approx. £119,000 for investigations and consultations. Using a Caldetect® (Preventis, GmbH) point of contact FC test, it was estimated that a saving of £89,000 could be achieved. A pathway for investigating chronic diarrhoea using Caldetect® was designed and implemented in the community (population 150,000) between September 2011-March 2012. (this will be presented). FC results were categorised using manufacturer cut-offs of <15 ug/g, 15–60 ug/g and >60 ug/g. Patients with FC results of 15–60 and >60 were deemed to have an inflammatory process and referred to Gastroenterology Clinics. Cost analysis was carried out using the 2010–11 tariffs for the NHS.

Results 142 Caldetect® tests were carried out in Primary Care during this pilot phase. Of these, a negative result (< 15 ug/g) was present in 89, with 36 tests being > 60 ug/g. 3 tests were at the intermediate level and 14 tests could not be accurately reported. Negative results were managed in primary care as IBS. A monthly cost savings of £6100 was calculated taking consultation and endoscopy tariffs into account.

Conclusion This pilot study demonstrates the feasibility and cost effectiveness of a Pathway for decision making and a point-of-care faecal calprotectin test in rationalising referrals to Gastroenterologists for chronic diarrhoea.

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PTU-058 ONE YEAR LIKELIHOOD OF RELAPSE IN ULCERATIVE COLITIS (UC) IS PREDICTED BY MUCOSAL APPEARANCE BUT NOT BY FAECAL CALPROTECTIN: DATA FROM THE CODA STUDY OF ONCE DAILY VERSUS THREE TIMES DAILY ASACOL

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Introduction Faecal calprotectin (FC) has become a useful marker of mucosal healing, with studies showing raised levels predictive of relapse[1,2,3]. These studies did not assess mucosal healing however, so did not compare calprotectin with mucosal appearance as predictors of relapse.

Methods In the CODA (Colitis Once Daily Asacol®) trial of once daily (OD) Asacol® (three 800 mg tablets) vs one 800mg tablet taken three times daily (TDS), 213 UC patients in remission for >4 weeks, but relapse in the past 2 years, were recruited. Baseline FC (Phical ELISA kit) was collected and rectal sigmoidoscopy (sig) score at baseline, and relapse or 1 year (using the modified Baron score: 0 = normal; 1 = erythema, decreased vascular pattern; 2 = marked erythema, absent vascular pattern, friability, erosions; 3 = spontaneous bleeding, ulceration). At entry patients had no symptoms of active disease, with a sig score of 0 or 1. Follow-up was for 1 year or until relapse (symptoms of active disease with a sig score of 2 or 3). Demographic factors, concomitant drugs, FC, sig score, CRP, and adherence were evaluated in a Cox regression model of time to relapse.

Results (Shown as median[IQR] unless stated otherwise). Remission duration prior to entry was 6.0 [3–12] months. Disease extent was extensive (30.0%), Lt. sided (54.9%), proctitis (13.6%). At entry FC was 78mg/kg stool [23.3–159.4], sigmoidoscopy score 0 (70.9%), 1 (29.1%). All were taking mesalazine, and 11.7% thiopurines. Baseline FC was higher if sig score was 1 (109[38–335]) than if 0 (62[21–120], p = 0.001, but did not differ according to disease extent or medication (including aspirin (n = 18) and occasional NSAIDs (n = 6). Remission rates at one year were 62% overall (68.9% in OD and 55.5% in TDS group). Factors associated with time to relapse were explored in a Cox proportional hazards model, with baseline FC dichotomised at 150mg/kg stool (as by Costa *et al*. Relapse risk was 2.5 times higher in those with baseline sig score 1 compared to score 0 (95% CI 1.32–4.76, p = 0.005). Age, concomitant medication, previous duration of remission, disease extent, smoking, trial medication adherence and baseline FC (cut off at 150 mg/kg stool or as a continuous variable) did not remain in the final model.

Conclusion In this study, sigmoidoscopy appearance at baseline was the sole factor predicting relapse over 1 year of maintenance mesalazine 2.4g, whereas calprotectin level was not a predictor, perhaps because of wide variability in this group of patients. FC may have more value in measuring relative change in individual patients.

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PTU-059 ADALIMUMAB THERAPY REDUCES HOSPITALIZATION AND COLECTOMY RATES IN PATIENTS WITH ULCERATIVE COLITIS AMONG INITIAL RESPONDERS

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Introduction Two double-blind, placebo-controlled trials (ULTRA 1 and 2) revealed that adalimumab (ADA) therapy significantly reduces hospitalisation and non-significantly decreases colectomy rates in patients with moderate to severe ulcerative colitis (UC).[1]

Methods We assessed the effect of an ADA 160/80/40 mg treatment regimen on risk reduction of all-cause and UC-related hospitalisation and colectomy in these 2 trials among initial ADA responders. The pooled dataset included 963 patients (480 ADA, 483 placebo [PBO]). Hospitalization and colectomy events were based on safety reports reviewed by 2 gastroenterologists who were blinded to treatment. Conservatively, hospitalizations from initial ADA non-responders (per Mayo score at Week 8) through Week 8 were counted, but were censored after Week 8 to reflect the clinical practise pattern of continuing treatment in initial ADA responders. Risk and number of hospitalizations were compared between groups using person-year (PY)–based incidence rates (IRs) and Poisson regression, respectively; Z-scores were used to assess statistical differences.[2]

Results 35% and 34% reductions in the number of patients hospitalised and number of hospitalizations for any reason, respectively, were observed with ADA therapy vs. PBO (**table**, $P < 0.05$ for both comparisons). When UC-related hospitalizations were compared, reductions for rate (50%) and number (54%) of hospitalizations were both statistically significant, too.

Conclusion Initial ADA-responders had a significantly lower risk for UC-related and all-cause hospitalisation compared with PBO. Reduction of all-cause hospitalisation is unique for ADA compared with any other anti–tumour necrosis factor agent. A non-significantly lower colectomy rate in patients receiving ADA vs. those receiving PBO was also observed.

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