Abstract PWE-101 Table 1 Context of small bowel imaging in ulcerative colitis (n = 47)

Context	n (%)
At the time of disease diagnosis (1st episode; equivocal histology)	7 (15%)
Prior to therapy escalation	17 (36%)
Gastrointestinal symptoms atypical for UC	9 (19%)
Abdominal pain (post-colectomy)	7 (15%)
Persistent anaemia	7 (15%)

disease definitions coupled with novel and evolving imaging paradigms have led to more sophisticated small bowel imaging in recent years. Despite this, studies on the relevance and yield of small bowel pathology in UC patients are limited.

Methods We conducted a retrospective review of consecutive UC patients seen at our institution between May-October 2013. Clinical data for demographics, disease characteristics, small bowel investigation, endoscopy, treatment and clinical outcomes were obtained from electronic patient records.

Results We analysed 321 patients with biopsy confirmed UC [61% male, mean age 53 yrs, range 18–91 yrs]. Mean age of diagnosis was 43 yrs and mean disease duration was 10 yrs. Montreal classification was E1 (14%), E2 (49%) and E3 (37%) respectively.

Forty-seven patients had small bowel investigations: MR enterography in 81%, CT enterography in 15% and barium follow-through in 4%. Disease severity at the time of small bowel imaging was mild to moderate in 68% and 32% had severe disease. Thirty-two percent of patients were on thiopurines, 19% on bimodal immunosuppression (infliximab + thiopurine) and 49% were on aminosalicylates. Seven patients had undergone colectomy.

Small bowel imaging was reported normal in 46/47 and one patient had distal and terminal ileal disease. Indications for small bowel imaging are shown in Table 1. Subsequent to small bowel imaging, 40% (19/47) had no change in therapy, 43% were escalated to immunosuppressive therapy and 11% underwent surgery for UC. In 3 patients, the diagnosis was changed from UC to Crohn's disease (2 with perianal Crohn's; 1 with small bowel Crohn's based on MRE) all subsequently treated with Anti-TNF therapy.

Conclusion The yield of small bowel pathology in our cohort was low, supporting current European Crohn's and Colitis Organisation (ECCO) recommendations.[1] Small bowel imaging in UC meanwhile should be considered in the well-selected patient and driven by the clinical question or diagnostic uncertainty.

REFERENCE

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Disclosure of Interest None Declared.

PWE-102 INFECTIVE DIARRHOEA COMPLICATING IBD VS NON-IBD PATIENTS

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Introduction Clinical features associated with infective diarrhoea and flare up of Inflammatory Bowel Disease (IBD) are very similar and presents a challenge to gastroenterologists to distinguish the two especially at the initial presentation.

Methods This was a retrospective cohort study for patients admitted to the gastroenterology department of a single tertiary care teaching hospital with a culture positive episode of bacterial infective diarrhoea, excluding Clostridium difficile. Data was collected from clinical notes of patients presenting over an 8 year period (2004–2012). We made comparisons between the cohorts of patients with and without IBD.

Results 103 patients were included in the study; 13 had pre-existing IBD (7 UC, 6 Crohn's), mean age [52 (17 – 82) IBD, 41 (18 – 103) non- IBD]. Organisms cultured; IBD [campylobacter 84% (11), salmonella 16% (2)], non-IBD [campylobacter 81% (73), salmonella 12% (11), ecoli 4% (4), shigella 2% (2)]. Median duration of symptoms was similar in both groups [4 days (IQR 2) IBD, 4 (IQR 6) non-IBD]. Patient gave history of (IBD vs non IBD); abdominal pain [77 vs. 90% OR 0.37 (95% CI: 0.08–1.6)], per rectal bleeding [46 vs. 52% OR 0.78 (95% CI: 0.24–2.5)], vomiting [38% vs. 43% OR 0.81 (95% CI: 0.24–2.71)]. Blood tests showed (IBD vs non IBD); platelet count [median 282 (IQR 130) vs. 237 (IQR 90)], CRP [56 (IQR 81) vs. 82 (IQR 102)], haemoglobin concentration [median 12.1 (IQR 2.4) vs. 14.3 (IQR 2.6)] and white cell count [median 8 (IQR 4) vs. 7 (IQR 3)]. A much higher proportion of patients in IBD group received steroids [77 vs 16% OR 16.6 (95% CI: 4.0–61)]. Patients in both group had comparable duration of hospital stay [median 5 (IQR 4) vs. 4 (IQR 3)].

Conclusion Infective diarrhoea presents similarly in patients who have a background of IBD to those that don't but is more likely to be treated with steroids. A short history with abdominal pain and vomiting suggest an infective cause should be considered even if there is a established diagnosis of IBD.

Disclosure of Interest None Declared.

PWE-103 TERMINAL ILEITIS AT ENDOSCOPY IN CLINICAL PRACTICE: IS IT ALWAYS DUE TO CROHN'S DISEASE?

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Introduction Terminal ileitis (TI) when identified at endoscopy is generally assumed to be secondary to Crohn's disease (CD). However, TI may be due to other causes including infection, malignancy, radiation, vasculitis and autoimmune disease. In the presence of histological findings such as granulomas, cryptitis, crypt abscesses, fissuring and ulceration, a diagnosis of CD can be inferred. In the absence of such histological correlation, a diagnosis of CD may be reinforced by finding inflammation on colonoscopy or small bowel studies in other parts of the gut, suggestive of skip lesions. We hypothesise that patients diagnosed with TI on endoscopy do not all have CD, but may be inaccurately labelled as such.

Methods Single-centre retrospective analysis of 56 patients diagnosed with TI on endoscopy at a district general hospital in London between 2007–2013. Data obtained from endoscopic reporting tool and patient records were correlated with histology and imaging. The number of patients with the finding of ileitis on endoscopy subsequently diagnosed with CD was studied and the basis of this diagnosis was evaluated.

Results 68% of patients (38/56) with TI on endoscopy had histological confirmation of ileitis: 11 of whom had characteristic

features of Crohn's on histology, whilst the remaining 27 had mildly active ileitis on histology. 22 of these 27 patients underwent additional investigations to confirm (19/22) or exclude IBD (3/22). 5 of the 27 patients with histological ileitis that was not typical of CD were diagnosed with IBD, without further evidence to demonstrate this. In total 35/38 (92.1%) patients with histological and endoscopic evidence of inflammation were diagnosed with CD. Of the 18/56 patients (32%) with TI on endoscopy but normal histology, 9 had further investigations including MRI, barium studies and US abdomen to exclude CD. 4 patients were diagnosed with CD despite normal histology. 6/18 patients with normal histology were lost to follow up, although all patients diagnosed with IBD were followed up in GI clinic.

Conclusion We conclude that although the majority of patients with TI on endoscopy have CD, 1/3 of our patients had no histological correlation of inflammation. 16% of patients with endoscopic TI with mildly active ilieits on histology had no further imaging to authenticate a diagnosis of CD and 8% of patients with normal histology with no further investigations were labelled as CD. The latter group of patients may be inaccurately labelled with a diagnosis of CD and along with this the potential stigma associated with a chronic ailment, risk of escalation therapy with immununosuppressives/biologics and occasionally unnecessary surgery.

Disclosure of Interest None Declared.

PWE-104 THE FINANCIAL IMPACT OF A NURSE-LED IBD (INFLAMMATORY BOWEL DISEASE) TELEPHONE ADVICE SERVICE, IN A LARGE DISTRICT GENERAL HOSPITAL

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Introduction It has become increasingly recognised that outpatient management is more cost effective in IBD.[1] IBD Standards (Revised 2013) recommend telephone advice for patients with regards to symptoms and medication management. This report attempts to quantify the net financial impact of this service at our hospital since it was introduced in August 2013.

Methods The Royal Alexandra Hospital in Paisley is a District General Hospital with a catchment population of 200,000[2] with approximately 2500 IBD patients. Data relating to the use of the Telephone Advice service was prospectively recorded on a daily basis for a period of 5 months. We Documented reasons for calling and the likely action taken by the patient had the telephone advice line not been available. Cost savings based on alternative outcomes were made in accordance the Department of health figures.[3]

Results The mean calls per month was was 88 [IQR 24] – (Mean calls which were deemed Non-IBD issues was, was 30 calls per month [IQR 8.0]) The mean cost of staffing the IBD advice line with an IBD Clinical Nurse Specialist was £482.00 per month [IQR 195.5]. The mean time spent on calls per month was 28.5 h [IQR 11.5]. Cost Savings over 5 months for avoidance of GP consultation was £3408.00. Savings for avoidance of a consultant appointment made over the 5 month period was £27454.00. Savings made from patients avoiding either an A+E or Hospital Admission were £540.00 and £11488.00 respectively over the 5 month period. The net saving was £42890.00.

Conclusion A Nurse-Led telephone advice line appears to be a cost effective intervention. It may prevent patients from unnecessary hospital attendance. Savings can be made to both primary and secondary care. Overall, it appears that the advice line is providing a highly valuable service, not just in terms of accessible treatment decisions and guidance for patients, but cost savings when Specialist Nurse time is compared to General Practitioners, Consultants or hospital facilities.

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3 Department of Health reference Costs 2011–2012 https://www.gov.uk

Disclosure of Interest None Declared.

PWE-105 BIOLOGICAL WORLD OF IBD, IS IT ONLY SAFE IN TERTIARY CARE CENTRES?

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Introduction Inflammatory bowel disease (IBD) has a prevalence of 400 per 100,000 with approximately 240,000 patient with IBD in UK. It is triggered by a combination of environmental, genetic and immunoregulatory factors including a dysfunctional mucosal immune response.

In the last 15 years, the introduction of biologicals has dramatically changed the landscape with improving natural history and outcome of IBD. Many multi-centre trials have confirmed the efficacy of both Infliximab (IFX) and Adalimumab (ADA) in the management of IBD. These drugs are however not without side effects and need close monitoring in specialist IBD clinics. We share our experience from a large-sized DGH [>400,000 population] in Northwest England with a dedicated IBD service and experience in the use of biologicals in IBD patients since 2000.

Methods We interrogated and audited our IBD data base and collected all the patients who were or had been on biologicals. The data goes back to the year 2000.

Results The basic demographics showed total of the 90 patients; 42% female. The mean age was 42.4 (female) vs. 39.3 yrs (male). Age at the time of diagnosis of IBD was 31.1 yrs for females and 32.4 years for males. 53% had crohn's disease and rest were UC. Patients with UC had higher body weight vs. crohn's disease with a mean of 76.1 vs. 67.6 kg respectively. 58% had Ileoceacal Crohn's of which 73% were males. 62.5% of females with UC had pan colitis vs. 42% males.

All patients were fully informed and consented prior to the initiation of biological therapy. 89% of the patients were on immunomodulators prior to biological therapy. 93% of the patients with UC were on infliximab with 5% on Adalulimab. 1 pt was on Basiliximab which was changed to infliximab. Those with crohn's disease, 83% were on Infliximab and 17% on Adalulimab. Infliximab was stopped in 30% due to either no further clinical need or change to Adalulimab and of these 6% due to adverse events. In the ADA group 2% stopped due to lack of clinical inefficacy. The median duration of biologicals was 38.2 months, maximum duration 156 months.

Conclusion In the context of IBD, biological drugs in a dedicated IBD service are highly efficacious. In our centre, paucity of adverse event maybe due to our cohort of patient population with little background incidence of TB. In contrast to the UK IBD audit, we had more usage of biologicals in the context of UC, of which 50% had pan colitis. Our experience shows that a treating IBD effectively and