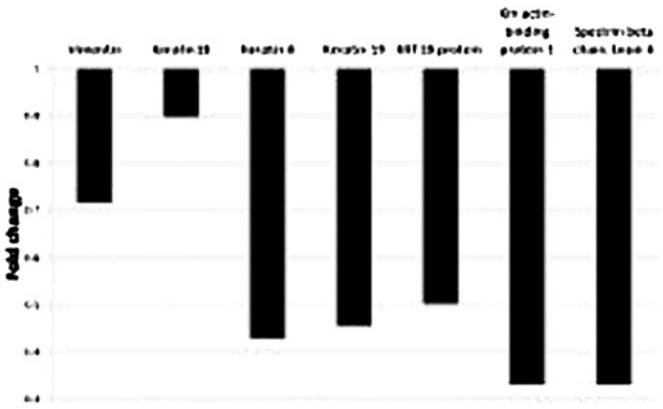
colonic mucosa in the same patient (n=10), and from normal controls (n=10). Endoscopic (Baron) and histological assessment was made. An iTRAQ-compatible extraction protocol for insoluble IF proteins was developed. Labelled peptides from pooled patients were analysed by SCX-LC-MS/MS (strong cation exchange-reverse phase HPLC tandem mass spectrometry) and data reconstituted in GeneBio Phenyx. Inter-group comparisons were made using in-house algorithms based on t-testing with multiple test correction.

Results Median age was 36 years (range 23–71). Endoscopic Baron score was ≥2 in inflamed mucosa for all patients. Tandem mass spectrometry (MS/MS) identified 52 proteins, 32 (61.5%) matched by two or more peptides, showing significant log fold change, with reduced levels of keratins and vimentin in inflamed mucosa compared to controls (Abstract PMO-250 table 1). Abstract PMO-250 figure 1 shows significantly reduced IF protein levels in inflamed mucosa compared to inactive mucosa. Cytokine proteins neutrophil defensin 1 and bone morphogenetic protein 4 were increased only in actively inflamed mucosa.

Abstract PMO-250 Table 1 Inflamed and non-inflamed mucosa vs controls (log fold change)

Protein	Accession no	MolWeight (kDa)	Peptide no	Active	Inactive
K8	P05787	53.7	35	0.4*	NS
K18	P05783	48.0	17	0.7*	NS
K19	P08727	44.1	31	0.4*	NS
Vimentin	B3KRK8	46.9	4	0.6*	NS

*p<0.05.



Abstract PMO-250 Figure 1 Decreased levels of IF proteins in inflamed colonic mucosa.

Conclusion Using a quantitative proteomic approach, we have shown significantly decreased levels of keratins in the actively inflamed colonic mucosa in UC providing further evidence of interaction between keratins and inflammatory pathways—which requires further elucidation.

Competing interests None declared.

PMO-251 A RETROSPECTIVE AUDIT OF COLORECTAL CANCER SURVEILLANCE IN INFLAMMATORY BOWEL DISEASE IN SECONDARY CARE

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Introduction Patients with colitis are at increased risk of colorectal cancer (CRC). Colonoscopic surveillance to detect dysplasia and early cancers has been advocated by the BSG since 2002.[1] Our aims were to assess whether patients with colitis in our patient cohort are receiving appropriate colonoscopic surveillance for CRC according to these guidelines, and to assess the impact of the updated 2010 BSG guidelines[2] on local endoscopy services.

Methods Patients with IBD were identified from secondary care coding databases and verified by paper records. A retrospective review of case notes was performed. Data on diagnoses, duration of symptoms, extent of disease and CRC surveillance was collected and analysed. Individualised recommendations for colonoscopic screening and surveillance were made according to the 2010 BSG guidelines.

Results 45 colitis patient records were reviewed; 20 CD: 25 UC, M:F 23:22. The average age was 59.4 (range 18.6–87); average duration of disease 18.6 (range 0–56). 35 (78%) had colitis extent requiring surveillance. 26 patients (58%) had symptom onset >10 years; 11 patients (42%) underwent screening colonoscopy at 8–10 years; 14 (54%) did not, one patient underwent colonoscopy but date of diagnosis was unclear. Nine patients (35%) underwent inconsistent surveillance, in six patients (23%) there was no record of a colonoscopy. Reasons for inconsistent or absent surveillance included non-attendance (2), patient declined (1) and unclear (11). 24 patients were eligible for repeat colonoscopy; 3 (13%) underwent this at the recommended interval; one patient was due in 2011; 11 (46%) underwent inconsistent surveillance; nine (38%) did not undergo any surveillance. Reasons for absent or inconsistent surveillance included non-attendance (2), lost to follow-up (1), patient declined (1), procedure unnecessary due to disease extent (1), patient undergoing surgery in the interval between colonoscopies (1) and unclear (14). Of 26 patients eligible for surveillance, 3 were excluded due to disease extent and intervening surgery. Of 23 remaining patients, the surveillance interval between colonoscopies would be increased in 12 patients (52%), unchanged in 6 (26%) and reduced in 3 (13%) with the introduction of the 2010 BSG guidelines. The impact was unclear in two patients (9%).

Conclusion Patients with colitis in our patient cohort at NBT are not receiving appropriate CRC surveillance according to BSG guidelines. These results emphasise the need for a robust coordinated surveillance programme. The 2010 guidelines have had the net effect of increasing the time interval between colonoscopies, which may lead to an overall reduction in endoscopy workload from surveillance cases.

Competing interests None declared.

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PMO-252 EFFICACY OF INFLIXIMAB THERAPY IN ACUTE AND SUB-ACUTE ULCERATIVE COLITIS

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Introduction Ulcerative colitis (UC) has a chronic relapsing course. Infliximab is beneficial in severe disease, but conflicting data exists regarding the subsequent colectomy rates. We aimed to review outcomes post-infliximab usage in acute and sub-acute UC in our clinical practice.

Methods We conducted a retrospective review of all patients who had received a maximum of three doses of infliximab for acute or sub-acute exacerbations of UC between January 2010 and October 2011. Medical treatment (initial and subsequent) and colectomy rates were recorded for all patients.

Results 21 patients received infliximab during the study period. 12 patients were emergency admissions who had failed to respond to intravenous steroid therapy (acute group). Nine patients had failed to respond to maximum oral therapy, which included immunomodulators and oral prednisolone (sub-acute group). In the acute group, 42% (n=5) of patients had avoided a colectomy at a median follow-up of 467 days (IQR 370–612). The other 58% (n=7) proceeded to colectomy after a median of 69 days (IQR 30–136). Of the patients who proceeded to colectomy, 57% had been prescribed immunomodulator therapy prior to infliximab usage. However, all the patients who avoided colectomy were immunomodulator naive prior to infliximab. In the sub-acute group, only 33% (n=3) of patients required a colectomy after a median follow-up of 153 days (IQR 110–180). The remaining 67% (n=6) were well and off steroids after a median of 303 days (IQR 209–400).

Conclusion This review of patient outcomes shows the potential benefits of infliximab for treating both acute and sub-acute UC. After a maximum of three doses of infliximab, 42% of acute and 67% of sub-acute UC patients were able to avoid a colectomy. Our results are comparable to those of Oxford (1 to 7 doses of infliximab as needed) who reported that 43% of acute and 50% of sub-acute were able to avoid a colectomy.[1] Furthermore, our results confirm the greater potential benefit of infliximab in acute, immunomodulator naive patients. In addition, all sub-acute patients, who avoided colectomy, were well and off steroids at the end-of follow-up, compared to only 38% from the Oxford group, suggesting additional benefit from planned infliximab doses.[1]

Competing interests None declared.

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PMO-253 IMPACT OF INFLAMMATORY BOWEL DISEASE NURSE SPECIALIST ON QUALITY OF PATIENT CARE AND MEETING STRATEGIC NATIONAL AIMS

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Introduction The UK IBD Audit has now completed its 3rd round with continued marked variation in the resource and quality of care for IBD patients. This analysis of the national data aims to measure the quality of care for patients in centres with: a IBD nurse >1 WTE, IBD nurse <1 WTE and those with no IBD nurse; to demonstrate the impact of the IBD nurse in terms of quality of care; and how the role assists in meeting specific aims of the White Paper (Equity and excellence: Liberating the NHS, 2010).

Methods A comparison was carried out of the 2010 audit results of hospitals with no IBD nurse, <1 WTE nurse and those with ≥1 nurses. It cannot directly be inferred that the IBD nurse is the causative factor in the reduction in hospital admissions or improvements in care. The results also do not reflect the number of nurse sessions per week dedicated to IBD care or long the IBD nurse had been in post.

Results There was a significant reduction in the number of patients admitted to hospital with an IBD nurse in post and a difference in the range and choice of care delivery. More patient education was offered in the presence of the IBD nurse (28%, 60%, 74%, p<0.001), more patient involvement in service development (12%, 20%, 39%, p<0.001), clearer guidance for patients to seek a 2nd opinion (93%, 20%, 45%, p<0.009) and clinical data more likely to be captured (23%, 50%, 61%, p<0.001).

Conclusion The NHS White paper states reducing avoidable hospital admissions, increasing the proportion of people with a long term condition to self care and the ability to offer choice of care are High Level Outcomes which lead to commissionable services. The presence of an IBD nurse, within the IBD team, correlates with fewer admissions, the availability of self management programmes and greater overall choice in care provision and new modes of care delivery.

Competing interests None declared.

PMO-254 COMPARISON OF IBDQIP SCORES FOR TWO SERVICES WITHIN ONE TRUST

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Introduction The Heart of England NHS Foundation Trust is one of the largest in England, with over 1200 beds and serves over a million people throughout north and east Birmingham and surrounding areas. It has three sites: Birmingham Heartlands, Good Hope Hospital and Solihull Hospital.

Methods Good Hope Hospital and Heartland & Solihull Hospitals entered data separately into IBD Quality Improvement Project. Services were asked to meet as a team to enter data about their service. The majority teams were able to complete data entry within 2–3 h. Each team comprised of two Consultant gastroenterologists a Consultant Colorectal surgeon and an IBD CNS. Results were not discussed between services at the time of data entry. After completion the sites requested comparative results and arranged a joint meeting to discuss the outputs.

Results As a response to this the teams reviewed their data together and agreed the following action points: (1) Good Hope Hospital will join Heartlands and Solihull's Transition Clinic at Birmingham Children's Hospital. This takes place twice a year and a joint team from both sites will attend. (2) A shared care agreement for patient's on immunosuppressive, between primary and secondary care is being devised for use across the Trust. (3) Nutritional support, which was initially available at Heartlands but has been extended to Good Hope. (4) Heartlands hospital have recently trialled a changed on-call system, to provide daily Gastroenterology ward rounds, to improve appropriate patient flow to specialist gastroenterology beds.

Conclusion (1) There are significant differences in service provision between the two services within the same Trust (2) The Trust

Abstract PMO-253 Table 1

	No IBD CNS	<1 WTE IBD CNS	1 or more WTE IBD CNS	p Value
% Patients admitted to hospital 1 September 2009–31 August 2011	19% (10.8–34.0)	10% (5.1–23.3)	11% (7.2–19.4)	<0.001
The site offers a range of arrangements for outpatient care including email, drop—in, telephone	61% (35/57)	85% (34/40)	84% (88/105)	0.002
The service offers guided self—management with access to support when needed.	34% (12/35)	62% (21/34)	63% (55/88)	0.013
Expedited specialist review of relapsed patients	83% (47/57)	98% (39/40)	98% (103/105)	0.002
A clear structured pathway for the patient to discuss their treatment with the multidisciplinary team	16% (9/57)	45% (18/40)	57% (60/105)	<0.0001
There is written information for patients on whom to contact in the event of a relapse.	42% (24/57)	88% (35/40)	95% (100/105)	<0.0001