

REFERENCE

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PWE-090 **OUTCOMES OF PATIENTS WITH ULCERATIVE COLITIS WHO ARE AZATHIOPRINE TOLERANT AND AZATHIOPRINE INTOLERANT**

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Introduction Azathioprine therapy is an immunosuppressive drug that is widely used in the management of ulcerative colitis. 20% of patients with normal TPMT are not able to tolerate the drug and 30% do not respond [1]. For patients who are intolerant to azathioprine, other medicines have been proposed and these include methotrexate, mercaptopurine and infliximab.

Methods A cross sectional study was performed using the Milton Keynes Hospital IBD database to compare patients were azathioprine intolerant and those that were azathioprine tolerant. A descriptive analysis of clinical features and outcomes of these two groups was performed. Disease activity scores were based on the montreal classification ranging from S0 (clinical remission) to S3 (severe disease).

Results 98 patients were recruited of which 32.7% were intolerant to azathioprine. The median age of azathioprine intolerant patients was 47.5 years and 30.3% were male. In the azathioprine tolerant cohort, the median age was 46 years and 53.0% were male. Azathioprine was not tolerated due to deranged liver function tests in 43.3%, gastrointestinal symptoms of nausea/vomiting in 23.3%, cutaneous side effects in 10.0%, migraines in 6.7% and infections in 3.3%.

Abstract PWE-090 Table

	Azathioprine intolerant (n = 32)	Azathioprine tolerant (n = 66)
Requiring surgery (%)	6 (18.8)	11 (16.6)
Extensive disease (%)	9 (28.1)	24 (36.4)
S2/S3 disease (%)	11 (34.4)	19 (28.7)
S0/S1 disease (%)	21 (65.6)	47 (71.2)
S0 disease-remission (%)	12 (37.5)	30 (45.5)
Steroid dependent (%)	9 (28.1)	0 (0.0)

Conclusion Azathioprine is a drug that is not tolerated in nearly a third of Ulcerative Colitis patients and this effect demonstrated a sex bias towards females. The most likely reason for azathioprine intolerance was deranged liver function tests, however, intolerable gastrointestinal symptoms are noted. The intolerance of azathioprine is not a prognostic marker that patients will be more likely to undergo colectomy or that their ulcerative colitis will become extensive. However, there is evidence that compared to azathioprine tolerant patients, for every 100 who are intolerant, 8 less will be in remission and 6 will have more severe disease. Finally, we note that prolonged use of low-dose steroids in modern practise is utilised rarely and it is feasible that this trend may lead to increased symptoms at a population level.

Disclosure of Interest None Declared.

REFERENCES

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PWE-091 **ARE QUALITATIVE FAECAL CALPROTECTIN ASSAYS USEFUL IN CLINICAL PRACTICE?**

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Introduction Distinguishing organic and functional bowel disease is often clinically difficult. Faecal biomarkers have been used to aid the diagnosis of inflammatory bowel disease (IBD) and reduce the need for invasive investigations. Quantitative faecal calprotectin (CAL) at certain thresholds has been shown to have a high sensitivity and specificity for identifying IBD. There is also similar evidence for faecal lactoferrin (LAC). There is less evidence for the use of point of care qualitative assays in clinical practise, however previously it has demonstrated comparable efficacy to the quantitative test.

Methods This is a retrospective study of 528 patients with abdominal symptoms who had faecal CAL measured (Quantum Blue® LFCAL) from June 2011 to June 2012 in Queen Elizabeth Hospital, Woolwich and Queen Mary's Hospital, Sidcup. Faecal LAC (IBD EZ VUE®) was only measured when CAL was positive. The tests were ordered by both hospital physicians and general practitioners (GPs). Definitive outcome for hospital patients was determined by blood tests, endoscopy with histology and further imaging. Outcome was not recorded for patients with a negative test result.

Results 136 patients had positive CAL and therefore also had LAC measured. 392 patients had negative CAL. Outcome was not known for 42/136 patients as these tests were ordered by GPs and they possibly attended other hospitals. Some tests were carried out to assess patients with known IBD (15 tests total – 7 CAL +/LAC -, 8 CAL +, LAC +). 121 patients with positive CAL had the test for primary diagnostic purposes.

60 patients had a positive CAL and a negative LAC, of which 47/60 (78%) had normal colonoscopies; 13/60 (22%) had an abnormal result.

34 patients had a positive CAL and a positive LAC, of which 10/34 (29%) had normal colonoscopies; 24/34 (71%) had an abnormal result.

Abstract PWE-091 Table 1

Outcome	CAL +ve/LAC -ve	CAL +ve/LAC +ve
Normal	47	10
New IBD	1	11
Other*	5	5
Unknown**	29	13
Total	89	47

*other included: polyps, rectal angiodysplasia, bile acid malabsorption, ischaemia, sigmoid carcinoma, pelvic mass, coeliac disease

**Unknown: included missed follow-up or appointments, resolved symptoms

Conclusion In this study, a positive qualitative CAL result was a poor marker of bowel inflammation. The number of false positive results was greatly reduced by using it in conjunction with LAC, 29% in comparison to 78%. Qualitative CAL may be useful at excluding IBD when it is negative and the threshold is low, however, our data shows that a positive test is not specific and cannot be compared to a quantitative CAL test. This may be because of the low threshold of our particular test (30–300 ng/ml) and qualitative LAC testing may improve this.

Disclosure of Interest None Declared.