hemostasis. The following parameters were measured in 3 female pigs: histological assessment and pre-coagulation endoscopic performance. All animals were recovered for 2, 5 and 7days.

Results In animal one, microwave bursts of 5 , 10 and 15 sec were applied to the revealed submucosa compared to standard monopolar bursts of a 1 sec. Histology showed that 5 and 10 sec of microwave has equivalent histological appearance with standard monolopar preserving the serosal integrity with mild muscle alteration. In animal 2 and 3, microwave was applied for 9 sec in 6 lesions, standard monopolar was applied for 1–2 sec in 6 lesions and standard bipolar was applied for 3–4 sec in 6 more lesions. Histology showed viable serosa with no muscle alterations in microwave group, viable serosa with mild muscle alterations in standard bipolar and viable serosa with mild/moderate muscle alterations in standard monopolar group. In all cases muscle layer cells were contiguous. During the pre-coagulations endoscopic assessment, all modalities were applied to coagulate vessels with median calibre of 2 mm before and after dissection. Effective pre-coagulation was achieved in 3 out of the 6 visible vessels (microwave group) and in 2 out of the 6 visible vessels (standard monopolar and bipolar groups). Effective coagulation (defined when blood flow stopped) was achieved after the dissection, in all three groups.

Conclusion Compared to Coagrasper (monopolar) and Gold Probe (bipolar), the microwave modality of Speedboat RS2 appears to be equivalent during the pre-coagulation phase. The safety profile of coagulation phase resembles the profile of the other two modalities but with less muscle alterations in the histological specimens.

Disclosure of Interest Z. Tsiamoulos Consultant for: Creo Medical Ltd, C. Hancock Shareholder of: Creo Medical Ltd, P. Sibbons Paid instructor for: Creo Medical Ltd, B. Saunders Consultant for: Creo Medical Ltd, Paid instructor for: Olympus KeyMed.

Inflammatory bowel disease II

PWE-070 PERSPECTIVES AND ATTITUDES TO COLONOSCOPY IN PATIENTS WITH INFLAMMATORY BOWEL DISEASE

C Alexakis*, L Medcalf, V Chhaya, J-Y Kang, P Neild, A Poullis, R Pollok. *Department of Gastroenterology, St George's Hospital, London, UK*

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Introduction Visualisation of mucosa at ileocolonoscopy (IC) remains the gold standard in the assessment of mucosal healing (MH) in patients with inflammatory bowel disease (IBD). MH is evolving as a key endpoint in assessing response to therapy. This will invariably mean an increased endoscopic burden on these patients. We aimed to investigate IBD patients' perspectives on this, as well as their tolerance of IC.

Methods Consecutive patients attending IBD clinic between September and December 2013 were questioned on their experience of IC. Data on sex, age, disease type (Crohn's (CD) or ulcerative colitis (UC)), duration of illness, and no. of IC was obtained. They were asked to grade various components of the IC experience (concerns about complications, bowel preparation, disruption to life, procedure discomfort, travel to hospital) on a standardised tolerance scale from 1–5. They were also asked to qualitatively rate their overall experience of IC (not unpleasant/neither unpleasant nor pleasant/bearable/unpleasant/very unpleasant). Finally, they were asked how often they would be prepared to undertake IC in the future.

Results 98 patients responded (46% male). Mean age was 43.2 years. 33 had UC, 50 had CD, and 11 were unsure of diagnosis. Mean no. IC was 3.7. 62% had a disease duration >5 years, with only 4% diagnosed in the previous year. Mean tolerance scores for the group were: concerns about complications 2.6, bowel preparation 3.0, disruption to life 2.4, discomfort during procedure 3.0, travel to/from hospital 1.7. Comparisons between patient subgroups CD versus UC, age ≥55 years versus age <55 years, ≥4 IC versus <4 IC, and diagnosis ≥5 years versus diagnosis <5 years, revealed no significant differences in scores. However, comparison between sexes showed females were more worried about the procedure than males (3.0 vs. 2.1, $p = 0.02$), were less tolerant of bowel preparation (3.5 vs. 2.3, $p < 0.001$), experienced more disruption to their lives (2.9 vs. 1.9, $p < 0.001$) and were more troubled by travel concerns (2.0 vs. 1.4, $p = 0.02$). The majority of the patients felt IC was bearable (53%) with only 13% describing it as very unpleasant. 55% would have the procedure as frequently as required if their physician felt it appropriate. 7% would only have IC every 5 years.

Conclusion Bowel preparation and procedural discomfort are the most bothersome aspects of IC amongst IBD patients. There are clear differences in tolerance between female and male patients, and these results should prompt endoscopy units to find ways of improving patient acceptability. This could be provided in the form of a pre-test telephone consultation. A minority of patients were reluctant to increase their frequency of IC, which may be relevant in the monitoring of MH in their future management.

Disclosure of Interest None Declared.

PWE-071 EFFICACY OF INFLIXIMAB AS SECOND-LINE BIOLOGIC IN CROHN'S DISEASE

[1]E Russo*, [2]R Hackett, [3]S Campbell, [4]JO Lindsay, [5]PM Irving, [6]TR Orchard. *[1]Medicine, Imperial College London, UK; [2]Barts and the London School of Medicine and Dentistry, London, UK; [3]Gastroenterology, MAnchester Royal Infirmary, Manchester, UK; [4]Gastroenterology, Barts and the London NHS Trust, London, UK; [5]Gastroenterology, Guy's and St Thomas' Hospitals, London, UK; [6]Gastroenterology, St Mary's Hospital, London, UK*

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Introduction A common therapeutic strategy in events of failure of the first-line anti-TNFα biologic in Crohn's Disease (CD) is to switch to another biologic agent from the same class. There is a significant body of evidence to support using adalimumab (ADA) as second-line therapy following infliximab (IFX) intolerance or loss of response. The aim of this study is to provide evidence around the use of IFX as second-line therapy in CD, an empirical strategy gaining popularity since both agents have recently been licensed as first line agents for moderate-to-severe CD.

Methods Inflammatory Bowel Disease (IBD) specialists from 5 hospitals were invited to contribute all suitable cases through a secure online questionnaire. Data was gathered on patient demographics, disease extent and behaviour, prior or concurrent therapies, duration and outcome of ADA and IFX therapy and reason for switching. Response to the biologic was determined using Physician's Global Assessment (PGA) by each IBD specialist.

Results Data on 28 patients (10 male) were gathered. Median duration of disease before starting biologics was 4.5years.

Of the 19 patients on ongoing IFX, 5/19 (26%) are on monotherapy 11/19 (58%) are on concurrent immunomodulator 2/19