biosimilar IFX switch (Remicade® to Remsima® to Zessly®), in a real-life IBD cohort.

Methods A retrospective cohort study was carried out, and eligible patients were identified through a in-house database. All patients on treatment with Remsima® were eligible for the switch to Zessly®. The primary aim of the study was to assess the clinical outcomes (in terms of continuation of therapy, loss of response and achievement of remission allowing cessation of biologic therapy) between the two patient groups, over a six month period following their switch to Zessly®. Secondary outcomes measured were infusion reactions and rates of hospitalisation for an acute flare.

Results A total of 147 patients were eligible for and underwent the biosimilar-to-biosimilar switch; median age was 41 (IQR 28-56), 95 (64.6%) were male, and 107 (72.8%) had Crohn's Disease. Of the total cohort, 96 (65.3%) were undergoing their first biosimilar switch (Remsima® to Zessly®), whereas 51 (34.7%) were undergoing their second biosimilar switch (Remicade® to Remsima® to Zessly®). In those with one versus two biologic switches, there were no differences seen in the number of patients being able to continue Zessly® (79.2% vs 80.4%, p=0.861), loss of response to Zessly® (11.5% vs 5.9%, p=0.273), or achievement of remission on Zessly® resulting in cessation of therapy (1.0% vs 0%, p=0.465). None of the patients from either group experienced any infusion-related reactions. There was no difference in hospitalisation in the six months following biologic switch (3.1% vs 2.0%, p=0.680).

Conclusions This real-life, single centre, short-term evaluation demonstrated that switching between biosimilar IFX brands appears to be as safe and effective as switching from originator to biosimilar IFX. A larger randomised-controlled study would be needed to confirm both the safety and effectiveness of switching between multiple biosimilar brands to substantiate the results of this evaluation.

PMO-34 IBD DISK TOOL FOR EVALUATION OF PATIENT REPORTED OUTCOMES IN PATIENTS SUFFERING FROM RECURRENT POUCHITIS

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Introduction Although the primary treatment for UC is medical, approximately 20% to 30% of patients with Ulcerative Colitis (UC) will undergo proctocolectomy. (1) Ileal Pouch anal anastomosis (IPAA) surgery is an option for patients to restore gut continuity post proctocolectomy. The majority of patients will develop acute pouchitis and over time up to 25% develop chronic pouchitis. (2) The IBD-Disk was adapted from the Inflammatory Bowel Disease –Disability Index (IBD-DI) as a tool to capture patient's functional status for Health Care Professionals (HCPs) to review. (3) We report the patient use and applicability of the IBD-Disk in pouchitis patients at a tertiary IBD Centre in the West Midlands.

Methods 11 patients attending the pouch clinic at a tertiary IBD centre in West Midlands were interviewed over a 6 month period (December 2020 to May 2021) with regards to their functional disability using the IBD Disk. In addition they were asked to provide their insights as to what additional symptoms should be included as part of the Disk. This element was deemed crucial as the original IBD Disk did not include patient involvement in its design.

Results 9/11 (82%) were male. Age ranged from 35 to 73 years, mean 51 years. 8/11 (72%) were White British and the remaining were Asian. Mean pouch duration was 18 years, range 3 to 30 years. Except for 1 patient, all others had a single IPAA procedure. 5/11 (45%) had a single course of antibiotics with a maximum duration of a month, namely Ciprofloxacin or Metronidazole.

Out of the 10 components of the IBD Disk, lack of energy and feeling tired was the most important for our patients with a mean score of 7.3/10 followed by abdominal pain with a mean score of 6.7 and difficulty sleeping with a mean score of 6.4. The lowest scoring domains were education and work, mean score 3.5 followed by interpersonal interactions (3.7).

Additional symptoms that were important to this patient group but not included in IBD disk were mental wellbeing, rectal bleeding and fever. Incontinence for liquid stools also proved to be an important concern to 82% (9/11) of patients. Further aspects of concern comprised needing to wear a pad or plug and the effect of food on their pouch symptoms (54.5%) (6/11).

Conclusions Currently there are no validated patient reported outcome (PRO) tools available to assess patients suffering from pouchitis. The IBD Disk was used to assess its potential in our pouchitis patients. Its limitation however is that it is not designed for pouchitis specifically and was not developed with patient involvement. This work would suggest however that IBD disk may be adaptable for use in this patient group by the addition of the following symptoms- mental well being, rectal bleeding, fever and incontinence.

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PMO-35 UK NATIONAL AUDIT ON DIAGNOSIS AND MANAGEMENT OF COLITIS IN PATIENTS WITH PRIMARY SCLEROSING CHOLANGITIS

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Introduction The increased risk of colorectal cancer in patients with primary sclerosing cholangitis (PSC) and inflammatory bowel disease (IBD) justifies an enhanced surveillance strategy with annual colonoscopy and dye spray or protocol biopsies. As symptoms are frequently mild in PSC-IBD colitis can be missed unless colonoscopy and biopsies are undertaken at

diagnosis of PSC. We audited the colitis surveillance against audit standards published in the BSG and UK PSC guidelines.
Methods All UK PSC investigators were invited (March 2019-Jan 2021) to complete an electronic questionnaire encompassing demographics, diagnosis and bowel cancer surveillance data on each patient with PSC under the care of their service.
Results 1,795 patients across 30 centres (liver units n=1548, general gastroenterology units n=247) were included. Median age at diagnosis was 51 years and 56.4% were men.

Concurrent IBD was present in 1264 patients (70.4%) with 256 (20.3%) having had a colectomy. Where classified, colitis was present in 924/939 (98.4%) patients whereas isolated ileal disease was present in 15/939 patients. Pancolitis (Montreal classification E3) was the commonest disease distribution (673/939, 71.7%).

Most patients with IBD were followed up by an IBD specialist (n=616, 48.7%), 266 (21.1%) were followed by a general gastroenterologist, 236 (18.7%) by a hepatologist, whereas 15 (1.2%) patients were followed in a joint IBD/Hepatology clinic.

Among those with colitis without previous colectomy (n=743), 580 (78.1%) underwent annual colonoscopic surveillance; 30 (5.2%) with dye spray, 230 (39.7%) with biopsies and dye spray, and 252 (43.4%) with protocol biopsies alone.

Of those without documented IBD diagnosis, only 303/507 (59.7%) had this excluded by colonoscopy and biopsies.

Age<40 was associated with poorer compliance with colonoscopy surveillance. (P=0.023).
Conclusions IBD screening and colonic cancer surveillance is suboptimal in this large UK cohort of patients with PSC. This highlights the need for awareness of PSC-IBD management to address this unwarranted variation in care of people with PSC in the UK.

PMO-36 SAFETY AND EFFICACY OF USTEKINUMAB FOR CROHN'S DISEASE IN THE ELDERLY POPULATION

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Introduction The rising incidence of inflammatory bowel disease (IBD) worldwide and an ageing population has led to a marked increase in elderly IBD patients. Anti-tumour necrosis factor (TNF) agents are associated with an increased risk of serious infections and treatment discontinuation among elderly IBD patients; little is known about non anti-TNF biologics in this cohort. We aimed to examine safety and efficacy of ustekinumab in elderly Crohn's disease (CD) patients.
Methods Patients ≥60 years old commencing ustekinumab for CD were included in this retrospective multi-centre cohort study. We gathered data on adverse events, Harvey Bradshaw Index (HBI) and steroid therapy. The primary outcome was serious infections, defined as requiring hospitalisation. Efficacy was assessed by serial HBI measurement and treatment persistence.
Results 70 patients were included, with a median age of 68 years (range 60-87), male:female ratio of 9:5 and median Charlson co-morbidity index of 4 (range 2-9). 44 (62.9%) had prior anti-TNF exposure and 15 (21.4%) previous vedolizumab. Median treatment duration was 12 months (range 2-48), with a total of 84 patient years. 31 patients (41.3%) had steroids at initiation and 33 (47.1%) required a later course of steroids.

Abstract PMO-36 Table 1 infection aetiology and severity

	Aetiology	Number of patients (%)
Severe	Pneumonia	3 (4.3)
	Line infection	2 (2.9)
	Covid-19	1 (1.4)
	Biliary	1 (1.4)
	Epididymo-orchitis	1 (1.4)
	Shingles	1 (1.4)
Non-severe	Lower respiratory tract	9 (12.9)
	Urinary	6 (8.6)
	Coryzal	4 (5.7)
	Pneumonia	1 (1.4)
	Diarrhoea	1 (1.4)
	Line infection	1 (1.4)
	Soft tissue	1 (1.4)

7 patients (10%) had a combined 9 serious infections, of which 1 was life threatening requiring organ support. Incidence of serious infections was 0.107 per patient year. A further 18 had a combined 22 non-severe infections (Table 1). The overall infection rate was 0.42 per patient year. Charlson co-morbidity index was numerically higher in those developing severe infections (median 5, range 3-7 vs. median 4, range 2-9, P=NS). 3 patients developed a malignancy; non-Hodgkin's lymphoma, melanoma and pancreatic cancer.

Mean HBI improved from baseline 8.13 to 4.64 at 6 months and 4.10 at last follow up (both P<0.0001). Treatment persistence rate was 61.4% (N=43) and 36 (51.4%) were steroid-free. Reasons for discontinuation were primary non-response (42%), adverse event (32%), secondary loss of response (10%), malignancy (10%) and lack of funding (5%).
Conclusion Ustekinumab was safe and effective in a cohort of elderly CD patients. Infections were mostly mild and did not result in therapy discontinuation. Risk of serious infection was very low at 0.107 per patient year of treatment.

PMO-37 COVID-19 IMPACT ON CARE AND PRESCRIBING FOR INFLAMMATORY BOWEL DISEASE: DATA FROM THE IBD REGISTRY

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Introduction The first wave of the COVID-19 pandemic saw a sharp rise in UK cases during March 2020. We analysed UK IBD Registry data to investigate changes in contacts and prescribing in the immediate post-COVID period to gain insights into the impact of the pandemic on IBD care.
Methods We aggregated quarterly data (Jan-Mar 2019 to Apr-Jun 2020), extracting counts of clinical events (outpatient contacts and biologics reviews), contact types (face-to-face, 'F2F'; or telephone/virtual, 'non-F2F'), new diagnoses and drug starts (oral steroids, further categorised as prednisolone and non-