The safety and efficacy of retreatment with IFX after a short “drug holiday” was recently demonstrated in the STORI trial. However, data regarding re-treatment after a long drug holiday (≥1 year) are few. With increased use of biologics, the number of patients who have lost response to both biologics is increasing. These patients have limited therapeutic options but retreatment with IFX has been proposed.

**Methods** We performed a retrospective review of patients with Crohn’s disease who had been re-treated with IFX after a period off treatment of at least 1 year. Patients were identified from our biologics database and their records were reviewed. Patient details and clinical outcome measures were extracted into a standardised form.

**Results** 24 patients (14 male) were studied with a median age of 38 years (range: 21–61 years). 15 patients had responded to their first course of treatment; IFX was stopped due to episodic treatment being the norm at that time (n=9), patient choice (n=5), failure to re-attend for planned treatment (n=1) and development of strictures requiring surgery (n=2). The median time between stopping IFX and retreatment was 55 months (range 14–102). In this cohort, 80% responded to retreatment (12/15), 2 developed infusion reactions and 1 developed secondary loss of response. Median follow-up among continued responders was 20 months (range 2–45). Nine patients stopped their first course of IFX for either primary non-response (n=5), secondary loss of response (n=2) or infusion reaction (n=2). The median time between treatments was 32 months (range 18–42). In this cohort, 78% of patients responded to retreatment (7/9); 2 had infusion reactions. Follow-up among ongoing responders was for a median of 11 months (range: 2–84 months). All infusion reactions occurred on the second retreatment dose despite premedication with hydrocortisone (200 mg iv).

**Conclusion** Re-treatment with IFX after a drug holiday of at least 1 year was frequently successful, whether the patients had initially responded to IFX or not. The main limiting factor was the development of infusion reactions. We conclude that retreatment with IFX is a viable option in people with limited therapeutic options even if they failed to respond to their first course of treatment or have previously lost response.

**Abstract PTU-102 Table 1**

| Disease duration (y) (median (range)) | 36 (21–59) |
| Age at diagnosis (median (range)) | 22 (11–50) |
| % ileal disease | 4% (1/24) |
| % ileocolonic disease | 25% (6/24) |
| % Colonic disease | 71% (17/24) |
| % B1 (non-stricturing/penetrating) | 21% (5/24) |
| % B2 (stricturing) | 38% (9/24) |
| % B3 (penetrating) | 42% (10/24) |
| % p (perianal) | 38% (9/24) |
| Concurrent immunosuppressants | 63% (15/24) |

**Competing interests** None declared.

**Abstract PTU-103 Table 1**

<table>
<thead>
<tr>
<th>Number of ATIs</th>
<th>95% CI</th>
<th>RR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Episodic Infliximab</td>
<td>95/128 (74.2%)</td>
<td>0.66 to 0.81</td>
</tr>
<tr>
<td>Episodic Infliximab + immunosuppression</td>
<td>77/171 (46.0%)</td>
<td>0.38 to 0.53</td>
</tr>
<tr>
<td>Maintenance Infliximab</td>
<td>148/423 (35.0%)</td>
<td>0.31 to 0.40</td>
</tr>
<tr>
<td>Maintenance Infliximab + immunosuppression</td>
<td>32/215 (10.2%)</td>
<td>0.07 to 0.14</td>
</tr>
</tbody>
</table>

**Competing interests** None declared.

**PTU-104 THIOGUANINE NUCLEOTIDES: OPTIMISING THIOPURINE THERAPY IN INFLAMMATORY BOWEL DISEASE (A DGH PERSPECTIVE)**

**Introduction** Azathioprine (AZA) and 6-mercaptopurine (6MP) have been used in treatment of inflammatory bowel disease since introduction in the 1960s. 6-thioguanine nucleotides (TGN) levels are affected by thiopurine methyltransferase (TTMT) and its activity is therefore important. Methylated derivatives like 6 methyl mercaptopurine (MMP) are possibly partially responsible for hepatotoxic effects and maximum threshold value has been established at 5700 pmol/8×10⁶ RBC in a paediatric IBD population.