

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

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**Disclosure of Interest** None Declared.

### PWE-094 SETTING STANDARDS BY DEFINING THE AIMS AND OPTIMAL DESIGN OF THE INFLAMMATORY BOWEL DISEASE (IBD) MULTIDISCIPLINARY TEAM (MDT) MEETING

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**Introduction** The National IBD Audit revealed 75% of participating institutions undertake a weekly MDT meeting for IBD patients. There is however little evidence of its efficacy in this context and currently there is no guidance on how this intervention may be standardised and used effectively.<sup>1–3</sup> Providing a standardised framework for the IBD MDT meeting will enhance its capacity to establish effective quality improvement. The aim of this study is to use national expert consensus to define the aims, optimal design, format and function of an IBD MDT meeting.

**Methods** 25 semistructured interviews were undertaken with a multidisciplinary sample (5 surgeons, 5 gastroenterologists, 5 IBD nurse specialists, 5 pathologists and 5 radiologists), from 2 UK regions: the Southwest of England and London. Interviews were audiotaped and transcribed verbatim. A standardised interview protocol with a clearly defined coding framework was used. The interview protocol explored key themes encompassing the optimal design format of the IBD MDT:

1. Purpose
2. Processes
3. Logistics
4. Redesign

**Results** 28 interviews were performed across a multidisciplinary sample of healthcare professionals. Thematic analysis and coding demonstrated common markers for each theme. High ranking markers for each theme included:

1. Purpose: *Requires multi-disciplinary input; to share collective expertise; and to improve patient outcome.*
2. Processes: *Good attendance; sharing workload with colleagues; proactive discussions; core members being clinicians, surgeons, radiologists, pathologists and nurse specialists all with IBD interests; facilities required including IT and an appropriate space to meet; provisions for internal feedback to the IBD MDT on MDT decision outcomes; submitting names in advance; an MDT coordinator.*
3. Logistics: *Duration of 1 h; once a week; protected time; selective cases.*
4. Redesign: *Single centre each running their own IBD MDT; 'hub and spoke' model.*

**Conclusion** Defining key elements for an optimal design format for the IBD MDT is necessary to ensure quality of care and reduce variation in care standards. This study demonstrates the methodology used for construction of provisional standards for the IBD MDT through interviews from a multidisciplinary group. Selection and adjustments of these standards through expert consensus are required to validate measures.

## REFERENCES

- 1 UK IBD Steering Group 2007 IBD Audit 2006: National Results for the Organisation and Process of IBD Care in the UK
- 2 Group 2009 IBD Audit 2008: National Results for the Organisation and Process of IBD Care in the UK
- 3 IBD Standards Working Group 2009 Quality Care: Service Standards for the Healthcare of People who have Inflammatory Bowel Disease (IBD)

**Disclosure of Interest** None Declared.

### PWE-095 FAECAL CALPROTECTIN IS USEFUL IN PREDICTING LONG TERM DISEASE RECURRENCE IN POST-OPERATIVE CROHN'S

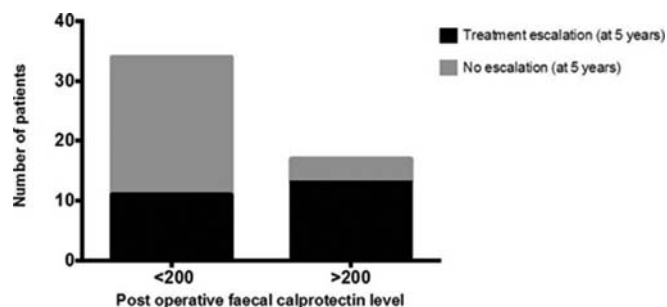
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**Introduction** The concept of using faecal biomarkers to predict prognosis and direct treatment in patients with Crohn's disease is attractive but long term follow-up data is lacking.

A cohort of 51 patients with previous ileal resections for Crohn's disease provided a one-off stool sample for faecal calprotectin (FC). These patients were followed up for 5 years to assess whether FC could predict disease progression in the long term.

**Methods** Patients were identified from a database of patients who had participated in a previous study evaluating the use of



Abstract PWE-095 Figure 1

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  $\geq$  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  $\geq$ 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

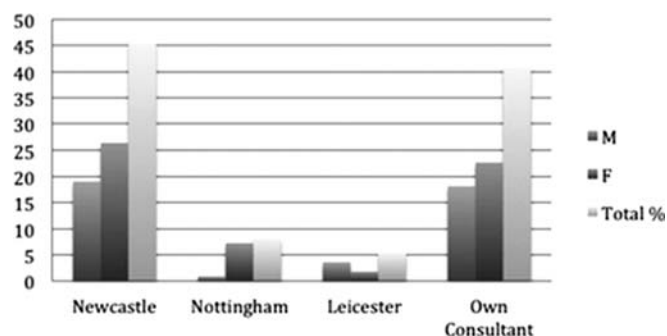
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**Introduction** Patients have a legal right to choose their own treatment and care within the modern NHS<sup>1</sup>. NHS England and the *Association of Coloproctology of Great Britain and Ireland*<sup>2</sup> has recently released the mortality 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), a fictional surgeon with the highest mortality rate who was local (Leicester) and a fictional surgeon with an average mortality rate who was based in between (Nottingham). There was an additional option of the patient allowing their fictional gastroenterologist to decide for them. Similarly, ten Gastroenterology colleagues were also questioned about this surgeon-specific outcome data.

#### Patient choice



Abstract PWE-096 Figure 1

**Results** The majority of the 110 IBD patients chose between two options. 45% chose a fictional surgeon with the lowest mortality rate based furthest away (Newcastle) and 41% opted for their fictional Gastroenterology consultant to decide for them. Of the 10 Gastroenterology colleagues questioned 50% were aware that the information was now publicly accessible, 20% were aware of where to access the information and 10% had reviewed the information online. On answering which fictional surgeon they would choose if the patient wanted their Gastroenterologist to decide for them, 40% 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.

#### REFERENCES

- 2013/2014 Choice Framework, NHS England
- Individual surgical outcomes for England 2013, The Association of Coloproctology of Great Britain and Ireland

**Disclosure of Interest** None Declared.

#### 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.<sup>1</sup> 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.