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Methods: Retrospective study of patients admitted to a London-based district general hospital under the gastroenterology team with a flare of inflammatory bowel disease between 2015 and 2018. Characteristic including but not limited to demographics, disease type, length of stay during index admission, biochemistry and biologic use were recorded. Hospital software (Sunquest Integrated Clinical Environment, Medway) was used to identify patients re-admitted at 30 and 90 days after discharge. Multivariate logistic regression was performed.

Results: 138 patients were admitted with an IBD flare during the study period (74 (53.6%) Crohn’s disease (CD), 56 (40.6%) ulcerative colitis (UC), 8 (5.8%) IBD-U). Median age 33.5 (IQR 26 – 52), 71 (51.4%) female. Median length of stay was 4.5 days (IQR 1.8 – 8). 36 (26%) patients were taking a biologic.

Re-admissions occurred within 30 days in 19 patients (13.7%) and within 90 days in 30 patients (21.7%). Multivariate logistic regression showed that a raised CRP on discharge was associated with re-admission. For every increased unit of CRP by one there was a significantly less likely to be readmitted (OR: 0.38, p=0.015). Male patients were significantly more likely to be readmitted (OR: 2.52, p=0.05).

Conclusion: The 30 day and 90 day re-admission rate for our IBD population is just over 10% and 20%, respectively. CRP at discharge is significantly associated with both 30 and 90 day readmission. After adjusting for confounders; CRP, age older than 40 and male gender were associated with re-admission to hospital. We advise caution in discharging IBD patients with raised inflammatory markers. Close follow up within a few days of discharge would be appropriate in this high risk sub-group.

Table 1. Demographics and biochemistry associated with IBD re-admissions within 30 days of discharge.

<table>
<thead>
<tr>
<th>Age, median (IQR)</th>
<th>30-day Re-admission (n=21)</th>
<th>No Re-admission (n=117)</th>
<th>p value</th>
</tr>
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<tbody>
<tr>
<td>Gender (M, n (%))</td>
<td>10 (47.6)</td>
<td>64 (54.7)</td>
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<td>CRP on discharge (median, IQR)</td>
<td>23 (5.5 – 59.3)</td>
<td>9 (2 – 25)</td>
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<td>Albumin on discharge (median, IQR)</td>
<td>37 (31.5 – 41.5)</td>
<td>36 (31.3 – 41)</td>
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<td>Biologic use, n (%)</td>
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Table 2. Demographics and biochemistry associated with IBD re-admissions within 90 days of discharge.

<table>
<thead>
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<th>Age, median (IQR)</th>
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<th>No Re-admission (n=106)</th>
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<tr>
<td>Gender (M, n (%))</td>
<td>19 (59.4)</td>
<td>52 (49.1)</td>
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<tr>
<td>Type of IBD (CD, n (%)</td>
<td>17 (53.1)</td>
<td>57 (53.8)</td>
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<tr>
<td>LOS, days (median, IQR)</td>
<td>4.5 (1 – 9.5)</td>
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<td>CRP on discharge (median, IQR)</td>
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P012

HOSPITAL RE-ADMISSION IN PATIENTS WITH INFLAMMATORY BOWEL DISEASE – WHAT ARE THE RISK FACTORS?

Rajan Patel, Renate Fromson, Emma Routledge, Emma Johnson, Sina Jameie-Oskooei, William Blad, Saaidq Moleiena, Voishim Wong

Introduction: Early re-admission after hospitalisation for an inflammatory bowel disease (IBD) flare is a negative quality indicator and causes unnecessary healthcare expense. Scoring systems to predict IBD readmissions have been shown to be ineffective. We aimed to describe the IBD re-admission rate at our hospital and investigate the risk factors.

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P013

IBD 101: AN INTRODUCTORY COURSE FOR FIRST YEAR GASTROENTEROLOGY FELLOWS

Sarah Lopatin, Sunanda Kane, Simon Hong, David Hudesman, David Rubin, Lisa Malter

Introduction: Inflammatory bowel disease (IBD) management is changing at a rapid rate, with the emergence of multiple new therapies and evolving care goals. In addition, the quality and quantity of IBD fellowship education is highly variable, based on patient populations and institutional expertise. Therefore, it is crucial to develop improved ways to educate our trainees. Here, we describe an educational initiative designed to familiarize first year gastroenterology (GI) fellows to key concepts in the management of IBD.

Methods: IBD 101 is a one-day course designed to introduce first-year GI fellows to various clinical topics relevant to the management of IBD. The program was held on September 14, 2019. Fellows from U.S. allopathic GI training programs were selected by their training directors for participation. The course included small group didactic sessions led by expert faculty members and group observed structured clinical examinations (OSCEs), in which fellows observed encounters
between expert faculty and standardized patients followed immediately by de-
brief sessions to reinforce key concepts. The topics included need for surgery in
IBD, pregnancy and IBD, escalation of care for acute severe UC, initiating biologic
therapy, treatment of mild-moderate IBD, treatment of moderate-severe IBD and
managing loss of response to therapy. A review of supplemental opportunities for
education in IBD was presented at the conclusion of the course. Pre- and post-
course surveys using Likert scoring (1=“strongly disagree” through 4=“strongly
agree”) were administered to assess baseline knowledge and educational impact
of the course on each addressed topic.

Results: 55 fellows from 32 programs participated. 49/55 (89%) completed pre-
and post-course surveys to assess the educational impact of the program on the
didactic sessions and on the group OSCE format. 100% of fellows felt that the course con-
tent was appropriate for their scope of clinical practice. Substantial improvement
in comfort with all addressed clinical topics was noted (figure 1). In the post-course
survey, all fellows reported an improved ability to manage and treat patients with
IBD. Comparing career interest in IBD, more participants expressed interest in pur-
suing a career in IBD after participating (pre: 63% vs post: 75%). 96% of attendees
stated that they would strongly recommend this course to future GI fellows.

Conclusions: This single day course for first-year GI trainees was effective and
well-received, and offers a novel intervention to address the challenges of IBD ed-
ucation and training. Follow-up of this cohort of trainees and expansion for next year is planned.

Figure 1.

P002
IBD PARTNERSHIPS: UNDERSTANDING PATIENTS VS. CLINICIANS PERSPECTIVES
OF IBD TREATMENT OPTIONS TO IMPROVE SHARED DECISION-MAKING
Sandra Zelninsky, Catherine Finlayson

Background: The patient is the only constant in the care journey, the person who
experiences both processes and the outcomes of care. There is an international shift
towards including patients as equal partners in research. Co-producing research
requires collaborative research strategies to understand values, needs and priorities when making treatment decisions will potentially improve shared
decision-making between IBD patients and their Healthcare Providers (HCPs). To
facilitate this process patients and HCPs must have a common understanding of
expected medication benefits, risks and the potential impact on quality of life. The
information available to facilitate this conversation must be aligned and reflect
the priorities that IBD Patients and Healthcare Providers consider when making
treatment decisions. Both parties can then share information and work towards an
agreement to what treatment plan should be implemented.

Aims: To understand what matters most to IBD patients when making treatment
decisions by conducting a qualitative patient-led peer to peer study which will in-
form the development of an IBD patient and HCP survey.

Methods: IBD patients (≥ 18 years of age) were recruited through the IBD clinic
at a University of Calgary and via social media. Focus groups were held in three
separate provinces (British Columbia, Alberta and Ontario) in both rural and
urban locations. The focus groups were facilitated by a Patient Engagement
Researcher to alleviate any potential power dynamics and to create a safe space
for IBD patients to share their perspectives. A participatory approach was used to encourage co-production with participants throughout
the focus groups. The focus groups were audio recorded. Flip charts and sticky
notes were used for brainstorming and prioritization exercises. All audio and
written data were transcribed. Thematic analysis was used to identify emerging
themes and patient priorities.

Results: A total of 21 participants attended the focus groups from both rural and
urban locations. Participant diversity ranged in ethnicity and age. Most of the par-
ticipants were female (18 females and 3 males) of which 4 were biologic naïve
and 7 were biologic exposed. The Top 5 IBD Patient Priorities when making treatment
decisions are 1) Risks (more serious/long term) 2) Education (Support/Evidence
Based Information/Resources) 3) Side Effects (short term/less serious) 4) Efficacy
5) Impact (Quality of Life/Lifestyle/Logistics).

Conclusions: Co-producing research ‘with’ and ‘by’ IBD patients helped to gen-
erate priorities that matter most to patients when making treatment decisions. The
patient priorities will help in the development of an IBD Patient and HCP survey.
The results from the two surveys will be compared to understand patient vs. HCP
perspectives.

P014
IBD AND VTE RISK: LET’S TALK ABOUT IT
Jenny Dave, Karan Chawla, Francis Carro-Cruz, Vinay Rao, Jessica Gibilisco,
Scott Baumgartner, Katherine Negreina, Marie Borum

Background: Patients with inflammatory bowel disease (IBD) have a 1.5–3 fold in-
crease in the risk of venous thromboembolism (VTE). Additionally, VTE in patients
with IBD is associated with a 2.1 fold increase in mortality compared to the general
population. The risk of VTE is increased with active inflammation. It is speculated
that individuals with IBD are inconsistently advised about VTE risk. This study eval-
uated the frequency of counseling about VTE in IBD patients.

Methods: A retrospective medical record review of all IBD patients seen at a univer-
sity gastroenterology practice during a 5 year period was performed. Patients’ age,
gender, disease type and documented counselling about VTE risk were obtained.
A database was treated maintaining patient confidentiality. Analysis was con-
ducted using Fisher’s Exact Test with significance set at p < 0.05. The study was
approved by the university IRB.

Results: Records of 381 patients were reviewed. There were 209 females and 172
males with a mean age of 44 years (range 20–82). 279 had ulcerative colitis, 96 had
Crohn’s disease and 6 had indeterminate colitis. Self-reported ethnicity included
195 White, 97 Black/African-American (AA), 11 Asian, 1 Hawaiian, 34 other and 43
did not report their ethnicity. 13 (3.4%) patients (7 females, 6 males) were coun-
selled about VTE risk. The 7 women who were counselled were <50, with no signific-
cant difference in counselling of women <50 compared to women >50 (p=0.11).
The 6 men who were counselled were <50, with no significant difference in coun-
seling of men <50 compared to men >50 (p=0.09). There was no difference in the
rate of counselling based upon gender (p=1.00), ethnicity (Whites vs non-Whites,
p=0.57; Whites vs AA, p=1.00) or disease type (p=0.31).

Discussion: Venous thromboembolism is a known risk of inflammatory bowel dis-
ease. While VTEs infrequently occur in IBD patients, it is important that there is
awareness about the potential risk. This study revealed that VTE risk is rarely dis-
cussed with IBD patients. While this study is limited by single institutional design,
size and reliance on documentation, it suggests that increased efforts can be made
to educate IBD patients about VTEs. Recognition of VTE risks can improve IBD man-
agement and optimize clinical outcomes.