

Abstract PWE-095 Figure 1

FC in post-operative Crohn's. Patients were included in the study if they had been followed up for at least 5 years after the initial FC was recorded. Case notes were reviewed retrospectively and information on the need for escalation of medical therapy or for further surgery for disease recurrence was recorded. A FC of more than 200 was taken as the cut-off value for evidence of active inflammation. Statistical analysis was performed using Prism 6 (GraphPad Software, San Diego, USA).

Results 17 patients had a FC ≥ 200 (median 751, IQR 593–916). Of these 13 required either escalation of medical treatment and/or further surgery over the 5 year follow-up period. 34 patients had a FC <200 (median 18, IQR 4–71). Of these 11 required treatment escalation and/or surgery. A FC of ≥ 200 correlated significantly with need for escalation of medical treatment and/or further surgery over a 5 year follow up (p 0.003).

Conclusion A FC of less than 200 predicts a better prognosis in patients with post-op Crohn's disease over a prolonged (5 year) period and could therefore potentially be used to stratify treatment and target early intervention.

Disclosure of Interest None Declared.

PWE-096 THE IMPACT OF SURGEON SPECIFIC OUTCOME DATA ON PATIENT CHOICE

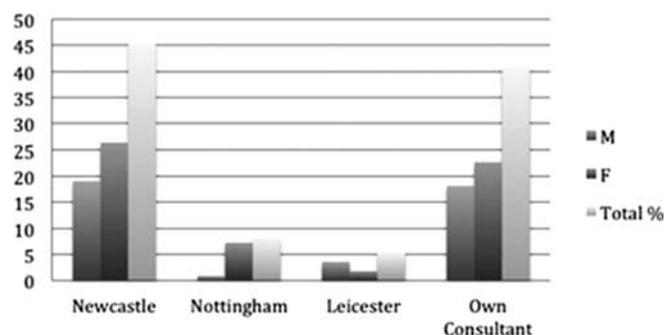
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Introduction Patients have a legal right to choose their own treatment and care within the modern NHS¹. NHS England and the *Association of Coloproctology of Great Britain and Ireland*² has recently released the mortality rates for individual colorectal surgeons for patients within the first 90 days of a planned operation undertaken for bowel cancer. With these figures now publicly accessible on the Internet, Gastroenterology physicians, in collaboration with their inflammatory bowel disease (IBD) patients, could utilise the information to assist in deciding who they would choose to perform the surgery should it be required.

Methods One hundred and ten consecutive IBD patients who had stable disease, and seen within the outpatient setting, completed a questionnaire about which fictional surgeon they would choose dependent on the published mortality rates and their location within the country. The options included a fictional surgeon with the lowest mortality rate who was based furthest away (Newcastle), a fictional surgeon with the highest mortality rate who was local (Leicester) and a fictional surgeon with an average mortality rate who was based in between (Nottingham). There was an additional option of the patient allowing their fictional gastroenterologist to decide for them. Similarly, ten Gastroenterology colleagues were also questioned about this surgeon-specific outcome data.

Patient choice



Abstract PWE-096 Figure 1

Results The majority of the 110 IBD patients chose between two options. 45% chose a fictional surgeon with the lowest mortality rate based furthest away (Newcastle) and 41% opted for their fictional Gastroenterology consultant to decide for them. Of the 10 Gastroenterology colleagues questioned 50% were aware that the information was now publicly accessible, 20% were aware of where to access the information and 10% had reviewed the information online. On answering which fictional surgeon they would choose if the patient wanted their Gastroenterologist to decide for them, 40% chose the fictional surgeon with the lowest mortality rates based furthest away (Newcastle) and 20% chose the fictional surgeon with the highest mortality rates based locally (Leicester).

Conclusion The Government has proposed that the NHS allows patients to make informed choices about their own care. These results demonstrate that given that choice these IBD patients would either choose a surgeon with the lowest mortality rates, even if they were not based locally, or would allow their own Gastroenterologist to decide for them. However, the majority of the Gastroenterologists surveyed had not utilised the information on surgeon-specific outcomes. The legal consequences for gastroenterologists who choose the "less than best" option are yet to be tested in court.

REFERENCES

- 2013/2014 Choice Framework, NHS England
- Individual surgical outcomes for England 2013, The Association of Coloproctology of Great Britain and Ireland

Disclosure of Interest None Declared.

PWE-097 PATIENT KNOWLEDGE OF INFLAMMATORY BOWEL DISEASE IS NO BETTER THAN IN 1999

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Introduction In the UK, key professional organisations have collaborated to provide inflammatory bowel disease (IBD) Standards to be delivered by the NHS, highlighting the importance of patient education and support.¹ Little literature exists however regarding the impact of these standards on patient's knowledge of their disease.

The study aim is to utilise the Crohn's and Colitis Knowledge Score (CCKNOW) to assess patient knowledge and make a comparison with results achieved in 1999.

Methods 100 outpatients with CD or UC were prospectively enrolled to complete the CCKNOW questionnaire between May and September 2013 at two Leicestershire Hospitals.

Results 100 patients, 58 female with a mean age of 49.2 (range 18–75), 42 male with a mean age of 47.1 (range 18–77). Mean disease duration was 12.8 (range 0–41). Mean and median scores for IBD patients were 10.15 (95% CI: 9.2–11.1) and 9 (95% CI: 8–11) respectively. CD (38) patients achieved a significantly higher score than UC (61), median scores of 10.5 and 9 respectively, $p = 0.007$. CCKNOW scores achieved were significantly lower with increasing age, $p = 0.0006$. Patient gender, ethnicity, disease duration or perceived disease activity had no significant effect upon CCKNOW score.

Conclusion Patient understanding of inflammatory bowel disease is no better now than when assessed in 1999, median scores being 9 and 10 respectively. There are persisting knowledge deficits regarding the subjects of fertility and the complications of IBD. Elderly patients performed significantly worse than younger counterparts and may therefore benefit the most from increased access to appropriate educational programmes and support.

REFERENCE

- 1 Quality Care Service standards for the healthcare of people who have Inflammatory Bowel Disease (IBD) IBD Standards Group. 2009 <http://www.ibdstandards.org.uk/> [accessed 21.4.13]

Disclosure of Interest None Declared.

PWE-098 EARLIER USE OF AZATHIOPRINE IN ULCERATIVE COLITIS DOES NOT ALTER SUBSEQUENT NEED FOR HOSPITALISATION, BIOLOGIC THERAPY, OR COLECTOMY

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Introduction Azathioprine (AZA) is an established treatment for ulcerative colitis (UC). However, controversy exists regarding its efficacy in inducing and maintaining clinical remission, particularly with the advent of biologics which, unlike AZA, have been tested in large, rigorously designed randomised controlled trials. We studied the effectiveness of AZA as second-line therapy after failure of 5-aminosalicylates (5-ASAs) in a large cohort of UC patients, with particular emphasis on whether its earlier use alters the natural history of the disease course.

Methods All UC patients treated with AZA at our centre were identified from a prospective electronic database. We excluded individuals who had received either infliximab or ciclosporin as a bridge to AZA. The following demographic data were collected: gender, age at diagnosis, age at AZA commencement, concomitant therapy at AZA commencement, and duration of disease prior to AZA commencement.

We assessed response to therapy at 4 months and remission at last point of follow-up, using physicians' global assessment, need for hospitalisation, escalation of therapy to a biologic, or colectomy, and serious adverse events (including infections and malignancies). We examined whether earlier AZA use (within 12 months of diagnosis) reduced need for hospitalisation, biologic therapy, or colectomy.

Results In total, 255 patients were included (55% male, mean age at diagnosis 36.4 years). Mean age at commencing AZA was 42.3 years. Mean disease duration prior to AZA commencement was 70 months. Concomitant therapy at AZA commencement was oral 5-ASAs in 87%, topical 5-ASAs in 22%, and oral prednisolone in 77%. At 4 months, 207 (81%) of 255 patients were still on AZA (46 had discontinued due to adverse events and 2 due to non-response), and 163 (64%) had responded to therapy.

There were 165 (65%) patients still receiving AZA at last point of follow-up, of whom 153 (60%) were in remission (mean duration of therapy 64.5 months). 26 patients required admission to hospital for an exacerbation during AZA treatment, 20 patients ultimately required biologic therapy, and 21 underwent colectomy. Among 90 patients receiving AZA within 12 months of diagnosis, 21 (23%) patients experienced one of these three endpoints, compared with 29 (19%) of 154 who commenced AZA >12 months after diagnosis ($p = 0.40$).

Serious adverse events included 6 cases of pancreatitis, 6 cases of cancer (3 non-melanoma skin cancers) and 1 case of neutropenic sepsis presenting within 1 month of AZA commencement.

Conclusion AZA is a safe and effective therapy for UC patients who fail 5-ASAs, and should continue to be used prior to instituting biologic therapies. However, earlier use does not seem to alter the natural history of the disease.

Disclosure of Interest None Declared.

PWE-099 DIRECT DETECTION OF THIOPURINE METABOLITES IN ERYTHROCYTES AND LEUKOCYTES USING A NOVEL LCMS/MS METHOD TO INTERROGATE DRUG RESPONSE AND *IN VIVO* METABOLISM

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Introduction One of the major issues hampering the understanding of metabolism and response to thiopurine drugs (azathioprine (Aza), mercaptopurine (MP) and thioguanine (TG)) is the indirect method for measuring their metabolites in red blood

Abstract PWE-099 Table 1

Treatment	RBC methyl metabolites pmol/mg protein	Commercial RBC MMP pmol/8 x 10 ⁸ RBC	RBC TGNs pmol/mg protein	Commercial TGNs pmol/8 x 10 ⁸ RBC
LDAA	47.28	464	52.76	825
	2.8	ND	26.5	1645
	19.75	ND	36.64	559
6TG	11.3	ND	57.07	1890
	2.4	ND	29.1	1794
	23.5	ND	69.21	2772
FDA	14.2	380	13.14	307
	157.2	9730	21.62	210
	5.1	ND	36.6	349