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 period (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.

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**REFERENCE**

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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), 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.