Results Median age of pts was 41 (range 20–79) yrs. Total lifetime yrs on anti-TNFs was 740.6 (331.2 on Ifx, 409.4 on Al) yrs. 133 pts were treated with Ifx (75 females), 4 had previously been on Al. Median length of Rx with Ifx was 20 (range 1 dose-still on at 140) months. 98 (73.6%) pts on Ifx were on a concomitant immunomodulator drug. 141 pts were treated with Al (79 females), 53 had previously been on Ifx. Median length of Rx with Al was 33 (range <1-still on at 89) months. 62 (44.0%) pts on Al were on a concomitant immunomodulator.

54 (40.6%) pts had AEs whilst on Ifx (see Table 1 for severity), including lymphoma (2 pts), solid organ tumours (3), pulmonary TB (2), infusion reaction (13), cutaneous side effects (SEs) (7), other infections (12). 33 pts were still on Ifx at the time of this study. 30 pts (22.6%) stopped Ifx due to AEs. 13 pts had an infusion reaction. Pts were most likely to have an infusion reaction at infusion 2 (6 pts).

Overall, 57 (39.7%) pts suffered from AEs on Al (see Table 1 for severity), including solid organ tumours (2 pts), cutaneous SEs (10), neurological symptoms (3) and other viral/bacterial infections (28). 88 pts were still on Al at the time of this study. 21 pts (14.9%) stopped Al due to AEs.

Pts were more likely to suffer from an AE with increasing age ($p = 0.041$ for Ifx, $p = 0.016$ for Al). Patients over 50 yrs were more likely to suffer from an AE than those less than 50 ($p = 0.015$ for Ifx, $p = 0.015$ for Al). Pts over 70 yrs were more likely to suffer from a moderate or severe AE on Al ($p = 0.009$), there was no relationship for Ifx. Gender, smoking status and use of immunomodulators had no effect on AEs. No significant relationship found between length of Rx and development of AEs. No statistically significant difference found in AEs frequency between Ifx and Al.

Conclusion This study found that AEs are independent of the length of time on anti-TNFs, but are associated with increasing age of the patient. Patients over 50 yrs are more likely to have an AE on Ifx and Al. Patients over 70 yrs are more likely to have a moderate or severe AE on Al.

Disclosure of Interest None Declared.

PTU-070 NON-ADHERENCE WITH RECTAL PREPARATIONS IN COLITIC PATIENTS. FACT OR FICTION?

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Introduction Rectal preparations containing steroids or 5-aminosalicylates are an effective treatment for distal colitis. Nonetheless, it is perceived that this therapy is associated with poor levels of adherence and that patients are not readily accepting of it. This might make gastroenterologists reluctant to prescribe rectal preparations. The patient experience and factors determining adherence with this modality of treatment have not been investigated before. The aim of our survey is to evaluate patient compliance with rectal preparations and explore the possible reasons why compliance is not always achieved.

Methods A short anonymised survey was distributed over a 3-month period at general gastroenterology and IBD outpatient clinics to patients with a known diagnosis of ulcerative colitis. There were questions on baseline demographics and other details relating to compliance. A free text option was also available for suggestions that could improve compliance.

Results Over the period November 2013–January 2014, a total of 59 completed surveys were received. 21 of 59 patients (36%) had never been prescribed a rectal preparation. Of the remaining 38 patients with reported experience of rectal preparations, 60% were male with a median age of 45 years. Surprisingly, 76% of these (29 patients) answered 'Yes' to being compliant with the preparation (s), and they had been prescribed courses ranging from once/day for 2 weeks to thrice/day long-term. 20 patients had been prescribed foam and/or liquid enemas, 8 patients a suppository, and 1 patient a suppository and foam enema. 93% of the compliant patients reported an improvement in their symptoms with the use of rectal preparations. Though compliant, 24% reported 'Yes' to having difficulties using the rectal preparation citing "insertion difficulties" and "difficulty retaining the fluid" and "at work" as the main reasons. When asked for suggestions to improve compliance, 62% felt reduction of treatment frequency to once/day would help, and 21% felt that better explanation about administration would help. Of the 9 patients who admitted to being noncompliant, 3 had difficulties with administration, 2 experienced pain, and the majority felt that a better explanation about administration would have improved compliance. As expected, the majority of noncompliant patients felt that the rectal preparation had made no difference to their symptoms.

Conclusion Compliance with prescribed rectal preparations is surprisingly high. This is an encouragement to continue promoting its use. Compliance could be further improved by allowing for patient factors such as work hours and adjusting dosing times, and by dedicating time to explain how the medication should be administered.

Disclosure of Interest None Declared.

PTU-071 METHOTREXATE THERAPY FOR ULCERATIVE COLITIS IN THE DISTRICT GENERAL HOSPITAL SETTING: A USEFUL SECOND-LINE OPTION FOR PATIENTS

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Introduction The case for methotrexate (MTX) therapy has been comprehensively compiled in Crohn's disease, with trials showing its efficacy in both induction and maintenance of remission. By contrast, the evidence remains patchy for ulcerative colitis (UC). BSG guidelines recommend its trial as a second-line agent in those patients intolerant of, or resistant to, azathioprine (AZA) or mercaptopurine (MP). Previous studies show conflicting results for MTX in UC; with response rates between 22–33%, with a high rate of colectomy, 44%, in one of the studies. We aimed to review the clinical effectiveness of MTX in our cohort of UC patients who had previously tried, or failed, with thiopurine therapy.

Methods A retrospective analysis of patients taking MTX for UC was carried out. Subjects were identified from our inflammatory bowel disease database. All patients had trialled thiopurine therapy prior to MTX. Their outcomes on these treatments, including reasons for discontinuation, were recorded. It is current policy within our department to start with oral MTX (plus folate supplementation), initially 15 mg once weekly, increasing to 20mg or 25mg as necessary. Clinical response at 12 weeks and 12 months was used to assess efficacy of MTX treatment. The primary endpoint was steroid-free remission.

Results A total of 21 UC patients (male = 62%) were identified. Median age was 61 years (range 21–82). Disease pattern was extensive (43%), left-sided (19%), and recto-sigmoid (38%).

Reasons for AZA/MP discontinuation were intolerance to therapy (38%), and failure of therapy (62%) despite dose optimisation.

Steroid-free remission was achieved in 11 patients (52%), and this appears sustained at 12 months follow-up. A further 4 patients (19%) report improved symptoms with MTX, but remain dependent on low-dose steroids (although it is noted that 1 of these patients has co-existent rheumatoid arthritis which may explain this). MTX was discontinued in 4 patients (19%) because of a lack of clinical response (n = 1), side-effects (n = 2) or planned pregnancy (n = 1). Side-effects reported with MTX were liver toxicity and skin rashes. A final 2 patients (10%) have shown promising results with MTX but are not yet eligible for 12-month follow-up. Of the 21 patients included, 20 remain on oral therapy, and one has switched to parenteral MTX. Of note, none of the MTX patients have progressed to colectomy, in contrast to previous studies.

Conclusion Our study has shown good efficacy with MTX, with approximately half of UC patients achieving steroid-free clinical remission at 12 months. In contrast to previous studies, our experience suggests it is a useful treatment option in patients previously failing or intolerant of optimised thiopurine therapy.

Disclosure of Interest None Declared.

PTU-072 OUTCOMES OF THE USE OF INFLIXIMAB AND ADALIMUMAB IN PATIENTS WITH CROHN'S DISEASE AT A DISTRICT GENERAL HOSPITAL

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Introduction Infliximab (IFX) and adalimumab (ADA) are licensed for the treatment of severe Crohn's disease (CD). NICE recommends patients should receive these agents as a planned course of treatment for 12 months or until treatment failure. Patients should have their disease reassessed to determine if they have active disease and whether ongoing therapy is appropriate. We assessed our adherence to the NICE recommendations and present our outcomes for patients who had treatment discontinued following remission.

Methods Patients who had received treatment with IFX and/or ADA from Jan 2011 to Sep 2013 were identified from a database held by our pharmacy. Data was collected from patient case notes and a database of clinic letters. A total of 49 patients were identified. Cases were assessed for adherence to NICE recommendations.

Results 24 patients had been on IFX only (49%), 14 patients on ADA only (28.6%) and 11 started on IFX then switched to ADA (22.4%). 8 patients had evidence of fistulating disease. Mean age was 39 years (range 17–60). All patients (100%) had severe active CD that did not respond to conventional therapy (79.6%) or were intolerant or had contraindications (20.4%) to therapy. All patients (100%) were reassessed to determine whether ongoing treatment was still clinically appropriate. All patients (100%) were treated and reviewed by clinicians with experience in their use. Discussion regarding risks and benefits of continued treatment occurred in 77.8% of cases. 39 patients (79.6%) had been on treatment for greater than 1 year. Of these, 20 patients had treatment discontinued (51.3%); 3 were due to a reaction/intolerance, 10 were due to treatment failure, and 7 due to deep clinical remission (17.9%). 2 patients (28.6%) had disease recurrence following treatment withdrawal due to remission. Mean time to relapse following withdrawal was 9 months (range 3–15). Of all patients found to be in deep clinical remission (n = 12, 30.8%) after 12 months of treatment, 6 patients had treatment continued partly due to patient choice (66.7%). Patients who continue treatment all had their disease reassessed at least every 12 months.

Conclusion There is good adherence to NICE guidelines in our cohort, however despite evidence of deep clinical remission some patients declined to have treatment discontinued partly due to anxiety of relapse. Our relapse rate following withdrawal of biological treatment appears lower than that found in the literature.

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Disclosure of Interest None Declared.

PTU-073 COMPARISON OF SICUS VERSUS MR-ENTEROGRAPHY IN PATIENTS WITH CROHN'S DISEASE

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Introduction Small intestinal contrast-enhanced ultrasonography (SICUS) is an emerging radiological technique for the imaging of patients with Crohn's disease that avoids exposure to diagnostic medical radiation. We have previously demonstrated that SICUS is diagnostically comparable to small bowel barium follow through and computerised tomography in the diagnosis of Crohn's.[1] MR enterography (MRE) is becoming the gold standard radiological technique for the diagnosis of complications in patients with Crohn's, but is expensive and access is limited. We aimed to compare the diagnostic sensitivity of SICUS with MRE in routine clinical practice.

Methods Patients with established Crohn's disease, who had undergone both SICUS and MRE within 6 months of each other were identified retrospectively from the radiology database at a UK tertiary centre. Imaging and reports were reviewed for both modalities. Kappa coefficient data was calculated for luminal parameters including the presence of strictures, stricture number and location, the presence of abscess/fistulae, mucosal thickening, active mucosal inflammation and fibrotic changes. Reported stricture lengths were compared using paired student's *t*-test. Inflammatory markers including platelet levels, where available, were recorded within 2 weeks of each of the imaging modalities as a surrogate marker for active inflammation.

Results 20 Crohn's patients were identified (10 male), with a mean age of 30.1 years at time of first investigation. Mean time between modalities was 72.3 days (range 2–147). There was no significant difference between mean platelet counts between the 2 radiological tests. Agreement between the 2 modalities was excellent for the presence of stricturing disease (k=0.92, 95% CI 0.71–1.00), stricture number (k=0.91, 95% CI 0.73–1.00) and stricture location (k=0.91, 95% CI 0.71–1.00). Agreement was good for the presence of fistulae (k=0.74, 95% CI 0.40–1.00) and mucosal thickening (k=0.74, 95% CI 0.40–1.00).