Results: We identified 9,284 pIBD patients enrolled between 2007 and 2016, 62% with Crohn's disease. The mean age of the cohort was 13.7 years (SD, 4.2) and comprised of 47% females. The median follow-up was 24 months (IQR, 33). Twenty-four percent of this cohort were treated with an anti-TNF agent during follow-up and 38% with an immunomodulator ( Thiopurine or Methotrexate). Nearly 8.5% were started on an ATNF agent while treated with an immunomodulator, of which 90% were Thiopurines. We identified 3 cases of lymphoma occurring over 25,413 person-years of follow-up (incidence rate, 1.18 cases/100,000 person-years). The absolute risk of lymphoma in our pIBD sample was 0.3 x 10^-5. There were no cases of hepatosplenic T cell lymphoma observed. The medication exposure history for cases of lymphoma did not include treatment with an ATNF agent and/or an immunomodulator.

Conclusion: Among our cohort of pIBD, the overall incidence and absolute risk of lymphoma were extremely low. Treatment with ATNF agents and/or immunomodulators was not associated with an increased risk of malignancy. Our results would support prioritization of the clinical benefits of ATNF agents over the low risk for malignancy.

P101
REAL-WORLD COMPARISON OF ARTHRALGIAS WITH INFlixIMAB VS. VE Dolizumab in the Treatment of Bio-naive inflammatory Bowel Disease

Timothy Ritter, Chris Fournet, Samantha Kuten, Lucinda Van Anglen

Background: Both infliximab (IFX) and vedolizumab (VDZ) are approved for the treatment of inflammatory bowel disease (IBD) in adults. VDZ is gut-specific and thought to be less effective in controlling extraintestinal manifestations than IFX.

The purpose of this study was to compare the incidence and timing of arthralgias between IFX and VDZ.

Methods: We performed a retrospective cohort study of bio-naive adult patients treated with IFX or VDZ for ulcerative colitis (UC) or Crohn’s disease (CD) at a large multicenter gastroenterology private practice. Patients were case-matched 1:1 based on age, gender, diagnosis, and baseline disease severity using the partial Mayo (pMayo) for UC and the Harvey-Bradshaw Index (mHBI) for CD. Arthralgias were captured out to 12 months of therapy and classified as pre-existing or new-onset based on time to occurrence. Those with pre-existing arthralgias were excluded from new-onset arthralgias analyses. Rates of arthralgias and time to new-onset arthralgias were compared between IFX and VDZ patients.

Results: A total of 77 IFX (58 UC, 19 CD) and 77 VDZ (58 UC, 19 CD) case-matched pairs were generated. Baseline demographics were similar between IFX and VDZ groups: mean age 45±16.9 vs 46±16.2, male gender 60% vs 61%, rates of pre-existing arthralgias were 13/77 (17%) and 12/77 (16%) in IFX and VDZ cohorts (p=0.83), respectively. Resolution of pre-existing arthralgias was also similar between groups (6/13 vs 7/12, p=0.70). Of the remaining 64 IFX and 65 VDZ patients without arthralgias at baseline, 16 (25%) IFX patients and 17 (26%) VDZ patients experienced new-onset arthralgias (p=1.0). Median time to new-onset arthralgias was 5.0 (IQR 3.4–7.0) months in IFX patients, compared to 3.3 (IQR 1.4–5.3) months in VDZ patients (p=0.15). While VDZ patients appeared to develop new-onset arthralgias earlier, this was not significant (p=0.20) [Figure 1]. Of note, two IFX patients discontinued therapy due to suspected drug-induced lupus with arthralgias; there were no VDZ discontinuations due to arthralgias.

Conclusions: Our data suggests that resolution of pre-existing arthralgias and outcomes of new-onset arthralgias were similar, despite the gut selectivity of VDZ compared to IFX.

P100
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Timothy Ritter, Chris Fournet, Samantha Kuten, Lucinda Van Anglen

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Conclusions: Our data suggests that resolution of pre-existing arthralgias and outcomes of new-onset arthralgias were similar, despite the gut selectivity of VDZ compared to IFX. Additionally, there was no difference in overall time to new-onset arthralgias. These data need to be verified in a larger cohort.