or maybe both, remains unanswered, and is confounded by the complexity of inflammation, IBD and vitamin D. Fat malabsorption has been proposed as a possible reason for deficiencies of vitamin D in IBD. The aim of this study was to further understanding of vitamin D deficiency in IBD by investigating possible causal relationships of fat malabsorption and inflammation on vitamin D levels in this complex context.

**Methods:** In a comparative, cross-sectional study in IBD patients, 25(OH)D was analysed by LC/MS/MS. Serum β-carotene levels were used as a biomarker for fat malabsorption. Vitamin K1, another fat-soluble vitamin, was used to affirm a possible causative relation between β-carotene and vitamin D in case of fat malabsorption. β-carotene and vitamin K were measured in serum by HPLC. Inflammation was characterised by serum hsCRP level.

**Results:** 51 IBD patients (30f;20CD/18UC;45.3±16.3y; 21 with inflammatory activity) were enrolled. In patients with vs. without inflammation, serum 25(OH)D levels were significantly lower (26.5±14.6ng/mL vs. 36.8±12.6ng/mL, p<0.05), while serum vitamin K1 (1.4±0.5µg/L vs. 1.2±0.4µg/L) and β-carotene (28.5±6.9µg/dL vs. 35.9±5.4µg/dL) levels were similar (p>0.05). 36/51 of the patients had low serum β-carotene levels, indicating steatorrhoea. Neither 25(OH)D (32.1±13.8ng/mL vs. 33.6±15.8ng/mL) nor vitamin K1 (1.3±0.5µg/L vs. 1.2±0.4µg/L) nor vitamin K1 (1.3±0.5µg/L vs. 1.2±0.4µg/L) levels differed according to the presence vs. absence of steatorrhoea (p>0.05). Similarly, no correlation was found for 25(OH)D (r=0.24, p=0.875) or serum vitamin K1 (r=0.111, p=0.462) with β-carotene levels. On the other hand, 25(OH)D levels were significantly inversely correlated with hsCRP (r=-0.338, p=0.015), whereas vitamin K1 (r=0.050, p=0.731) and β-carotene (r=-0.118, p=0.438) did not show a similar relation.

**Conclusion:** Vitamin D levels were confirmed to be related to inflammation in IBD. A lack of correlation with fat malabsorption, as indicated by β-carotene levels, or with steatorrhoea, was found for vitamin D and confirmed by measuring and comparing serum levels of an additional fat-soluble vitamin, K1. We conclude that low vitamin D levels in patients with IBD are related to inflammation rather than fat malabsorption.

**P659**

**Colonoscopic screening of symptomatic patients suggests an emerging inflammatory bowel disease (IBD) in urban and rural south India**

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**Background:** Recent studies suggest that IBD is on the rise in the developing world. This is also the region with limited access to healthcare facilities, poor physician and patient awareness of the disease and diagnostic dilemmas with the infectious bacterial diarrhoeas preventing adequate diagnosis. There is very limited data on the relative prevalence of IBD compared to the infectious diarrhoeas. We screened symptomatic patients to assess the diagnostic profile in the real world settings with free of cost service to people below poverty line and the un-insured.

**Methods:** The study is being conducted in a large tertiary care centre in Southern India from March 2020 till date. We present the results of an interim analysis. Symptomatic patients with diarrhea, unintentional weight loss, bleeding per rectum, chronic abdominal pain and unexplained anaemia were screened with a blood test (Haemogram, liver function, serum protein), abdominal ultrasound and colonoscopy/ileoscopy to ensure an early diagnosis and initiation of treatment. Data including the demographics of the patients, predominant symptoms, rural/urban residence, investigations, biopsy and final diagnosis were entered into an excel spreadsheet and analysed.

**Results:** 6878 patients, 2188 female (32%), median 44 years (1–82 years) were screened between March 2020 to January 2021. Bloody diarrhoea was noted in 1212 (18%), chronic non-bloody diarrhoea in 887 (13%), altered bowel habits in 2381 (35%), pain abdomen in 4030 (59%), un-intentional weight loss in 648 (10%) and anaemia in 188 (3%). IBD was diagnosed in 397 patients (6%) of which 169 (25%) were UC and 228 (33%) were CD. Infective etiology including intestinal tuberculosis was seen in 577 (8.3%). Colorectal cancer was diagnosed in 251 (3.6%), polyps in 614 (8.9%). Overall, 4921 (71.5%) were urban and 1957 (28.5%) rural. The proportion of UC (2.5% rural vs. 2.5% urban, p=0.65) and CD (3.6% rural and 3.2% urban, p=0.43) were not different in rural and urban groups. There was significantly higher proportion of infectious colitis in the rural subgroup (p=0.01)(Table 1).

|                             | Rural          | Urban          |
|-----------------------------|---------------|---------------|
| Total number of patients    | 1957          | 4921          |
| Ulcerative colitis          | 45 (2.3%)     | 124 (2.5%)    |
| Crohn’s disease             | 70 (3.6%)     | 156 (3.2%)    |
| Infective etiology          | 191 (9.7%)    | 386 (7.8%)    |

**Conclusion:** This interim analysis indicates a rising IBD in both urban and rural India. A vis the infectious diarrhoeas. However, proportion of infectious colitis was significantly higher in the rural subgroup compared to the urban.

**P660**

**The impact of COVID-19 on the provision of care for patients with Inflammatory Bowel Disease: A cross sectional survey**

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**Background:** COVID-19 was declared a worldwide pandemic in March of 2020. Since its onset, the focus of many healthcare systems shifted toward limiting non-essential visits to hospitals in order to prioritize and allocate resources toward treating those affected by COVID-19. Those with Inflammatory Bowel Disease (IBD) have been particularly impacted. We aimed to survey IBD patients to determine how they have been affected by changes to the provision of care due to the COVID-19 pandemic.

**Methods:** A mixed methods survey was conducted with patients with an IBD diagnosis who received care for their IBD since March 17, 2019 in Canada. The primary aims of the survey were to evaluate any differences in access to or usage of IBD-related care including medications, clinic visits in addition to patient experience with virtual care.

**Results:** A total of 135 complete or partial responses were received, of which 90 responses were included for having answered >50% of
Radon exposure and inflammatory bowel disease in a radon prone area

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Background: Inflammatory Bowel Disease (IBD) is a multifactorial pathology with an increasing incidence. There are environmental factors, many unknown, that participate in its development. There is no study having assessed a possible relationship with residential radon concentration. The Spanish Galician Radon Map and correlated with demographic factors and type of IBD. We used the Spearman’s correlation coefficient to test the existence of any association.

Methods: We performed an ecological study where we included all incident cases of IBD in the area of Santiago de Compostela between January and December 2017 in order to estimate municipal incidence rates. Radon levels at a municipal level were obtained from the Galician Radon Map and correlated with demographic factors and type of IBD. We used the Spearman’s correlation coefficient to test the existence of any association.

Results: 96 patients were included, 63 (65.6%) with Ulcerative Colitis, 29 (30.25) with Crohn’s Disease and 4 (4.2%) with indeterminate colitis. Median age was 41 (IQR: 33.5 to 56 years), and 50.0% were women. The incidence rate per 100,000 inhabitants-year in the study area was 21.6 cases. The median radon concentration was 104.9Bq/m³ (IQR: 91.0 to 154.6), without statistically significant differences in function of the location of the house (rural vs. urban) nor the type of edification (flat vs house), p >0.05. There were no statistically significant differences on the type of IBD developed (ulcerative colitis, Crohn’s disease or indeterminate colitis) regarding radon levels either (p>0.05). There were no statistically significant differences (p>0.05) between radon and sex of IBD cases. No correlation between radon levels and age of the individuals was observed (Spearman’s rho = -0.13, p-value 0.2), nor radon levels variation by age groups (p>0.05). There was no correlation between radon concentration and cumulative incidence of IBD at municipal level (Spearman’s rho = 0.13, p-value 0.5), as it is shown in figure 1.

Conclusion: In the area of Santiago de Compostela there is a higher incidence of IBD in comparison with previous studies taking western countries as reference. It is possible that some environmental risk factors, could be responsible of this difference. In this study we have not found any correlation with municipal average radon concentration and incidence of IBD or any of its types.