PTU-076 MANAGEMENT OF INFLAMMATORY BOWEL DISEASE (IBD) IN PREGNANCY IN THE NORTHERN DEANERY

C Parker*, M Gunn. *Gastroenterology, Royal Victoria Infirmary, Newcastle Upon Tyne, UK*

10.1136/gutjnl-2014-307263.150

Introduction A European consensus on issues surrounding IBD in pregnancy was published in 2010.[1] We conducted a questionnaire to gain information about knowledge and management of IBD in pregnancy in the Northern region in both gastroenterology consultants and specialist trainees.
Methods A questionnaire assessing the management of IBD in pregnancy and pre-conception was devised. 34 questionnaires were given out at a joint trainee and trainer teaching session and were completed anonymously.
Results 34 questionnaires were returned; 16 consultants, 14 trainees, 4 not specified.
Pre-conception 22/34 (65%) routinely ask women of childbearing age about intentions to conceive, 16/34 (47%) routinely ask about contraception. If intending to conceive 24/34 (71%) would routinely give supplements (19/24 (79%) specified folate).
Pre natal 29/34 (85%) would routinely refer to obstetrician on discovery of pregnancy, 24/34 (71%) would see more frequently during the pregnancy. 27/34 (79%) would advise Caesarean section (CS) in certain patient groups; 2 would not advise CS and 5 did not know. The suggested indications for CS by respondents were: perianal disease (24) ileoanal pouch (6), previous CS (1), uncontrolled disease (1), previous surgery (2). 20/34 would recommend the flu jab in pregnancy.
Postnatal 10/34 (29%) were aware of live vaccinations that may be contraindicated in a neonate (7/10 were trainees).
Medications specific questions were asked about which medications would be recommended to be stopped in the pre and antenatal periods and which were considered safe in breastfeeding (See Table).
Conclusion Within the North East Region there is a varied consensus to the management of IBD preconception and during pregnancy both in terms of medication and indication for surgery. This is despite the European consensus document. There are areas which could be improved; only 6 of 27 who would consider CS in certain groups would consider it for ileoanal pouch and although this should be tailored to each individual patient guidelines would suggest that CS be strongly considered in those with a pouch and perhaps further education in this area would be beneficial. Although the majority would ask about plans for conceiving, discussion of contraception occurs in less than half of consultations. We would advocate a combined approach for these patients in conjunction with an interested gastroenterologist and obstetrician in order to optimise management and outcomes.

REFERENCE

1 Janneke van der Woude *et al*. *J Crohns Colitis* 2010:4:493–510

Disclosure of Interest None Declared.

PTU-077 NOVEL TECHNIQUES TO UNRAVEL THE IMMUNE MECHANISMS DRIVING INFLAMMATORY BOWEL DISEASE

[1]P Wright, [1]H Wessel, [1]S Milling, [2]D Gaya*. *[1]Infection, Immunity and Inflammation, University of Glasgow, UK; [2]Gastroenterology Unit, Glasgow Royal Infirmary, Glasgow, UK*

10.1136/gutjnl-2014-307263.151

Introduction The inflammatory bowel diseases (IBD), ulcerative colitis (UC) and Crohn's Disease (CD) occur when failures of immune regulation result in an accumulation of immune effector cells that damage the intestine. A detailed understanding of these processes has heretofore been hampered by difficulties in obtaining phenotypic and functional analyses of the multitude of closely-related immune cells present in both normal and in the diseased intestine. Here we show data from our recently-developed 12-parameter flow cytometric analyses of leukocytes from blood and intestinal biopsies. We anticipate that this approach will enable us to identify immune mechanisms causing or controlling IBD.
Methods After written informed consent was obtained, endoscopic biopsies from the colon and/or terminal ileum were obtained from patients with UC, CD, or from unaffected individuals attending for polyp surveillance colonoscopies. Blood samples were obtained from UC or CD patients attending IBD clinics, or from healthy volunteers. Live single cell suspensions were prepared, and were prepared for flow cytometric analysis, focusing on dendritic cell and T cell populations. Data were analysed using FlowJo software. Differences were analysed by Mann-Whitney or ANOVA, with post tests to assess significance.
Results We have developed novel and reproducible methods for purification of live cells from fresh colonic and ileal biopsies, and for enumerating of T cell and antigen presenting cell populations using 10-colour flow cytometry. We have compared data from IBD patients and healthy controls. Initial analyses of intestinal dendritic cell populations ($CD45^+$ $CD14^-$ $CD64^-$ $CD11c^+$ MHC class II^+) have identified three distinct subsets based on CD103 and SIRPα expression. Our preliminary data indicate that dendritic cells are differently distributed along the intestine. Analyses of intestinal T cells ($CD45^+$ $CD3^+$ $CD4^+$, $CD25^{+/-}$ $CD45RA^{+/-}$) have revealed the proportions of naïve, activated, memory, and regulatory T cells expressing the chemokine receptors CCR6, CCR9, CXCR3 and CCR10 in each population.

Abstract PTU-076 Table 1

Drug	Would stop preconception	Would stop in the antenatal period	Would consider safe for breastfeeding
5ASA	1 (3%)	1 (3%)	25 (74%)
Azathioprine	3 (9%)	2 (6%)	22 (65%)
Methotrexate	31 (91%)	28 (82%)	1 (3%)
6mercaptopurine	2 (6%)	2 (6%)	18 (53%)
AntiTNF	6 (18%)	6 (18%)	1 (3%)
Prednisolone	5 (15%)	4 (12%)	18 (53%)
Don't know	3 (9%)	6 (18%)	7 (21%)