Abstract IDDF2021-ABS-0059 Figure 4

events. Short myotomy is associated with significantly shorter procedural duration and possibly reduced reflux as compared to long myotomy.

IDDF2021-ABS-0060

COMPARISON OF CLINICAL OUTCOMES BETWEEN RADIOLOGICAL AND ENDOSCOPIC STRICTURES IN CROHN'S DISEASE: WHICH TYPES OF BOWEL STRICTURES REQUIRE MORE ATTENTION FROM CLINICIAN?

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Background The definition of 'bowel stricture' in Crohn's disease (CD) is not uniform across studies, including radiological strictures (RS) and endoscopic strictures (ES). Few studies reported the differences of clinical outcomes between RS and ES in CD. Moreover, whether upstream dilatation (UD) is necessary to diagnosis RS remains unknown. We aimed to compare the clinical outcomes between RS and ES, for exploring which type of stricture requires more attention from clinicians and the significance of UD in RS.

Methods This retrospective study enrolled 431 strictures which simultaneously underwent endoscopy and radiologic examinations. ES was defined as an endoscopic non-passable stricture; RS was defined as a luminal narrowing (at least 50% decrease) with wall thickening (at least 25% increase) relative to adjacent normal gut on CT/MRI. The strictures were categorized as Group 1 (G1, only met RS definition; further divided into G1a [without UD] or G1b [with UD]), Group 2

(G2, only met ES definition), or Group 3 (G3, met the definitions of RS and ES). Clinical adverse outcomes (CAO) referred to stricture-related surgery or penetrating diseases. The follow-up endpoint was the time occurring CAO or November 30, 2020, if absent of CAO.

Results G1b (65.0%) had the highest occurrence rate of CAO, followed by G3 (40.4%), G1a (12.6%), and G2 (4%) ($P < 0.0001$). Using Kaplan-Meier curves analysis, the time distribution of occurring CAO among these groups also had significant differences ($P < 0.0001$; IDDF2021-ABS-0060 Figure 1). In G1, G1b had a higher occurrence rate of CAO than G1a ($P < 0.0001$). UD (HR 2.082; 95% CI, 1.651–2.628) was a risk factor for predicting CAO in multivariate analysis; after adding it into radiologic model, UD significantly improved the prediction efficiency of the model (integrated discrimination improvement, 13.30%, 13.20%, 9.90% in 52, 156, 260 weeks, respectively; IDDF2021-ABS-0060 Figure 2). However, if adding UD to diagnose RS, 40 high-risk strictures would be unnoticed.

Conclusions The CAO is different between ES and RS; clinicians should pay more attention for strictures in G1b and G3. UD has an important impact on the clinical outcome of RS but may not an essential factor for RS diagnosis.

Abstract IDDF2021-ABS-0060 Figure 1

Abstract IDDF2021-ABS-0060 Figure 2