features of Crohn's on histology, whilst the remaining 27 had mildly active ileitis on histology. 22 of these 27 patients underwent additional investigations to confirm (19/22) or exclude IBD (3/22). 5 of the 27 patients with histological ileitis that was not typical of CD were diagnosed with IBD, without further evidence to demonstrate this. In total 35/38 (92.1%) patients with histological and endoscopic evidence of inflammation were diagnosed with CD. Of the 18/56 patients (32%) with TI on endoscopy but normal histology, 9 had further investigations including MRI, barium studies and US abdomen to exclude CD. 4 patients were diagnosed with CD despite normal histology. 6/18 patients with normal histology were lost to follow up, although all patients diagnosed with IBD were followed up in GI clinic.

Conclusion We conclude that although the majority of patients with TI on endoscopy have CD, 1/3 of our patients had no histological correlation of inflammation. 16% of patients with endoscopic TI with mildly active ilieits on histology had no further imaging to authenticate a diagnosis of CD and 8% of patients with normal histology with no further investigations were labelled as CD. The latter group of patients may be inaccurately labelled with a diagnosis of CD and along with this the potential stigma associated with a chronic ailment, risk of escalation therapy with immununosuppressives/biologics and occasionally unnecessary surgery.

Disclosure of Interest None Declared.

PWE-104 THE FINANCIAL IMPACT OF A NURSE-LED IBD (INFLAMMATORY BOWEL DISEASE) TELEPHONE ADVICE SERVICE, IN A LARGE DISTRICT GENERAL HOSPITAL

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Introduction It has become increasingly recognised that outpatient management is more cost effective in IBD.[1] IBD Standards (Revised 2013) recommend telephone advice for patients with regards to symptoms and medication management. This report attempts to quantify the net financial impact of this service at our hospital since it was introduced in August 2013.

Methods The Royal Alexandra Hospital in Paisley is a District General Hospital with a catchment population of 200,000[2] with approximately 2500 IBD patients. Data relating to the use of the Telephone Advice service was prospectively recorded on a daily basis for a period of 5 months. We Documented reasons for calling and the likely action taken by the patient had the telephone advice line not been available. Cost savings based on alternative outcomes were made in accordance the Department of health figures.[3]

Results The mean calls per month was was 88 [IQR 24] – (Mean calls which were deemed Non-IBD issues was, was 30 calls per month [IQR 8.0]) The mean cost of staffing the IBD advice line with an IBD Clinical Nurse Specialist was £482.00 per month [IQR 195.5]. The mean time spent on calls per month was 28.5 h [IQR 11.5]. Cost Savings over 5 months for avoidance of GP consultation was £3408.00. Savings for avoidance of a consultant appointment made over the 5 month period was £27454.00. Savings made from patients avoiding either an A+E or Hospital Admission were £540.00 and £11488.00 respectively over the 5 month period. The net saving was £42890.00.

Conclusion A Nurse-Led telephone advice line appears to be a cost effective intervention. It may prevent patients from unnecessary hospital attendance. Savings can be made to both primary and secondary care. Overall, it appears that the advice line is providing a highly valuable service, not just in terms of accessible treatment decisions and guidance for patients, but cost savings when Specialist Nurse time is compared to General Practitioners, Consultants or hospital facilities.

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Disclosure of Interest None Declared.

PWE-105 BIOLOGICAL WORLD OF IBD, IS IT ONLY SAFE IN TERTIARY CARE CENTRES?

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Introduction Inflammatory bowel disease (IBD) has a prevalence of 400 per 100,000 with approximately 240,000 patient with IBD in UK. It is triggered by a combination of environmental, genetic and immunoregulatory factors including a dysfunctional mucosal immune response.

In the last 15 years, the introduction of biologicals has dramatically changed the landscape with improving natural history and outcome of IBD. Many multi-centre trials have confirmed the efficacy of both Infliximab (IFX) and Adalimumab (ADA) in the management of IBD. These drugs are however not without side effects and need close monitoring in specialist IBD clinics. We share our experience from a large-sized DGH [>400,000 population] in Northwest England with a dedicated IBD service and experience in the use of biologicals in IBD patients since 2000.

Methods We interrogated and audited our IBD data base and collected all the patients who were or had been on biologicals. The data goes back to the year 2000.

Results The basic demographics showed total of the 90 patients; 42% female. The mean age was 42.4 (female) vs. 39.3 yrs (male). Age at the time of diagnosis of IBD was 31.1 yrs for females and 32.4 years for males. 53% had crohn's disease and rest were UC. Patients with UC had higher body weight vs. crohn's disease with a mean of 76.1 vs. 67.6 kg respectively. 58% had Ileoceacal Crohn's of which 73% were males. 62.5% of females with UC had pan colitis vs. 42% males.

All patients were fully informed and consented prior to the initiation of biological therapy. 89% of the patients were on immunomodulators prior to biological therapy. 93% of the patients with UC were on infliximab with 5% on Adalulimab. 1 pt was on Basiliximab which was changed to infliximab. Those with crohn's disease, 83% were on Infliximab and 17% on Adalulimab. Infliximab was stopped in 30% due to either no further clinical need or change to Adalulimab and of these 6% due to adverse events. In the ADA group 2% stopped due to lack of clinical inefficacy. The median duration of biologicals was 38.2 months, maximum duration 156 months.

Conclusion In the context of IBD, biological drugs in a dedicated IBD service are highly efficacious. In our centre, paucity of adverse event maybe due to our cohort of patient population with little background incidence of TB. In contrast to the UK IBD audit, we had more usage of biologicals in the context of UC, of which 50% had pan colitis. Our experience shows that a treating IBD effectively and

safely requires a dedicated service as outlined in BSG guidelines for IBD, and not necessarily a tertiary care referral!

Disclosure of Interest None Declared.

PWE-106 SMALL INTESTINE ULTRASONOGRAPHY WITH ORAL CONTRAST (SICUS) FOR THE DETECTION OF SMALL BOWEL COMPLICATIONS IN CROHN'S DISEASE: CORRELATION WITH INTRA-OPERATIVE FINDINGS

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Introduction SICUS accurately assesses small bowel lesions in patients with Crohn's disease (CD) without exposure to diagnostic medical radiation.[1] Its role in identifying intra-abdominal complications associated with CD remains to be confirmed. The aim of this retrospective study was to compare the diagnostic sensitivity of SICUS with subsequent surgical findings.

Methods Patients with CD evaluated by SICUS who subsequently required bowel resection within 6 months were identified. Radiological findings and operation notes were collated. The accuracy and agreement of SICUS to detect the site and length of strictures, fistulae, abscesses and mucosal thickening, was compared with surgical findings and assessed by kappa (κ) coefficient statistical analysis. Stricture lengths were compared using student's t-test. CRP and platelet count were recorded within 2 weeks of SICUS and surgery as surrogate markers of disease activity.

Results A total of 25 patients (12 male) with a mean age of 29.9 years were included in the study. Mean time from SICUS to respective bowel surgery was 91.5 days (Range 5–176). Ultrasonographic and surgical inter-rater agreement was good for the presence of strictures (κ=0.73, sensitivity and specificity both 88%), their number (κ=0.65, 95% CI: 0.31–0.96) and stricture site (κ =0.72, 95% CI: 0.44–1.00). Stricture length was 7.4 ± 1.5 cm identified at surgery vs. 5.8 ± 1.8 cm by SICUS (NS). Agreement was excellent for the presence of fistulae (κ = 0.82, sensitivity 86%, specificity 94%), location of fistula (κ=0.92, 95% CI: 0.76–1.00), presence of abscess (κ = 0.87, sensitivity 100%, specificity 95%) and its location (κ = 0.87, 95% CI: 0.63–1.00). Agreement was moderate for mucosal wall thickening (κ = 0.51, sensitivity 95%, specificity 50%). Markers of inflammation (CRP and platelet count) showed no significant difference at the time of SICUS and surgery.

Conclusion SICUS accurately identifies small bowel complications in CD and offers an alternative in the pre-operative stage of CD complications. Its wider use should be adopted.

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Disclosure of Interest None Declared.

PWE-107 ACCURACY OF MAGNETIC RESONANCE ENTEROGRAPGY IN PREDICTING ANASTOMOTIC STENOSIS IN RECURRENT CROHN'S DISEASE

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Abstract PWE-107 Table 1 Baseline characteristics

	Median	Range
Age (years)	44	29–71
Disease duration (years)	23.5	5–45
Time since last resection (years)	7	4–25
Time between MRE and endoscopy (days)	46	3–144

Introduction Up to 80% of patient with Crohn's disease (CD) undergo intestinal resection, commonly an ileocaecal resection. Eighty percent of patients develop endoscopic recurrence at the anastamotic site at 1 year and 50% develop clinical recurrence at 3 years. The severity of endoscopic recurrence varies from no endoscopic lesions to anastamotic stenosis and/or diffuse inflammation. Direct endoscopic visualisation is recommended to detect recurrence but it is invasive. Magnetic resonance enterography (MRE) has become a standard imaging investigation for CD but only few studies have evaluated its utility in recurrent anastamotic stenosis. Accurate characterisation of recurrence grade is critical as strictures up to 5cms can be successfully treated with endoscopic balloon dilatation. We evaluated the utility of MRE in the assessment of anastamotic stenosis in recurrent CD.

Methods This retrospective study was done at the Royal Liverpool Hospital and included all CD patients who underwent endoscopic balloon dilatation for anastomotic stenosis between 2009–2013. Patients who had an MRE done within 6 months of the endsocopic procedure were eligible for inclusion. MRE was done following administration of oral polyethylene glycol solution and sequences were analysed for the presence of stenosis, length of stenosis, pre-stenotic dilation and the presence of enhancement by an experienced gastrointestinal radiologist. The length and presence of stenosis was extracted from the endoscopy report and correlated against the MRE findings.

Results 16 patients were included in the study (5 male, 11 female). There was good agreement between endoscopy and MRE for the presence of anastamotic stenosis. Using endoscopy as the gold standard, the sensitivity and specificity of MRE in detecting anastomotic stenosis was 86% and 100% respectively. A significant variation was noted in the length of stenosis as assessed by MRE (45 ± 12 mm, mean ± SE) and endoscopy (20 ± 3 mm, mean ± SE), two sided $p < 0.05$. All patients underwent successful endoscopic dilatation.

Conclusion MRE is an accurate tool for predicting the presence of anastomotic stenosis in recurrent CD. However, the discrepancy observed in the length of stenosis between the two modalities may mean suitable patients for endoscopic dilatation are missed. Therefore, endoscopy and MRE should be used as complementary tools in the assessment of anastamotic stenosis.

Disclosure of Interest None Declared.

PWE-108 FACTORS INFLUENCING THE MANAGEMENT OF INFLAMMATORY BOWEL DISEASE IN PRIMARY CARE

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Introduction Between 30–70% of United Kingdom (UK) adults with Inflammatory Bowel Disease (IBD) are managed solely by