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.[1] 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.[2] IBD limits a majority of patients choice of travel destination.[1] 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.

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Disclosure of Interest None Declared.

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.[1] 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.[1–3] Data from small, selected case series have observed FC correlates better with colonic rather than ileal Crohn's disease (CD)[4] and median FC concentrations are higher in extensive or left-sided ulcerative colitis (UC) disease than in proctitis.[5] 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.