

Results 65 cases of abdominal TB were identified. Average age was 42 years (range 18–97). 49.2% females and 50.8% males. Ethnicity and mean ages are outlined in Table 1.

The mean age of European Caucasians was significantly older than from combined black and minority ethnic (BME) groups (72.4 v 39.5, $p = 0.016$). The number of cases over the 10 year period has remained stable, with an average of 6.5 per year (range 4–10). 13.85% were HIV positive. all in BME patients (1 South Asian, 8 Africans).

Conclusion Abdominal TB remains an active disease in London, affecting a wide range of ages and ethnicities, with the majority of patients South Asian and African, in accordance with national data. It should be considered as a differential in all patients, but particularly those who are at high risk. It presents as a disease of elderly Europeans and young BME groups. A significant number of BME group patients have HIV infection.

Disclosure of Interest None Declared.

PTU-091 ANTI-TNF THERAPY REDUCES IONISING RADIATION EXPOSURE IN PATIENTS WITH CROHN'S DISEASE

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Introduction Patients with Crohn's Disease [CD] are often exposed to ionising radiation for the diagnosis and evaluation of disease with inherent risks from protracted exposure. Meanwhile, bolder definitions of disease control have changed treatment paradigms with earlier introduction of biological therapy in many. Our aim was to compare the effective radiation dose a year prior and 1 and 3 years after initiating anti-TNF therapy or corticosteroid.

Methods We performed a retrospective review of CD patients treated with anti-TNF (infliximab or adalimumab) or corticosteroids at our institution from 2005 to 2013. Clinical data (demographics, disease characteristics, treatment) were obtained from patient records. All instances of imaging in the previous year and 1 and 3 years after initiation of therapy were recorded. Effective and cumulative radiation doses were calculated from published tables [Royal College of Radiologists, UK].

Results We analysed 170 patients with CD (114 anti-TNF, 56 corticosteroid). In the anti-TNF group, 55% were female (median age 35 yrs; mean disease duration 8.2yrs). Disease location was ileal (46%), colonic (21%), ileocolonic (31%) and perianal (22%) with inflammatory, stricturing and penetrating disease in 63%, 14% and 23% respectively. In the corticosteroid group, 53% were females (median age 48; mean disease duration 13.2yrs). Disease location was ileal (44%), colonic (27%), ileocolonic (29%) and perianal (14%) with inflammatory, stricturing and penetrating disease in 75%, 20% and 5% respectively.

The anti-TNF cohort had a significant reduction in the cumulative radiation dose (4.2 vs. 1.8 mSv, $p < 0.0001$) compared to the previous year. There was no change in the cumulative radiation dose in the corticosteroid group (7.5 vs. 7.3 mSv, $p = 0.8$). The number of CT scans reduced from 3.3 to 1.2 ($p < 0.0001$) in the anti-TNF cohort. There was no reduction the number of CT scans in the corticosteroid group after one year (2.7 vs. 2.5, $p = 0.006$).

In 31 patients with 3-year exposure to corticosteroids, there was a significant increase in the cumulative radiation dose (7.0 vs. 13.8 mSv, $p < 0.0003$) compared to the anti-TNF group (3.5 vs. 4.8 mSv, $p = 0.7$). There was a significant increase in the

number of CT scans in the corticosteroid group (2.6 vs. 4.9, $p < 0.001$) compared to the anti-TNF group (2.5 vs. 2.8, $p = 0.9$).

Linear regression analysis showed a decrease in cumulative radiation dose by 2.7 mSv ($p = 0.07$) and number of CT scans by 2 ($p < 0.001$) in the anti-TNF group compared to the corticosteroid group within a year of therapy after adjusting for age, gender, disease duration, disease location and disease behaviour.

Conclusion Anti-TNF but not corticosteroid therapy is associated with a significant reduction in diagnostic radiation exposure a year after treatment and persisted after 3 years although not statistically significant

Disclosure of Interest None Declared.

PTU-092 PATIENT AND PROFESSIONALS PERCEPTIONS OF TRAVEL BEHAVIOUR IN INFLAMMATORY BOWEL DISEASE

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Introduction Travellers with inflammatory bowel disease (IBD) are at greater risk of travel-related morbidity.¹ ECCO recommend patients seek expert advice prior to travel, including information on vaccination and obtaining antibiotics for self-treatment of travellers diarrhoea.² Wasan *et al.* report only 3.5% of patients on immunosuppression therapy were counselled on avoiding particular live vaccines³ and 30% of gastroenterologists would erroneously recommend live vaccines.⁴

Methods We explored both patient and gastroenterology health care professionals (HCP) perceptions of IBD and travel: whether disease affected travel, interventions people took to travel, and whether ECCO guidelines were being followed. IBD patients attending our IBD clinic during November 2013 were asked to complete a questionnaire collecting demographic, disease specific and travel related information. Using N-ECCO and RCN IBD nurse network databases, HCP were asked to complete online questionnaire collecting information on perceptions of IBD and travel, confidence at providing travel advice, and the content of that advice.

Results 136 IBD patients (67[49%] Crohn's disease, 60[44%] male, median age 38 years[range 18–85]) and 105 HCP (98/105 [93%] nurse specialists, 6/105[6%] consultant, 1/105[1%] registrar) responded. 85%[106/136] patients report feeling adequately prepared for travel, although only 24%[32/136] seek travel medical advice of any kind and only 11%[15/136] from the IBD team; all despite 60%[82/136] reporting their IBD affected travel. Despite recommendations, only 4%[5/136] had been prescribed antibiotics for self-medication of travellers diarrhoea. 52%[36/69] of immunosuppressed patients are unaware they should avoid live vaccines. 39%[53/136] patients buy travel insurance covering IBD, 70%[37/53] of which pay a premium. 70%[74/105] HCP felt IBD might limit travel in patients. 70%[74/105] HCP are confident giving travel advice, but 51%[38/74] refer them to a travel clinic. 90%[94/105] are confident giving advice on travellers diarrhoea, but only 54%[57/105] on vaccinations and 40%[42/105] on insurance.

Conclusion Patients travel is affected by IBD, however, few seek expert medical advice prior to travel. HCP agree IBD affects travel and a majority are confident giving limited advice. It is concerning 52% of immunosuppressed patients are unaware they should avoid live vaccines, and only 54% of HCP are