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CROHN’S DISEASE LIKE POUCH INFLAMMATION IS ASSOCIATED WITH DECREASED ODDS OF TEMPORARY ILEOSTOMY TAKEDOWN AFTER ILEAL POUCH ANAL ANASTOMOSIS

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Background: The staged restorative proctocolectomy (RPC) with ileal pouch anal anastomosis (IPAA) is the gold standard surgery for patients with medically refractory ulcerative colitis (UC). Complications such as anastomotic leak, small bowel obstruction and pouch inflammation may occur after final surgical stage and require the creation of a temporary diverting ileostomy. In this study, we sought to identify risk factors for ileostomy takedown after IPAA at an academic tertiary care institution.

Methods: This was a retrospective chart review conducted at a single tertiary care inflammatory bowel disease (IBD) center at Mount Sinai Hospital (MSH). All patients with UC who underwent RPC with IPAA for medically refractory disease or dysplasia followed by a diversionary ileostomy, and describe the predictors for successful ostomy takedown and restoration of intestinal continuity.

Results: Of the 2,580 GI surgery patients seen, 50.3% were in person and 49.5% were telemedicine visits. Patients were predominantly female (59.3%) and white (81.2%). Patients seen in-person and via telemedicine were similar except patients seen telemedicine lived further from the hospital (mean distance 60.6 mi vs 49.8 mi, p = 0.003). Living 100 mi or more from the hospital and a ZIP code with the lowest quintile of median income were independent predictors of telemedicine use (OR 1.51, 95% CI 1.16-1.97; OR 1.39, 95% CI 1.04-1.85, respectively). Among patients who used telemedicine, those with phone use were more likely to be Black compared to those with video use (17.3%, vs 29.4%, p = 0.043). Patients with video use were older (mean age = 54.0 yr vs 50.5 yr, p = 0.003) and came from ZIP codes with lower median income ($35,618 vs $37,846, p = 0.037). They were more likely to have Medicaid (10.7% vs 6.1%) or Medicare (32.1% vs 25.0%) and less likely to be privately insured (50.5% vs 60.2%) compared to patients with video use (p = 0.003). Living more or farther from the hospital was an independent predictor of video use (OR 2.27, 95% CI 1.56-3.30). Having Medicaid and age greater than 80 were independent predictors of phone use (OR 0.46, 95% CI 0.29-0.73; OR 0.37, 95% CI 0.16-0.86, respectively). Conclusions: Patients who live farther from the hospital are more likely to use telemedicine. Phone visits are used more by patients who are Black, older, from lower income ZIP codes, publicly insured, and live closer to the hospital. Variations in patient telemedicine use exist across a diverse surgical population in the Deep South, suggesting telemedicine use exist across a diverse surgical population in the Deep South, suggesting that there may be an attractive alternative strategy. Further research is needed to determine its efficacy in this patient population.