OUTCOMES OF AN ANAEMIA SERVICE EVALUATION USING THE IBD REGISTRY

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Introduction
Iron deficiency (ID) and iron deficiency anaemia (IDA) are frequent complications of Crohn’s disease (CD) and Ulcerative Colitis (UC). Assessing iron status in IBD patients can be challenging as tests may be unreliable in the presence of inflammation. European Crohn’s and Colitis Organisation (ECCO) guidelines state FBC, CRP and ferritin are the minimum to detect IDA.

The UK IBD audit of inpatient care found 56% of those with ID did not receive iron, but the standard of care for IDA is unknown. IBD patients with IDA rarely have an iron deficit of <1000 mg iron and effective treatment for ID/IDA requires correct and sufficient dosing of iron. This project compares current practice with the ECCO guidelines.

Initial pilot data on ID/IDA diagnosis is presented from a Joint Working project using an adapted Webtool with anaemia specific parameters to determine the standard of care for IBD patients.

Methods
20 consecutive consented patients (10 CD, 10 UC) were recruited at 5 sites and followed for around 12 months.

Anaemia: Hb <120 g/L ♂ or <130 g/L ♀

ID: MCV <80 fl AND/OR ferritin <30 μg/L if CRP ≤5 mg/L OR ferritin ≥30 μg/L to <100 μg/L if CRP >5 mg/ml AND/OR TSAT <20%

IDA: Anaemia and ID

Results
Baseline data were available for 94 patients: 45 (48%) male and 49 (52%) female, 47 (50%) with CD and 45 (48%) with UC (2 patients with unidentified CD) mean age 46.5 years.

82 patients had ≥1 recorded haematinic and 18 of these (22%) had 26 anaemic episodes, with 10 (56%, 5 UC and 5 CD) and 14 (54%) of these patients and episodes being IDA. 23 (28%), 8 CD, 14 UC, 1 undefined IBD) patients experienced 34 episodes of ID.

136 Hb results were recorded, but only 78 (57%) were combined with ferritin plus CRP.

Conclusions
Most cases of anaemia were IDA, and more episodes of ID than IDA were found. An equal number of CD and UC patients had IDA, but non-anaemic ID was more common in UC than CD patients. As only 57% of haematinic tests fulfilled the minimum requirement to detect ID in anaemic IBD patients (HB combined with ferritin plus CRP) ID/IDA may be significantly underdiagnosed conditions in IBD. However, these findings are limited due to the small, real-world, dataset.

An adapted Registry Webtool may allow easy data collection though there are challenges in completing data input during consultations. Iron status could therefore be better monitored if haematinics were a default part of the IBD Registry dataset, allowing for quality improvement.

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of microscopic colitis (MC). Due to the association of PPIs with diarrhoea there is a risk of confounding bias due to increased investigation with colonoscopy and biopsies. This has resulted in a controversy in case-control studies with regard to using a control group from the background population (BP) or a control group with investigated chronic diarrhoea (ICD). This abstract evaluates the use of the null hypothesis for MC and PPIs with relation to published case-control studies of MC and PPIs and with discussion of potential mechanisms.

Methods The Null Hypothesis for MC and PPIs can be categorised according to MC being largely clinical and investigated or a largely subclinical uninvestigated disease.

Hypothesis 1: PPIs and MC are unrelated and MC is always overt and investigated by colonic biopsies.

Hypothesis 2: PPIs and MC are unrelated and MC is always subclinical.

For age and sex matched groups – those with clinical MC (hypothesis 1) that are detected will have the same percentage on PPIs as those from the background population (BP), whereas those with subclinical MC (hypothesis 2) that are detected will have the same percentage on PPIs as those with investigated chronic diarrhoea (ICD)

Results There are 6 published case-control studies and a recent abstract that provide adjusted odds ratios (AORs) for PPIs and MC. Some of the larger studies have divided MC patients into the two subgroups; collagenous colitis (CC) and lymphocytic colitis (LC).

Abstract PWE-040 Table 1

<table>
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<th>% PPI</th>
<th>AOR</th>
<th>IDC%</th>
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<tr>
<td>LC</td>
<td>70</td>
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Conclusions MC is unlikely to be always investigated and there is some evidence that MC can be detected in asymptomatic individuals. However, it is also unlikely that MC is largely subclinical and not investigated. All but one case-control studies have shown increased AORs for MC and PPIs for BP controls and similarly in 2 of 3 studies for ICD controls. The only study not showing an association included only 26 cases with MC and a very high usage of PPIs in the control BP of 45%. The mechanisms of how PPIs may cause MC are unclear but theories include increased intestinal epithelial permeability, alteration of colonic bacterial flora and increased production of collagen by colonocytes. The association of MC with medications including PPIs should not be ignored and cessation of potentially causative medications requires consideration.