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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