greater; however in 27% (7) cases this was static, and in 11% (3) bowel wall thickness was greater. Total disease burden was greater in 2 patients. Complete radiological remission was demonstrated in only 2 patients.

Conclusion Response of Crohn's disease to ATT is well documented, and we are able to demonstrate quantifiable interval improvement using MRE. Recording the disease burden by way of stricture length and bowel wall thickness is a mode of measuring MRE response to treatment in Crohn's disease and may be used for disease reassessment as required by NICE.

Disclosure of Interest None Declared.

PTH-093 EFFICACY OF METHOTREXATE IN ULCERATIVE COLITIS: A DISTRICT GENERAL HOSPITAL EXPERIENCE

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Introduction Uncontrolled studies have reported methotrexate (MTX) to be efficacious in patients with Ulcerative Colitis (UC). British Society of Gastroenterology guidelines recommend MTX in patients who are unresponsive or intolerant of thiopurines. Biologics are not available for UC because of local funding restrictions. Our practise is to only consider MTX in UC patients who have failed thiopurine therapy despite dose optimisation, including allopurinol co-therapy, to achieve therapeutic 6-thioguanine (TGN) and normal methylmercaptopurine nucleotide (MMPN) levels. To the best of our knowledge this is the first study to assess the clinical outcome of UC patients treated with MTX following thiopurine dose optimisation.

Methods Patients with UC treated with MTX were identified from a prospective IBD database. Outcomes following treatment with thiopurines were identified. All patients received MTX with folic acid supplementation. Patients were loaded with intramuscular 25mg MTX for 16 weeks followed by weekly maintenance MTX of 15mg. Clinical response at 16 weeks and 12 months was used to assess the efficacy of MTX.

Results 9 patients (male = 8) with UC treated with MTX were identified. Median age was 47.3 years (range; 24.8–77.8). Median time since diagnosis was 4.5 years (range; 1–25.5). Disease extent was extensive (n = 5), left sided (n = 1) and rectosigmoiditis (n = 3). Thiopurines had previously been discontinued in 9 patients because they were intolerant (n = 5) or unresponsive (n = 4) despite therapeutic TGN and normal MMPN levels.

2 patients (22%) entered a steroid-free clinical remission with MTX at 16 weeks, which was sustained at 12 months. Both were intolerant of thiopurines because of severe nausea and dyspepsia. 7 patients (78%) discontinued MTX at 16 weeks because of a lack of response (n = 6) or side effects (n = 1, pneumonitis). Clinical outcomes at 12 months for patients who failed MXT were colectomy (n = 4), arsenic suppositories (n = 2), and diagnostic reclassification (n = 1) to Crohn's disease with CMV colitis treated with ganciclovir and infliximab.

Conclusion The efficacy of MTX in UC patients in this study was poor with a low clinical response rate (22%) and high colectomy rate (44%). Previous retrospective studies have reported MTX to be efficacious in patients failing thiopurines without reporting on the use of thiopurine optimisation. This study suggests that MTX has limited use in UC patients who are unresponsive to thiopurines despite dose optimisation.

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PTH-094 FAECAL CALPROTECTIN TESTING IN PRIMARY AND SECONDARY CARE – ARE THE CURRENT MANUFACTURER'S CUT-OFF LEVELS CLINICALLY USEFUL?

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Introduction Faecal Calprotectin (FC) is a protein complex found in high concentrations in neutrophils and is released within the bowel when inflammation occurs. It can be measured quantitatively using ELISA and is very sensitive and specific in discriminating inflammatory from non-inflammatory pathologies causing diarrhoea. The manufacturer recommends a positive stool FC test (> 60μg/g) to be indicative of inflammation and further investigations (e.g. endoscopy, histology and imaging) and referral to a Gastroenterology clinic is advised.

Methods Aims: To determine whether the manufacturer's cut-off levels for referral (> 60μg/g) are clinically useful in making a positive diagnosis in patients presenting with chronic diarrhoea.**Methods**: We analysed the outcome of 122 FC test results done in primary and secondary care during a 3 month period from October to December 2011 performed on patients who presented with chronic diarrhoea without a pre-existing diagnosis of Inflammatory Bowel Disease (IBD). According to manufacturer's guidance, a FC result of > 60μg/g was considered positive and ≤60μg/g negative. Positive FC patients were seen in a Gastroenterology Clinic and investigated appropriately. The primary outcome of this study was to record the final diagnosis arising out of FC testing and investigations thereof. Secondary outcomes were to correlate FC levels to the final diagnosis.

Results Of 122 FC tests, 41% (n = 51) were read as positive vs. 58% (n = 71) negative. 19/51 (37%) FC positive patients had a positive organic diagnosis (IBD = 9, Diverticulosis = 5, Colonic Polyps = 3, Infective colitis = 1 and Chronic Pancreatitis = 1) while the remaining 32 pts (63%) were given a diagnosis of functional bowel disorder after investigations. Of 71 patients testing negative on FC, 94% (n = 67) had functional bowel disorder; only 6% (n = 4) were found to have an organic condition, none of them IBD. This correlates with a positive predictive value of 37% and a negative predictive value of 94% for organic disease. The FC levels of those tested positive with a diagnosis of functional bowel disorder ranged from 61 – 547μg/g (mean 153μg/g) whereas FC values of those with organic conditions ranged from 63 – 1573μg/g (mean 746μg/g).

Conclusion The current manufacturer's cut-off at > 60μg/g is not clinically useful to diagnose an organic bowel pathology and further studies are needed to determine the true cut off value for a higher yield of a positive diagnosis. Cost effectiveness studies are also needed to determine referral cut off values.

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PTH-095 ARE IBD PATIENTS EITHER CRP PRODUCERS OR NON-PRODUCERS? A LONGITUDINAL STUDY

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Introduction C-reactive protein (CRP) is an established marker of disease activity in inflammatory bowel disease (IBD). However not all flares in IBD are associated with an elevated CRP. This raises the