limit of normal (ALT >40 IU/l, ALP >200 IU/l, GGT >30 IU/l and bilirubin >17 mmol/l). The investigations performed to identify the cause of the abnormalities were noted.

Results A total of 450 phone calls were made to the IBD help line during the study period. Of those, 82 patients with ulcerative colitis were identified. Of these, 15 patients (18.3%) had so far been found to have abnormal LFTs at some time during the course of their illness. Persistently abnormal LFTs were identified in 10 patients (12.2%). Of these 10, 6 (60%) had auto immune screen, four patients (40%) had viral hepatitis screen, four patients (40%) had a liver ultrasound, three patients (30%) had CT abdomen. Furthermore no patients had targeted investigations to exclude PSC such as a liver biopsy or magnetic resonance cholangiography.

Conclusion Our results suggest that 12% of ulcerative colitis patients in our cohort had persistently abnormal liver function tests although none had had further investigations for PSC. Given expected prevalence data we could perhaps expect to see one patient with PSC in this cohort. The monitoring and following of LFTs in patients with UC should be part of standard follow-up procedures.

Competing interests None declared.

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A PROSPECTIVE AUDIT OF THE USE OF CALCINEURIN INHIBITORS IN PATIENTS WITH REFRACTORY ULCERATIVE PROCTO-COLITIS IN A DISTRICT GENERAL HOSPITAL

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Introduction Calcineurin inhibitors (CI), most commonly ciclo-sporin, may be used as salvage therapy in patients with refractory moderate-severe ulcerative procto-colitis (UC), who would other-wise require surgery.[1] However, use of CI may be limited by drug toxicity. For patients who have a good clinical response to ciclo-sporin but experience side effects, tacrolimus may be used as an alternative.[2] We report our experience with CI in patients with moderate-severe UC whom either failed, or were intolerant of, thiopurines and as an alternative to surgery.

Methods NICE (January 2008) did not support the use of infliximab in patients with moderate-severe UC.[3] Our patients were offered the choice of surgery or treatment with CI. Clinical response was assessed by AWH in clinic. If ciclosporin (4—6 mg/kg/day in two divided doses) led to a clinical response but caused intolerable side effects, tacrolimus (0.1 mg/kg/day in two divided doses) was offered as an alternative. Failure of therapy prompted referral for surgery.

Results 14 patients (8 female; mean age 38 [range 22—56] years) were treated with CI (13 ciclosporin, 1 tacrolimus). Ten of 14 (71%) patients had an initial clinical response to CI. Adverse effects were common (57%): nausea, paraesthesia, menstrual disturbance, maculopapular rash, hypertension (two patients) and renal dysfunction (one patient). Of the four patients who failed to respond to CI, three were referred for surgery and one patient is managed on mesalazine suppositories. A further four patients stopped treatment with CI due to adverse effects: two were referred for surgery and two were offered treatment with methotrexate. 6 (43%) of 14 patients responded successfully to CI and without side

effects. 4 (30%) of these remain on CI: 3 on ciclosporin (mean duration of treatment 39 [range 19—71] months) and one patient on tacrolimus (duration of treatment 24 months); two patients stopped treatment with CI for reasons unrelated to efficacy or adverse effects (one to start a family and the other out of choice).

Conclusion CI should be considered as an alternative therapy for patients with refractory moderate-severely active UC who would otherwise require surgery. CI can be used safely and effectively in the presence of an established evidence-based protocol to ensure safe prescribing and monitoring for adverse side effects.

Competing interests None declared.

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IS THE RUTGEERTS' SCORE OF ANY CLINICAL VALUE AFTER ILEO-COLIC RESECTION FOR CROHN'S DISEASE? A PROSPECTIVE STUDY IN DISTRICT GENERAL HOSPITAL PRACTICE

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Introduction Disease recurrence after surgical resection for Crohn's disease (CD) is observed in 20%—30% of patients at 1 year, with a 10% increase per year in subsequent years. The European Crohn's and Colitis Organisation currently recommends ileo-colonoscopy 1 year after ileo-colic resection, since this predicts the need for further surgery (Statement 8C) within 2 years.[1] This statement is not supported by the BSG guidelines, highlighting a need for prospective studies to determine the role of the Rutgeert's score following ileo-colic resection. The aim of this study was to deter-mine if the Rutgeert's score[3] at 1—2 years after ileo-colic resection predicts clinical recurrence and/or need for further surgery in patients with CD in district general hospital practice.

Methods Between 2005 and 2011, 43 patients with fibrostenotic or penetrating terminal ileal or right sided CD underwent ileo-colic resection. Ileo-colonoscopy was performed in 34 asymptomatic patients between 1 and 2 years following surgery. A single expert observer (AWH) assessed the surgical anastomosis to determine the Rutgeerts' score[3] (i_0—i_4). Nine patients who underwent resection were excluded either because ileo-colonoscopy was unsuccessful or the patient refused endoscopic assessment.

Results 14 of 15 (93%) patients with Rutgeert's scores i_0 or i_1 remained asymptomatic from CD (Harvey Bradshaw Index ≤4) at January 2012 (range of follow-up 4—69 months, mean of 30 months after ileo-colonoscopy). Three (20%) of these patients smoked. Of 19 patients scoring i_2 to i_4, 12 (63%) had clinical recurrence requiring medical treatment with immunosuppression and/or biologics. 47% of patients with a Rutgeert's score of i2—i4 and 50% of those with clinical recurrence were current smokers.

Conclusion In district general hospital practice, a low Rutgeert's score (i_0 or i_1) at 1—2 years after ileo-colic resection for CD predicts prolonged clinical remission without the need for medical treat-ment. By contrast, in those patients with a Rutgeert's scores ≥i_2 clinical recurrence occurred within a maximum of 16 months following surgical resection with a higher rate of recurrence among smokers.

Abstract PMO-234 Table 1

Rutgeerts' score	No. of patients	No. of patients with clinical recurrence at last follow-up
i_0	5	0
i_1	10	1
i_2	5	2
i_3	9	6
i_4	5	4

Competing interests None declared.

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PMO-235 | **A RANDOMISED PLACEBO-CONTROLLED DOUBLE-BLIND STUDY OF OCTASA® 4.8 G/DAY (800 MG TABLETS 5-ASA) FOR THE INDUCTION OF ENDOSCOPIC REMISSION IN PATIENTS WITH ACTIVE ULCERATIVE COLITIS**

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Introduction High concentration 5-ASA formulations have potential to improve patient adherence and increase therapeutic efficacy in ulcerative colitis (UC). We conducted a multicenter, double-blind, randomised placebo controlled trial to assess the efficacy and safety of an 800 mg Octasa® tablet for induction of remission.
Methods The trial was conducted at 26 centres in Belarus, India, Turkey and Ukraine from November 2009 to May 2011. Eligible patients had active UC with a minimum disease extent of 15 cm from the anal verge, a modified UC disease activity index (UC-DAI) score of 4−10 with a sigmoidoscopic score of ≥2 and a rectal bleeding score of ≥1. Patients requiring other treatments for UC, those with severe disease or those who had previously failed treatment with >2 g/day of 5-ASA were not eligible. Eligible patients were randomly assigned to receive three Octasa® 800 mg tablets BID or matching placebo for 10 weeks. At Week 6 and Week 10, the proportion of patients in endoscopic remission, defined by a sigmoidoscopic score of ≤1, was compared by the χ^2 test. Patients who did not undergo sigmoidoscopy were analysed as not being in endoscopic remission.
Results 281 patients were randomised, 140 received Octasa® and 141 received placebo. Of the 281 randomised patients, 248 had an evaluable post-randomisation sigmoidoscopy. The baseline characteristics were similar between the treatment groups; the mean age was 42.4 and 40.1 years, disease duration was 54.3 and 51.8 months, UC-DAI was 6.7 and 6.6, respectively for Octasa® and placebo groups. At Week 6, endoscopic remission was achieved in 45.7% of Octasa® treated patients vs 24.8% of placebo treated patients (p<0.001; 95% CI of the between group difference, 9.7% to 31.3%). The corresponding values at Week 10 were 52.1% vs 36.9% (p=0.010; 95% CI of the between group difference, 3.6% to 26.3%).

The mean decrease in the sigmoidoscopic score at the end of treatment was -0.8±0.8 vs −0.5±0.7 respectively for the Octasa® and placebo treatment groups (p=0.002). The most frequently occurring adverse events were gastrointestinal disorders. Worsening of UC was reported in 9.3% Octasa® treated patients and 23.1% placebo treated patients.
Conclusion The 800 mg Octasa® tablet was safe and more effective than placebo for inducing endoscopic remission in patients with active UC.

Competing interests B Feagan: Grant/Research Support from: Tillotts, Consultant for: Tillotts, U Mittmann: Consultant for: Tillotts, D Gilgen: Employee of: Employee of Tillotts, C Wong: Grant/Research Support from: Tillotts, E Mikhailova: Grant/Research Support from: Tillotts, O Levchenko: Grant/Research Support from: Tillotts, Y Marakhouski: Grant/Research Support from: Tillotts.

PMO-236 | **ARE GUIDELINES FOLLOWED IN HISTOLOGY REPORTING IN INFLAMMATORY BOWEL DISEASE (IBD)?**

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Introduction IBD has 240 000 suffers in the UK. Diagnosis is made on consideration of clinical, macroscopic, microscopic and radiological findings to classify Crohns disease (CD), ulcerative colitis (UC) and IBD type unclassified (IBDTU) (previously indeterminate colitis). An accurate diagnosis to differentiate between the different types of IBD is important as evidence based treatment differs among the different types. An accurate histological classification of IBD increases diagnostic accuracy by 5%−41%. In line with the BSG 2011 IBD guidelines, histopathology should "attempt to define the type of IBD, mention other coexistent diagnoses, or complications and the absence or presence of any dysplasia and its grade". There are eight recognised histological features consistent with a UC diagnosis and two further criteria to differentiate between active, inactive or quiescent disease. That for CD includes nine features with a further three to mark active disease.
Methods To assess whether histopathology reporting in IBD are in line with BSG guidelines. Using the BSG guideline "A Structured Approach to Colorectal Biopsy" the histopathology reports of 60 IBD patients were scrutinised to see if they correlated with the guideline; examined for 8 histological features of UC, 9 for CD, disease activity, complications and presence and grade of dysplasia.
Results The cohort identified 60 patients (38 UC, 22 CD). The type of IBD was specified in 25% (IBDTU 3%, UC 10%, CD 4%) and not mentioned in 40%. 23% of UC specimens were labelled as such by the histolpathologist; in that cohort there was also 3% IBDTU, 37% "IBD", 0% CD. In the CD group; 0% IBDTU, 4% UC, 18% CD, 28% "IBD". 80% of specimens had no mention of complications/coexistent features. Of those documented CMV was noted in only 1 UC case, fistulae in 2 CD cases and infection in a total of nine across the groups. Dysplasia was not mentioned in 22% UC and 59% CD; listed as a relevent negative finding in 71% UC and 36% CD and identified as low grade dysplasia (tubuloadenoma) in 3 UC cases and 1 CD case. The features most frequently identified: In UC: (1) severe crypt architectural distortion; (2) severe widespread decreased crypt density, In CD it was (1) mucosal surface normal, irregular, villous; (2) crypt atrophy.
Conclusion In our study the majority of histology reports lack important information pertaining to and even attempting to classify IBD. On average for patients suffering from CD or UC, the histological reports only state two histological signs which are of immense importance in confirming either diagnosis. None of the