PTU-074 
LOW-DOSE THIOPURINE AND ALLOPURINOL CO-THERAPY RESULTS IN SIGNIFICANT COST SAVINGS AT A DISTRICT GENERAL HOSPITAL

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Introduction Thiopurines are used for maintenance of remission in IBD. In England and Wales biologics are approved by NICE (National institute for health and clinical excellence) for Crohn’s disease (CD) but not ulcerative colitis. Azathioprine (ADA) is a well-tolerated, effective drug with a long-term record of use. We present data on the effectiveness and cost of thiopurine use in conjunction with allopurinol in the treatment of patients with IBD.

Methods A retrospective cohort study of patients started on thiopurine as the initial treatment strategy for IBD at our institution were included in the analysis. Cost data were gathered for the formulation of thiopurine used (liquid/capsule/tablet). Mean annual drug costs were calculated using the cost of thiopurine used (liquid/capsule/tablet) and the dose prescribed. Costs of attending the day unit for an infusion were not included.

Results Of the 182 patients who started AZA, 67 (37.8%) had an escalation of therapy – 20 (30%) started methotrexate, 18 (26.8%) started biologics and 29 underwent surgery. Of the 125 patients who stopped AZA, 40 (11.3%) patients did so due to side effects, 17 (5.6%) patients due to theraputic failure, hepatitis or side effects. In this situation most UK clinicians start biologics in CD patients. This has significant cost implications. An alternative treatment strategy is low dose thiopurine and allopurinol (LDTA) co-therapy which is effective in most patients who fail standard dose thiopurines. Some patients require liquid thiopurine to achieve the correct (low) dose -this formulation is significantly more costly than tablets.

Conclusion In the present study we have identified significant annual cost savings when this treatment strategy is used to prevent escalation to biologics. These cost savings are likely to be even greater when this treatment strategy is used to pre-empt escalation to biologics. The annual drug costs of their treatment with LDTA compared with biologic therapy (adalimumab for patients over 65kg, infliximab for patients over 65kg) were calculated including the cost of the formulation of thiopurine used (liquid/capsule/tablet) and the dose prescribed. Costs of attending the day unit for an infusion were not included.

Disclosure of Interest None Declared

PTU-075 
LONG TERM OUTCOME OF AZATHIOPRINE THERAPY IN 353 CONSECUTIVE IBD PATIENTS

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Introduction Thiopurines are the mainstay of therapy in Inflammatory Bowel Disease (IBD). Azathioprine (AZA) and Mercaptopurine are very effective at maintaining remission but have a wide range of side effects which can limit their use as long term maintenance therapy. To assess how effective AZA was in IBD, and what its limitations were, the outcome of 353 consecutive IBD patients started on AZA with at least onw year follow up was assessed.

Methods Since 2005 all patients started on AZA for IBD have been recorded and monitored. These data were then used to assess the outcomes of patients where there had been at least one year of follow up. Outcomes recorded were whether AZA was still being taken or not. If still being taken information about the disease activity was recorded. If AZA therapy had been discontinued then the reason for this was recorded and subsequent therapeutic interventions noted.

Results 353 patients had started AZA and had at least one year of follow up. TMTT status was checked in all patients. Dosing was as follows: low TMTT, 50mg and increased as tolerated. Normal TMTT: 2–2.5mg/kg.

Of the 353 patients, 204 had Crohn’s disease (CD), 141 had Ulcerative Colitis and 8 had IBD-unclassified. The male:female ratio was 184:169 (52.1% male). Age range was 16–86 years (mean; 46).

322/353 (91%) remain under follow up. 127 (36%) of patients stopping AZA at one year. After six years 152 (43.1%) remained on AZA, 182 (51.6%) had stopped and in 19 (5%) the outcome was unknown. Nausea and myalgia were the main reasons for stopping AZA. 40 (11.3%) patients developed hepatitis (ALT rise > 2xULN), 6 (1.7%) developed myelosuppression and 7 (2%) developed pancreatitis (consistent clinical presentation and raised amylase). Of the 182 patients who stopped AZA, 67 (37.8%) had an escalation of therapy – 20 started methotrexate, 18 started biologics and 29 underwent surgery. Of the 52 who continued AZA, 138 (90.8%) were in a clinical remission based on clinical assessment supported by normal C-reactive protein in 126 (91.3%), Harvey Bradshaw Index in those with CD 55 (40%) patients and endoscopic findings in 22 (15.9%). 112 (73.6%) patients had blood monitoring (FBC and LFTs) at least quarterly and 147 (96.7%) at bi-annually.

Conclusion For such an important drug in IBD management a significant number of patients stop AZA due to side effects. This study highlights these so that patients can be accurately informed. It also highlights that AZA when tolerated is a very effective maintenance therapy. TMTT status was checked in all patients. Dosing was as follows: low TMTT, 50mg and increased as tolerated. Normal TMTT: 2–2.5mg/kg.

Disclosure of Interest None Declared

PTU-076 
DIAGNOSTIC POTENTIAL OF VOLATILE ORGANIC COMPOUNDS AS FAECAL BIOMARKERS IN INFLAMMATORY BOWEL DISEASE

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Introduction Volatile Organic Compounds (VOCs) can be utilised as non invasive biomarkers for gastrointestinal diseases such as IBD, as changes in VOCs reflect internal metabolic and pathological processes.

Methods Patients were recruited from outpatients with proven Crohn’s disease(CD N = 41), ulcerative colitis(UC N = 49), IBS(N = 50) and healthy volunteers(N = 47). Disease activity was recorded using Harvey-Bradshaw index(HBI) in CD and simple clinical colitis activity index(SCCAI) in UC. Faeal headspace gas was sampled with SPME and transferred to GC-MS for VOC identification. Statistical analysis was performed on presence or absence and peak area of VOCs.

Results

Disclosure of Interest None Declared