

restricted its utilisation. A murine model has provided evidence that splitting a normal daily dose of TG could prevent exposure of the liver to harmful levels of TG; furthermore safety has not been an issue in human studies with low dose TG.

**Methods** We report from two centres on a retrospective experience of the safety and efficacy of an oral split-daily TG dose regimen, to avoid any individual dose  $>0.3$  mg/kg, in 62 IBD patients who were unresponsive or had suffered adverse drug reactions to conventional therapies including thiopurines (60), biologics (18) and calcineurin inhibitors (17). Clinical response was measured using the Harvey Bradshaw Index for Crohn's, or the Simple Clinical Colitis Score for ulcerative and indeterminate colitis. Patients were followed regularly in clinic with bloods, liver biopsy (9) and progress ultrasound at 6 months (21) or MR imaging (2).

**Results** Median duration of TG treatment was 7.8 (0.3–45) months. Median TG dose used was 0.6 (0.3–1) mg/kg/d. Of patients attaining 6 months of TG therapy, 91% (19/21) of Crohn's patients and 71% (27/38) with ulcerative or indeterminate colitis had a clinically significant response, off steroids. At study end, 33 (53%) patients maintained their good clinical response off steroids; 12 of these had continued with concomitant biologic or calcineurin inhibitor therapy.

Previous thiopurine-related adverse reactions were not encountered. 29 (47%) patients withdrew from the study because of loss to follow-up (5), medical adverse events (2) or surgery (22). Possible early NRH was found on liver biopsy in 1 patient who was heterozygote-deficient for thiopurine methyltransferase (TPMT); the patient continued TG at a lower dose. TG was discontinued in a patient found to have NRH and concomitant anti-phospholipid syndrome. There was one successful term pregnancy; cord blood and breast milk TG were low.

**Conclusion** A split-dose regimen of TG appeared well-tolerated, efficacious and safe for selected IBD patients. Close monitoring, knowledge of TPMT and exclusion of risk factors for NRH prior to treatment are warranted to maximise safety.

## REFERENCES

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**Disclosure of Interest** None Declared.

## PWE-094 SETTING STANDARDS BY DEFINING THE AIMS AND OPTIMAL DESIGN OF THE INFLAMMATORY BOWEL DISEASE (IBD) MULTIDISCIPLINARY TEAM (MDT) MEETING

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**Introduction** The National IBD Audit revealed 75% of participating institutions undertake a weekly MDT meeting for IBD patients. There is however little evidence of its efficacy in this context and currently there is no guidance on how this intervention may be standardised and used effectively.<sup>1–3</sup> Providing a standardised framework for the IBD MDT meeting will enhance its capacity to establish effective quality improvement. The aim of this study is to use national expert consensus to define the aims, optimal design, format and function of an IBD MDT meeting.

**Methods** 25 semistructured interviews were undertaken with a multidisciplinary sample (5 surgeons, 5 gastroenterologists, 5 IBD nurse specialists, 5 pathologists and 5 radiologists), from 2 UK regions: the Southwest of England and London. Interviews were audiotaped and transcribed verbatim. A standardised interview protocol with a clearly defined coding framework was used. The interview protocol explored key themes encompassing the optimal design format of the IBD MDT:

1. Purpose
2. Processes
3. Logistics
4. Redesign

**Results** 28 interviews were performed across a multidisciplinary sample of healthcare professionals. Thematic analysis and coding demonstrated common markers for each theme. High ranking markers for each theme included:

1. Purpose: *Requires multi-disciplinary input; to share collective expertise; and to improve patient outcome.*
2. Processes: *Good attendance; sharing workload with colleagues; proactive discussions; core members being clinicians, surgeons, radiologists, pathologists and nurse specialists all with IBD interests; facilities required including IT and an appropriate space to meet; provisions for internal feedback to the IBD MDT on MDT decision outcomes; submitting names in advance; an MDT coordinator.*
3. Logistics: *Duration of 1 h; once a week; protected time; selective cases.*
4. Redesign: *Single centre each running their own IBD MDT; 'hub and spoke' model.*

**Conclusion** Defining key elements for an optimal design format for the IBD MDT is necessary to ensure quality of care and reduce variation in care standards. This study demonstrates the methodology used for construction of provisional standards for the IBD MDT through interviews from a multidisciplinary group. Selection and adjustments of these standards through expert consensus are required to validate measures.

## REFERENCES

- 1 UK IBD Steering Group 2007 IBD Audit 2006: National Results for the Organisation and Process of IBD Care in the UK
- 2 Group 2009 IBD Audit 2008: National Results for the Organisation and Process of IBD Care in the UK
- 3 IBD Standards Working Group 2009 Quality Care: Service Standards for the Healthcare of People who have Inflammatory Bowel Disease (IBD)

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## PWE-095 FAECAL CALPROTECTIN IS USEFUL IN PREDICTING LONG TERM DISEASE RECURRENCE IN POST-OPERATIVE CROHN'S

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**Introduction** The concept of using faecal biomarkers to predict prognosis and direct treatment in patients with Crohn's disease is attractive but long term follow-up data is lacking.

A cohort of 51 patients with previous ileal resections for Crohn's disease provided a one-off stool sample for faecal calprotectin (FC). These patients were followed up for 5 years to assess whether FC could predict disease progression in the long term.

**Methods** Patients were identified from a database of patients who had participated in a previous study evaluating the use of