(FC) is useful in differentiating inflammatory bowel disease (IBD) from non-organic functional bowel disorders. FC may also be useful in monitoring patients with IBD to identify acute flares in disease, long before the patient becomes symptomatic. This allows appropriate treatment to be given in situations where disease activity is objectively measured to be greater than any perceived deterioration in symptoms.

Methods Faecal calprotectin data was collected over a 2 year period from 110 patients with IBD, who underwent regular outpatient assessment. Results were recorded as normal (<50 μg/g), borderline (50–100 μg/g) and elevated (>100 μg/g). A retrospective analysis of management outcome was made from reviewing patient records on the local clinical correspondence store and the new National IBD-Registry.

Results 44, 5 and 61 patients had normal, borderline and elevated FC levels, respectively. Three patients with normal FC (6.8%), compared to 29 (47.5%) with elevated FC, required upregulation of their management for symptom control. FC returned to normal levels in those selected for treatment escalation. In total, 104/110 (94.5%) of patients avoided investigative colonoscopy. Six patients did require colonoscopic assessment, 1 had normal FC, 1 was borderline and 4 had elevated FC. Three of these 6 colonoscopic examinations were performed as part of surveillance and 2 were carried out in FC +ive patient, 1 for planned therapeutic dilatation of a known stricture and the other to confirm the severe and extent of their disease prior to referral for surgical intervention.

Conclusion FC is a useful monitoring tool in IBD and in identifying those who have developed or are about to suffer an acute flare in their disease. This allows adjustment of treatment without having to subject patients to colonoscopic investigation. A positive result directs the need to upregulate management, whilst a negative one can be reassuring, allowing physician to concentrate on treating functional aspects if the patient is symptomatic.

Disclosure of Interest None Declared.

PTU-098 HIGH LEVELS OF EMOTIONAL AND PHYSICAL DISTRESS AMONG FAMILY CAREGIVERS OF INDIVIDUALS WITH INFLAMMATORY BOWEL DISEASE (IBD)

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Introduction In chronic debilitating disorders, caregiving can be stressful and may contribute to serious illness and depression. However, in less debilitating disorders, such as IBD, limited data are available about the impact of the disease on caregiver's well-being. Our aim was to identify the emotional and physical distress among family caregivers of IBD patients in order to provide preventive services to an at-risk but hidden population.

Methods Over a 19 month period, in the tertiary referral centre for IBD in Central Greece, we interviewed 44 family caregivers of Crohn's Disease (CD) and 41 of Ulcerative Colitis (UC) patients. Caregiver's distress was assessed by using the caregiver self-assessment questionnaire "How Are You ?" of the American Medical Association. Disease activity was assessed using the Harvey-Bradshaw index for CD and Simple Colitis Activity Index for UC. A card with the sociodemographic and clinical characteristics of the population were also collected. The impact of each characteristic on caregiver's well-being was studied with one and two way ANOVA.

Results 84,7% of the caregivers showed high levels of emotional and physical distress with the majority of them to be middle-aged women (61.2%) with basic educational level (61,2%)and full-time employment (65,9%) at the time of the study. No significant difference found on the level of distress between caregivers of CD and those of UC patients. Factor analysis identified that female gender, active disease, disease related complications and long lasting disease had significant impact on the caregiver's level of distress.

Conclusion

1. Family caregivers of IBD patients experience high levels of emotional and physical distress.
2. Active disease, disease related complications, long lasting disease and female gender have significant impact on caregiver's level of distress.
3. It is necessary to organise a network to provide psychosocial services for the caregivers of IBD patients.

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Disclosure of Interest None Declared.

PTU-099 SURVEILLANCE COLONOSCOPY IN INFLAMMATORY BOWEL DISEASE IN A DISTRICT GENERAL HOSPITAL – ARE WE IMPROVING?

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Introduction Patients with inflammatory bowel disease (IBD) have an increased risk of colorectal cancer. In 2009 the British Society of Gastroenterology updated guidelines recommending chromoendoscopy with targeted biopsies of suspicious areas, Grade A; or 2–4 biopsies every 10cm, Grade C. A local audit in Forth Valley Royal Hospital (FVRH) looking at adherence to guidelines was carried out in 2009 showing adherence to guidelines in 27% (12/44) of cases. Subsequent to this, information regarding the current guidelines was disseminated to clinicians and three medical consultants took responsibility for performing chromoendoscopy. Practice was then re-audited.

Methods FVRH is a district general hospital with a catchment area of 300,000. The endosocpy reporting tool Unisoft was used to identify patients undergoing colonoscopy with the indication "follow up - colitis surveillance" during a 1 year period from 01/01/2012. The endoscopy report was reviewed noting the endoscopist, completeness of procedure, and adherence to a surveillance guideline. The pathology reports were accessed via the SCI store computer system.

Results 87 patients were identified (44 identified over 6 months during the previous audit) as having colitis surveillance colonoscopy. 60 (69%) procedures adhered to one of the recognised surveillance strategies (37 dye-spray, 23 biopsy protocol) compared to 27% (12/44) in 2009. There has also been a marked increase in the number of patients who had chromoendoscopy; 43% (37/87) versus 4.5% (2/44) in 2009. The other main difference in this audit was the type of endoscopist performing the procedure (medical 70% v 32%, nurse 22% v 43%, surgeon 25% v 8%). Medical gastroenterologists performed 34 of the 37 chromoendoscopic

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procedures. Compliance rates increased in medical endoscopies to 79% (v 32%), nurses 63% (v 37%) compared to the previous audit. Dysplasia was found in 10 of the 87 cases. 8 showed low grade dysplasia in tubular adenomas, 1 was high grade dysplasia in DALM discovered using chromoendoscopy and colectomy was performed. Low grade dysplasia was also identified in one patient and they are awaiting discussion about colectomy.

Conclusion There has been a significant improvement in adherence to current guidelines after dissemination of this information to the relevant clinicians. The use of chromoendoscopy has been successfully adopted in a significant number of patients. Streamlining of procedures to endoscopists with an interest in IBD surveillance has added to the improved compliance with guidelines but there are still a number of procedures performed outwith guidelines likely in part due to the 'generic pooling' of endoscopy lists. The setting up of specific surveillance lists may improve compliance and chromoendoscopy rates further.

Disclosure of Interest None Declared.

PTU-100 DEVELOPMENT AND INITIAL VALIDATION OF A NEW ASSESSMENT TOOL FOR FAECAL INCONTINENCE IN INFLAMMATORY BOWEL DISEASE: THE INTERNATIONAL CONSULTATION ON INCONTINENCE QUESTIONNAIRE-INFLAMMATORY BOWEL DISEASE (ICIQ-IBD)

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Introduction Faecal incontinence (FI) in IBD is common and under-reported. In a prior study[1] an existing questionnaire[2] was found unsuitable for assessing FI in IBD due to inability to address fluctuating symptoms and IBD-related concerns. We aimed to develop a new psychometrically robust IBD-specific FI questionnaire.

Methods Participantswere purposefully sampled from a UK IBD charity's membership. The International Consultation on Incontinence[3] Questionnaire development and validation protocol was followed in a two phase study. Phase 1: we progressively developed content, terminology and format of the new tool from feedback in the original study[1] and four rounds of cognitive interviews. A modified Delphi survey of clinicians identified important clinical content. Phase 2: participants completed the final version of the ICIQ-IBD and a disease activity index twice, to evaluate validity of the questionnaire and consistency of assessment. A principal exploratory factor analysis identified underlying domains in the questionnaire.

Results 24 respondents (female n = 18, 75%; age: mean 50 yrs) participated in cognitive interviews. Ten clinicians clarified clinical content. 166/188 respondents (88%) returned the first (test) questionnaire. 143 (86% [76% of total sample]) returned the second (retest) questionnaire 2–6 weeks later. Most questions were relevant to most respondents. The new ICIQ-IBD discriminates between patients with and without FI, low and high disease activity, and concern levels.110 respondents returning test and retest data had stable disease – weighted kappa was used to determine stability (test-retest reliability). 36/41 questions (87.8%) showed good or moderate agreement, suggesting the questionnaire is reasonably stable and reliable. Two domains were identified: bowel symptoms and quality of life, with a simple additive score for each domain.

Conclusion The new ICIQ-IBD is valid and reliable. Further psychometric testing to evaluate sensitivity to change will be conducted in a forthcoming intervention study.

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Disclosure of Interest None Declared.

PTU-101 WE'RE NOT IMMUNE TO IMMUNISATIONS IN IBD

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Introduction Immunomodulator therapy is commonplace in the management of inflammatory bowel disease, IBD. The European Crohn's and Colitis Organisation, ECCO, published guidelines in 2009 recommending every patient with IBD be considered for varicella, human papilloma virus, influenza, pneumococcal and hepatitis B vaccination. This study examines current immunisation practices in an IBD population at a District General Hospital.

Methods 100 consecutive patients with IBD attending general gastroenterology outpatient clinics were asked to complete a questionnaire. All subtypes of IBD were included. Information regarding IBD related medication, recent infections and immunisation status were collected. The results were analysed using the statistical package for the social sciences, SPSS software.

Results 100 questionnaires were collected; 3 were excluded, 2 due to duplication of patients, 1 was submitted blank. The patients' median age was 52 (17–86), with a male to female ratio of 36:64%. Of IBD subtypes, 52 had Crohn's disease, CD, 42 ulcerative colitis, UC, and 3 had colitis of undetermined type or aetiology, CUTE. 91 (94%) of patients had been on prescribed medication for IBD in the last 6 months. Of those, a majority (69%) had taken mesalazine, nearly half (42%) thiopurines, a quarter (24%) steroids and 15% anti tumour necrosis factor, anti-TNF. Of the 97 patients, 64% had been on an immunosuppressing medication in the previous 6 months, 29% of which reported having had an infection in the preceding 12 months. Chest and urinary tract infections were the most commonly reported in 33% and 22% of those reporting an infection respectively. 39% of patients on immunosuppressants reported a doctor discussing vaccinations with them. 74% of immunosuppressed patients had received an immunisation of any sort. 92% of these had received influenza vaccine, 40% Pneumovax, 21% hepatitis B vaccination, and 1 (2%) human papilloma virus. Of note, all patients who reported a chest infection had received the influenza vaccine and two thirds had received Pneumovax.

Conclusion A significant number of patients diagnosed with IBD will require immunosuppressing medications at some point during their care. Despite ECCO guidelines advising all patients with IBD be considered for a vaccination program at initial diagnosis, only three quarters had received any vaccinations whatsoever. Interestingly, in our small cohort, influenza and pneumococcal vaccinations did not seem to protect against self reported chest infections. Traditionally the role of vaccination has been seen as a function of primary care. Increasing awareness of the need for vaccination in primary care may improve adherence. Ultimately, with the increasing use of immunomodulators and their inherent infection risks, perhaps more responsibility should be taken on by the IBD clinician?

Disclosure of Interest None Declared.

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