
REFERENCES

PTU-060 PHENOTYPIC CHARACTERISATION OF INFLAMMATORY BOWEL DISEASE IN SOUTH ASIANS IN THE UNITED KINGDOM-INSIGHTS INTO A SHIFTING LANDSCAPE
doi:10.1136/gutjnl-2013-304907.152

Introduction The aetiology of inflammatory bowel disease (IBD) remains elusive. The increasing incidence of IBD in developing countries and immigrant populations appears to outpace what genetic influences alone could instigate. There is a relative dearth of literature on the phenotypic characteristics of South Asian immigrant populations. The aim of our study was to define the clinical phenotype of IBD in South Asians in North-West England.

Methods We conducted a retrospective study of 102 patients of South Asian origin attending IBD clinics at our hospital. Clinical data including demographics, disease characteristics (Montreal classification), treatment and blood results were obtained using electronic case records.

Results Of 106 patients reviewed, 55 were male. The median age was 38 years (range 16–80) and mean disease duration was 9.5 years. Seventy-six patients had ulcerative colitis (UC) and 30 had Crohn’s disease (CD). Five patients were current or ex smokers (4.7%). Seventeen patients had extra-intestinal manifestations of IBD (16.0%). Of UC patients 37 had pancolitis, 34 left sided disease and 4 proctitis. Of patients with CD, 3 had ileal disease, 11 had colonic disease and 16 had ileocolonic disease. Five CD patients had strictureing disease, 10 had penetrating disease (6 also strictureing) and 15 had non-penetrating, non-stricturing disease. Penileal disease was noted in 3 at diagnosis and in 5 subsequently. Eighty-four patients received steroids, topical steroids (51), 5-ASA (99), topical 5-ASA (31), azathioprine (56), 6- mercaptopurine (4), cyclosporine (2), methotrexate (10), infliximab (21) and adalimumab (10). Fifty eight patients received at least one immunomodulatory therapy with the median time to use being 12 months (range 0–276 months). Thirteen patients (7 CD, 3 UC) required surgery (3 total colectomy, 10 subtotal). Mean time to surgery was 4 years (range 0–15 years). Seventeen patients had disease progression leading to Montreal reclassification (median time 60 months; range 1–216 months).

Conclusion We noted a higher prevalence of UC with predominately pancolonic disease and a significant proportion of CD with penetrating or strictureing disease. The majority of patients required immunomodulatory therapy. Epidemiologic insights from such populations may provide further clues in defining an aetiologic paradigm for IBD and should form an important area of further research. A case control study exploring differences is underway at our institution.

Disclosure of Interest None Declared

PTU-061 VITAMIN D DEFICIENCY IS WIDELY PREVALENT IN SOUTH ASIAN PATIENTS WITH INFLAMMATORY BOWEL DISEASE
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Introduction There has been resurgent interest in recent years in the pro-hormone vitamin D in its role and plausible effects on immune regulation and inflammatory bowel disease (IBD). We postulated a wide prevalence of vitamin D deficiency in South Asian patients with implications for the control of their IBD. The aim of our study was to review vitamin D assessment in a South Asian IBD cohort.

Methods We conducted a retrospective review of 102 South Asian patients attending IBD clinics in our institution. Clinical data including demographics, disease characteristics (Montreal classification) and therapy were obtained from electronic record review. Serum 25-hydroxyvitamin D (25-OHD) concentrations were recorded in all patients tested and in all having serial measurements.

Results Of 106 patients reviewed, 55 were male. The median age was 38 years (range 16–80) and mean disease duration was 9.5 years. Seventy-six patients had ulcerative colitis (UC) and 30 had Crohn’s disease (CD). Five patients were current or ex smokers (4.7%). Vitamin D status was assessed in 52 patients (49%), 26 with deficiency and all 52 had insufficient levels. Vitamin D status was assessed in 52 patients (49%), 26 had insufficient levels. Median 25-OHD was 10.25 (range 3.3–44.4). Fifty one patients had levels 25 ng/ml consistent with deficiency and all 52 had insufficient levels < 25 ng/ml. Of the patients with deficiency 35 had UC and 16 had CD. Of the UC patients, 18 had pancolitis, 13 had left sided disease and 4 proctitis. Of the CD patients 5 had penetrating disease and 4 had strictureing disease. Forty-three of the deficient patients had received
steroids and 29 received immunomodulatory therapy (27 azathioprine, 3 methotrexate, 1 cyclosporin, 2 6MP, 10 infliximab, 6 adalimumab). Seven deficient patients (4 CD, 3 UC) required a colectomy and the mean 25-OHD level in this group was 10.7 (range 4.0–20.1 ng/ml). Mean time to surgery was 3.6 years (range 0–8 years). Of the CD patients 1 had a subtotal colectomy, 3 had hemicolectomy and of the UC patients 2 had subtotal colectomy and 1 had total colectomy.

**Conclusion** There was a high prevalence of Vitamin D deficiency although assessment was suboptimal and probably reflective of a wider experience. Patients with vitamin D deficiency appeared to have a more aggressive disease course. The role of vitamin D in IBD is a science in evolution underpinning exciting implications for research. Meanwhile vitamin D deficiency is under-recognised and consequently undertreated with likely implications for adequate disease control in this potentially vulnerable group.

**Disclosure of Interest** None Declared

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**PTU-062 VALUE OF MRI IN PREDICTING SEVERE OUTCOME IN SMALL BOWEL CROHN’S DISEASE**

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**Introduction** The optimal approach to managing terminal ileal (TI) Crohn’s disease remains to be defined. It is unclear at what stage surgery or biological therapy should be offered and current clinical and biochemical parameters offer poor prediction of disease course. Small bowel MRI scanning (SBMRI) has been correlated with endoscopic and histological disease severity in Crohn’s disease and may offer better global assessment of the extent and severity of disease. We aimed to determine which MRI features might predict the need for surgery or biological therapy.

**Methods** 48 sequential patients with Crohn’s disease who underwent SBMRI in a 20 month period to Feb 2011 were identified from a radiological database. 8 patients were excluded due to predominant colonic disease. All remaining 40 patients had confirmed isolated TI disease. Standard management with escalation of therapy via immunomodulators, biological agents and surgery based on clinical follow up was applied. Patients were followed for a minimum of 2 years after the initial MRI. MRI scanning was performed using oral fluid load, IV buscopan, T1/2 axial, coronal and dynamic post contrast sequences. The images were reviewed by a radiologist blinded to outcome of cases and key abnormal features recorded (mesenteric abnormalities, wall thickness > 6 mm, disease extent > 15 cm or proximal dilatation > 25 mm). Patients were then divided into 2 groups, those requiring biological therapy or surgery (severe) and those managed with 5ASA or immunomodulators alone (non severe).

**Results** The characteristic of the two groups is shown in the table. Means given unless stated.

### Abstract PTU-062 Table

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<th>n</th>
<th>Age</th>
<th>CDAI at MRI</th>
<th>CRP at MRI</th>
<th>Years post diagnosis</th>
<th>Previous surgery (%)</th>
<th>Immunomodulator use (%)</th>
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<tbody>
<tr>
<td>A Non severe</td>
<td>20</td>
<td>36</td>
<td>77</td>
<td>19</td>
<td>9.9</td>
<td>45</td>
<td>45</td>
</tr>
<tr>
<td>B Severe</td>
<td>20</td>
<td>42</td>
<td>120</td>
<td>30</td>
<td>9.8</td>
<td>45</td>
<td>75</td>
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6/20 patients in the non-severe group (A) had two or more adverse radiological features compared with 12/20 in the severe (B) group (p = 0.06). However, only 3/20 patients had lumen > 25 mm or extent > 15 cm in A compared with 15/20 in B (p < 0.001). Wall thickness and mesenteric involvement were not associated with a severe outcome. Disease extent and proximal luminal diameter were significantly associated with surgery (p = 0.02 and p = 0.001). 85% of patients who eventually required surgery had either proximal lumen > 25 mm or disease extent > 15 cm.

**Conclusion** Two or more adverse radiological MRI features are associated with the need for surgery or biological therapy. Small bowel dilatation > 25 mm proximal to the disease segment and disease extent > 15 cm are particularly associated with the need for surgery. These MRI findings may be helpful in deciding appropriate longer term strategies for managing these patients.

**Disclosure of Interest** None Declared