.10, 95%CI 1.02–1.18). Furthermore, rural residents had a higher risk of IBD-specific (HR=1.23, 95%CI 1.13–1.34) and IBD-related (HR=1.20, 95%CI 1.11–1.31) hospitalizations than their urban counterparts. We did not observe significant rural-urban differences in the access to colonoscopies, biologic and immune modulator therapies, and surgeries for IBD. **Conclusion:** We identified rural-urban disparities in IBD health care access, specifically, lower outpatient gastroenterology visits, higher 5-ASA claims, and a higher risk of hospitalizations for individuals living in rural locations at IBD diagnosis. Our findings reflect rural-urban inequities in the access to IBD care that require the attention of health care providers and decision-makers to promote health care innovation and equitable management of patients with IBD living in rural areas.

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Inflammatory bowel disease in immigrants to Spain: results of the EIIMIGRA study from GETECCU (ENEIDA registry)

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Background: Previous studies comparing inflammatory bowel disease (IBD) features between migrant and native patients have shown clinical phenotype differences. To date, no study has focused on IBD immigrants (MP) in Spain. The aim of this study was to explore the features of MP in Spain and to compare age of disease onset, IBD phenotype and therapeutic requirements with native-born IBD patients (NP).

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Table 1

	Immigrants n:1864	Natives n:11660	P
Gender, % female	936 (50.2)	5444 (46.7)	0.005
Current median age, yr (SD)	45.3 (12.6)	54.5 (16.0)	<0.001
Median age at diagnosis, yr (SD)	31.2 (12.0)	36.5 (15.6)	<0.001
Median disease duration (yr)(SD)	14.0 (7.2)	18.0 (8.7)	<0.001
UC/CD, n(%)	1029 (55.4)/777 (41.8)	6665 (57.2)/4755 (40.8)	0.068
CD age at diagnosis A1/A2/A3 n(%)	67 (8.6)/586 (75.3)/125 (16.1)	275 (5.8)/3223 (67.8)/257 (26.4)	<0.001
CD location L1/L2/L3 n(%)	154 (28.5)/112 (20.7)/233 (43.1)	1025 (28.4)/640 (17.7)/1636 (45.3)	0.368
CD behaviour B1/B2/B3 n(%)	482(63.9)/144(19)/128(17)	2744(57.7)/1158(24.4)/853(17.9)	0.002
Perianal disease n(%)	242 (13.7)	1776 (15.4)	0.069
UC extension E1/E2/E3, n(%)	83 (13.3)/186 (29.7)/357 (57.0)	459 (9.9)/1478 (31.9)/2689 (58.1)	0.031

Methods: This was an observational, multicentric and case-control study of the nationwide ENEIDA registry. We selected all IBD patients who were born outside of Spain and compared with a control cohort of NP. All included patients were diagnosed with IBD before 2015.

Results: A total of 13,524 patients were included (1864 MP and 11660 NP). The most prevalent ethnic migrant group was Caucasian (771, 41%), followed by Latin American (572, 31%) and Arabian (341, 18%), whereas Asian represented only 6%. Table 1 summarizes the demographic and phenotypic features. 71% of MP were diagnosed with IBD in Spain. There was not a gender predisposition to IBD in the overall migrant group, however more female UC MP were detected compared to UC NP (52% vs 45%, $p < 0.001$). MP were younger at the onset of the disease and had a shorter disease duration compared to NP, in both UC and CD patients. Significantly more CD patients were diagnosed under 16 years (A1) among MP, and more patients over 40 years (A3) among NB. More NB patients had CD stricturing phenotype (24% vs 19%, $p = 0.002$) compared to MP. Disease extension in CD and UC did not differ between groups. The overall proportion of abdominal or perianal surgery was similar in both groups but the use of biologic therapy was more common in MP (36% vs 30%, $p = 0.001$).

Conclusion: In the largest cohort of migrant IBD patients in Spain, immigrants were younger, had a shorter disease duration and required a higher use of biologics than natives, pointing phenotypic differences in this population and a universal access to the healthcare system all over the country.

P631**Food triggers in inflammatory bowel disease from the patients' and doctors' perspective**

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Background: Diet is receiving growing attention as a key environmental factor involved in the pathogenesis of Inflammatory Bowel Disease (IBD). Dietary components have a relevant role in triggering symptoms from the patients' perspective, but there is a gap between patients' and doctors' beliefs. Every patient has collected his or her own list of prohibited foods and reports a clinical benefit from avoiding such foods. Elimination of nutrients can lead to nutritional deficiencies and impact on style and quality of life. The aim of this

study is to identify frequently avoided foods in a Mediterranean cohort of patients with IBD.

Methods: Consecutive patients with IBD attending our tertiary center for infusion of biologics or for follow-up visits were enrolled. Demographics and disease characteristics (UC or CD) were recorded in a dedicated database. A questionnaire investigated food avoided and reasons for dietary changes, if self-driven or advised by doctors or other healthcare professionals.

Results: 167 patients agreed to participate in the study. Eighty-one patients (48.8%) had UC, 86 (51.5%) had CD. Mean age was 48.6 ± 16 (range 18–77 years), 57.5% were males. Patients were in clinical remission or with mild activity. Most patients, about 80%, and especially patients with CD avoided certain foods considered as triggers, and this avoidance was usually practiced in both exacerbations of the disease and remission periods. This occurred upon medical advice in a minority of patients, especially for vegetable avoidance (13.2%). Foods more frequently avoided were spicy foods, seasoned foods, fried foods, milk and dairy products, carbonated drinks, spirits, vegetables, legumes, and whole grain bread. Processed meat was avoided in about 6.6% (only in 1.8% upon medical advice) and coffee in 12.6%. A lactose-free diet was advised by the treating physicians only in 14.3% of patients. 4 patients were on a gluten-free diet because of a self-reported gluten sensitivity. The role of other healthcare professionals (dietitian, nurses) was marginal in their food choices.

Conclusion: Most of the patients set diet on self-experience and give up many foods. Our results are comparable with those of previous studies. Spicy foods, seasoned and fried foods, carbonated drinks, and dairy products are on top of the list. Legumes and vegetables, the cornerstones of the Mediterranean diet, are also avoided even though the evidence that dietary fibers can induce relapse is lacking. The benefit reported could be related to the effect on IBS-related symptoms frequent in IBD in remission. Further studies and a greater involvement of doctors in providing dietary recommendations are warranted.

P632**Is the gender or age of the physician key to a good physician-patient with Inflammatory Bowel Disease relationship?**

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