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. Ileo-colonoscopy 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 ileo-colonoscopy 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 ileo-colonoscopy.

Of 99 normal MRE, treatment was unchanged in 96%; with normal CRP in 68/87 and ileo-colonoscopy 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)[1]. 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

Papilloma Virus (HPV) - in women, Annual Influenza (inactivated vaccine), Pneumococcus (3- 5 yearly) and Hepatitis B (if HBV seronegative) in immunocompromised IBD patients.

Methods We retrospectively collected the data on the serology status for Hep B&C, VZV of our patients receiving biologics from pathology results reporting system and Chest X-ray (CXR) results from PACS. BCG vaccination status and previous Chicken pox exposure was obtained from the clinic letters.

The information on the vaccination status was obtained by contacting the general practioners via telephone and from patients at attendance for their infliximab infusions. Data was also taken from the clinic letters and IBD MDT proformas.

Results Of the 37 patients who are currently receiving biologics (18 males; 19 females; mean age: 37.3±2.3 years), 31 had Crohn's disease, 5 UC and 1 indeterminate colitis. All patients received anti-TNF therapy with 33(91.7%) exposed to combination therapy with azathioprine (27) (81.8%) and (6) (18.2%) with methotrexate. Serology status on Hep B, C and Varicella was available in 26(77%), 5(13%), and 21(56%) patients respectively. A CXR was done in 65% of patients with 5 patients having their BCG status documented. IGRA was done on 2 patients with ambiguous mantoux results. Influenza, pneumococcal, HPV vaccines were administered in 6 (16.2%), 4 (10.8%) and 1 patients (2.7%) respectively.

Conclusion Relevant serology status and vaccination history was available/recorded in a minority of patients only. Non/poor-adherence to guidelines, poor documentation or limits of data collection may explain this.

To improve compliance information leaflets on the ECCO-recommended vaccines are being sent to GPs and patients. Adherence to checklists prior to biologic administration is enforced.

We believe patient education with support of our IBD nurses and empowering patients with relevant personalised information given at diagnosis and during their treatment may increase the uptake of vaccinations in these high risk patients.

The development of a dedicated IBD database ideally with GP links to allow vaccinations records to be accessed will allow us to audit our practise accurately and determine the efficacy of the current recommendations.

Disclosure of Interest None Declared.

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PTH-111 CHANGES IN MRI ENETROGRAPHY IN CROHN'S PATIENTS TREATED WITH ADALIMUMAB

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Introduction MRI enterography has become the gold standard radiological assessment for Crohn's disease. The radiological response of Crohn's disease following mono therapy with Adalimumab is not clearly documented. The aim of this study was to compare pre and post treatment MRI enterograms in Crohn's patients on treatment with Adlumimab monotherapy

Methods 24 consecutive Crohn's patients being treated with Adalimumab monotherapy according to NICE guidelines. Median age was 37.5years (range 21–66). Pre treatment MRI enterograms were compared with enterograms at a median of 6 months after commencement of treatment. MRI parameters compared were bowel thickness (BT), enhancement ration (ER), diffusion value (DV) and the apparent diffusion coefficient (ADC). Post treatment enterograms were compared with 24 control subjects without inflammatory bowel disease. Changes in these parameters were further correlated with changes in biochemistry (FBC, CRP and Albumin)

Results Significant improvements in all MRI parameters were noted with treatment (Mean changes: BT 2.0, $p = < 0.001$; ER –0.32, $p = < 0.0001$;DV –111.09, $p = < 0.0001$, ADC 0.18, $p = < 0.0001$). There was a trend to an improvement in biochemical parameters, none of which were statistically significant. Changes in biochemical parameters did not correlate with MRI changes. On comparison with control MRI enterograms, ER was the only parameter not significantly deleterious in Crohn's patients indicating ongoing inflammation

Conclusion Marked radiological improvement is apparent 6 months into Adalimumab monotherapy for Crohn's disease. However, significant features of inflammation persist indicating mucosal healing has not been achieved in this treatment period.

Disclosure of Interest None Declared.

PTH-112 INFLIXIMAB PROMOTES STEROID FREE REMISSION IN PATIENTS WITH CHRONIC ACTIVE ULCERATIVE COLITIS– A UK SINGLE CENTRE EXPERIENCE

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Introduction The role of infliximab (IFX) in the salvage treatment of acute severe ulcerative colitis (UC) is well established and both licenced and approved in the UK. Studies have demonstrated that IFX IS effective in the treatment of chronic steroid dependent/refractory UC [(1)] In the UK IFX is not routinely approved for the treatment of chronic steroid-dependent colitis. Our aim was to assess the long-term outcomes of patients treated with IFX for chronic active UC in a single UK IBD centre.

Methods A retrospective single centre review was undertaken of patients with severe active UC who received IFX (5mg/kg) between May 2008 and April 2012. Clinical remission was defined as complete steroid withdrawal, normalisation of bowel frequency and absence of blood with defecation. Treatment with IFX was only continued if steroid free remission was maintained.

Results 23 patients were included.10 (43%) of patients were treated with induction therapy only (0, 2 & 6 wks) due to funding constraints. 6 (60%) of this group were not on thiopurines, having been either unresponsive or intolerant. 5 (50%) entered clinical remission-median follow up 18 months (IQR 15–25) & 2 (20%) had colectomy. 13 (57%) were treated with induction and maintenance therapy. Of these 7 (85%) were already established on a thiopurine without clinical response. All 13 (100%) entered clinical remission as defined, median follow up 21 months (IQR 11–26). 1 patient required dose escalation to 10mg/kg. None of the patients in the maintenance group were admitted during this time. No significant side effects were reported in either group.

Conclusion In our patients treated with IFX for chronic active UC, IFX maintenance therapy appears to have more sustained steroid free remission rates compared with induction therapy only. All patients treated this way avoided colectomy, hospital admission and had complete steroid free remission during follow-up. Experience of maintenance IFX therapy for UC in the UK is limited due to funding constraints but our data confirms the efficacy of this approach in carefully selected patients the response rate may be higher than in other published series.

Disclosure of Interest None Declared.

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