Introduction
Thiopurine therapy is effective in maintaining clinical remission in IBD. However, long-term therapy is associated with an increased risk of lymphoma; therefore in clinical practice it may be appropriate to withdraw thiopurines after prolonged remission. Nevertheless, many patients will experience disease relapse within 12 months of drug withdrawal.

The Aim of the present study was to retrospectively determine the relapse rate in ulcerative colitis (UC) and Crohn’s disease (CD) following azathioprine (AZA) or mercaptopurine (MP) withdrawal and to determine factors predictive of relapse.

Methods
Patients were identified by electronic case note review of IBD patients in eight major centres around the United Kingdom. Major inclusion criteria were AZA and/or MP therapy for a minimum of 3 years, AZA/MP withdrawn due to sustained clinical remission no steroid therapy for 6 months prior to drug withdrawal, and minimum 12 months follow-up.

The primary outcome was disease relapse requiring AZA reinitiation, steroids or colectomy within 12 months of AZA/MP withdrawal, with secondary outcome assessed at 24 months. Clinical/laboratory predictors of relapse were sought.

Results
Data was obtained on 97 patients with CD and 78 with UC. Median age at diagnosis was 26y (interquartile range [IQR] 20–38), and 49% were female. Median duration of thiopurine use was 73 months (IQR 54–104). Median duration of follow-up was 39 months (IQR 24–65 months).

CD was associated with a significantly higher risk of relapse than UC on Kaplan Meier analysis (Figure 1, p = 0.024). The moderate-severe relapse rate for 12 months was 27% for CD and 14% for UC. For 24 months, relapse rates were 41% for CD and 28% for UC. Elevated CRP was predictive of relapse at 12 months for CD (0 = 0.017), while elevated platelet count was predictive of relapse at 24 months for UC (0.021).

Retreatment with a thiopurine after relapse was successful in 34/39 (87%) for CD and 17/18 (94%) cases for UC.

Conclusion
Relapse rates after withdrawal of a thiopurine are high, particularly for CD, and predicting this remains difficult. The findings regarding CRP and CD in this data highlight the importance of ensuring patients are in deep remission prior to drug withdrawal. Further studies should evaluate the role of faecal calprotectin in this.

Disclosure of Interest None Declared.

Abstract PTH-079 Figure 1

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Disclosure of Interest None Declared.

PITH-080 DO WE NEED TO SCREEN OUR INFLAMMATORY BOWEL DISEASE (IBD) PATIENTS FOR DEPRESSION: THE PREVALENCE AND SEVERITY OF DEPRESSION WITHIN A TYPICAL D CERNAL COHORT OF IBD PATIENTS

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Introduction
Depression is believed to occur in 15 to 30% of IBD patients, in which suicide is not an uncommon ideation. Some researchers believe that psychiatric illness may have an aetiological role to play in the onset of inflammatory bowel disease (IBD), as the incidence of depression seems to be concentrated in the year before and after the initial diagnosis is made.

Objectives
To assess the true prevalence and severity of depression within our inflammatory bowel disease patients.

Methods
2400 patients with IBD in the Luton & Dunstable catchment were invited to participate in a web-based quality of life assessment, with the option to request a paper copy. All patients were deemed eligible provided they were over 18 and under 90 years of age, with no major learning difficulties or pre-existing serious mental disorders. The well validated 9-item self-report “Patient Health Questionnaire” (PHQ) was used. The PHQ-9 has a minimum possible score of 0 and a maximum possible score of 27. Scores of 5, 10, 15, and 20 represent cut-off scores for mild, moderate, moderately severe, and severe depression.

Results
245 patients completed the assessment (45% male; mean age = 53, SD = 17). 45% had Ulcerative Colitis, 45% had Crohn’s disease, and only 10% had IBD. In total, 42% of patients had a positive PHQ-9 score, indicating the presence of depression. 21% of the patients were categorized as having mild depression, 15% moderate, 15% moderately severe and 11% severe depression.

Conclusion
Depression is a common complication of inflammatory bowel disease and screening all IBD patients is a feasible strategy of identifying patients who may benefit from depression treatment. Referral to mental health services is indicated for all patients with PHQ-9 scores of 10 or higher.

Disclosure of Interest None Declared.

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THIOPURINE WITHDRAWAL FOR SUSTAINED REMISSION IN IBD: A UK MULTICENTRE STUDY

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Disease and 10% had an alternative form of IBD (e.g. Proctitis, Lymphocytic Colitis or Collagenous Colitis). The ethnic mix in the responding cohort was 91% Caucasian, 6% Asian, 2% Mixed and 1% was not stated. The sample had a mean score of 7.8 (CI 7 – 8.6). 98 (40%) of patients' scores reflected “no depression”; 64 (26%) reflected “mild depression”; 33 (14%) reflected “moderate depression”; 36 (15%) reflected “moderately severe depression”; 12 (5%) of scores reflected “severe depression”. Despite the severity, few of these patients were receiving treatment or therapy for their condition.

Conclusion 29% of our responding IBD patients were shown to have clinically significant levels of depression (moderately severe + severe), with 5% demonstrating scores suggestive of severe depression (1% expressing suicidal ideation). Relapse rates are known to be closely correlated with the severity of depression, and yet very few are on active treatment or review for this. The prevalence and severity of depression in our cohort of responding IBD patients supports the argument for screening all new IBD patients in order to optimise clinical well-being and treatment efficacy.

Disclosure of Interest None Declared.