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 indetermediate 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