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SOCIO-ECONOMIC STATUS AND DEPRIVATION IN CROHN’S DISEASE: A CASE-CONTROL STUDY
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Background: an aims: Previous reports have shown that Crohn’s disease (CD) affects people with higher income and higher social class more frequently than other groups in the population.

Methods: To confirm this statement, we used an individual index of deprivation, the EPICES score [“Evaluation de la Précarité et des Inégalités de santé” (Evaluation of Precarity and Inequalities in Health Examination Centers); http://www.cetaf.asso.fr], a validated score of deprivation developed in French hospitals. We compared the EPICES score (calculated from 11 socioeconomic questions, a score > 30 was associated with high deprivation) of CD patients to three control groups followed in the same hospital from September 2006 to June 2007. The first control group was made by patients with type 1 diabetes (chronic disease affecting young patients like CD), the second by patients consulting for hemorrhoid disease (non affected by deprivation status), and the last one by patients with a presumed high level of deprivation (alcoholic addicted patients consulting in an addiction center by hospital referral).

Results: We included prospectively 78 CD patients (49 Females/29 Males; 41±14 yrs); 27 type 1 diabetes patients (9W/18M; 39±22 yrs); 47 patients with hemorrhoids (23F/24M; 53±15 yrs) and 135 with alcohol addiction (30F/105M; 41±11 yrs). The median of the deprivation score was: 13.6 (0-57) for CD patients; 16.6 (0-64) for diabetics; 23.1 (0-75) for patients with hemorrhoids and 31.4 (0-90) for alcoholic addicted patients. CD patients were significantly less deprived (EPICES score <30) than 1) diabetics (77% vs. 60%, p<0.001), 2) patients with hemorrhoids (77% vs. 59%, p=0.04) and 3) alcoholic addicted patients (77% vs. 41%, p<0.0001). CD patients have received a bachelors degree or higher more frequently than 1) diabetics (51.5% vs. 35%, p<0.01), 2) patients with hemorrhoids (51.5% vs. 45%, p=0.003) and 3) alcoholic addicted patients (51.5% vs. 33%; p=0.01).

Conclusion: Using a socioeconomic deprivation score, we showed that CD patients were less deprived and had a higher educational level than: 1) young patients affected by a chronic disease, 2) patients affected by a disease not associated with deprivation and 3) deprived patients. In our hospital population, we confirm the statement that CD patients have a better socio-economic and educational levels than other patients.

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MORTALITY IN INFLAMMATORY BOWEL DISEASE IN GIJÓN (ASTURIAS, SPAIN). A POPULATION-BASED EPIDEMIOLOGIC STUDY FROM 1954-2006

Background: Last years have witnessed the development of new diagnostic and therapeutic options for the management of Inflammatory Bowel Disease (IBD). All have contributed to a better quality of life in affected patients. We did not know whether such improvements resulted in a better survival of IBD patients in our setting.

Aims: We performed a population cohort study on 1192 patients with CIBD, corresponding to 524 Crohn’s (CD); 636 ulcerative colitis (UC), and 32 indeterminate colitis (IC), diagnosed in the city of Gijón, Region of Asturias, Spain, between 1954 and 2006, to assess survival and its changes according to time.

Methods: The cohort was followed-up upon their attendance to an outpatient clinic, with telephone contact with those who did not attend the clinic in the last year. Observed deaths were compared to expected deaths using the individual death risk in Asturias. The cumulative survival rate was calculated. We compared standardized mortality ratio in time periods (1954-76 vs 1977-91 vs 1992-2006) and mortality in 10-year periods according to date of diagnosis.

Results: We observed a total of 117 deaths, with a global mortality rate of 98.15 (CD: 80.15; UC: 116.35; IC: 31.25), without differences between sexes. Thus, 117 deaths occurred, against 12.02 expected deaths (standardized mortality ratio, 9.73; 95% CI, 2.82-11.6). In UC, 74 deaths were observed, and 6.41 expected (SMR,11.54; 95%CI, 3.47-18.7). In CD, 42 deaths were observed, and 5.28 expected (SMR, 7.95; 95%CI, 2.38-10.05). In IC, 1 deaths were observed, and 0.32 expected (SMR, 3.12; 95%CI, 0.67-6.34). SMR comparison from 1954-76:12.65; 1977-91:16.06 and 1002-06:6.44. See table for survival in years.

Conclusions: Our data support the hypothesis that IBD patients have a higher mortality than the general population. Globally, survival time has remained stable, being slightly better for CD, with a slight increase for patients diagnosed after 2000. In CD patients, survival tends to decrease, and to increase in UC. The survival were higher for CD, but no significant difference between CD and UC.

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INCIDENCE AND CLINICAL CHARACTERIZATION OF IBD IN MADRID (SPAIN)

Objectives: A continuous increase in the incidence of inflammatory bowel disease (IBD) has been suggested. We aimed to study incidence of IBD in the sanitary area of the Hospital of Alcorcón (239390 inhabitants), in Madrid (Spain) and the epidemiological features and clinical patterns of these patients.

Methods: All patients diagnosed with IBD during 2003-2005 were followed prospectively. Patients diagnosed between 1997-2003 were studied retrospectively. Clinical characteristics such as disease extent, extraintestinal manifestations, smoking habits, medical treatment and surgical interventions were registered.

Results: Sixty-eight patients were diagnosed with IBD in the prospective period of study, resulting in a mean annual incidence of 7.9/105 for CD and 7.5/105 for UC. The annual incidence in the retrospective period of study was lower: 7.1/105 for CD and 6.2/105 for UC (p<0.05). Incidence rates were slightly higher in men for CD and in women for UC.

Median age at diagnosis was 33.5 ± 14.7 years among CD patients versus 41.3 ± 17.2 years among UC (p<0.001). Fifty five percent of CD versus 41.2% of UC patients were male (p=0.01). No seasonal variation in disease onset or diagnosis was observed. Family history of IBD and smoking was more common in CD than in UC. Extraintestinal manifestations were observed in 40% of patients, without differences between CD and UC.

Regarding clinical pattern in CD, 32.9% of patients had a ileal disease (L1), 19% confined to colon and 48.1% had a ileocolic disease (L3). Upper gastrointestinal disease (L4) was present in 5.6% of patients. The nonstricturing and nonpenetrating (B1) behaviour was the more frequent (61.4%), whereas the stricturing (B2) and penetrating (B3) were concerning to 7.3% and 17.1% of patients respectively. Perianal disease was present in 23% of the total. Older age at diagnosis was related to pure colonic disease.

Left-sided disease was the more common localization among UC patients (43%), whereas the following localization in frequency was the extensive colitis in men (35,1 vs 21,1%) and the proctitis in women (35,3 vs 22,4%) (p<0.01).

Regarding medication, 68.8% of UC patients were taking aminosalicylates. 28.7% of CD patients and 22% among UC were corticosteroid-dependent, and 30.2% and 8.3% respectively were on immunosuppressive treatment. Moreover, 12% of CD were on anti-TNF therapy. About surgery, 13% of CD patients and 4.1% of UC underwent intestinal resection.

Conclusion: The incidence of IBD, mainly CD incidence, has increased noticeably during last decades in Madrid. In this area CD, contrary to previously described, is more frequent in men and UC in women. CD patients are younger at diagnosis than UC, and older age at diagnosis in CD patients is related to pure colonic disease. The risk of surgery is lower than earlier reported.

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THE RISK OF COLORECTAL CARCINOMA IN IBD PATIENTS IS LIMITED IN NON-TERTIARY CENTERS: RESULTS OF A NATION WIDE LONG-TERM SURVEY

Background and aim: Surveillance guidelines in patients (pts) with inflammatory bowel disease (IBD) recommend initiating surveillance for IBD after 8-10 yrs of extensive disease for left-sided colitis, based on earlier reports demonstrating increased risk of colorectal cancer (CRC) in IBD pts. Most of these reports were based on selected tertiary care pts with chronic severe disease, and conflict with more recent data. Recently was demonstrated that, in academic centers in The Netherlands, even before the recommended start of surveillance pts were diagnosed with IBD-related CRC. It is unknown whether this also reflects high-risk tertiary referrals. The overall epidemiology of CRC in IBD pts is therefore very relevant for monitoring and adaptation of clinical guidelines. We assessed the risk of IBD-associated CRC in non-academic centers in The Netherlands.

Methods: IBD related CRC pts in all non-tertiary centers in The Netherlands were identified by using the nation wide network and registry of histology and cytopathology (PALGA). Pts who had IBD and CRC diagnosed synchronously were identified by using the nation wide network and registry of histology and cytopathology (PALGA).