

most helpful in evaluating patients with symptoms suggestive of IBS with abnormal blood tests, and in those in whom previous investigations were equivocal for IBD

**Disclosure of Interest** None Declared.

#### Abstract PWE-099 Table

OUTCOMES FOR PATIENTS WITH ELEVATED FAECAL CALPROTECTIN	n = 98 of whom 5 await tests
<b>Management unaltered</b>	
Not pursued (n = 14), or did not attend or refused investigation (n = 5)	19
Further investigation indicated anyway (symptoms/bloods)	25
Self-limited or other illness	16
<b>Misleading positive result</b>	
Colonoscopy +/- capsule NAD (or insignificant incidental finding)	27
<b>Helpful positive result</b>	
Previous investigations equivocal: IBD later confirmed	2
Prompted positive capsule, colonoscopy or MR enterography	4

#### PWE-100 HOW COMMONLY DOES FAECAL CALPROTECTIN ALTER MANAGEMENT IN PATIENTS WITH I.B.D?

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**Introduction** Faecal calprotectin is often measured in patients with inflammatory bowel disease (IBD). Some believe it is a useful surrogate marker for mucosal healing, and normal values may strengthen the case for stopping biological agents. It is unclear, however, to what extent such measurements alter patient investigation and management over standard history taking, examination and routine blood tests.

**Methods** We reviewed all faecal calprotectin results from samples submitted by 98 adults with IBD between February 2010 and April 2012. Using the Health Board's Clinical Workstation relevant outpatient letters, results of subsequent investigations and changes of treatment were reviewed. A calprotectin value of >60 ug/g was considered elevated.

**Results** Seventy of the patients (71%) had an **elevated result**. Their outcomes are summarised in the table. Most changes in patient management and investigation requests were made at the same visit as the calprotectin request. Elevated results prompted escalation of treatment in 6 patients. Among 28 patients with a **normal result**, symptoms prompted escalation of treatment (6 patients) and colonoscopy (3 patients) before knowledge of the result, No endoscopic or radiological investigations or changes of treatment occurred in 12 patients. In no cases was maintenance treatment reduced on the basis of a normal result. Measurements seemed to help management in 7 patients: there were 2 with previous equivocal investigations who may have avoided further tests, and there were 5 whose symptoms were in excess of objective findings who could be reassured about absence of active inflammation).

**Conclusion** This study casts doubt on the value of faecal calprotectin measurement in the follow-up of most patients with IBD. Normal results assisted in the reassurance of some patients whose symptoms seemed out of proportion to objective evidence of disease activity. There were no instances of a normal result leading to scaling back of maintenance treatment, and none stopped biological agents.

**Disclosure of Interest** None Declared.

#### Abstract PWE-100 Table

OUTCOMES FOR I.B.D. PATIENTS WITH ELEVATED FAECAL CALPROTECTIN	n = 70
<b>Management unaltered</b>	
No change in treatment	32
Further investigation indicated on basis of symptoms and/or blood results	11
Treatment escalated on basis of symptoms and/or blood results (one had surgery)	18
<b>Management altered</b>	
Led to escalation of treatment	6
Colonoscopy requested (but bloods or WC scan also pointed to disease activity)	2
Prompted MR enterography, which was positive, but treatment left unaltered	1

#### PWE-101 PATIENT'S AWARENESS OF THE NEED FOR VACCINATIONS WHILST ON IMMUNOSUPPRESSIVE THERAPY

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**Introduction** With the ever increasing use of immunosuppressive therapy for the management of inflammatory bowel disease (IBD) patients are being exposed to infections which can be prevented by vaccinations administered prior to or during therapy. The European Crohn's and Colitis Organisation guidelines currently recommend that IBD patients who receive immunosuppressive medications should be vaccinated yearly with the influenza vaccine and a pneumococcal vaccination 3–5 yearly.

**Methods** An audit was carried out within our department to assess our patient's knowledge and uptake of such vaccines. Patients with Inflammatory Bowel Disease were identified from an established data base and those receiving immunosuppressive therapy were invited to complete a questionnaire. Data gathered included age, gender, current treatment and awareness of the need for vaccinations. We also gathered data on the number of patients already vaccinated.

**Results** A cohort of 88 patients on immunosuppressive therapy was analysed. 61% of patients were female and 39% male. Patients ranged between 16–21 years (11%), 22–30 years (18%), 31–50 years (40%), 51–70 years (24%) and above 70 (7%). 59 (67%) patients had Crohn's disease, 26 (29.5%) ulcerative colitis and 3 of them (3.5%) had indeterminate colitis. The majority of patients received immunomodulators including Azathioprine or Mycophenolate (n = 48, 54%). 13 (15%) were treated with biologics alone (Infliximab or Adalimumab), 21 (24%) with combination of biologics and immunomodulators and 6 patients (7%) received immunomodulators with a reducing dose of steroids.

77% of patients were aware of recommended vaccinations but as many as 23% were not. 42% were aware of the importance of receiving dual vaccinations, 35% were only aware of the need for either the influenza or pneumococcal vaccine, with 23% unaware of the need for either. In this cohort 54 (61%) patients had already had or were planning to have the influenza vaccine this year. Patients between the ages of 31–50 years had the highest awareness of the recommended vaccines (86%), with the majority of uptake of vaccines seen in the 31–50 year group (63%). Unfortunately 39% of patients were not receiving recommended vaccinations with more than half (56%) of patients being unaware of the need to avoid live vaccinations.

**Conclusion** Our data suggest that a significant proportion of patients within our cohort are still not receiving vaccinations