Oral presentations

Inflammatory bowel disease section free papers

OC-001 ANTI-TNF WITHDRAWAL IN IBD: INITIAL RESULTS FROM A PAN-UK STUDY

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Introduction Infliximab and adalimumab have established roles in IBD therapy. NICE and SMC guidelines mandate reassessment of disease activity after 12 months. Therapy should ordinarily be discontinued where clinical remission and mucosal healing has been achieved. However, there are presently few data about outcomes of anti-TNF withdrawal.

Methods We conducted a retrospective clinical audit of outcomes following withdrawal of anti-TNF therapy. Inclusion criteria were confirmed diagnosis of IBD; ≥ 12 m continuous anti-TNF therapy; primary withdrawal reason sustained clinical remission (no corticosteroids for 6 m); ≥ 12 m follow-up post-withdrawal. Relapse was defined as moderate (oral steroids, immunomodulators, recommencement of anti-TNF agent) or severe (hospitalisation, iv steroids, surgical resection). All UK centres were invited to participate. Demographic and phenotypic data plus clinical, laboratory and endoscopic parameters were recorded.

Results 80 cases (62 infliximab; 18 adalimumab) with a median follow-up time of 26 m post drug withdrawal were included in

Abstract OC-001 Figure 1

this analysis (59% female; median age at drug withdrawal 32y). All were in clinical remission at withdrawal; 47/80 had normal laboratory parameters (Hb, WCC, plts, Albumin, CRP, FC) prior to withdrawal. 49/80 had endoscopic re-evaluation with mild disease noted on 9/50 and moderate on 1. 23/70 (33%; 2/23 severe) of patients with Crohn's disease relapsed by 12 months and 49% relapse (3/35 severe) by 24 months (Fig 1, median time to relapse 10.4 m). Younger age at diagnosis ($p = 0.017$) and elevated WCC ($p = 0.025$), but not CRP or faecal calprotectin, were predictive of relapse. 4/10 (none severe) with UC/IBDU had relapsed by 12 and 24 months. Anti-TNF therapy was re-introduced in 30 patients following relapse and was successful in 93%.

Conclusion Planned withdrawal of anti-TNF therapy for sustained clinical remission is associated with a moderate relapse of Crohn's disease in up to half of patients by 2 years. Data collection of an expanded cohort is ongoing around the UK to improve power to dissect predictive factors at time of drug withdrawal.

Disclosure of Interest None Declared.

OC-002 PREDICTING OUTCOME IN ACUTE ULCERATIVE COLITIS: COMPARISON OF THE TRAVIS AND HO SCORES USING UK IBD AUDIT DATA

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Introduction Patients with severe Ulcerative Colitis (UC) are commonly identified using the Truelove and Witts¹ criteria on presentation. The Travis² and Ho³ scores are subsequently used to identify patients with severe UC who are at high risk of failing medical therapy and needing second line therapy or colectomy. To date there has been no direct comparison between Travis and Ho scores to determine which is superior.

Methods We analysed data from 3049 patients with UC collected during the 2010 round of the UK IBD audit. 984 patients had acute severe UC according to the Truelove and Witts criteria. Those that failed steroid therapy were scored using both Travis and Ho criteria and allocated into either a Travis "high" or "low" risk group and either a Ho "high", "medium" or "low" risk group. We assessed whether further medical or surgical intervention varied between groups.

Results Patients requiring surgery did not differ between the high risk groups (Travis 49%, $n = 93$ and Ho 51%, $n = 84$, respectively). However, only 35% ($n = 53$) in the medium risk Ho group, 26% ($n = 17$) in the low risk Ho group and 32% ($n = 65$) in the low risk Travis group underwent surgery. Similarly 41% ($n = 78$) and 38% ($n = 63$) of patients in the high risk Travis and Ho groups respectively were treated with ciclosporin, whereas only 34% ($n = 51$) were treated in the medium risk Ho group, 25% ($n = 16$) in the low risk Ho group and 27% ($n = 55$) in the low risk Travis group. Resistance to ciclosporin correlated with increasing risk stratification, although this failed to reach statistical significance for all groups. The use of anti-TNFs was the same across all three groups, although like ciclosporin, the tendency to TNF resistance also increased with increasing risk group.

Conclusion The Travis and Ho scores are equally able to identify patients who are at high risk of failing medical therapy and needing colectomy or second line medical therapy. The Ho score may also be able to identify an intermediate risk group which