

Abstract PWE-071 Table 1 demonstrates the aetiology and outcome of Anti-TNF switching.

Reason for stopping ADA	N	Effect of swapping	N on ongoing IFX therapy	Responders' median (range) t on IFX (months)
Primary failure	9	6/9 (66%) Achieved response 3/9 (33%) No response	5/9	8 (3–55)
Secondary loss of response	14	12/14 (86%) Re-captured response 2/14 (14%) Not recaptured response	11/14	24 (4–39)
Intolerance	3	2/3 (66%) Maintained response 1/3 (33%) Lost response	2/3	6 (2–9)
Other	2	2/2 (100%) Maintained response	1/2	13
Total	28	22/28 (79%) Positive outcome	19/28 (68%)	13 (2–55)

(11%) on concurrent mesalazine and 1/19 (5%) are on concurrent steroids.

3 people discontinued IFX following an initial response due to hypersensitivity reaction (2/3) and due to conversion back to ADA due to patient preference (1/3).

Conclusion Using ADA as first-line and IFX second-line for ADA failures is a successful and safe strategy in patients with moderate-to-severe CD.

REFERENCE

Sandborn WJ. *Ann Intern Med.* Jun 19;2007;146(12):829–38

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PWE-072 THE EFFECTS OF ANTI-TNF THERAPY ON GROWTH IN IBD IN SCOTTISH CHILDREN

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Introduction Growth failure is well-recognised in paediatric IBD (PIBD; <18 years). Evidence (usually case series from single/multiple centres) shows anti-TNF therapies improve linear growth. We aimed to examine if anti-TNF therapy improves growth in a PIBD population-based cohort.

Methods Retrospective review of all children receiving anti-TNF (infliximab (IFX) and adalimumab (ADA)) from 2000–2012 in paediatric services in Scotland. Height (Ht), weight and Tanner stage were collected at 3 times: 12 months before anti-TNF (T-12), start of anti-TNF (T0) and 12 (T+12) months after anti-TNF. Ht and growth were converted into standard deviation scores (SDS) and height velocity (HV, cm/ year) were calculated. **Results** 97/201 PIBD cases (3ADA, 94 IFX) had 12 month growth data, 58 (59%) males and 90 (93%) Crohn's disease (CD); 84 (87%) received immunomodulators and 47 (48%) corticosteroids at T0. Median age at diagnosis was 10.3 years. In IFX treated, mean Ht SDS T-12 was -0.67 +/-1.1; improvement was then seen from T0 -0.82 +/-1.1 to T+12 -0.74 +/-1.1 (p = 0.031). Mean ΔHtSDS improved from -0.16 +/-0.38 at T0 to 0.08 +/- 0.36 at T+12 (p < 0.001) with HV improving from

3.9 cm/yr +/-2.5 at T0 to 5.0 cm/yr +/-2.9 (p = 0.003). 56 (60%) entered remission, HtSDS improved from -0.77 +/- 1.1 at T0 to -0.56 (+/-1.1) at T+12 (p = 0.0004). ΔHtSDS improved from T0 -0.14 (+/-0.04) to 0.21 (+/-0.04) at T+12 (p < 0.001) and HV from 4.0 cm/yr (+/-2.3) at T0 to 5.6cm/yr (+/-2.9) at T12 (p = 0.003).

44/94 IFX (48%) were Tanner stage 1–3; 40 CD. Mean HtSDS decreased from -1.0 (+/- 1.1) at T-12 to -1.2 (+/-1.3) at T+12 but, HV 3.6 cm/yr (+/-2.1) at T0 improved to 5.5cm/yr (+/-2.7) at T12 (p < 0.001). In Tanner 4and5, no change in HtSDS or ΔHtSDS was seen.

61 (65%) had disease for ≥2 years at start of IFX, HtSDS improved from -0.77 +/-1.2 at T0 to -0.65 +/-1.2 at T+12 (p = 0.007) whilst disease <2 years (n = 33) had no change; HtSDS -0.93 +/- 0.97 at T0 and -0.92 +/-0.89 at T+12 (p = 0.89). Improvement was seen in height velocity in ≥ 2; years HV 4.1 +/-2.5 at T0 and 5.0 +/-2.9 at T+12 (p = 0.039) compared to HV <2 years 3.6 +/-2.3 at T0 and 4.8 +/-3.0 at T+12 (p = 0.08). Greater improvement in ΔHtSDS in ≥2 yrs; ΔHtSDS at T0 -0.12 +/-0.35 improved to 0.12 +/-0.33 at T+12 (p < 0.001) vs. -0.22 +/-0.43 at T0 to 0.16 +/-0.4 (p = 0.018) for <2 yrs.

In UC (n = 7) no change was seen in ΔHtSDS or HV at T-12, T0 or T+12 (p 0 >0.05).

Conclusion Improvements in HtSDS and height velocity at 12 months were seen in the whole cohort. In Tanner 1–3 improvement was only seen in HV after 12 months with no improvement in Ht sSDS. No improvement in height noted in UC. Further follow up will determine if growth improvement is maintained or further improves.

Disclosure of Interest None Declared.

PWE-073 ARE WE USING ANTI-TNF EARLY ENOUGH IN CROHN'S DISEASE IN THE UK?

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Introduction Anti-TNF (a-TNF) prescription is tightly controlled by NICE guidelines and reserved for severe or resistant Crohn's disease in the UK, with annual review of ongoing prescription required and discontinuation for patients in remission.

Methods Retrospective review of 135 patients with Crohn's disease who have received anti-TNF at UHNS.

Results 135 patients received a-TNF; 51 male, 84 female with a mean age of 29 at diagnosis. 28% of patients smoke. Table 1 shows most advanced stage of disease at diagnosis and when a-TNF started.