

Results: The cohort included 494 patients with UC, of whom 42.7% were women. Median age at diagnosis of UC was 35 years (range, 1.2–91.4). There were a total of 34 patients treated with infliximab, 3 patients treated with adalimumab, and 1 patient treated with golimumab as their first anti-TNF. The cumulative probability of any anti-TNF use after UC diagnosis was 3.2% at 5 years (95% CI, 1.6%–4.8%), 5.1% at 10 years (3.1%–7.2%), 9.0% at 20 years (6.0%–12.1%), and 10.7% at 30 years (6.8%–14.6%). Nineteen of 38 patients using anti-TNF agents stopped medication within 5 years after initiation. After the first anti-TNF medication was started, the cumulative probability of discontinuation was 21.3% at 6 months (95% CI, 7.0%–33.4%), 34.9% at 1 year (17.6%–48.5%), 43.4% at 2 years (24.8%–57.7%), and 54.3% at 5 years (33.6%–71.7%). Seven patients started a second anti-TNF agent. Among patients discontinuing use of their first anti-TNF medication, the cumulative probability of starting a second anti-TNF was 5.3% after 30 days (95% CI, 0%–14.8%), 31.6% after 90 days (7.1%–49.6%), 31.6% after 6 months (7.1%–50.2%), and 31.6% after 1 year (7.1%–50.2%). Seven patients had either an adverse event or serious infection; the cumulative probability of any adverse event or infection after medication initiation was 0 after 30 days, 2.6% after 90 days (95% CI, 0%–7.7%), 8.4% after 6 months (0%–17.1%), 8.4% after 1 year (0%–17.9%), and 11.9% after 2 years (0.1%–23.3%).

Conclusions: In this population-based inception cohort, only a minority of UC patients were treated with anti-TNF agents, perhaps reflective of not only the study period, but also the overall disease severity in this unselected population without referral bias. Infliximab was the most common anti-TNF used for UC. About 50% of patients initially started on an anti-TNF had discontinued medication use within 5 years of treatment initiation. Less than 50% of these patients were started on a second anti-TNF. Adverse events/serious infections related to anti-TNF use were noted in about 18% of patients.

P-028

Predictors of Suicidal Severity Amongst Suicidal IBD Patients

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Background: Suicidal ideation is a serious symptom understudied in IBD patients. We aimed to assess demographic and clinical factors of suicidal IBD patients and evaluate significant predictors of suicidal severity in IBD patients who are screened for depression at routine outpatient visits.

Methods: We conducted a prospective observational study of consecutive adults presenting to a tertiary care IBD clinic over an 18-month period. All included patients have an IBD diagnosis. Patients were screened for depression using patient health questionnaire (PHQ-9). Item-9 of PHQ-9 measures self-reported suicidal ideation on a scale of 0 to 3. Patients scoring ≥ 1 on this item were selected for further analysis. IBD disease severity was measured by Harvey-Bradshaw Crohn's Disease Index (HBCDI) or Ulcerative Colitis Activity Index (UCAI). Quality of Life (QOL) was measured using Short IBD Questionnaire (SIBDQ). Demographic data including sex, age, race, social history and marital status were obtained from electronic medical records. Other data including labs, narcotic use, medications, pain, presence of current ostomy, prior intestinal surgery, and visits to the Visceral Inflammation and Pain Center were recorded. Logistic regression modeling techniques were used for statistical analysis. In an exploratory analysis, individual depression items of PHQ-9 (minus suicide) and QOL items of SIBDQ were entered into a principal components analysis (varimax rotation). Eigen values and Scree plot revealed best fit with a 2-factor solution: Factor 1 (IBD-Related) consisting of somatic depressive symptoms and functional impairment, and Factor 2 (Depression-Related) consisting of emotional and cognitive symptoms. There was no significant correlation between the 2 factors ($r = 0.009$; $P = 0.462$).

Results: Seventy-one (54.9% male, 81.7% white, 71.8% CD) out of 1352 consecutively screened outpatient IBD patients were suicidal. There was significant correlation between suicidal severity and depression severity, use of tricyclic antidepressant (TCA), IBD related QOL, low vitamin D levels, and current substance use, including narcotics. Univariate regression showed that depression severity (minus suicidal item), TCA use, QOL, and substance use each significantly predicted degree of suicidality. These variables were then added into a multivariate regression prediction model with depression severity ($\beta = 0.51$; $P = 0.002$) and TCA use ($\beta = 0.29$; $P = 0.034$) making significant unique contribution; and drug use at a trend level ($\beta = 0.25$; $P = 0.061$). Suicidal severity was not associated with IBD activity, IBD type, inflammatory biomarkers, use of IBD medications or other psychotropic agents (other antidepressant classes). In exploratory analysis of the 2 factor scores, only factor 2 significantly correlated with suicidal severity but did not correlate with IBD activity. Opposite was true for factor 1. Univariate regression analysis of factor 2 predicting suicidality showed that it explained 14% of variance in suicidality in this model ($P > 0.003$; $\beta = 0.395$; $P = 0.003$).

Conclusions: Suicidal severity is associated with depression severity (especially mood symptoms: depressed, anxious, angry) and cognitive (low self-esteem) rather than disease activity, somatic depressive symptoms (fatigue, sleep, appetite) or inflammatory biomarkers. Substance abuse, especially narcotics and low dose TCA (as a marker for chronic pain) are also risk factors. Future work needs to identify other psychosocial risk factors for suicidality.

P-029

YI

The Impact of IBD Patient Demographic Characteristics on Access to Healthcare

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Background: In 2013, the Crohn's and Colitis Foundation of America (CCFA) Health Care Access Task Force performed a national survey using the modified CDC National Health Interview Survey. This survey provided data regarding access to healthcare resources and expert care for patients with inflammatory bowel diseases (IBD)¹ and previously identified a significant number of patients with healthcare-related financial worry who had forgone a variety of medical services due to cost, lack of prompt access to care, and worry over medical coverage. In this analysis, we sought to determine the demographic variables that influence access to care, and specifically, to identify the patients at high risk for insufficient access to care.

Methods: This is a subset analysis of the previously described survey, which had been emailed to the entire CCFA mailing list. We reviewed the data from the 3646 U.S. respondents and analyzed patient characteristics associated with reduced healthcare access, including healthcare-related financial worry, insurance status, access to medical therapies, and delays in care. Analysis of data was performed using SPSS Inc. statistical analysis software, utilizing ANOVA, χ^2 tests, binary logistic regression, and independent-sample t-tests.

Results: Of the total cohort, one fifth of patients (21.8%, $n = 770$) were "very worried" about paying medical bills. Patient characteristics that significantly contributed to the variance of worry about medical bills include IBD severity, IBD symptom control, age, gender, insurance type, education, income, marital status, work status and employment (all with $P < 0.001$). Of the 452 patients (12.5%) who purchased insurance in the past 3 years, 323 patients (71.5%) reported it was "very difficult" to find an insurance plan they could afford, and 270 patients (59%) found it "very difficult" to find the insurance coverage they need. Several demographic variables were significantly associated with difficulties with insurance coverage and affordability ($P < 0.05$), including more frequent IBD symptoms, lower income, younger age, and self-identification as disabled or not currently working. Whether or not patients had delayed therapy recently was significantly associated with healthcare-related financial worry, $\chi^2(4, N = 3528) = 367.14$, $P < 0.001$, with half of patients in the "very worried" group reporting delayed care (49.7%, $n = 383$), and only 11% ($n = 139$) of the "not worried" group delaying care. Of the 902 patients (25%) who reported delayed medical care in the past 12 months, half of these individuals (52.4%, $n = 848$) reported that the delay was due to the cost of care. Those most likely to delay medical care had more severe IBD, reported a flare in the past 12 months, were age 21 to 30 years or 41 to 50 years, had lower income, and had either no insurance, insurance through a spouse's plan, Medicare/Medicaid, or were the primary person on the plan. Patients who delayed getting healthcare were 1.3 times more likely to have reported an IBD flare in the past year (95% CI 1.2–1.4, $P < 0.001$).

Conclusions: We define an at-risk group of IBD patients who have inadequate health care access and associated disability, active IBD symptoms, and delays and deficiencies in their receipt of care. Ongoing and future interventions should target this group of high-risk patients.

P-030

YI

Chronic but Not Active Inflammation Is Linked with Fibrosis in Ulcerative Colitis

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Background: Chronic intestinal inflammation and impaired tissue repair leading to intestinal fibrosis is a commonly observed complication in inflammatory bowel disease (IBD). This is particularly true for small bowel Crohn's disease (CD). However, the development of fibrosis in ulcerative colitis (UC) has remained largely unexplored. We aimed at characterizing the location and severity of UC associated fibrosis and its link to clinical parameters.