

**PTH-108** **MAGNETIC RESONANCE ENTEROGRAPHY FOR THE ASSESSMENT OF CROHN'S DISEASE: CHANGING IMAGING PARADIGMS?**

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**Introduction** Advances in therapy and definitions of inflammatory bowel disease (IBD) control have led to increasing reliance on imaging. Awareness of effects of ionising radiation has placed emphasis on radiation-free imaging. We assessed the role of magnetic resonance enterography (MRE) in small bowel Crohn's disease (CD).

**Methods** We conducted a retrospective review of 948 MRE studies between June 2009 and December 2012 at our institution. Clinical data (demographics, disease characteristics and therapy) were obtained from electronic record review. Inflammatory markers, radiological tests and ileocolonoscopy within 90 days of MRE were recorded. MRE reports were recorded using accepted activity criteria- small bowel dilatation, stenosis, wall thickening, enhancement, mucosal irregularity, mesenteric inflammation, hypervascularity, lymph node enlargement, abscesses, fistulation and extraintestinal features.

**Results** Of 455 patients with IBD, 385 had CD (224 of these female; mean age 36; range 12–72 and median disease follow up 4 years (range 0–39).

Abnormalities were noted in 285 scans; 162 had active non-stricturing, 109 active stricturing and 13 fibrostenotic disease. Within active groups, there were 29 fistulae and 12 abscesses in 33 patients. Ileocolonoscopy was performed in 70 patients with active non-stricturing disease with 57/70 showing active colitis and raised CRP in 65/146. Treatment was increased in 55% of the active non-stricturing group, 28/89 to azathioprine, 24/89 to infliximab, 10/89 to surgery, 14/89 had 5-ASA with no change in 45%, of whom 12/39 had normal ileocolonoscopy and 54/68 normal CRP.

In 50% of active stricturing group, treatment was increased to azathioprine in 11, biologics (25) and 17 to surgery. Thirty-eight of 82 patients in the group had an elevated CRP and 23/39 active colitis at ileocolonoscopy.

Of 99 normal MRE, treatment was unchanged in 96%; with normal CRP in 68/87 and ileocolonoscopy in 17/38.

Of 13 fibrostenotic subjects, 9 had normal CRP and 6 had mild colitis at colonoscopy. Four had surgery and 1 had endoscopic dilatation of a stricture while 5 had no change as MRE showed improved appearances (2 commenced steroids and 1 changed to adalimumab). In the abscess/fistula group 6 were referred for surgery, 6 had infliximab (fistula), 2 had adalimumab (fistula), 2 had azathioprine (fistula) and 4 were treated with antibiotics.

**Conclusion** The small bowel remains difficult to assess endoscopically. The choice of investigation will be driven by the clinical question, available expertise and economic factors. MRE aids assessment of CD, in addition to endoscopy and biological markers identifying patients with active disease for meaningful treatment escalation.

**Disclosure of Interest** None Declared.

**PTH-109** **PERCEPTIONS OF ULCERATIVE COLITIS (UC) AMONG PATIENTS (PTS), PHYSICIANS, AND NURSES IN THE UNITED KINGDOM (UK)**

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**Introduction** Differing perceptions between pts and physicians on the experience of living with and managing UC have been reported; the perspective of nurse specialists treating UC has not been fully explored. An international online survey of pts with UC and healthcare professionals (HCPs) treating UC was conducted in 6 countries to explore these differences; results from the UK are reported.

**Methods** Structured, cross-sectional, Web-based questionnaires assessing multiple aspects of UC and its management were administered to pts with UC, and nurses and physicians treating pts with UC. Participants were identified via access panels or "phone-to-Web" recruitment. Statistical comparisons among the 3 groups were not conducted.

**Results** In the UK, 150 pts, 50 nurses and 100 physicians completed the survey. Overall, the majority of pts (55%) described their UC severity as moderate. In contrast, HCPs estimated that their UC caseloads were primarily composed of mild compared with moderate pts (nurses: 49% vs 37%; physicians: 52% vs 35%). Pts reported experiencing a mean of 6.5 flares/year, but only discussed 3.4 flares with their HCP. Nurses and physicians, respectively, estimated that UC pts experienced a mean of 3.8 and 2.6 flares/year. Pts listed stress (41%) and natural disease course (35%) as the most common causes of flare. Both nurses and physicians, respectively, listed natural disease course (44% and 59%) followed by not taking preventive therapy (32% and 29%) as the most common flare causes. Most pts (58%) defined remission as "living with some symptoms". A similar proportion of nurses (62%) and physicians (53%) defined remission as the "complete absence of symptoms". Pts ranked urgency (43%) and pain (23%) as the most bothersome UC symptoms; while urgency was also rated most bothersome by a majority of nurses (58%) and physicians (51%), pain was rated most bothersome by the fewest nurses (6%) and physicians (1%). A total of 48% of pts reported that UC symptoms disrupted their quality of life (QoL); nurses and physicians estimated that 37% and 35% of pts, respectively, had their QoL disrupted by UC symptoms.

**Conclusion** In the UK, nurses' perception of UC was more aligned with physicians' rather than pts' perceptions. Both nurses and physicians may underestimate the burden of UC perceived by pts.

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**PTH-110** **ARE WE DOING ENOUGH VACCINATIONS? – A DGH EXPERIENCE OF PATIENTS ON BIOLOGICS**

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**Introduction** Immunomodulators (IM) and biological agents are now used more often and earlier in Inflammatory Bowel Disease (IBD) leading to an increase in opportunistic infections (OI)<sup>1</sup>. European Crohn's and Colitis Organization (ECCO) recommends screening and vaccinations for Varicella Zoster Virus (VZV) (if no history of chickenpox/shingles and serology negative), Human