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.