provided stool for FC concentration analysis and the study was terminated once the last recruited patient reached a follow up period of 365 days. Remission was defined as a Crohn's disease activity index (CDAI) of < 150. Relapse was defined as either a need for escalation of medical therapy, surgery for active CD or progression of disease phenotype using the Montreal classification. The study was approved by the West of Scotland Research Ethics Service (REC reference 10/S0704/1). The Receiver Operating Characteristic (ROC) curve of relapse by 12 months, based on FC value at baseline, was calculated. Kaplan-Meier curves of time to relapse, some of which were longer than 12 months, were based on the resulting best FC cut-off value for predicting relapse (with patients who had not relapsed being censored at end of follow-up) and compared using the log-rank tests.

Results 98 patients were recruited. One patient was lost to follow up, 1 died and the care of 3 patients was transferred to another centre, before either relapsing or being followed up for 12 months. Of the 93 remaining patients 11 (12%) had relapsed by 12 months. The median FC was lower for non-relapsers, 96 μg/g (IQR 39–237), than for relapsers, 328 μg/g (IQR 189–574), (p = 0.008). The area under the ROC curve to predict relapse using FC was 74.8% (Figure 1). A cut-off FC value of 240 μg/g to predict relapse of quiescent Crohn's disease over the course of one year was associated with a sensitivity of 72.7% and specificity of 74.3%. Negative predictive value was high at 95.3% and positive predictive value was 27.6%. There was a significant difference in time to relapse for those with the first FC value below or above 240 μg/g (p = 0.011).

Conclusion In this prospective dataset, FC appears to be a useful, non-invasive tool to help identify quiescent Crohn's disease patients at a low risk of relapse over the ensuing 12 months. A FC value of 240 μg/g was deemed the best cut-off value in our patients.

Disclosure of Interest None Declared.

PTH-079 THIOPURINE WITHDRAWAL FOR SUSTAINED REMISSION IN IBD: A UK MULTICENTRE STUDY

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Introduction Thiopurine therapy is effective in maintaining clinical remission in IBD. However, long-term therapy is associated with an increased risk of lymphoma; therefore in clinical practise it may be appropriate to withdraw thiopurines after prolonged remission. Nevertheless, many patients will experience disease relapse within 12 months of drug withdrawal.

The Aim of the present study was to retrospectively determine the relapse rate in ulcerative colitis (UC) and Crohn's disease (CD) following azathioprine (AZA) or mercaptopurine (MP) withdrawal and to determine factors predictive of relapse.

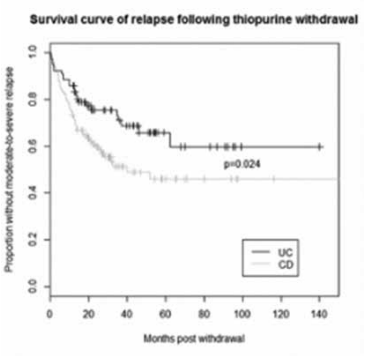
Methods Patients were identified by electronic case note review of IBD patients in eight major centres around the United Kingdom. Major inclusion criteria were AZA and/or MP therapy for a minimum of 3 years, AZA/MP withdrawn due to sustained clinical remission no steroid therapy for 6 months prior to drug withdrawal, and minimum 12 months follow-up.

The primary outcome was disease relapse requiring AZA reinitiation, steroids or colectomy within 12 months of AZA/MP withdrawal, with secondary outcome assessed at 24 months. Clinical/laboratory predictors of relapse were sought.

Results Data was obtained on 97 patients with CD and 78 with UC. Median age at diagnosis was 26y (interquartile range [IQR] 20–38), and 49% were female. Median duration of thiopurine use was 73 months (IQR 54–104). Median duration of follow-up was 39 months (IQR 24–65 months).

CD was associated with a significantly higher risk of relapse than UC on Kaplan Meier analysis (Figure 1, p = 0.024). The moderate-severe relapse rate for 12 months was 27% for CD and 14% for UC. For 24 months, relapse rates were 41% for CD and 28% for UC. Elevated CRP was predictive of relapse at 12 months for CD (0 = 0.017), while elevated platelet count was predictive of relapse at 24 months for UC (0.021).

Retreatment with a thiopurine after relapse was successful in 34/39 (87%) for CD and 17/18 (94%) cases for UC.



Abstract PTH-079 Figure 1

Conclusion Relapse rates after withdrawal of a thiopurine are high, particularly for CD, and predicting this remains difficult. The findings regarding CRP and CD in this data highlight the importance of ensuring patients are in deep remission prior to drug withdrawal. Further studies should evaluate the role of faecal calprotectin in this.

Disclosure of Interest None Declared.

PTH-080 DO WE NEED TO SCREEN OUR INFLAMMATORY BOWEL DISEASE (IBD) PATIENTS FOR DEPRESSION: THE PREVALENCE AND SEVERITY OF DEPRESSION WITHIN A TYPICAL DISTRICT GENERAL COHORT OF IBD PATIENTS

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Introduction Depression is believed to occur in 15 to 30% of IBD patients, in which suicide is not an uncommon ideation. Some researchers believe that psychiatric illness may have an aetiological role to play in the onset of inflammatory bowel disease (IBD), as the incidence of depression seems to be concentrated in the year before and after the initial diagnosis is made.

Objectives To assess the true prevalence and severity of depression within our inflammatory bowel disease patients.

Methods 2400 patients with IBD in the Luton & Dunstable catchment were invited to participate in a web-based quality of life assessment, with the option to request a paper copy. All patients were deemed eligible provided they were over 18 and under 90 years of age, with no major learning difficulties or pre-existing serious mental disorders. The well validated 9-item self-report "Patient Health Questionnaire" (PHQ) was used. The PHQ-9 has a minimum possible score of 0 and a maximum possible score of 27. Scores of 5, 10, 15, and 20 represent cut-off scores for mild, moderate, moderately severe, and severe depression.

Results 245 patients completed the assessment (43% male; mean age = 53, SD = 17). 45% had Ulcerative Colitis, 45% had Crohn's