

Results 21 patients received infliximab during the study period. 12 patients were emergency admissions who had failed to respond to intravenous steroid therapy (acute group). Nine patients had failed to respond to maximum oral therapy, which included immunomodulators and oral prednisolone (sub-acute group). In the acute group, 42% (n=5) of patients had avoided a colectomy at a median follow-up of 467 days (IQR 370–612). The other 58% (n=7) proceeded to colectomy after a median of 69 days (IQR 30–136). Of the patients who proceeded to colectomy, 57% had been prescribed immunomodulator therapy prior to infliximab usage. However, all the patients who avoided colectomy were immunomodulator naive prior to infliximab. In the sub-acute group, only 33% (n=3) of patients required a colectomy after a median follow-up of 153 days (IQR 110–180). The remaining 67% (n=6) were well and off steroids after a median of 303 days (IQR 209–400).

Conclusion This review of patient outcomes shows the potential benefits of infliximab for treating both acute and sub-acute UC. After a maximum of three doses of infliximab, 42% of acute and 67% of sub-acute UC patients were able to avoid a colectomy. Our results are comparable to those of Oxford (1 to 7 doses of infliximab as needed) who reported that 43% of acute and 50% of sub-acute were able to avoid a colectomy.¹ Furthermore, our results confirm the greater potential benefit of infliximab in acute, immunomodulator naive patients. In addition, all sub-acute patients, who avoided colectomy, were well and off steroids at the end-of follow-up, compared to only 38% from the Oxford group, suggesting additional benefit from planned infliximab doses.¹

Competing interests None declared.

REFERENCE

1. **Jakobovits SL**, Jewell DP, Travis SPL. Infliximab for the treatment of ulcerative colitis: outcomes in Oxford from 2000 to 2006. *Aliment Pharmacol Ther* 2007;**25**:1055–60.

PMO-253 IMPACT OF INFLAMMATORY BOWEL DISEASE NURSE SPECIALIST ON QUALITY OF PATIENT CARE AND MEETING STRATEGIC NATIONAL AIMS

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¹E Fernandez, * ²K Kemp. ¹Clinical Standards Department, Royal College of Physicians, London, UK; ²Department of Gastroenterology, Manchester Royal Infirmary, Manchester, UK

Introduction The UK IBD Audit has now completed its 3rd round with continued marked variation in the resource and quality of care for IBD patients. This analysis of the national data aims to measure the quality of care for patients in centres with: a IBD nurse >1 WTE, IBD nurse <1 WTE and those with no IBD nurse; to demonstrate the impact of the IBD nurse in terms of quality of care; and how the role assists in meeting specific aims of the White Paper (Equity and excellence: Liberating the NHS, 2010).

Methods A comparison was carried out of the 2010 audit results of hospitals with no IBD nurse, <1 WTE nurse and those with ≥1 nurses. It cannot directly be inferred that the IBD nurse is the causative factor in the reduction in hospital admissions or

improvements in care. The results also do not reflect the number of nurse sessions per week dedicated to IBD care or long the IBD nurse had been in post.

Results There was a significant reduction in the number of patients admitted to hospital with an IBD nurse in post and a difference in the range and choice of care delivery. More patient education was offered in the presence of the IBD nurse (28%, 60%, 74%, p<0.001), more patient involvement in service development (12%, 20%, 39%, p<0.001), clearer guidance for patients to seek a 2nd opinion (93%, 20%, 45%, p<0.009) and clinical data more likely to be captured (23%, 50%, 61%, p<0.001).

Conclusion The NHS White paper states reducing avoidable hospital admissions, increasing the proportion of people with a long term condition to self care and the ability to offer choice of care are High Level Outcomes which lead to commissionable services. The presence of an IBD nurse, within the IBD team, correlates with fewer admissions, the availability of self management programmes and greater overall choice in care provision and new modes of care delivery.

Competing interests None declared.

PMO-254 COMPARISON OF IBDQIP SCORES FOR TWO SERVICES WITHIN ONE TRUST

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¹E Fernandez, * ²D Hall. ¹Clinical Standards Department, Royal College of Physicians, London, UK; ²Department of Gastroenterology, Birmingham Heartlands Hospital, Birmingham, UK

Introduction The Heart of England NHS Foundation Trust is one of the largest in England, with over 1200 beds and serves over a million people throughout north and east Birmingham and surrounding areas. It has three sites: Birmingham Heartlands, Good Hope Hospital and Solihull Hospital.

Methods Good Hope Hospital and Heartland & Solihull Hospitals entered data separately into IBD Quality Improvement Project. Services were asked to meet as a team to enter data about their service. The majority teams were able to complete data entry within 2–3 h. Each team comprised of two Consultant gastroenterologists a Consultant Colorectal surgeon and an IBD CNS. Results were not discussed between services at the time of data entry. After completion the sites requested comparative results and arranged a joint meeting to discuss the outputs.

Results As a response to this the teams reviewed their data together and agreed the following action points: (1) Good Hope Hospital will join Heartlands and Solihull's Transition Clinic at Birmingham Children's Hospital. This takes place twice a year and a joint team from both sites will attend. (2) A shared care agreement for patient's on immunosuppressive, between primary and secondary care is being devised for use across the Trust. (3) Nutritional support, which was initially available at Heartlands but has been extended to Good Hope. (4) Heartlands hospital have recently trialled a changed on-call system, to provide daily Gastroenterology ward rounds, to improve appropriate patient flow to specialist gastroenterology beds.

Conclusion (1) There are significant differences in service provision between the two services within the same Trust (2) The Trust

Abstract PMO-253 Table 1

	No IBD CNS	<1 WTE IBD CNS	1 or more WTE IBD CNS	p Value
% Patients admitted to hospital 1 September 2009–31 August 2011	19% (10.8–34.0)	10% (5.1–23.3)	11% (7.2–19.4)	<0.001
The site offers a range of arrangements for outpatient care including email, drop-in, telephone	61% (35/57)	85% (34/40)	84% (88/105)	0.002
The service offers guided self-management with access to support when needed.	34% (12/35)	62% (21/34)	63% (55/88)	0.013
Expedited specialist review of relapsed patients	83% (47/57)	98% (39/40)	98% (103/105)	0.002
A clear structured pathway for the patient to discuss their treatment with the multidisciplinary team	16% (9/57)	45% (18/40)	57% (60/105)	<0.0001
There is written information for patients on whom to contact in the event of a relapse.	42% (24/57)	88% (35/40)	95% (100/105)	<0.0001

covers a large geographical area and differing population sizes. Despite now existing within the same directorate services have maintained their historical ways of working. (3) This assessment has provided a catalyst for joint working and improved care for patients.

Domain	Question	Heartlands and Solihull	Good Hope
PATIENT EXPERIENCE	Information on the IBD Service	C	A
	Rapid access to specialist advice	A	A
	Provision of information and supporting patients to exercise choice between treatments	B	B
	Involvement of patients in service improvement	D	D
	Education of patients	A	A
CLINICAL QUALITY	Information and support for patient organisations	B	C
	The IBD team	C	C
	Inpatient monitoring	A	B
	Mental health services	D	D
	Sexual and reproductive health	B	B
	Multidisciplinary working	A	C
	Access to Nutritional support and therapy	A	D
	Arrangements for use of immunosuppressives	C	C
	Surgery for IBD	D	A
	Inpatient facilities	D	B
ORGANISATION AND CHOICE OF CARE	Access to diagnostic services	D	D
	Inpatient care	C	D
	Referral of suspected IBD patients	B	D
	Supporting patients to exercise choice between care strategies for outpatient management	D	D
	Outpatient care	C	B
RESEARCH, EDUCATION AND AUDIT	Transitional care	D	D
	Arrangements for shared care	B	A
	Register of patients under the care of the IBD service	C	C
	Participation in audit	C	C
	Training and education	C	C
	Research	B	C
	Service development	D	A

Abstract PMO-254 Figure 1

Competing interests None declared.

REFERENCE

1. Quality Service standards for the healthcare of people who have Inflammatory Bowel Disease <http://www.ibdstandards.org.uk/>

PMO-255 THE EXPRESSION OF INTERLEUKIN 2 RECEPTOR IN INTESTINAL RESECTION SPECIMENS FROM PATIENTS WITH CROHN'S DISEASE AS ASSESSED BY IMMUNOHISTOCHEMISTRY

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¹E Russo,* ¹G Petts, ²T Lloyd, ²R Goldin, ¹P Matthews, ²T Orchard. ¹Imperial College London, London, UK; ²Imperial College Healthcare NHS Trust, London, UK

Introduction Interleukin-2 (IL-2) is a key cytokine in inflammatory pathways involving T-cells. Several studies assess the potential of IL-2 scintigraphy to quantify T-cell infiltrates in conditions such as diabetes, coeliac and Crohn's Disease (CD). To assess the potential utility of IL-2-based Positron Emission Tomography (PET) radioligands that target the IL-2 receptor (IL-2R) in Crohn's disease imaging, we examined the differential expression of the α -subunit of the IL-2R (CD25) in intestinal resection specimens from patients with CD.

Methods Stored, formalin-fixed paraffin-embedded blocks from Crohn's intestinal resection specimens were retrieved. Four 1 μ m-thick consecutive sections from each block were stained with H&E and CD25 (CD25 1:100, Leica NCL-CD25:305). A pathologist carried out a semi-quantitative grading of acute and chronic inflammation from H&E stained slides attributing a score of 0–3 for each of the two components. Their sum represented the Global Inflammatory Score (GIS). Specimens were subcategorised on the basis of GIS into Group A (GIS 0–1, no or mild inflammation), Group B (GIS 2–4, moderate) and Group C (GIS 5–6, severe). While blinded to the GIS, the pathologist quantified CD25 expression by counting CD25+ve cells in 1mm-wide full thickness regions of bowel wall on slides containing complete, well-orientated mucosa, submucosa and muscularis propria. Results were expressed as CD25

+ve cells/mm². Groups were compared using the Mann–Whitney test. In addition, qualitative co-localisation studies of CD25 and CD3 (CD3 1:50 Leica NCL-L-CD3-565) or CD45 (CD45 1:100 Dako M0701) were performed on a sub-selection of six slides.

Results 12 sets of slides were produced from five resection specimens. A median of 3 (range 2–6) 1 mm wide well orientated bowel wall regions were scored on each slide (total 41). Of these, 15 (37%) were in Group A, 12 (29%) in Group B and 14 (34%) in Group C (see above). Median CD25+ve cell count per mm² was 2.04 (range 0.32–6.94), 2.74 (range 0.97–13.86) and 8.89 (range 2.14–59.66) respectively. CD25 was significantly more abundant in Group C than in Group A ($p=0.0005$) and Group B ($p=0.019$). The difference in CD25 expression between Groups A and B did not reach statistical significance ($p=0.08$). Co-localisation studies of CD25 and CD3 or CD45 suggest that the majority, but not all CD25 expression occurs on leucocytes (CD45 positive cells) and specifically T-lymphocytes (CD3 positive cells).

Conclusion IL2R was significantly more abundant in areas with a severe inflammatory infiltrate, therefore 18F-IL2 PET scanning could be useful in delineating such areas. CD25 appears predominantly but not exclusively expressed on T-cells.

Competing interests None declared.

PMO-256 THE REALITY OF THE TOLERANCE AND EFFICACY OF ORAL IRON IN PATIENTS WITH INFLAMMATORY BOWEL DISEASE (IBD)

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F Beal,* S Lugg, D Rattehalli, C Tselepis, T Iqbal. *The Queen Elizabeth Hospital, Birmingham, UK*

Introduction Iron deficiency anaemia (IDA) is the most common complication of Inflammatory Bowel Disease (IBD) and impacts negatively on patients' quality of life. The aim of this audit was to explore the use and tolerability of oral iron supplementation in IBD practice.

Methods We used a patient directed questionnaire aimed at adult IBD outpatients over a 7-week period at the Queen Elizabeth Hospital. The use of oral iron therapy was ascertained in patients treated over 20 years. Patients were asked about the type of iron taken, dosing frequency, duration, side-effects and completion of therapy. We calculated the number of patients whose anaemia had resolved and where the data were available, the efficacy of treatment was determined by the mean change in haemoglobin (Hb) from baseline.

Results 91 IBD patients who received iron were surveyed, (62 Crohn's disease, 27 ulcerative, 2 microscopic colitis). All received oral iron (73 ferrous sulphate, 15 ferrous fumarate and 3 ferrous gluconate) and 17 also received intravenous (IV) iron. There were 56 females and 35 males. Variable dosing regimens were followed: 31.5% taking iron once, 37% twice and 31.5% three times daily. Although 69% patients were able to complete the course of oral iron, 31% had to abort treatment due to intolerance, which was unrelated to dose frequency. Only 35 patients (38%) were able to complete their intended course of oral iron without any side effects. Of these patients, the baseline Hb (mean 11.1 g/dl, range 8.9–13.3) returned to reference baseline in only 51% patients, with average Hb change 1.43 (range -0.7–4.7). Side effects were reported in 52% patients who received oral iron, including nausea and vomiting (21%), abdominal pain (19%), constipation (19%) and diarrhoea (18%). However, despite side effects the average duration of treatment in this cohort was 10.3 months (range 0.03–156), 19.3 months (range 1–240) in patients without side effects and 5.2 months (range 0.03–36) in intolerant patients who had to cease treatment. No adverse effects were reported in the 17 who received IV iron.