Introduction Anogenital granulomatosis (AGG) is a recently recognised cause of genital lymphoedema[1–3] an association of CD with AGG has been noted in previous case reports.[1,3] It presents with genital erythema and swelling, and flares are frequently misdiagnosed as cellulitis. We present a large case series.
Methods Patients were identified from referrals to the regional to the Lymphoedema Service at St George's Hospital after failure of antibiotics and topical steroids to improve symptoms. Demographic, clinical and endoscopic finding were correlated in patients with histological features of AGG in patients.
Results Sixteen patients (15 male, 1 female; aged 34.8 ± 15.0 yr (mean ± s.d.)), were referred with AGG.

14 of 16 patients initially presented with genital swelling whilst 2 others presented with buttock swelling. Swelling of additional sites was noted in several patients (mons pubis – 25% of patients; natal cleft – 25%; peri-anally – 19%; buttocks – 12.5%). Although initially intermittent (15/16 patients), genital swelling was typically well established and irreversible by the time of presentation to the Lymphoedema Clinic. Flares involved erythema and deterioration of swelling which failed to return to baseline. Established swelling was associated with an increased risk of cellulitis in addition to the non-cellulitic flares.

Histological examination of the affected areas demonstrated dermal (and one case of intra-lymphatic) non-caseating granulomas in 12 patients with the remainder diagnosed clinically. Gastroenterology review, including colonoscopy, confirmed a diagnosis of Crohn's disease in 37.5% of patients.

Treatment of AGG has proven difficult. Initial treatment with compression garments and prednisolone showed a reduction (but not elimination) of scrotal and penile shaft swelling in 9/11 patients. Antibiotics reduced the frequency of flares in only 3/11 patients. Steroid-sparing immunosuppression was successful in 4/11 patients. In 6 patients, lymphoedema of the foreskin caused difficulties in micturition and therefore circumcision was successfully utilised to improve urinary flow. Debulking surgery has been used in only a small number of our cases to date.
Conclusion AGG should be considered in all patients (especially male) presenting with isolated genital lymphoedema and may unusually be the presenting feature of Crohn's disease. Early diagnosis allows for prompt initiation of systemic immunosuppression therapy which is currently the treatment of choice. We hypothesise that swelling is precipitated by non-infective granulomas blocking lymphatic vessels, research in this regard is in progress.

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Disclosure of Interest None Declared.

PTU-109 AZATHIOPRINE IN THE ELDERLY – IS IT TOLERATED AND IS IT SAFE?

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Introduction The use of Azathioprine (AZA) for maintenance of remission in Inflammatory Bowel Disease (IBD) is common practice as part of national and international guidelines. Side effects however are common. Of 353 consecutive patients commencing AZA in our organisation, 36% were not taking it at one year. With an ageing population, IBD is increasingly relevant in those over 75 years old. However there is little data concerning the efficacy and tolerability of AZA in this age group.
Methods We maintain a prospective database of IBD patients. All patients commenced on AZA between June 2005 and October 2012 over the age of 75 were identified. Thiopurine Methyl Transferase (TPMT) levels were checked in all patients and AZA was prescribed at 2–2.5 mg/kg, with 50% dose reduction in those with low TPMT. We monitor full blood count and LFTs weekly for 8 weeks after commencing therapy.
Results 25 patients were identified, (7 CD, 18 UC). The mean age at which AZA was started was 78 (range 75–86), 16 were male (64%). All patients were followed up for at least one year. 12 (48%) were intolerant of AZA. Reasons for stopping AZA were; hepatitis, 2 (8%); vomiting, 5 (10%); pancreatitis, 1 (4%); myelosupression (1); joint pain (1); infection (1); and general malaise (1). The mean duration of AZA use in these patients was 34 days (Range 3–89). 13 (52%) tolerated the drug well with one of this group having the drug actively withdrawn at 701 days in complete clinical, endoscopic and histological remission. There were four deaths (16%). Two died in the group intolerant of AZA (84 year old died of stroke 888 days after 13 days of AZA; 82 year old died in the community 140 days after 5 days of AZA). Two people died in the AZA treated group (83 year old died in the community on day 1476 of AZA; 79 year old died following cardiac arrest on day 212 of AZA).
Conclusion Our data demonstrate that AZA is an effective treatment in the elderly. It appears to be less well tolerated than in the general population with 48% intolerant of the drug within 3 months. Within the limitations of this study it appears to be safe. The increased incidence of drug intolerance in this population group may suggest that low-dose azathioprine and allopurinol co-therapy should be considered first-line therapy in this group. A further study to clarify this is required.
Disclosure of Interest S. Dharmasiri Conflict with: Funding from Warner Chicott to attend ECCO congress 2014, H. Johnson Conflict with: Guest at Falk symposium, Barcelona and London 2013, S. McLaughlin Conflict with: sponsorship from Falk to attend Ecco 2013 and falk symposia in London and Barcelona. Attendance at local evening ibd dinner meetings sponsored by falk and Abbvie, S. Weaver: None Declared.

Liver I

PTU-110 REDUCTION IN SERUM SODIUM (NA) IN PATIENTS TREATED WITH TERLIPRESSIN FOR VARCIEAL BLEEDING (VB) AND HEPATORENAL SYNDROME (HRS)

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Introduction Terlipressin is used in the management of VB and HRS. Studies have suggested decrease in Na levels on terlipressin, usually in VB.

We set out to report the incidence of fall in serum Na in patients receiving terlipressin for VB or HRS.
Methods Consecutive patients admitted to Gwent Liver Unit who received terlipressin were identified. Main outcome measure was fall in Na level during and up to 5 days post therapy.
Results 60 patients were analysed (32 HRS, 28 VB). Median Na pre-treatment was 133 and 29/60 (48%) had existing hyponatraemia; 16 (27%) had Na <125mmol/l.