COMPARISON OF MORTALITY FOLLOWING CROHN’S GUT HOSPITALISATION WITH UC IN SCOTLAND BETWEEN 2007–2009, PROVIDING AN EVIDENCE-BASED ARGUMENT TO REDUCE MORTALITY THROUGH PREVENTIVE STRATEGIES

Methods

1. Patients were retrospectively identified at two hospitals in the UK and in Australia, using our local IBD databases. All pregnancies of co-therapy patients were included. TPMT activity and pre-pregnancy weight were used to calculate thiopurine dosing. Data regarding pregnancy and fetal outcomes were collected from patient notes.

2. Results

   a. Eleven females on co-therapy became pregnant, totalling twelve pregnancies with eight live births (Table 1) and four ongoing pregnancies. There were no reported terminations, miscarriages or spontaneous pre-term deliveries (<37 weeks). Four patients gave birth by spontaneous vaginal delivery (SVD); four by Caesarean section (C-section). There were no low birth weight (<2.5kg) babies. The APGAR scores of all babies were normal and no congenital malformations were identified either on fetal ultrasound scans or on neonate checks. The median duration of follow-up of babies was 6.5 months with no indication of morbidity.

   b. Conclusion

      i. All twelve cases were treated successfully with co-therapy without any adverse pregnancy related events or adverse fetal outcomes. Intrauterine exposure of the fetus to thiopurine metabolites is not greater with combination therapy compared with thiopurine monotherapy. There are only two reports of fetal outcomes. Intrauterine exposure of the fetus to thiopurine metabolites is not greater with combination therapy compared with thiopurine monotherapy.

      ii. The case for an association based on two cases is weak, moreover a negative publication bias with respect to successful maternal allopurinol use is suspected. Our study provides support for the conclusion of the authors that thiopurine monotherapy is safe and effective during pregnancy.

Disclosure of Interest

None Declared.

REFERENCE


Disclosure of Interest

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CROHN’S DISEASE AND ANOGENITAL GRANULOMATOSIS PRESENTING WITH GENITAL OEDEMA

Methods

1. The Scottish Morbidity Records and linked datasets were used to assess 3-year crude mortality, standardised mortality ratio (SMR) and multivariate analyses of factors associated with 3-year mortality. The 3-year mortality was determined after four admission types: surgery-elective or emergency; medical-elective or emergency. Age-standardised mortality rates (ASR) were used to compare mortality rates between periods.

2. Results

   a. The admission rate with UC increased from 10.6 per 100,000 of the Scottish population per year in Period 1 to 11.6 in Period 2 (p = 0.046). Among those admitted with UC, the proportion aged <30yrs increased (p = 0.009). Crude and adjusted 3-year mortality fell between time periods (Crude 12.2% [Period 1] to 8.3% [Period 2], adjusted OR 0.59, CI 0.42 to 0.81, p = 0.04). Following emergency medical admission, 3-year mortality was reduced in Period 2 (OR 0.58, p = 0.003).

   b. Within the >65 yrs age group crude 3-year mortality fell (38.8% to 28.7%, p = 0.02). The overall SMR in period 1 was 3.04 and 2.96 in Period 2.

   c. Directly age standardised mortality decreased from 373 (CI 309–437) to 264 (CI 212–316) per 10,000 person years. On multivariate analysis, older age and co-morbid remained associated with 3-year mortality in Period 2.

   d. Conclusion

      i. Although the mortality associated with admission remains high at 3 years, crude and adjusted rates suggest significant reductions over the last decade.

Disclosure of Interest

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