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Background: Steroid-free remission is an important goal of IBD therapy. Improved access to effective therapies and changes in physician awareness of excess steroid exposure might impact this goal. The aim of this study was to evaluate temporal changes in steroid prescribing in UK IBD outpatients in the context of major changes in UK prescribing guidelines and physician participation in audit and tailored service changes.

Methods: Steroid use over the previous 12 months was recorded for unselected outpatient attenders against a definition of excess from ECCO guidelines. Data were collected from seven centres that had completed a steroid assessment audit cycle in 2015, as well as from 12 new matched centres.

Results: Data were collected for 2385 patients (May–July 2017) and compared with 2015 data from 1176 patients. Overall disease distribution was 47.1% Crohn’s (CD), 49.6% UC and 3.3% IBD-U, whilst 77.7% of patients were in clinical remission at the time of assessment (no significant differences between 2015 and 2017 subgroups). There was only a modest increase in patient exposure to anti-TNF from 2015 to 2017: 30.6% to 37.2% in CD (p = 0.009) and 9.9% to 12.0% in UC (p = NS). Anti-integrin usage increased from 0.8% to 3.3% in CD (p = 0.002) and from 1.6% to 2.4% in UC (p = NS). For centres taking part in the 2015 audit, steroid exposure rates fell from 30% to 23.8% (p = 0.003) and steroid excess from 13.7% to 11.5% (p = NS). Steroid exposure and excess rates for sites that had not been part of the previous audit were significantly higher (31.0% exposure, 17.1% excess, p = 0.0001 for both). There were no significant differences in important baseline characteristics of two groups of sites. Logistic regression analysis revealed independent predictors of reduced risk of steroid excess, after correction for disease severity. For CD these included treatment with anti-TNF therapy (p = 0.04), treatment in a centre with regular IBD multidisciplinary team (MDT) meetings (p = 0.01) and treatment in an original 2015 centre (p = 0.02). For UC treatment in a 2015 centre was also significant predictor of protection (p = 0.04) and treatment with thiopurine monotherapy a predictor of risk of excess (p = 0.01); usage of anti-TNF therapy in UC did not reach significance for protection from excess.

Conclusions: Changes in biologic access in the UK have resulted in only modest changes in prescribing behaviour and have not yet impacted significantly on excess steroid exposure in UC, unlike in CD. Participation in an audit cycle of steroid usage was associated with a meaningful reduction in steroid excess. These data support the concept that steroid excess could be used as a key performance indicator in IBD and physicians should be engaged in this process.

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A propensity score-matched comparison of infliximab and adalimumab in naive and non-naïve patients with Crohn’s disease

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Background: In the absence of head-to-head trials, there is an unmeet need to better understand the relative effectiveness of different biologics in inflammatory bowel disease (IBD). The Sicilian Network for Inflammatory Bowel Disease (SN-IBD) is a group composed by all Sicilian centres which continuously enter in a web-based software all clinical data of IBD patients treated with biologics.

Methods: Data of all incident Crohn’s disease (CD) patients treated with infliximab (IFX) and adalimumab (ADA) from January 2013 to April 2017 were extracted from the cohort of SN-IBD. Patients were divided in biologic-naïve and non-naïve, and the two groups were analysed singularly. We used a one-to-two propensity score matching (1 IFX: 2 ADA) accounting for the main baseline characteristics in naive patients, and a one-to-one propensity score matching (1 IFX: 1 ADA) in non-naïve.

Results: Seven hundred and forty-seven naive and 188 non-naïve patients were included. After propensity score matching, 453 naive (IFX: 151; ADA: 302) and 100 non-naïve patients (total treatments: 122; IFX: 61; ADA: 61) were analysed. Among naive patients, the rates of response/remission at 12 weeks for IFX and ADA were 80.1% and 81.1%, respectively (adjusted OR 0.97, p = 0.923); over a median follow-up of 11 months, the rates of response/remission for IFX and ADA were 70.2% and 66.2%, respectively, without significant differences (adjusted OR 1.14, p = 0.401). Among non-naive patients, the rates of response/remission at 12 weeks for IFX and ADA were 68.9% and 60.7%, respectively (adjusted OR 1.54, p = 0.320); over a median follow-up of 8.9 months, the rates of response/remission for IFX and ADA were 57.4% and 54.1%, respectively, without significant differences (adjusted OR 1.96, p = 0.297). Cox regression analysis showed no differences in risk of treatment failure between ADA and IFX, neither in naive (adjusted HR 1.23, p = 0.381) nor in non-naive patients (adjusted HR 1.23, p = 0.488). At multivariable conditional logistic regression analysis of naive CD patients, upper GI involvement (OR 0.18, p = 0.038), previous surgery (OR 0.24, p = 0.003), and older age (OR 0.97, p = 0.036) were associated with lower clinical benefit at 12 weeks, while previous surgery was the only independent predictor of treatment failure at the end of follow-up (HR 2.13, p = 0.03). Mixed effect Cox analysis showed that non-naive patients experiencing more than one previous line of treatment with biologics have a significant higher risk of treatment failure compared with those previously treated with one biologic only (HR 2.57, p = 0.002).

Conclusions: In this large, propensity score matched, real-life, multicentre, cohort study of CD patients, there was no significant difference in the effectiveness of ADA and IFX. Both drugs showed a good efficacy.