possibility that some patients are not CRP producers^{1,2,3}. In this retrospective observational study, we have assessed if patients consistently produce a low or high CRP level in response to a flare in IBD.

Methods 31 patients were identified, over a 5 year period across 3 centres, with endoscopic mucosal assessments of two consecutive exacerbations of IBD which were at least 3 months apart. Patients were included if they had a CRP measurement within 7 days of each endoscopic examination (colonoscopy or flexible-sigmoidoscopy), and if they had active inflammatory colitis confirmed on mucosal biopsy. A CRP non-producer was defined as a CRP level of less than 10mg/L as according to the laboratory reference range used in the centres.

Results In the cohort of 31 patients, 19 had biopsy proven UC, 3 had Crohn's disease, 6 were unclassified, and 3 had differing classifications of Crohn's disease and UC on successive endoscopies. There was an overall mean period of 11.3 months between successive endoscopies. 17 patients were CRP non-producers and 9 were CRP producers during successive IBD flares. The table below shows the disease classification in different CRP response groups.

Abstract PTH-095 Table 1

	Total number of patients	Crohn's disease	UC	Unclassified	Differing histological classification
CRP non-producer	17	8	3	4	3
CRP producer	9	6	0	3	0
Variable CRP response	5	5	0	0	0

Disease extent was defined in both flares in 97% of patients. In the CRP non-producer group, 10 out of 17 (59%) patients had left sided disease or proctitis compared to 4 out of 8 (50%) in the CRP producer group. This difference in proportion did not reach statistical significance as assessed by Fisher's exact test. Three of the five patients with a variable CRP response had more extensive disease at the time of the higher CRP level.

Conclusion

Most patients (84%) in this study had a consistent CRP response; but this was not universal. Disease extent appears to contribute to CRP, but patient specific factors also appear to play a role.

Disclosure of Interest None Declared.

REFERENCES

1. Gut. 2008 Nov; 57(11):1518–23. Epub 2008 Jun 19. C-reactive protein: a predictive factor and marker of inflammation in inflammatory bowel disease. Results from a prospective population-based study. Henriksen M, *et al.* IBSEN Study Group
2. Inflamm Bowel Dis. 2005 Aug; 11(8):707–12. Correlation of C-reactive protein with clinical, endoscopic, histologic, and radiographic activity in inflammatory bowel disease. Solem CA, *et al.*
3. Inflamm Bowel Dis. 2004 Sep; 10(5):661–5. C-reactive protein as a marker for inflammatory bowel disease. Vermeire S, *et al.*

PTH-096 ORAL CICLOSPORIN IN STEROID REFRACTORY, ACUTE, SEVERE ULCERATIVE COLITIS

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Introduction Ciclosporin (CsA) has been shown to be effective in treatment of steroid refractory severe ulcerative colitis and reducing the need for colectomy¹. Most published evidence concerns intravenous infusions; however oral microemulsion ciclosporin (Neoral®) is well absorbed, more convenient and potentially less toxic. We report our experience with oral ciclosporin for treatment of steroid refractory severe ulcerative colitis.

Methods 30 consecutive patients receiving oral Ciclosporin for steroid refractory acute severe ulcerative colitis from October 2001 till July 2012 were retrieved from our clinical and pathology database. One patient received therapy twice. Hence, 31 episodes were analysed for this study.

Results 19/31 patients were males. The median age at diagnosis and at the time of starting CsA was 39 years and 42 years respectively. 19 patients had pancolitis and 11 patients had left sided colitis. 4 patients were not on any treatment at the time of acute flare up. 28 patients were treated as inpatients. CsA was started after a median of 5 days after treatment with intravenous hydrocortisone in admitted patients (range 2–13 days). The mean CsA dose was 7.31 mg/kg on admission (range 5 to 8). The mean ciclosporin trough levels at 48–72 hours and days 5–7 were 167ng/ml and 254ng/ml respectively. The mean length of treatment was 23.6 weeks (range 1–123). 50% had no side effects. One patient developed pyrexia of unknown origin necessitating stoppage of CsA. 26/31 (84%) had initial clinical response. 5/31 had colectomies during the same admission while 15/31 (48%) had colectomies within one year of starting ciclosporin treatment. 14/31 (46%) have had no surgery till date after a mean follow up of 46 months (range 2–131). 14/26 who had initial response to CsA were started on azathioprine. Eleven were thiopurine naïve and out of these, 8/11 (72%) are colectomy free till date. 12/26 were on thiopurines in the past. Only 4 of these 12 patients (33%) are colectomy free till date.

Conclusion 84% of the cohort of patients having steroid refractory severe ulcerative colitis responded to CsA and 52% retained their colon after 1 year. Our experience confirms CsA to be a safe drug with few side effects and should be used as a bridging therapy to azathioprine. Patients who are azathioprine naïve prior to CsA appear to have lower colectomy rates.

Disclosure of Interest None Declared.

REFERENCE

1. Campbell S, Travis S, Jewell D. Ciclosporin use in acute ulcerative colitis: a long term experience. Eur J Gastroenterol Hepatol 2005 Jan; 17(1):79–84

PTH-097 DEFINING PATIENT-CENTRED PROFESSIONALISM IN GASTROENTEROLOGY

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Introduction The UK IBD audit 3rd round (RCP,2011) shows that there has been sustained improvement in patient-centred care in terms of clinician commitment to improved quality of care and the provision of specialist IBD nursing and patient education for patients with IBD. This study explores the meaning of the concept 'patient-centred professionalism' in gastroenterology. The objectives of this study are:

1. To clarify the meaning of patient-centred professionalism in terms of how it relates to professional practise and patient-professional interaction in gastroenterological outpatient clinic consultations
2. To define the concept according to the views and experiences of healthcare professionals, stakeholders and IBD patients.
3. To create materials which may support and enhance optimal professional practise in outpatient clinics for patients with IBD

Methods A qualitative study using observation and semi-structured interviews. Ethnographic observation was conducted in 8 outpatient clinics from within one local health board (Abertawe Bro Morgannwg University Health Board). Clinics were led by consultant physician gastroenterologists; surgeons, specialist nurses and