+ and from Day 2 (median 6; 2–19), 5/20 were CMV+ ($p = 0.96$). Median cumulative steroid dose prior to biopsy was 0.28 g prednisolone equivalent for CMV+ patients and 0.39 g for CMV- patients ($p = 0.51$). 3/13 CMV+ patients had had prednisolone ≥ 10 mg/day for > 14 days prior to biopsy and 11/32 CMV- patients ($p = 0.46$). No biopsies contained typical histological features of CMV infection. Mayo and Baron scores did not differ between CMV+ and CMV- patients. Mucosal CMV DNA titre in CMV+ patients did not correlate with Baron or Mayo scores. Of the mucosal CMV+ patients, 8/8 tested (100%) were anti-CMV IgG positive with 0/7 IgM positive. Peripheral blood CMV PCR was positive in 10/13 in the biopsy PCR+ group and 0/7 in those biopsy PCR- (sensitivity 60%, specificity 100%). 12/13 CMV PCR+ patients were treated with ganciclovir. 11/13 (84.6%) achieved remission. 2/13 (15.3%) CMV+ and 2/32 (6.2%) CMV- required colectomy ($p = 0.33$). All 6 patients treated concomitantly with Infliximab and ganciclovir responded fully.

Conclusion PCR of mucosal biopsies detects CMV infection due to viral reactivation in almost a third of patients with deteriorating or acute severe UC. No relationship was demonstrated between CMV infection and disease severity, response to treatment or prior steroid use. Treatment with anti-TNF agents was administered safely in combination with anti-viral drugs.

Disclosure of Interest None Declared.

PTU-084 PREVENTION OF OPPORTUNISTIC INFECTIONS IN PATIENTS ON BIOLOGICAL AGENTS FOR MANAGEMENT OF INFLAMMATORY BOWEL DISEASE

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Introduction Patients with inflammatory bowel disease are at increased risk of infection; this is especially true of the 20% on biological agents. ECCO guidelines recommend the following vaccines:

Influenza (annual), Pneumococcal, Hepatitis B, Varicella, HPV (women under 26).

The guidelines also highlight the need to exclude latent TB; local policy is to perform an interferon gamma release assay.

Within the UK vaccination services are provided by primary care.

Methods The measures taken to prevent opportunistic infection in patients prescribed anti-TNFs for IBD at Chelsea and Westminster Hospital in 2013 were audited against the ECCO OI Guidelines.

The following were retrieved from electronic records: age, sex, anti TNF prescribed, pneumococcal antibodies, hepatitis B core and surface antibodies, varicella IgG, Elispot®.

Attempts were made to retrieve vaccination history from General Practice.

Results 60 patients were prescribed infliximab and 15 patients were prescribed adalimumab. 46 GPs were able to provide vaccination history.

Influenza: 50% (23/46) patients received vaccination against influenza within the past year.

Pneumococcus: 55% (47/85) patients demonstrated immunity. 6% (5/85) were not immune and the remainder were not tested. The vaccination history of 26 patients who were not immune or not tested was retrieved. 27% (7/26) had since been vaccinated.

Hepatitis B: No patients were core Ab positive. Surface Ab levels demonstrated immunity in 7% (6/85). 53% (45/85) were

not immune, and the remainder were not tested. Vaccination history of 44 patients who were not immune or not tested was retrieved. Of these, 25% (11/44) had since been vaccinated.

HPV: 4 patients were women under 26 years old. 25% (1/4) had confirmed HPV vaccination.

Varicella: 21% (18/85) patients demonstrated immunity to varicella. 2% 2/85 were not immune.

Elispot: 65% (55/85) patients had a nonreactive assay. 1% (1/85) had a positive result and the remainder were not tested.

Conclusion The standards set out by ECCO to protect patients from opportunistic infection are not being met.

Problems obtaining accurate vaccination history from GP records include incorrect surgery details, lack of availability of staff able to review records and incomplete records. HPV vaccination usually takes place at school and is not routinely recorded by primary care.

Potential service improvements include provision of vaccines at clinic, improved patient education regarding the importance of vaccination and a check list to review bloods at first anti-TNF prescription.

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Disclosure of Interest None Declared.

PTU-085 DID THE 2010 NICE GUIDELINES IMPACT ON BIOLOGICS PRESCRIPTION?

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Introduction In 2010 NICE updated their guidelines on the prescription of anti-tumour necrosis factor alpha (a-TNF) for Crohn's disease (CD) to include Adalimumab as a treatment for patients with severe active CD. As a therapeutic option it provided an attractive alternative, both to units, struggling for infusion capacity and limited specialist nurse input, and to patients, as a time-saving, home delivered and administered option.

Methods A retrospective review of inflammatory bowel disease patients at University Hospital North Staffordshire up until December 2012.

Results Of 3600 inflammatory bowel disease 117 patients are on a-TNF. A further 47 patients have had, but are no longer on, a-TNF. 37 patients had their original a-TNF switched during their disease course (21%). 25 patients (68% of all switches) had their a-TNF switched for non-clinical reasons (*including patient choice and unit preference). All of these were from infliximab to adalimumab, 8 had to be switched back to infliximab.

Abstract PTU-085 Table 1

Year	No of non-clinical switches
2008	3
2009	0
2010	15
2011	3
2012	4

Prior to switching 23 of the 25 patients were in clinical remission with the other 2 being partial responders. After switching 11 remained in clinical remission, 13 did not have clinical remission and the data was unavailable in 1 patient.

Conclusion The revision of NICE guidelines to include adalimumab was associated with a significant percentage of *non-clinical switches. There was a 52% loss of efficacy in non-clinical switches. Loss of efficacy when switching has been confirmed in prospective trials.^{1,2}

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Disclosure of Interest None Declared.

PTU-086 ULCERATIVE COLITIS (UC) AND ANTI-TUMOUR NECROSIS FACTOR (A-TNF) THERAPY; A SINGLE UNIT'S REAL WORLD EXPERIENCE

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Introduction Prescription of a-TNF therapy in UC in the UK is limited to acute severe colitis by NICE. Increasingly physicians are under pressure from patients to offer an alternative to the traditional limited therapeutic options and this has resulted in the drug being used in the subacute setting, as it is in other countries.

Methods A retrospective review of all patients receiving a-TNF for UC up until December 2012.

Results Twenty-one patients have received a-TNF therapy for UC. Five are currently on a-TNF treatment, 4 of whom commenced in the last 12 months. Twelve were discontinued for non-response, 1 for funding, 1 for remission, 2 for side effects and 1 at the patient's request. Two were switched. Response to the agents are shown in Table 1.

Thirteen received infliximab as first agent, eight had adalimumab. Seven were on other immunomodulators at the time of commencing a-TNF and 11 were intolerant to immunomodulators. Three had a-TNF for acute colitis, 15 for subacute colitis and data unknown for 3 patients.

Currently 3 patients are in clinical remission, 11 had surgery and 7 have active disease (with 2 strongly recommended to have surgery). Twelve patients had steroids while on a-TNF. Mean time on a-TNF was 4.7 months.

Conclusion a-TNF use in UC does not appear to be very effective in this context, with 62% having or requiring surgery and 60% requiring concurrent steroids. To make this therapy more

cost effective in this patient group more work is needed to identify patients likely to be responders.

Disclosure of Interest None Declared.

PTU-087 INDETERMINATE AND INCONCLUSIVE RESULTS ARE COMMON WHEN USING INTERFERON GAMMA RELEASE ASSAY AS SCREENING FOR TB IN PATIENTS WITH IBD

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Introduction Anti-TNF treatment is widely used in inflammatory bowel disease (IBD) but has been linked with reactivation of tuberculosis (TB). Screening for active and latent TB prior to initiation of anti-TNF therapy is therefore mandated. ECCO recommends interferon gamma release assays (IGRAs) as, unlike tuberculin skin test, positive tests are not caused by previous Bacillus Calmette-Guérin (BCG) vaccine. However, immunosuppressive agents can result in indeterminate or unreportable results[i] and there is no clear guidance on managing them.

We quantified the prevalence of indeterminate or unreportable TB IGRA Elispot results in a large tertiary centre cohort of patients with IBD.

Methods A single centre retrospective study of IGRA tests performed on IBD patients prior to commencement of anti-TNF therapy between Oct 2010 and Oct 2013.

Results We included 140 patients (median age 34, range 24–86, 50% males). 92% had Crohn's disease, 4% ulcerative colitis, and 4% IBD-unclassified. At the time of IGRA testing, 115 patients were on immunomodulators and 6 on prednisolone.

3 were positive for latent TB and were referred to infectious disease (ID) department prior to anti-TNF therapy.

3 had indeterminate results; all were on immunosuppressants (2=azathioprine, 1=methotrexate). 2 had a lymphocyte count <1. In 2 cases the IGRA was repeated, one was negative and the second was unreportable on 2 occasions. None had TB risk factors and all were started on anti-TNF. To date, none have developed TB (follow up range 6–18 months).

10 had unreportable results, 9 of whom were on azathioprine. On repeat testing, 4 were negative, and the remainder were still unreportable, one of whom had risk factors for TB and was treated with isoniazid chemoprophylaxis on the advice of the ID team. The remaining 5 patients started anti-TNF based on the absence of risk factors for TB. No patient had reactivation of latent TB at follow up (range 1–18 months). Lymphopaenia was found to be associated with non-reportable cases as compared to the reported cases (median lymphocyte count unreportable = 0.4, reportable = 1.2; $p = 0.015$).

Conclusion Our results demonstrate TB IGRA is a useful test to screen for latent infection before initiating anti-TNF therapy. However, a minority of results are indeterminate or unreportable. In such cases repeat testing can produce definitive results. Low lymphocyte counts in association with immunosuppression may contribute to unreportable and indeterminate results; clinical risk stratification appears to be a safe way of managing such cases in this small cohort.

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Disclosure of Interest None Declared.

Abstract PTU-086 Table 1

Remission	Clinical	Radiological	Histological	Biochemical
Yes	4	0	0	7
No	16	1	6	13
Not assessed	0	19	14	0
Incomplete	1	1	1	1
Total	21	21	21	21