medications. Our findings emphasize the critical need for prevention and novel therapeutic options for this vulnerable patient population.

Figure 1. Annual incidence of hospitalization for Crohn’s disease (CD) and ulcerative colitis (UC) from 2002–2015. AAPC indicates average annual percent change. *p≤0.05

Figure 2. Rates of surgeries, post-operative complications, and comorbidities per 100 Crohn’s disease (CD) and ulcerative colitis (UC) hospitalizations. AAPC indicates average annual percent change. *p≤0.05

P132 OUTCOMES AND REASONS FOR ADMISSION IN CROHN’S DISEASE: AN ANALYSIS OF NATIONAL INPATIENT SAMPLE 2016

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Objective: Recent research suggests increasing nationwide admission for Crohn’s disease (CD), but the most common reasons for admission are not well known. We sought to enumerate the most common presentations of Crohn’s disease requiring admission in Nationwide Inpatient Sample (NIS) 2016 using ICD-10 codes.

Methods: We identified all adults aged greater than or equal to 18 years with a primary diagnosis of CD, using ICD 10 in Nationwide inpatient database. We analyzed inpatient demographics via chi-square. Inpatient mortality, Length of stay (LOS) and Total Charge (TOTCHG) was calculated using univariate and multivariable linear models.

Results: 60,244 patients with CD required inpatient admission. Majority of patients were females (53%), white (69%), with private insurance (46%) admitted to large bed sized (53.3%) teaching hospitals (68%). The common reasons for admission in CD patients included bowel obstruction at 24.6% (14,850) of which 57.8% (8,590) presented with small bowel obstruction (SBO). 42.1% (6260) were admitted with both SBO and LBO. Other reasons for admission were GI bleeding (6.5%) and fistulizing CD (2.4%). The inpatient mortality was 0.5%. Age was an independent predictor of mortality in these patients. (aOR 1.08, 95% CI 1.04–1.12; p=0.00). Protein energy malnutrition (PEM) (aOR 2.45, p=0.038), patients requiring pressor support (aOR 4.2, p=0.016) and those with bowel obstruction (aOR 1.19 p=0.04) had higher odds of mortality on multivariate analysis model, but couldn’t reach statistical significance. The mean LOS was 4.9 days and patients admitted over weekend had a longer LOS (coeff 0.22, 95% CI 0.08–0.37, p=0.002) as compared to weekdays on multivariate analysis.

Conclusions: The common reasons for inpatient admission in patients with CD include bowel obstruction, GI bleeding and fistulizing CD. Age was an independent predictor of mortality. The economic burden was highest amongst African-Americans, malnourished, patients requiring pressor support and those with bowel obstruction.

P133 PRESCRIPTION OPIOID USE AMONG VETERANS WITH INFLAMMATORY BOWEL DISEASE

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Background: Opioids are commonly prescribed to manage pain in patients with IBD despite increasing evidence of harm associated with chronic use. The aim of the current study was to describe trends in opioid use among veterans with IBD.

Methods: This was a retrospective cohort study derived from the Veterans Affairs (VA) Health Care System. A unique patient identifier facilitated longitudinal evaluation of electronic databases that include medical diagnoses, surgical procedures, pharmaceuticals, labs, vital status information, dates of treatment, and radiology findings. Veterans were labeled as having IBD if they were at least 2 outpatient or 1 inpatient health care encounters with an ICD-9/10 diagnostic code consistent with IBD from fiscal years 2002 to 2016. Veterans without a minimum of 2 years of follow-up or who had a cancer diagnosis within 1 year before or after IBD diagnosis were excluded. In order to standardize the quantity of opioid exposure, morphine milligram equivalents (MME) for each prescription was calculated using published conversion factors. Individual prescriptions with missing quantity or day’s supply and prescriptions exceeding 1000 MME/day were excluded. Opioid exposure was assessed during the first year following the initial diagnosis date was determined and averaged across MME/day for % of patients on opioid therapy. An annual opioid prescribing rate per 100 IBD patients was calculated. Comorbidities were assessed using a modified Charlson Comorbidity Index (CCI), excluding cancer from calculation.

Results: During the study period, 65,817 veterans with IBD were identified. The majority were males (92.1%), Caucasian (78.2%), and had a mean age of 58.2 years. In total, 1,471,019 individual opioid prescriptions were evaluated. The quantity and rate of opioid prescriptions peaked in 2012, with 115,774 unique prescriptions and 685,2 opioid prescriptions per 100 IBD patients, respectively. Twenty-seven percent (n=17,844) of IBD patients had at least one opioid prescription within the initial year of diagnosis. Mean opioid exposure during the initial year of diagnosis averaged 33.2 MME/day, and 12.2% had mean opioid exposure greater than 50 MME/day. Opioid exposure peaked in 2005 at 37.4 MME/day and consistently declined to 29.3 MME/day in 2016. Conclusion: There has been a significant decline in opioid prescriptions, prescribing rate, and mean opioid exposure since peaking in 2012. These trends are similar to those seen in the non-veteran US population.

P143 PREVALENCE OF LACTOSE INTOLERANCE IN INFLAMMATORY BOWEL DISEASE IN THE UNITED STATES BETWEEN 2014 AND 2019: A POPULATION-BASED STUDY

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Background: The role of dairy foods in the continued symptomatology of patients with IBD is unclear. This is in part due to limited data on epidemiology of lactose intolerance (LI) in IBD. We sought to utilize a large population based database to evaluate the prevalence of LI in IBD.

Methods: We queried a commercial database (Explorys Inc, Cleveland, OH), an aggregate of Electronic Health Record data from 26 major integrated healthcare systems in the US from 1999 to 2019. We identified an aggregated patient cohort with ≥2 inpatient or outpatient prescriptions per a diagnosis of Crohn’s disease (CD) and Ulcerative Colitis (UC) between June 2014 and 2019, based on Systematized Nomenclature Of Medicine – Clinical Terms. We calculated the prevalence LI in IBD overall, and among different age, race and gender sub-groups and identified risk factors for LI in IBD.

Results: Of the 35,521,930 individuals in the database from October 2014–2019, we identified 165,750 and 140,640 individuals with a diagnosis of CD and UC with overall prevalence rates of 0.47% and 0.4% respectively. The prevalence of LI in individuals without IBD was 0.2%. Compared to individuals without IBD, the prevalence of LI in CD was increased at 0.9% (OR: 4.56, 95% CI: 4.33–4.81, p<0.0001) and prevalence of LI in UC was increased at 0.8% (OR: 4.03, 95% CI: 3.80–4.28, p<0.0001) compared to individuals without IBD. (Figure 1).

The prevalence of LI in CD was increased in: females at 0.98% vs males at 0.77% [OR: 2.12, 95% CI: 1.31–1.41, p<0.0001]; African-Americans at 1.2% vs Caucasians at 0.87% [OR: 1.73, 95% CI: 1.50–2.00, p<0.0001] and children (<18yo) at 2.39% vs adults (≥18yo) at 0.88% [OR: 2.77, 95% CI: 2.13–3.60, p<0.0001]. The prevalence of LI in UC was increased in: females at 0.91% vs males at 0.64% [OR: 1.41, 95% CI: 1.25–1.60, p<0.0001]; African-Americans at 1.45% vs Caucasians at 0.78% [OR: 1.84, 95% CI: 1.55–2.19, p<0.0001] and children (<18yo) at 1.8% vs adults (≥18yo) at 0.79% [OR: 2.28, 95% CI: 1.46–3.57, p<0.0003].

Conclusion: This is one of the first large studies to date that has described the prevalence of LI in IBD in the United States. We found that the prevalence of LI to be increased nearly 4-fold in IBD. We recommend screening for LI in IBD patients with active symptoms to delineate active disease from symptomatology due to LI.