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**Number: Tu1099**

A GLOBAL ASSESSMENT OF DIAGNOSTIC AND THERAPEUTIC APPROACHES IN THE MANAGEMENT OF INFLAMMATORY BOWEL DISEASE

**Society:** AGA**Track:** Clinical Practice**Author(s) and Affiliation(s):**

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**Background** We aimed to determine how inflammatory bowel disease (IBD) care differed depending whether care providers were working in the highest tier of health care expenditure per capita (HCEPC, tier 1), the next tier of HCEPC (tier 2), or the lowest tier of HCEPC (tier 3).

**Methods** A survey was developed to gather information on physician demographics and practice approaches to diagnosing and treating patients with suspected and confirmed IBD. 425 respondents from 85 countries were grouped into three tiers [42% (tier 1), 29% (tier 2), and 29% (tier 3)] according to HCEPC. Survey responses were compared across tiers using chi square analyses. Mantel-Haenszel chi-square tests were used to account for the ordering of HCEPC (tier 1 > 2 > 3 or 3 > 2 > 1).

**Results** The median HCEPC in tier 1 countries was US\$5,738 (range: US\$2,499–US\$12,012); US\$1,146 in tier 2 countries (range: US\$558–US\$2,352); and US\$180 in tier 3 countries (range: US\$22–US\$494). Respondents were predominantly males and years in practice were similar across tiers. Over 80% of respondents across all tiers received advanced gastroenterology training. Nearly two thirds of tier 1 practitioners received advanced IBD training vs 41% in tier 2 and 32% in tier 3 (p<0.0001). Two thirds of practitioners in tier 1 countries worked in IBD specialty clinics, vs one-third in tier 3 countries (p<0.0001). Practitioners in tier 1 were more likely to see a higher volume of IBD patients (p<0.0001), and they were more likely to have advanced IBD training. For patients with new onset bloody diarrhea, most practitioners pursue colonoscopy rather than flexible sigmoidoscopy. Notably, 49% of respondents in Tier 3 countries reported that the results would be available within 3 days, vs 39% of tier 2 countries and 26% in tier 1 (p<0.0001). High resolution endoscopy was available in 81% of Tier 1 responses, 73% in tier 2, and only 55% in tier 3 (p<0.0001). Capsule endoscopy was available in tier 1 (97%) but less available in tier 2 (74%) and tier 3 (58%) (p<0.0001). Cross-sectional imaging was available faster in tier 3, with 78% receiving CT or MRI results within 2 weeks, compared to 59% in Tier 1 (p=0.006). 5-ASA were more likely to be prescribed and advanced therapies less likely to be available for Crohn's disease in tier 3. Mental health was considered important in IBD management by more in tier 1 (p=0.005), yet respondents from tier 3 were more likely to ask patients about mental health (p=0.008), more willing to prescribe psychotropic medications (p=0.0007), administer psychotherapy themselves (p=0.001).

**Conclusions**

We have identified key deficiencies in tier 3 countries, particularly in imaging capabilities and access to advanced therapies. Establishing a baseline standard for diagnostic and therapeutic approaches could enable the IBD community within each country to advocate for improved care.

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Dr. Charles Bernstein

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