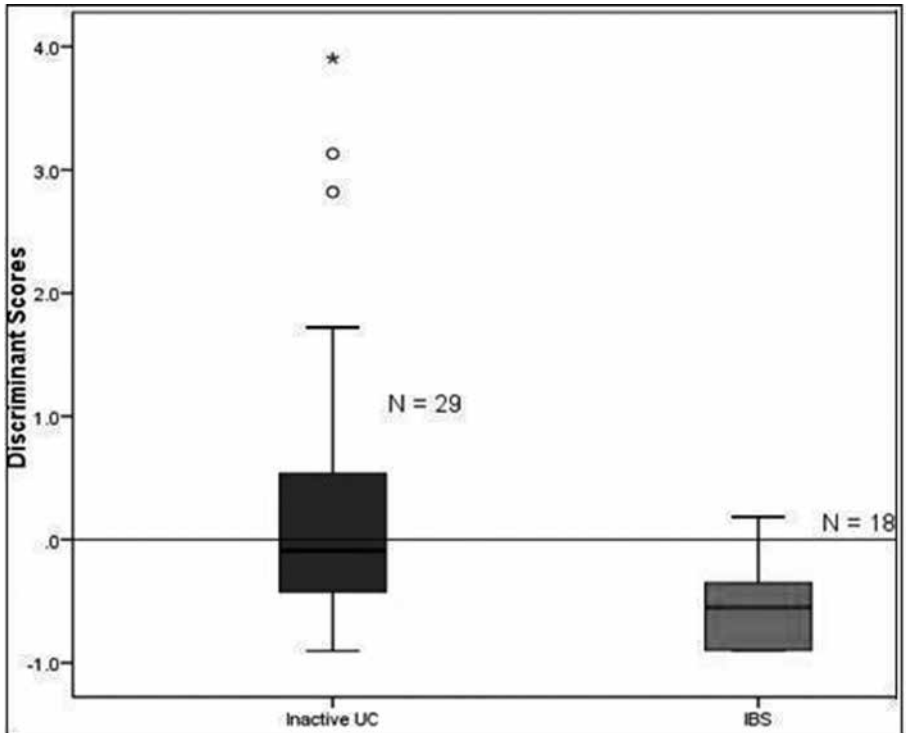
Abstract PTU-077 Table

Based on presence or absence of compounds (using Chi square test)	IBS	HEALTHY
UC INACTIVE (SCCAI≤ 2)	2-Butanone P = 0.004;2-Pentanone P = 0.003; 3-Ethylcyclopentanone P = 0.033; Benzaldehyde P = 0.003;Limonene P = 0.008; Pyrrole P = 0.037; UnknownF15.63 P = 0.001	2-Pentanone P = 0.007; 2-Butanone P = 0.026;Disulfide, dimethyl P = 0.033; UnknownF15.63 P = 0.013
UC ACTIVE (SCCAI ≥ 3)	1-Hexanol, 2-ethyl P = 0.017; 2-Heptanone P = 0.048; 3-Ethylcyclopentaone P = 0.018; 7-Octen-2-ol, 2,6-dimethyl- P = 0.014; Limonene P = 0.001; p-Xylene P = 0.018; UnknownF15.63 P = 0.001; UnknownU17.44 P = 0.004; UnknownU22.53 P = 0.006;	UnknownF15.63 P = 0.016
CD INACTIVE (HBI≤ 3)	Limonene P = 0.012; Unknown F15.63 P = 0.008	-
CD ACTIVE (HBI ≥ 4)	Benzaldehyde P = 0.03; Limonene P = 0.012	-



Abstract PTU-077 Figure

PTU-078 EFFICACY OF HIGH AND LOW DOSE ORAL VITAMIN D REPLACEMENT THERAPY IN INFLAMMATORY BOWEL DISEASE: SINGLE CENTRE COHORT

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Introduction Inflammatory bowel disease (IBD) patients are at risk of micronutrient deficiencies, including vitamin D. There is increasing evidence that vitamin D deficiency has a negative impact on disease activity. This study aims to determine the vitamin D status of a sub-set of IBD patients at a University Hospital and to evaluate the effectiveness of oral vitamin D treatment in correcting the deficiency.

Methods All IBD patients with recorded serum vitamin D levels measured in 2011 were identified. Vitamin D deficiency was determined as combined vitamin D2 and D3 plasma levels lower than 52 nmol/L and treatment response was assessed up to 4–6 months after initiation of oral treatment. Oral vitamin D supplementation was classified as 'low dose' when patients prescribed daily 800 units of vitamin D2 or D3 and classified as 'high dose' when given either 100'000 units once only or 50'000 units per week for 6 weeks.

Results 205 IBD patients with plasma vitamin D measurements were identified, 95 (46%) were found to be vitamin D deficient. There was no significant difference in the prevalence of vitamin D deficiency between the Crohn's disease (CD) and ulcerative colitis (UC) patients, 44% vs 50%, (p = 0.449). 50/95 (52.6%) patients received treatment and 32 treatment episodes had follow up vitamin D status measurement within 4–6 months. Those who received 'high dose' oral vitamin D demonstrated an increase in vitamin D levels of 150% after treatment compared to an increase of 34% in those put on 'low dose' vitamin D supplement (p = 0.001). There was no significant difference in treatment response between CD and UC (p = 0.874) (see table 1).

Abstract PTU-078 Table 1 Plasma vitamin D response to differing doses of oral treatment in CD and UC

	Subjects	Vitamin D deficient (%)	Treated orally + follow up Vitamin D available	% increase in plasma vitamin D	High dose Rx	% increase in plasma vitamin D	Low dose Rx	% increase in plasma vitamin D
All subjects	205	95 (46)	32	115	24	150	8	34
UC	70	35 (50)	11	100	8	167	3	47
All CD	135	60 (44)	21	116	16	150	5	29
Ileocolonic CD	45	20 (44)	9	132	7	156	2	13
Colonic CD	36	15 (42)	5	64	3	114	2	46
Small bowel -CD	54	25 (46)	7	145	6	173	1	14

Conclusion There were no differences in plasma vitamin D concentrations between patients with CD and UC. Oral vitamin D replacement is an effective treatment for vitamin D deficiency in IBD patients and appears to be dose responsive; irrespective of whether patient have UC or CD (including small bowel disease). The optimal dose of oral vitamin D supplementation is yet to be determined, but higher doses are significantly more effective.

Disclosure of Interest None Declared

PTU-079 THE INFLAMMATORY BOWEL DISEASE QUALITY IMPROVEMENT PROJECT – PROGRESS TWO YEARS ON

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Introduction The IBD Quality Improvement Project (IBDQIP) was established in 2010, as a project to help improve adult and paediatric IBD services across the UK. Here we report the first two years of progress.

Methods IBDQIP uses a web-based system (www.ibdqip.co.uk) to enable services to benchmark themselves against the national IBD standards and then action plan improvement using a combination of self-assessment, network support and a shared repository of best practise. Results are provided to sites graphically as a performance dashboard using a hierarchical grading system. Initial sites completed the first assessment in 2011, with a second round in 2012. Progress has been assessed by comparing scores between rounds and from site feedback.

Results Participation increased over time, with 69 sites (56 adult & 13 paediatric) participating in round 1 (2011) and 84 sites (66 adult & 18 paediatric) in round 2 (2012). 90% of sites completed their evaluation within 4 hours (median 2–3). 60% of sites met as an MDT to complete their return, which was rated as the most powerful catalyst for change (figure 1). Significant improvement has been made across a range of measures:

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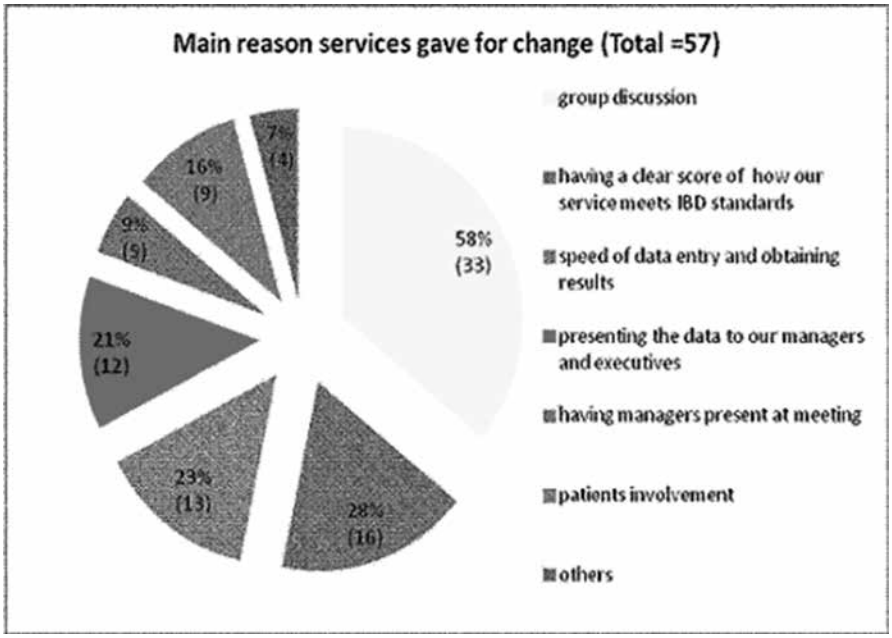
Sites with significant improvement in the year between 2011 and 2012 (for 44 adult sites completing both rounds)	
Statements	p value
Written information about IBD and a range of treatments is made available to all patients	0.002
All IBD patients are provided with information about their local patient support groups	0.039
> 50% IBD patients have regular stool chart documented during admission	0.008
IBD patients can be referred by the IBD Service for psychological or counselling input	0.039
Shared care agreement in place for management of stable patients discharged back to primary care.	0.039
Patient surveys carried out annually	0.013



Abstract PTU-079 Figure