

were detected, most patients required a biologic switch in or out of class, and/or surgery, in line with consensus algorithms. However, it appears that in some cases a durable ADA suppression following dose escalation is possible and should be considered when there are limited other therapeutic options.

#### PWE-051 BIOLOGICAL THERAPY FOR THE TREATMENT OF PRE-POUCH ILEITIS: A RETROSPECTIVE EXPERIENCE FROM THREE CENTRES

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**Introduction** Pre-pouch ileitis (PPI) is inflammation of the ileum proximal to an ileoanal pouch, usually associated with pouchitis. This pattern of inflammation can extend for a significant distance proximally. The estimated frequency of PPI is 6%. Symptoms are non-specific but can include increased frequency, obstructive symptoms and bleeding. The treatment of pre-pouch ileitis as a specific entity has been poorly studied, but it is generally treated concurrently with pouchitis. This to our knowledge is the largest study to explore the effectiveness of biologics for the specific treatment of PPI.

**Methods** This was a retrospective observational study across three centres. Data were collected between January 2008 and February 2018 from two centres in the United Kingdom and one centre in Italy. Patients were censored at the last clinical encounter following their most recent biologic therapy or until they had pouch failure defined by the need for an ileostomy to relieve pouch related symptoms. Patients with PPI treated with a biologic were followed up until last clinical encounter. Outcomes included the presence of PPI following biologic therapy, pouch failure defined by the need for an ileostomy, and remission of PPI defined by the absence of any PPI on endoscopic and histological assessment within a year of biologic therapy.

**Result** There were 30 patients in our cohort. The median age at diagnosis of IBD was 27 years old (range 6–48). The median time from pouch formation to diagnosis of pre-pouch ileitis was 81.5 months (range 1–147). The median length of time a patient was on biologics at the censorship of the study was 12 months (range 2–62).

On last endoscopic follow-up, 21/30 (70%) still had endoscopic and histological evidence of PPI, seven had achieved remission and two had no endoscopic follow-up. In our cohort 11 patients had an ileostomy after a median time from starting a biologic of 25 months (range 14–91). Of those who had their UC reclassified to CD, 3/10 (30%) had pouch failure compared with 8/19 (42%) who had UC ( $p=0.72$ ).

**Conclusion** Biologics fail to achieve endoscopic and histological remission of PPI in the majority of patients. In a small proportion of patients, they may help to prevent deterioration in symptoms. In a large proportion of patients with pre-pouch ileitis, surgery may be required despite biologic use.

#### PWE-052 LONG TERM OUTCOMES OF INITIAL IFX THERAPY FOR INFLAMMATORY POUCH PATHOLOGY: A MULTI-CENTRE RETROSPECTIVE STUDY

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**Introduction** Restorative proctocolectomy is considered the procedure of choice in patients with UC refractory to medical therapy. Inflammation of the pouch is a common complication and in some cases fails to respond to antibiotics, the mainstay of treatment. In such cases, corticosteroid, immunomodulatory or biologic treatments are an option. However, our understanding of the effectiveness of IFX for both chronic pouchitis and Crohn's-like inflammation are based on small studies.

**Methods** This was an observational, retrospective, multi-centre study to assess the effectiveness IFX for inflammatory disorders related to the pouch. The primary outcome was the development IFX failure defined by primary non-response or secondary loss of response to IFX.

**Result** 38 patients were included. 20/38 (53%) who were initiated on IFX for inflammatory disorders of the pouch had IFX failure, 4/38 (11%) had primary non-response and 16/38 (42%) had secondary loss of response with a median follow-up of 265 days (range 82–2119). Of those that had IFX failure 10/20 (50%) avoided an ileostomy by switching to an alternative biologic. In total, 28/38 (74%) avoided an ileostomy, of these, 17/38 (45%) continued on their IFX after a median follow-up of 311 days (42–3968), 5/38 (13%) were changed to Adalimumab after a median follow-up of 498 days (1–1544), 4/38 (11%) were changed to Vedolizumab after a median follow-up of 569 (251–1138), 1 achieved histological remission and stopped all treatments at 251 days and 1 was maintained on methotrexate and multiple antibiotics after 3968 days.

**Conclusions** After initial IFX therapy over half will fail first line IFX, of those that fail half can avoid an ileostomy by switching to an alternative biologic. Patients should be counselled about a high incidence of failure and alternatives should be considered.

#### PWE-053 BIOFEEDBACK IN PATIENTS WITH ILEOANAL POUCH DYSFUNCTION: A SPECIALIST CENTRE EXPERIENCE

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**Introduction** Restorative proctocolectomy is performed in patients with ulcerative colitis refractory to medical therapy,