restricted its utilisation. A murine model has provided evidence that splitting a normal daily dose of TG could prevent exposure of the liver to harmful levels of TG; furthermore safety has not been an issue in human studies with low dose TG.

**Methods** We report from two centres on a retrospective experience of the safety and efficacy of an oral split-daily TG dose regimen, to avoid any individual dose >0.3 mg/kg, in 62 IBD patients who were unresponsive or had suffered adverse drug reactions to conventional therapies including thiopurines (60), biologics (18) and calcineurin inhibitors (17). Clinical response was measured using the Harvey Bradshaw Index for Crohn’s, or the Simple Clinical Colitis Score for ulcerative and indeterminate colitis. Patients were followed regularly in clinic with bloods, liver biopsy (9) and progress ultrasound at 6 months (21) or MR imaging (2).

**Results** Median duration of TG treatment was 7.8 (0.3−45) months. Median TG dose used was 0.6 (0.3−1) mg/kg/d. Of patients attaining 6 months of TG therapy, 91% (19/21) of Crohn’s patients and 71% (27/38) with ulcerative or indeterminate colitis had a clinically significant response, off steroids. At study end, 33 (53%) patients maintained their good clinical response off steroids; 12 of these had continued with concomitant biologic or calcineurin inhibitor therapy.

Previous thiopurine-related adverse reactions were not encountered. 29 (47%) patients withdrew from the study because of loss to follow-up (5), medical adverse events (2) or surgery (22). Possible early NRH was found on liver biopsy in 1 patient who was heterozygote-deficient for thiopurine methyltransferase (TPMT); the patient continued TG at a lower dose. TG was discontinued in a patient found to have NRH and concomitant anti-phospholipid syndrome. There was one successful term pregnancy; cord blood and breast milk TG were low.

**Conclusion** A split-dose regimen of TG appeared well-tolerated, efficacious and safe for selected IBD patients. Close monitoring, knowledge of TPMT and exclusion of risk factors for NRH prior to treatment are warranted to maximise safety.

**REFERENCES**

Disclosure of Interest None Declared.
FC in post-operative Crohn’s. Patients were included in the study if they had been followed up for at least 5 years after the initial FC was recorded. Case notes were reviewed retrospectively and information on the need for escalation of medical therapy or for further surgery for disease recurrence was recorded. A FC of more than 200 was taken as the cut-off value for evidence of active inflammation. Statistical analysis was performed using Prism 6 (GraphPad Software, San Diego, USA).

Results 17 patients had a FC ≥ 200 (median 751, IQR 593–916). Of these 13 required either escalation of medical treatment and/or further surgery over the 5 year follow-up period. 34 patients had a FC <200 (median 18, IQR 4–71). Of these 11 required treatment escalation and/or surgery. A FC of ≥200 correlated significantly with need for escalation of medical treatment and/or further surgery over a 5 year follow up (p 0.003).

Conclusion A FC of less than 200 predicts a better prognosis in patients with post-op Crohn’s disease over a prolonged (5 year) period and could therefore potentially be used to stratify treatment and target early intervention.

Disclosure of Interest None Declared.

PWE-096 THE IMPACT OF SURGEON SPECIFIC OUTCOME DATA ON PATIENT CHOICE

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Introduction Patients have a legal right to choose their own treatment and care within the modern NHS1, NHS England and the Association of Coloproctology of Great Britain and Ireland2; has recently released the mortality rates for individual colorectal surgeons for patients within the first 90 days of a planned operation undertaken for bowel cancer. With these figures now publicly accessible on the Internet, Gastroenterology physicians, in collaboration with their inflammatory bowel disease (IBD) patients, could utilise the information to assist in deciding who they would choose to perform the surgery should it be required.

Methods One hundred and ten consecutive IBD patients who had stable disease, and seen within the outpatient setting, completed a questionnaire about which fictional surgeon they would choose dependent on the published mortality rates and their location within the country. The options included a fictional surgeon with the lowest mortality rate who was based furthest away (Newcastle) and 20% chose the fictional surgeon with the lowest mortality rates based furthest away (Newcastle) and 20% chose the fictional surgeon with the highest mortality rates based locally (Leicester).

Conclusion The Government has proposed that the NHS allows patients to make informed choices about their own care. These results demonstrate that given that choice these IBD patients would either choose a surgeon with the lowest mortality rates, even if they were not based locally, or would allow their own Gastroenterologist to decide for them. However, the majority of the Gastroenterologists surveyed had not utilised the information on surgeon-specific outcomes. The legal consequences for gastroenterologists who choose the “less than best” option are yet to be tested in court.

Disclosure of Interest None Declared.

REFERENCES
1 2013/2014 Choice Framework, NHS England

PWE-097 PATIENT KNOWLEDGE OF INFLAMMATORY BOWEL DISEASE IS NO BETTER THAN IN 1999

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Introduction In the UK, key professional organisations have collaborated to provide inflammatory bowel disease (IBD) Standards to be delivered by the NHS, highlighting the importance of patient education and support.1 Little literature exists however regarding the impact of these standards on patient’s knowledge of their disease.

The study aim is to utilise the Crohn’s and Colitis Knowledge Score (CCKNOW) to assess patient knowledge and make a comparison with results achieved in 1999.

Methods 100 outpatients with CD or UC were prospectively enrolled to complete the CCKNOW questionnaire between May and September 2013 at two Leicestershire Hospitals.