magnetic resonance enterography (MRE), barium study (BS), CRP and clinical assessment (CA).

**Results** Seventy-one patients (44 female; median age at diagnosis 24 years) were included with a median duration of IBD of 24 (0–264) months. Indications were severe active luminal (50/71), fistulating perianal (18/71) and other fistulating disease (5/71). The median treatment duration was 18 months (range 12–76) with 62 (87%) on immunomodulators post anti-TNF withdrawal. Relapse rates within 90,180 and 365 days were 3/71 (4.2%), 14/67 (21%) and 27/117 (24%) respectively. In perianal disease alone, the relapse rate was 6/18 (33%) at 1 year. 25 of those who relapsed were retreated with anti-TNF, with an overall recapture rate of 84%. In those retreated with the same agent as previously withdrawn the response rate was 80%. A further 5 were successfully retreated with ADA when IFX had been withdrawn. Those (6) who had a dose escalation in 6 months prior to withdrawal all relapsed.

Assessment practise changed following NICE guidance in 2010. Prior to this 5/15 (33%) stopping anti-TNF had a CA alone. Following NICE guidance 2/56 (3.6%) were assessed only by CA. Investigations to complement routine CA by Harvey Bradshaw Index (HBI), included ≥ 1 of colonoscopy (52), CC (4), MRE (19), SBC (5), BS (2) and CRP (66). HBI ≥ 4 and a CRP of ≥ 5 in the 6 months prior to formal assessment was observed in 26 patients. 14/26 (54%) relapsed following cessation of anti-TNF (positive predictive value of 61%). Further invasive investigations in this group were abnormal in 2 patients.

**Conclusion** In this UK cohort, elective withdrawal of anti-TNF was associated with a relapse rate of 48% after 12 months, with a high retrospect completion rate. Due to NICE guidance, increased invasive assessment occurred, but the role of endoscopy and imaging to evaluate remission prior to withdrawal of anti-TNF needs further evaluation.

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**Abstract PTU-055 Table**

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**Introduction** Objective To evaluate long-term efficacy of adalimumab (ADA) for patients with moderately to severely active ulcerative colitis (UC).

**Methods** The ADA UC development programme consists of two trials (ULTRA 1 and ULTRA 2) followed by an ongoing multicentre open-label (OL) extension. Patients entering the extension on OL weekly ADA dosing continued on same. Patients entering the extension study from any blinded cohort (ADA or placebo [PBO]) or an OL cohort receiving ADA 40mg every other week (eow) received OL ADA 40mg eow. For patients entering from a blinded cohort, increase to 40mg weekly for flare or non-response was allowed at or after week 12. For patients entering from an OL cohort, increase to 40mg weekly for flare or non-response was allowed at after week 12 for patients in clinical response at entry, or week 2 for patients with inadequate response at entry. Adjustments to concomitant medications including corticosteroids were allowed per protocol specifications. Partial Mayo score (PMS, Mayo score without endoscopy subscore) was collected at every study visit during the lead-in trials and the OL extension. Mean PMS over time through 3 years (172 weeks) from first dose of ADA was assessed using observed case method in the “any ADA” population (patients who received at least one dose of ADA in the lead-in or extension trials) using a data cut-off of 16 December 2011. The proportion of patients in clinical remission per PMS (PMS ≤ 2 with no subscore > 1) at week 60 of the OL extension was assessed in the intent-to-treat (ITT) population (patients enrolled in the extension, excluding patients from sites non-compliant with good clinical practises), using non-responder imputation (NRI) to handle missing data.

**Results** The observed mean PMS at day of first dose of ADA was 3.9 (N = 992), and decreased over time through 172 weeks of treatment to 1.5 (N = 210, Table). Of the 588 ITT patients from the lead-in studies who enrolled into the OL extension, 325 (55.3%, NRI) achieved clinical remission per PMS at week 60 of the OL extension. No new safety signals were observed.

**Conclusion** The results of the ongoing extension trial support clinically meaningful efficacy of adalimumab for the treatment of moderately to severely active UC, sustained for up to 3 years.

**REFERENCES**


**PTU-056** PREGNANCY OUTCOMES IN PATIENTS WITH CROHN’S DISEASE: LESSONS FROM AUDIT IN A SPECIALIST IBD CLINIC
doi:10.1136/gutjnl-2013-304907.148

**Conclusion** The number of pregnancies in a specialist IBD clinic is high up to 20/year in this series highlighting a potential additional service need. A specialist obstetric medicine service can provide reassurance regarding safety of drugs in pregnancy, which in turn may reduce flare rates and result in good pregnancy outcomes. Observed outcomes did not fall outside that expected from larger reported series.

**Disclosure of Interest** None Declared

**PTU-057** POINT-OF-CONTACT FAECAL CALPROTEIN (FC) TESTING IN DIARRHOEA HELPS DECISION MAKING FOR REFERRAL TO GASTROENTEROLOGISTS: A PRIMARY CARE PILOT STUDY IN NORTH EAST ENGLAND
doi:10.1136/gutjnl-2013-304907.149

**Introduction** Faecal Calprotectin (FC) is a cytosolic protein belonging to the S-100 family of calcium binding proteins found in neutrophils. It is excreted in the intestinal lumen in inflammatory conditions of the gut and can be used to distinguish irritable bowel syndrome (IBS) from other inflammatory bowel conditions such as colitis, diverticulitis, etc. Point-of-contact qualitative FC tests are now available and can be used in primary care to aid decision making for referrals to gastroenterologists for young patients presenting with chronic diarrhoea.

**Methods** To assess the feasibility and cost effectiveness of a primary care pathway using a point-of-contact FC Test (Caldepect®) to aid decision making for referrals to gastroenterology in young patients presenting to their primary physicians with chronic diarrhoea.

**Results** 80 pregnancies in 57 patients with CD were identified. 10 patients were pregnant, 9 patients (13 pregnancies) with incomplete data were excluded. Therefore, pregnancy outcomes of 57 pregnancies/38 patients (mean age: 30.7 years) were analysed. 31/38 (82%) of patients had luminal disease, 7/38 (18%) perianal disease. 36/38 (95%) conceived naturally, 1/38 (2.5%) by assisted reproduction, 1/38 (2.5%) by IVF. Flare rates and results in early pregnancy, 4/57 (7%) on biologics + t hydrocortisone (TNF-α), 4/57 (10%) on TNF-α, 6/57 (10%) on TNF-α+5-ASA, 7/57 (12%) on 5-ASA, 2/57 (3.5%) on steroids and 1/57 (1.7%) on elemental diet. 15/57 (26%) pregnancies had flares, of which 5/15 (33%) continued throughout pregnancy, 5/15 (33%) occurred in the 1st trimester, 4/15 (27%) in the 2nd, and 1/15 (7%) in the 3rd. Of all pregnancies with flares, 9/15 (60%) were on no CD therapy. The mean week of delivery was 39.5 weeks (36–42), 32/46 (70%) of deliveries were vaginal and 14/46 (30%) by Caesarian section (CS). Of CS, 8/14 (57%) were planned due to perianal disease 5/8 (63%) or obstetric indication 3/8 (33%). Flare rates and results in early pregnancy were: live births 46/57 (61%), miscarriages 10/57 (17%), termination 1/57 (2%). The mean birth weight (BW) of the newborns was 5 kg (1.9 kg–5.1 kg), 4/46 (11%) of the babies were of low BW (<2.5 kg). Neonatal issues were recorded in 5/46 (11%), 1 diabetes mellitus, 2 cardiac anomalies, 1 with viral infection at 8 days, 1 cot death. Of the miscarriages, 5/10 (50%) were on no CD therapy and 4/10 (40%) flared in early pregnancy. The termination was due to use of medication unrelated to CD that could potentially cause congenital anomalies.

**Disclosure of Interest** None Declared