Queen’s Hospital, Romford is one of the largest centres performing leucocytapheresis in the UK. Here we present a retrospective case series of patients treated with the Adacolumn® leucocytapheresis filter column for UC between 2008 and 2012, designed to assess these long term end-points with follow-up to June 2013.

Methods Case notes of all patients who underwent leucocytapheresis for refractory UC were reviewed retrospectively to assess the primary end-points of colectomy and death, and the secondary end-points of clinical remission and steroid-free remission.

Results 34 patients met the entry criteria and relevant outcome data was available in 31/34. Prior to leucocytapheresis 94% of patients were steroid dependent and 91% had previously failed treatment with a thiopurine. The mean number of leucocytapheresis columns given was 7.7 +/- 0.3. Following treatment 23% underwent colectomy a median 7 months after the start of this treatment with a mean overall follow-up of 500 days. 1 patient died during the study period (from a sub-arachnoid haemorrhage). 52% experienced an initial clinical response and 32% remained in steroid-free remission at 1 year after treatment.

Conclusion The rate of colectomy after leucocytapheresis compares favourably with other rescue therapies. The rate of steroid-free remission with leucocytapheresis is comparable to the response rates seen in randomised controlled trials of anti-TNF therapy. Given that the patients in this study were steroid dependent and had been refractory or intolerant to thiopurines, these results are similar to sub-group analysis of an earlier sham-controlled trial now required to replicate these findings and further delineate the pathways involved in the mechanism of action of many of these drugs, most convincingly azathioprine. Further work is now required to elucidate the pathways in vivo.

Disclosure of Interest None Declared.
obtained from healthy controls by centrifugation over Polymorphonuclear (PMN) leucocytes, which were obtained from healthy volunteers by venepuncture.

**Results**

No significant difference in the relative killing of E. coli K12 (-14 ± 11% vs. -45 ± 9%) and Staph. aureus (-52 ± 4% vs. -63 ± 5%) nor in the relative survival of AIEC HM605 (+50 ± 26% vs. +8 ± 22%) within macrophage-derived macrophages was seen (healthy controls vs. Crohn’s disease respectively; n = 10 each group). TNFα, IL-6 and IL-8 production were not significantly different between the two groups and macrophage-mediated neutrophil chemotaxis was equivalent. Smoking status did not affect bacterial survival, with no differences observed in killing between current smokers, ex-smokers and non-smokers.

**Conclusion**

AIEC are ineffecively killed by both Crohn’s disease and healthy macrophages. Macrophages from patients with Crohn’s disease do not appear to have an inherent defect in killing and exhibit equivalent ability to induce neutrophil chemotaxis relative to controls. These data suggest circulating inhibitors of Neutrophil chemotaxis may explain the previously observed defective neutrophil chemotaxis and bacterial clearance in vivo.

**Disclosure of Interest**

P. Flanagan Grant/research support from: Awarded a Shire innovation fund for SpRs, S. Subramanian: None Declared, B. Campbell: None Declared, J. Rhodes Consultant for: A member of advisory boards for Atlantic, Procter and Gamble and Falk, Speaker bureau with: Has received speaking honoraria from Abbott, Falk, Ferrering, Glaxo Smith Kline, Procter and Gamble, Schering Plough, Shire and Wyeth, Conflict with: With the University of Liverpool and Provexis UK, holds a patent for use of a soluble fibre preparation as maintenance therapy for Crohn’s disease plus a patent pending for its use in antibiotic-associated diarrhoea.

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**PWE-092**

**SYMPTOM RESPONSE FOLLOWING ADVICE ON A DIET LOW IN SHORT-CHAIN FERMENTABLE CARBOHYDRATES (FODMAPS) FOR FUNCTIONAL BOWEL SYMPTOMS IN PATIENTS WITH IBD**

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**Introduction**

The low FODMAP diet is an effective dietary intervention for people with functional bowel disorders (FBD), which are common in patients with inflammatory bowel disease (IBD). One study has reported that half of patients with IBD report improvements in abdominal pain, bloating, flatulence and diarrhoea after following a low FODMAP diet. Up to 70% of patients reported adherence to the diet. We aimed to assess the effectiveness of low FODMAP diet advice in patients with IBD in the UK.

**Methods**

Patients with inactive IBD and FBD (as diagnosed by their gastroenterologist), who had been referred to the dietitian and advised on a low FODMAP diet in the context of clinical practice. Symptoms were measured pre and post (at least 6 weeks) low FODMAP dietary advice as part of normal clinical practice using the global symptom question (GSQ)!Do you currently have satisfactory relief of your gut symptoms? and the gastrointestinal symptom rating scale (GSRS). Stool frequency was considered ‘normal’ if between 2–3 times per week to 3–5 times per day. Types 3–5 on the Bristol stool form scale were considered normal stool consistency. Comparisons were made using the McNemar test for categorical data and a paired t-test for continuous data.

**Results**

Data from 35 patients with IBD (17 ulcerative colitis, 17 Crohn’s disease, one IBD unclassified, 63% female, mean age 39y) were analysed. There was a significant increase in the number of patients reporting positively to the GSQ (n[%] pre: 8 [23] versus post: 29 [83]; p < 0.001) and the GSRS composite score (mean [SD] pre: 1.25 [0.48] versus post: 0.77 [0.45]; p < 0.001). Fewer patients reported symptoms including abdominal pain, bloating, flatulence and urgency, increased stool frequency, and type 6 or 7 Bristol stool form post dietary advice compared with pre dietary advice (Table).

**Conclusion**

The low FODMAP diet appears to be an effective treatment option for patients with IBD and FGD particularly for those with symptoms of abdominal bloating, flatulence, faecal urgency and lethargy. However, this is an evaluation of clinical practice and prospective randomised controlled evidence in IBD is currently lacking.

**Disclosure of Interest**

None Declared.

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**PWE-093**

**SPLITTING THE NORMAL DAILY DOSE OF THIOGUANINE MAY BE EFFICACIOUS TREATMENT FOR INFLAMMATORY BOWEL DISEASE AND AVOID HEPATIC TOXICITY**

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**Introduction**

6-thioguanine (TG) is a treatment for inflammatory bowel disease (IBD). However, its association with nodular regenerative hyperplasia (NRH) and portal hypertension has

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**Abstract PWE-092 Table 1**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Pre n (%)</th>
<th>Post n (%)</th>
<th>p</th>
<th>Symptom</th>
<th>Pre n (%)</th>
<th>Post n (%)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal pain</td>
<td>13 (37)</td>
<td>6 (17)</td>
<td>0.039</td>
<td>Nausea</td>
<td>3 (9)</td>
<td>0 (0)</td>
<td>0.250</td>
</tr>
<tr>
<td>Abdominal bloating</td>
<td>25 (71)</td>
<td>9 (26)</td>
<td>&lt;0.001</td>
<td>Heartburn</td>
<td>4 (11)</td>
<td>3 (9)</td>
<td>1.000</td>
</tr>
<tr>
<td>Flatulence</td>
<td>24 (69)</td>
<td>7 (20)</td>
<td>&lt;0.001</td>
<td>Acid regurgitation</td>
<td>4 (11)</td>
<td>1 (3)</td>
<td>0.250</td>
</tr>
<tr>
<td>Belching</td>
<td>6 (17)</td>
<td>3 (9)</td>
<td>0.508</td>
<td>Lethargy</td>
<td>27 (77)</td>
<td>14 (40)</td>
<td>0.002</td>
</tr>
<tr>
<td>Borborygmi</td>
<td>17 (49)</td>
<td>6 (17)</td>
<td>0.003</td>
<td>Stool frequency &gt;3 times/day</td>
<td>17 (49)</td>
<td>8 (23)</td>
<td>0.012</td>
</tr>
<tr>
<td>Faecal urgency</td>
<td>22 (63)</td>
<td>9 (26)</td>
<td>0.002</td>
<td>Type 6 or 7 Bristol stool form</td>
<td>12 (34)</td>
<td>9 (26)</td>
<td>0.549</td>
</tr>
<tr>
<td>Incomplete evacuation</td>
<td>9 (26)</td>
<td>8 (23)</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>