

## Results

Abstract PWE-112 Table 1

Male : female	34% : 66%
Age range	16–89 years
Mean age	41.7 years
FBC in past year	100%
Proportion anaemic patients	23%
If anaemic, were iron studies done	91.3%
Was the patient on iron if appropriate?	80%
Recommended type of iron?	100%
Was Hb rechecked after 4 weeks	81.2%
If Hb did not rise, was IV iron given?	100%

**Conclusion** Our study demonstrated good compliance with national guidance in screening for anaemia annually in IBD patients. Appropriate iron preparations were given in all patients. Only 81% patients commenced on iron had Hb rechecked after 4 weeks. Our study showed similar prevalence of iron deficiency in IBD patients to other studies but better detection and treatment (3).

We have a full-time IBD Specialist nurse who monitors patients' tolerance of iron supplements. Patients are advised to telephone if they have side effects of medications and are not able to tolerate them. The presence of a nurse may improve bloods monitoring and iron prescription but may not be a service that can be provided nationally. Our IBD clinics are run by consultants only, which may also facilitate adherence to guidelines.

## REFERENCES

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**Disclosure of Interest** None Declared.

## PWE-113 DIAGNOSTIC BENEFIT OF MRE FOLLOWING CT

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**Introduction** In patients presenting with symptoms suggestive of IBD (abdominal pain and/or diarrhoea) in common with ECCO guidelines colonoscopy is the first line test at our institution. In our practice magnetic resonance enterography (MRE) is then performed in those patients where there is a continuing clinical suspicion of small bowel Crohn's disease.

However in patients who present to non-IBD physicians Computed tomography of the abdomen and pelvis with contrast (CTAP) is often the first line investigation.

In this situation MRE is commonly performed to exclude small bowel disease following review in the gastroenterology clinic. We are not aware of studies that have evaluated the additional diagnostic yield of MRE in this clinical scenario.

**Aim** to establish the additional diagnostic yield of MRE in patients previously investigated with CTAP and ileo-colonoscopy.

**Methods** Our radiology department maintain a prospective electronic database. We searched for all patients who underwent CTAP followed by MRE within the same 12 month period between February 2005 and February 2013. Electronic medical records were then reviewed.

**Results** 80 patients were identified. The mean age at time of MRE was 49 (range 17–87), 45 (56%) were female. Indication for these investigations were: assessment of known Crohn's disease; 18 (23%), abdominal pain; 34 (43%). Mean time between CTAP and MRE; 127 days (range 3–352). Final diagnosis was Crohn's disease; 37 (45%), coeliac disease; 4(5%), irritable bowel syndrome 4(5%). In 11(14%) MRE added further information or changed the management for the patient. Of this group in 3 patients MRE identified terminal ileal (TI) inflammation that was not identified at CTAP. In two of these cases ileal-colonoscopy collaborated TI inflammation and in the third case capsule enteroscopy confirmed TI inflammation. In all three the final diagnosis was Crohn's disease. Overall MRE identified one (1.25%) patient with possible CD that was missed at CTAP and ileo-colonoscopy.

**Conclusion** In this study the diagnostic yield of MRE in patients previously investigated with ileo-colonoscopy and CTAP was low. This suggests that MRE has a limited diagnostic role in this specific situation and should be reserved for those patients where clinical suspicion remains high despite negative CTAP and ileo-colonoscopy or to further define complex disease.

**Disclosure of Interest** None Declared.

## PWE-114 THE IBD-CONTROL QUESTIONNAIRE: MULTI-CENTRE VALIDATION PLUS EVALUATION IN ROUTINE CARE

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**Introduction** Routine capture of reliable, patient-centred health status measures for IBD has not become part of standard practice. The IBD-Control questionnaire is a short (13 item), generic patient-reported outcome measure which we developed to support routine care.<sup>1</sup>

**Methods** To further define performance in varied settings, we undertook: (A) A prospective study at an inner city teaching hospital and a DGH, to show reproducibility of psychometric properties. Clinic patients completed IBD-Control and the local IBD team recorded activity index, global physician assessment and treatment. (B) A prospective endoscopic study, with IBD-Control prior to endoscopy and Mayo score of mucosa. IBD teams were blinded to questionnaires. (C) A service evaluation in our unit, auditing implementation of IBD-Control to support a new virtual (telephone) clinic – a case study on integrating PROMs into routine care.

**Results** 113 IBD-Control questionnaires returned to date. Patients:

Age, mean [sd]: 50 [16] yrs; Female: 54%; UC: 73%; Disease duration, mean [sd]: 7.5 [7.7] yrs. Global Physician Assessment: Inactive 48.3%; Mild 41.3%; Moderate 10.3%; Severe 0%. Summary scores, mean [sd]: IBD-Control-8 (range: 0–16): 11.7 [5.2]; IBD-Control-VAS (range: 0–100): 73.5 [76.1]. Psychometric properties: *Completion rate*: 93–94% per item; Strong correlation between the 2 summary scores: IBD-Control-8 vs IBD-Control-VAS,  $r = 0.83$ ; *Validity* of summary scores,

IBD-Control-8 [IBD-Control-VAS]: (1) *Simple Clinical Colitis Activity Index*,  $r = -0.77$  [-0.72]; (2) *Harvey Bradshaw Index*,  $r = -0.91$  [-0.78] (3) *Mayo Score*,  $r = -0.64$  [-0.69]; (3) *Global Physician Assessment*, mean scores differed significantly across categories for both scores (inactive > mild > moderate;  $p < 0.01$ , ANOVA). Service Evaluation: 64 'delayed follow-up or DNA' patients invited for postal return of PROM then 4–6 wk review, with 59% return rate ('active disease' indicated in 10%). Telephone consultation in 63%. Unplanned care occurred in 2 respondents within 30 days, both with IBD-Control indicative of active disease.

**Conclusion** IBD-Control has strong measurement properties and is easy to administer. Our experience of integrating IBD-Control into non-face-to-face follow-up clinics suggests that using a validated PROM to support care is acceptable to patients and achievable.

#### REFERENCE

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**Disclosure of Interest** None Declared.

#### PWE-115 PATIENTS CONTINUE TO TRAVEL ABROAD DESPITE RECENTLY ACTIVE DISEASE AND TRAVEL CONCERNS: RESULTS OF A SINGLE CENTRE STUDY IN INFLAMMATORY BOWEL DISEASE AND TRAVEL

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**Introduction** Travellers with Inflammatory bowel disease (IBD) are at greater risk of travel-related morbidity.<sup>1</sup> Relapse and acquired infection are the main risks to IBD patients while abroad, and ECCO recommend expert consultation prior to travel, particularly for those on immunosuppression.<sup>2</sup> IBD limits a majority of patients choice of travel destination.<sup>1</sup> Despite this, there is limited data regarding IBD patients pre-travel preparation and travel experiences.

**Methods** Patients attending our IBD clinic during November 2013 were asked to complete an anonymous questionnaire. We asked for demographic and disease specific information, in addition to detailed travel questions; including perceptions, pre-travel planning and recent travel experiences. Data was entered and analysed on an anonymised database. We hypothesised that patients with travel concerns and those who had flared within the last 6 months would be less likely to go abroad in that same period.

**Results** A representative 136 IBD patients (67/136[49%] Crohn's disease, 60/136[44%] male, age 18–85 years [median age 38 years]) responded. 51%[69/136] were immunosuppressed and 43%[49/136] had IBD related surgery. 62%[84/136] experienced an IBD flare in the last 6 months. 60%[82/136] reported IBD affected travel. 58%[79/136] travelled in the last 6 months, despite a majority of those (65%[51/79]) reporting IBD affected travel. 59%[47/79] of travellers had experienced a flare in the last 6 months, although again, most of those (77%[36/47]) reported IBD affected travel. Only 18%[14/79] travellers (71% [10/14] had a recent flare) sought pre-travel medical advice of any kind and only 41%[32/79] (69%[22/32] had a recent flare) had travel insurance, the majority (88%[28/32]) paid a premium. 20%[16/79] travellers reported a change in bowel habit while

abroad, but of those only 27%[3/11] sought medical advice. We also report that 52%[36/69] of immunosuppressed patients are unaware of the need to avoid live vaccines.

**Conclusion** A majority of IBD patients feel their disease affects travel. However, despite concerns, patients still travel abroad, even if they have suffered a recent flare. Our results suggest patients are not receiving the recommended travel medical advice, including the need to avoid live vaccinations if immunosuppressed, and are possibly under or not insured. The small numbers of travellers suffering a change in bowel habit abroad tend not to seek medical advice while away. Further detailed investigation in travel behaviour in IBD patients is required, but we suggest there is a need for greater IBD travel education.

#### REFERENCES

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#### PWE-116 ASSOCIATION OF FAECAL CALPROTECTIN WITH EXTENT AND DISTRIBUTION OF INFLAMMATION IN IBD

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**Introduction** Calprotectin is a protein released by neutrophils in response to the presence of inflammation in the bowel.<sup>1</sup> Faecal calprotectin (FC) has been shown to be useful in the diagnosis of inflammatory bowel disease (IBD) as it correlates with mucosal disease activity and can help to predict response to treatment or relapse.<sup>1–3</sup> Data from small, selected case series have observed FC correlates better with colonic rather than ileal Crohn's disease (CD)<sup>4</sup> and median FC concentrations are higher in extensive or left-sided ulcerative colitis (UC) disease than in proctitis.<sup>5</sup> We report the association of FC concentration with extent and distribution of inflammation in consecutively performed tests at our centre.

**Methods** All FC tests performed between 01/07/12 and 31/12/12 were systematically collected and associations with activity and distribution using endoscopic, histological and radiological data explored. Proximal disease was defined as inflammation affecting the terminal ileum and ascending colon; left-sided disease as inflammation limited to the colorectum distal to the splenic flexure and pan-colitis with inflammation extending proximal to the splenic flexure.

**Results** 203 (n = 160 CD; n = 43 UC) patients with IBD had FC tests performed of whom 96 (47.3%) had endoscopic, histological or radiological evidence of active disease. The mean age of IBD patients was 44.7 (SD 17.0) years and 58% were female. The mean FC concentration was significantly higher in patients with active pan-colitis (1038.1 iu (SD 1104.1)) than in active left-sided disease (mean 820.2 iu (SD 1535.1));  $p = 0.01$ . The mean FC concentration was significantly higher in active pan-colitis than in active proximal disease (mean difference -669.3 iu (95% CI-1046.3, -292.4));  $p = <0.001$ . There was no significant difference in the mean FC concentration between active proximal or left-sided disease (mean difference -451.5 (95% CI -965.9, 62.9) or between CD and UC (mean difference 148.5 (95% CI-369.1–666.1).

**Conclusion** Mean FC concentrations are significantly higher in active pan-colitis than in active left-sided or proximal disease, perhaps reflective of the greater extent of inflammation.