

P132**Performance of a severity score in risk stratification of patients with ulcerative colitis**

B. Morão^{*1}, C. Frias Gomes¹, C. Gouveia¹, M.P. Costa Santos¹, J. Torres¹

¹Hospital Beatriz Ângelo, Surgery Department, Gastroenterology Division, Lisbon, Portugal

Background: Patient stratification according to the risk of developing complications is an essential step to define the best treatment approach in patients with ulcerative colitis (UC). Recently, Siegel et al (Gut 2017) published a score that aims to assess the disease severity, considering disease activity (both clinical and endoscopic factors) and complications during the disease course, ranging from 0 to 100 values (higher values indicating worse disease severity). Our goal was to evaluate the capacity of this score calculated at the time of diagnosis (dx) to predict disease course during follow-up (FU): steroid use, therapy escalation to immunomodulators or biologics, hospitalisation and/or abdominal surgery.

Methods: Retrospective cohort study including incident cases of UC in our centre between December 2012 and December 2018. We calculated the score at the time of dx and at the end of FU and collected data about disease course.

Results: Eighty-five patients (57% men with a mean age of 43 ± 17 years) with newly diagnosed UC were included. Disease extension according to Montreal was E1 in 30/85 patients, E2 in 37/85 patients and E3 in 18/85 patients. Median FU time was 40 months. Median risk score at the time of dx was 30 (IQR 3–91) and it was higher in patients with younger age (36 vs. 26, $p = 0.08$) and extensive colitis (64 vs. 26, $p < 0.001$). During FU, 19/85 and 17/85 patients needed steroid use and therapy escalation, respectively. Proximal disease extension occurred in one patient. Hospital admission for acute exacerbation and/or colectomy was required in 6/85. The score at dx was higher in patients who underwent hospital admission or colectomy (score: 70 vs. 26, $p = 0.002$), or that needed steroid (score: 57 vs. 26, $p < 0.001$) or therapy escalation (score: 57 vs. 26, $p < 0.001$) during FU. In a survival analysis, the time for steroid use (plogrank < 0.001) or therapy escalation (plogrank < 0.001) was lower in patients with a higher score at dx (61 vs. 88 months and 56 vs. 86 months, respectively). The median score at the end of FU was 3 (IQR 0–66); a second colonoscopy was not available in three patients, who were not included in this analysis. There was a score reduction in 77/82 patients (39/82 had a score of 0). Only one patient had a similar score and 4/85 patients had a higher score. Patients with a significant score reduction during FU (below the median) were more frequently patients with no need for steroid use ($p < 0.001$) or therapy escalation ($p = 0.002$).

Conclusion: This severity score seems to be a promising tool for risk stratification and prognosis determination in patients with UC, and its utility should be validated in prospective studies.

P133**Pregnancy in inflammatory bowel disease: experience of a Chilean cohort**

P. Núñez¹, E. Sepúlveda², D. Simian³, C. Figueroa³, L. Flores³, P. Ibáñez³, U. Kronberg^{*4}, J. Lubascher³, G. Pizarro³, R. Quera³

¹San Juan de Dios Hospital, Gastroenterology Department – IBD Fellow Clínica Las Condes, Santiago, Chile, ²Clínica Las Condes,

Gynecology and Obstetrics Department, Santiago, Chile, ³Clínica Las Condes, Gastroenterology Department – Inflammatory Bowel Disease Program, Santiago, Chile, ⁴Clínica Las Condes, Surgery Department, Colorectal Unit – Inflammatory Bowel Disease Program, Santiago, Chile

Background: In inflammatory bowel disease (IBD), a high percentage of women are diagnosed during their reproductive age. IBD in remission is the ideal scenario when planning a pregnancy. Here, we describe the demographic, clinical and pregnancy/childbirth characteristics in patients with IBD treated at a tertiary centre in Chile between 2017 and 2019.

Methods: Observational, analytic study. We retrospectively reviewed women diagnosed with IBD who were pregnant or delivered during the study period. Demographic, clinical, obstetric and delivery data were obtained from the IBD registry, approved by the local IRB. Descriptive statistics and association tests performed (χ^2 , $p < 0.05$).

Results: Forty-six women with IBD were included (Tables 1). At the beginning of pregnancy, 19 (41%) had active disease and 27 (59%) were in remission. Of those with active disease, 8 (79%) remained active and six had spontaneous abortions. In those who were in remission, 20 (74%) remained in this condition. Six patients (13%) discontinued treatment (four based on external medical advice, two on her own). Preconception counselling was performed in 16/40, group with a higher percentage of remission during pregnancy (69% vs. 25%, $p = 0.006$). Pregnancy outcomes by disease activity are presented in Figure 1. Patients who had a flare during pregnancy had newborn with lower weight compare with the group that always remained in remission (2,945 vs. 3,323 g; $p = 0.007$).

Table 1. Demographic and IBD clinical characteristics of women

| Variable | N = 46 (%) |
|-------------------------------------|------------|
| Age (median; range) | 32 (24–41) |
| Diagnosis | |
| Ulcerative colitis | 33 (72) |
| Crohn's disease | 12 (26) |
| Non-classifiable IBD | 1 (2) |
| Years of disease (median; range) | 6 (1–19) |
| Montreal classification | |
| Ulcerative colitis (extent) | |
| Pancolitis | 18 (55) |
| Left colon | 9 (27) |
| Proctitis | 6 (18) |
| Crohn's disease (localisation) | |
| L1: terminal ileon | 4 (33) |
| L2: colon | 3 (25) |
| L3: ileocolonic | 5 (42) |
| L4: upper gastrointestinal | 0 (0) |
| Crohn's disease (behaviour) | |
| B1: non stricturing non penetrating | 10 (83) |
| B2: Stricturing | 2 (17) |
| B3: penetrating | 0 (0) |
| Perianal disease | 2 |
| Medications | |
| Biological agents | 9 (19) |
| Adalimumab | 3 |
| Infliximab | 6 |
| Thiopurines | 15 (33) |
| Aminosalicylates | 22 (48) |

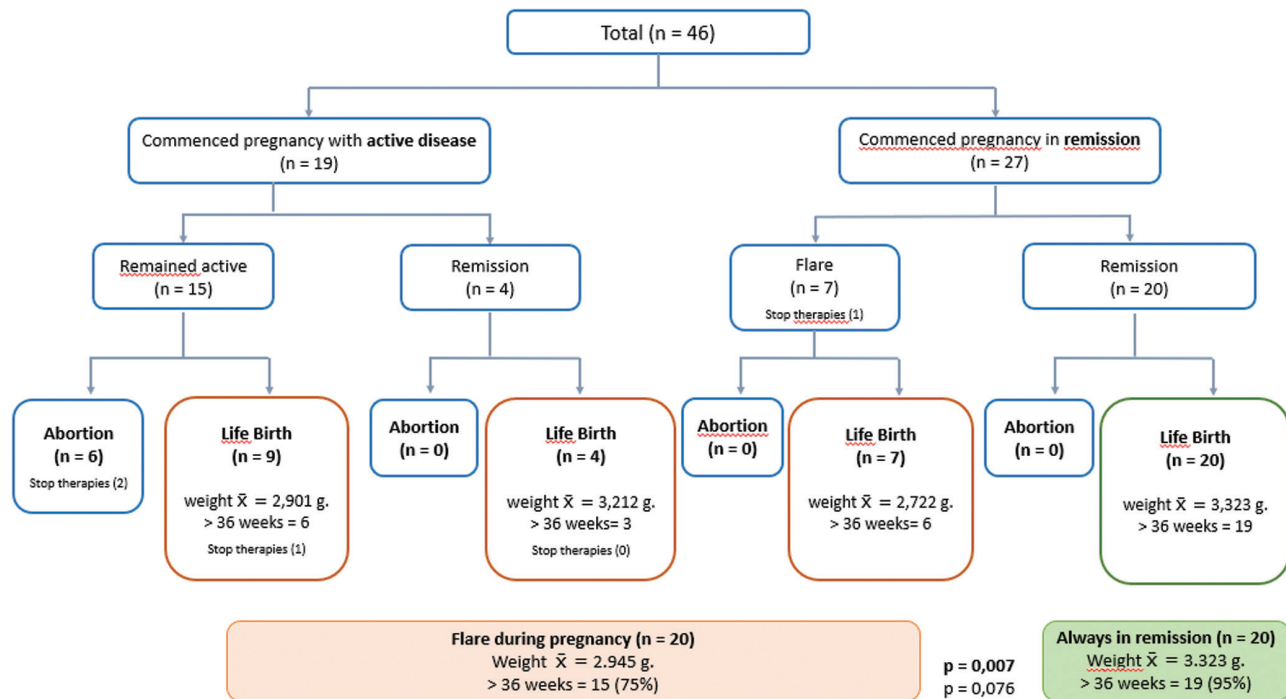


Figure 1. Pregnancy outcomes by disease activity.

Conclusion: In this cohort, we observed that pregnancy during remission presents better outcomes and that preconception counselling would allow a better IBD control during pregnancy.

P134

Patient empowerment in inflammatory bowel disease (IBD): early education at a new diagnosis IBD clinic (NDC)

V.A. Fenech^{*1}, N. Kamperidis¹, T. Tyrrell¹, L. Dyal¹, R. Fofaria¹, R. Misra¹, S. Barber², S. Randall³, J. Shah⁴, N. Arebi¹

¹St Mark's Hospital, Department of Gastroenterology, London, UK, ²National Institute for Health Research, Applied Research Collaborations, Northwest London, UK, ³Patient Information Forum, Head of Strategy and Partnership, London, UK, ⁴Crohns and Colitis UK, Publications and Information Manager, London, UK

Background: IBD is a chronic condition that affects young and older people. Co-existing diseases are common. Patient-centred care includes education and support to empower patients and is a recognised dimension of high-quality care. Patient empowerment with knowledge, skills and confidence ('patient activation') is associated with better outcomes in many chronic diseases. We aimed to measure patient activation in recently diagnosed IBD patients and to identify factors associated with levels of activation.

Methods: A NDC was set up at St Mark's Hospital to offer patients education, information resources and signposts to verified information sources. Patient activation was measured using the Patient Activation Measure (PAM[®]) tool (Insignia Health) before and after the first consultation. PAM[®] is a validated questionnaire with 13 questions to generate an activation score ranging from 1 to 4. Non-activation was defined as PAM levels 1 and 2. Demographic (age in years (SD)), disease specific characteristics and anxiety (Generalised Anxiety Disorder Scale, GAD-2) and depression [Patient Health Questionnaire (PHQ-2)] data were collated at the first visit. The

National Statistics Socio-economic classification (NS-SEC) was used to classify socio-economic status (SES). Categorical variables were analysed with chi-square test and numerical variables with Student's *t*-test.

Results: Twenty-nine patients (51.7% male) attended NDC (ulcerative colitis = 15, Crohn's disease = 10, unclassified IBD = 4). 28 completed PAM questionnaires. Mean age was 43.2 (± 16.4). 5/28 had a family history of IBD, 6/28 were smokers, 11/28 had another chronic condition, and 16/28 were of non-White ethnic background. Sixty-nine% had active disease. SES and psychological scores were available for 14/28 and 16/28 patients, respectively. Fifty per cent (14/28) of patients were non-activated before NDC; 57.1% (8/14) showed an improvement in activation after NDC. Mean age for activated and non-activated patients was 40.6 (± 19.0) and 46.6 (± 13.9), respectively (*p* = 0.35). There was no association between gender, family history, smoking, co-morbidity, ethnic background and SES with activation. None of the four patients (4/16) who scored for anxiety or depression were activated compared with 50% (6/12) of non-anxious/depressed patients (*p* = 0.07). No patients (0/7) in intermediate or higher SES were activated compared with 43% (3/7) of lower SES (*p* = 0.05).

Conclusion: Most non-activated patients had improved activation after attending NDC. Anxiety and depression may contribute to non-activation. Early assessment of patient activation may guide healthcare providers to offer individualised support. Further studies to evaluate the sustainability of patient activation and its effect on clinical outcomes are ongoing.

P135

Disease-related worries and concerns in UK patients with ulcerative colitis: 2-year data from ICONIC

N. Bhala^{*1}, A. Hart², D. Watts³, S. Lewis⁴, S. Ghosh⁵, S. van Haaren⁶, C. Hansell⁶, T. Ahmad⁷