IBD-Control-8 [IBD-Control-VAS]: (1) *Simple Clinical Colitis Activity Index*, r = −0.77 [−0.72]; (2) *Harvey Bradshaw Index*, r = −0.91 [−0.78] (3) *Mayo Score*, r = −0.64 [−0.69]; (3) *Global Physician Assessment*, mean scores differed significantly across categories for both scores (inactive > mild > moderate; p < 0.01, ANOVA). Service Evaluation: 64 'delayed follow-up or DNA' patients invited for postal return of PROM then 4–6 wk review, with 59% return rate ('active disease' indicated in 10%). Telephone consultation in 63%. Unplanned care occurred in 2 respondents within 30 days, both with IBD-Control indicative of active disease.

Conclusion IBD-Control has strong measurement properties and is easy to administer. Our experience of integrating IBD-Control into non-face-to-face follow-up clinics suggests that using a validated PROM to support care is acceptable to patients and achievable.

REFERENCE

Bodger K *et al*. Development and validation of a rapid, generic measure of disease control from the patient's perspective: the IBD-Control questionnaire. *Gut* 2013;published online October 9:2013 [ahead of print]

Disclosure of Interest None Declared.

PWE-115 | **PATIENTS CONTINUE TO TRAVEL ABROAD DESPITE RECENTLY ACTIVE DISEASE AND TRAVEL CONCERNS: RESULTS OF A SINGLE CENTRE STUDY IN INFLAMMATORY BOWEL DISEASE AND TRAVEL**

TC Shepherd*, K Greveson, JP Mulligan, MI Hamilton, CD Murray. *Gastroenterology, Royal Free Hospital, London, UK*

Introduction Travellers with Inflammatory bowel disease (IBD) are at greater risk of travel-related morbidity.[1] Relapse and acquired infection are the main risks to IBD patients while abroad, and ECCO recommend expert consultation prior to travel, particularly for those on immunosuppression.[2] IBD limits a majority of patients choice of travel destination.[1] Despite this, there is limited data regarding IBD patients pre-travel preparation and travel experiences.

Methods Patients attending our IBD clinic during November 2013 were asked to complete an anonymous questionnaire. We asked for demographic and disease specific information, in addition to detailed travel questions; including perceptions, pre-travel planning and recent travel experiences. Data was entered and analysed on an anonymised database. We hypothesised that patients with travel concerns and those who had flared within the last 6 months would be less likely to go abroad in that same period.

Results A representative 136 IBD patients (67/136[49%] Crohn's disease, 60/136[44%] male, age 18–85 years [median age 38 years]) responded. 51%[69/136] were immunosuppressed and 43%[49/136] had IBD related surgery. 62%[84/136] experienced an IBD flare in the last 6 months. 60%[82/136] reported IBD affected travel. 58%[79/136] travelled in the last 6 months, despite a majority of those (65%[51/79]) reporting IBD affected travel. 59%[47/79] of travellers had experienced a flare in the last 6 months, although again, most of those (77%[36/47]) reported IBD affected travel. Only 18%[14/79] travellers (71% [10/14] had a recent flare) sought pre-travel medical advice of any kind and only 41%[32/79] (69%[22/32] had a recent flare) had travel insurance, the majority (88%[28/32]) paid a premium. 20%[16/79] travellers reported a change in bowel habit while abroad, but of those only 27%[3/11] sought medical advice. We also report that 52%[36/69] of immunosuppressed patients are unaware of the need to avoid live vaccines.

Conclusion A majority of IBD patients feel their disease affects travel. However, despite concerns, patients still travel abroad, even if they have suffered a recent flare. Our results suggest patients are not receiving the recommended travel medical advice, including the need to avoid live vaccinations if immunosuppressed, and are possibly under or not insured. The small numbers of travellers suffering a change in bowel habit abroad tend not to seek medical advice while away. Further detailed investigation in travel behaviour in IBD patients is required, but we suggest there is a need for greater IBD travel education.

REFERENCES

1   Soonawala D, *et al*. *Inflamm Bowel Dis* November 2012;18(11):2079–85
2   Rahier JF, *et al*. *J Crohn Col* February 2009

Disclosure of Interest None Declared.

PWE-116 | **ASSOCIATION OF FAECAL CALPROTECTIN WITH EXTENT AND DISTRIBUTION OF INFLAMMATION IN IBD**

VI Astle*, NR Lewis. *Nottingham Digestive Diseases Centre, Nottingham University Hospital, Nottingham, UK*

Introduction Calprotectin is a protein released by neutrophils in response to the presence of inflammation in the bowel.[1] Faecal calprotectin (FC) has been shown to be useful in the diagnosis of inflammatory bowel disease (IBD) as it correlates with mucosal disease activity and can help to predict response to treatment or relapse.[1–3] Data from small, selected case series have observed FC correlates better with colonic rather than ileal Crohn's disease (CD)[4] and median FC concentrations are higher in extensive or left-sided ulcerative colitis (UC) disease than in proctitis.[5] We report the association of FC concentration with extent and distribution of inflammation in consecutively performed tests at our centre.

Methods All FC tests performed between 01/07/12 and 31/12/12 were systematically collected and associations with activity and distribution using endoscopic, histological and radiological data explored. Proximal disease was defined as inflammation affecting the terminal ileum and ascending colon; left-sided disease as inflammation limited to the colorectum distal to the splenic flexure and pan-colitis with inflammation extending proximal to the splenic flexure.

Results 203 (n = 160 CD; n = 43 UC) patients with IBD had FC tests performed of whom 96 (47.3%) had endoscopic, histological or radiological evidence of active disease. The mean age of IBD patients was 44.7 (SD 17.0) years and 58% were female. The mean FC concentration was significantly higher in patients with active pan-colitis (1038.1 iu (SD 1104.1)) than in active left-sided disease (mean 820.2 iu (SD 1535.1)); p = 0.01. The mean FC concentration was significantly higher in active pan-colitis than in active proximal disease (mean difference -669.3 iu (95% CI-1046.3, -292.4)); p = <0.001. There was no significant difference in the mean FC concentration between active proximal or left-sided disease (mean difference −451.5 (95% CI -965.9, 62.9) or between CD and UC (mean difference 148.5 (95% CI-369.1–666.1).

Conclusion Mean FC concentrations are significantly higher in active pan-colitis than in active left-sided or proximal disease, perhaps reflective of the greater extent of inflammation.

Further work is required to explore why FC concentrations are lower in proximal disease despite presence of active inflammation.

REFERENCES
1 *World J Gastroenterol* 2012;18(46):6782–6789
2 *Gut* 2005:54:364–368
3 *Inflammatory Bowel Diseases* 2013;19(2):332–341
4 *Am J Gastroenterol* 2010:105:162–169
5 *Scandinavian Journal of Gastroenterology* 2011:46:1081–1091

**Disclosure of Interest** None Declared.

PWE-117 | **HAVE PERIANAL SURGERY RATES DECREASED WITH THE RISE IN THIOPURINE USE IN CROHN'S DISEASE?**

[1]V Chhaya*, [2]S Saxena, [2]E Cecil, [3]V Subramanian, [4]V Curcin, [2]A Majeed, [1]R Pollok. [1]Gastroenterology, St Georges Hospital, Imperial College, London, UK; [2]School of Primary Care and Public Health, Imperial College, London, UK; [3]Gastroenterology, St James University Hospitals, Leeds, UK; [4]Department of Computing, Imperial College, London, UK

Introduction Although thiopurines (TPs) have proven efficacy in the maintenance of remission in Crohn's disease (CD) and may reduce the need for intestinal surgery, their impact on perianal disease is not firmly established since previous trials have not evaluated the efficacy of TPs on perianal disease as a primary endpoint. Our aim was to examine the temporal trends in perianal surgery and TP use using the Clinical Practice Research Datalink (CPRD).

Methods Using electronic primary care records, we performed a UK population based study. Incident cases of CD were identified between 1995 and 2009 from the nationally representative CPRD which contains clinical records and prescribing data for 13 million people in the UK and is a validated research database. Patients were included if they had been registered with a practice for greater than 12 months. The primary endpoint was first perianal surgery defined by READ/OXMIS coding. The cohort was divided into two defined historical era; era 1 (1995–2002) and era 2 (2003–2009). We performed Kaplan-Meier survival analysis to establish the 5 year rates of first perianal surgery and trends in TP prescribing by era of diagnosis. Log-rank test for trend was used to compare survival outcomes between groups.
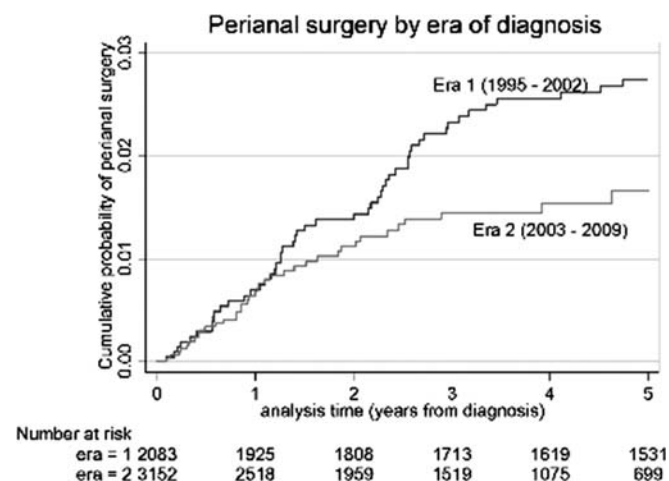
Abstract PWE-117 Figure 1

Results 5235 patients met the diagnostic criteria for an incident case of CD. 2083 were diagnosed in era 1 (1995–2002) and 3152 in era 2 (2003–2009). The mean duration of follow up was 4.8 years/person. 56.3% of patients were female and median age at diagnosis was 38.5 years (IQR: 24.8–58.1 years). 124 patients underwent perianal surgery. The overall 5 year rate of perianal surgery was 2.2% (95% CI: 1.8–2.7%). Stratified by era of diagnosis the rate was lower in the more recent era: 2.7% (95% CI: 2.1–3.6%) and 1.7% (95% CI: 1.2–2.3%) in era 1 and era 2 respectively (log-rank test for trend p = 0.03). Conversely, during the same period, the 5 year cumulative probability of receiving a TP increased between era 1 and era 2 from 29.1% to 42.2% (log-rank test for trend p < 0.001).

Conclusion Over the 15 year study period, the risk of perianal surgery fell by one third which coincided with a one third increase in TP use during the same period. Other changes in IBD management are also likely to have contributed to this fall in surgery. Further studies to determine independent risk factors associated with perianal surgery are in progress.

Disclosure of Interest None Declared.

PWE-118 | **PREDICTORS OF COLECTOMY AND THE IMPACT OF THIOPURINES ON THE RISK OF COLECTOMY IN ULCERATIVE COLITIS – A NATIONAL UK BASED OBSERVATIONAL STUDY**

[1]V Chhaya*, [2]S Saxena, [2]E Cecil, [1]S Chatu, [3]V Subramanian, [4]V Curcin, [2]A Majeed, [1]R Pollok. [1]Gastroenterology, St Georges Hospital, Imperial College, London, UK; [2]School of Primary Care and Public Health, Imperial College, London, UK; [3]Gastroenterology, St James University Hospitals, Leeds, UK; [4]Department of Computing, Imperial College, London, UK

Introduction Thiopurines (TPs) including azathioprine and mercaptopurine have an established role in maintaining disease remission in ulcerative colitis (UC) but their impact on the risk of colectomy remains unknown. Our aim was to establish predictors of colectomy and determine the effect of TPs on the risk for colectomy using the Clinical Practice Research Datalink (CPRD).

Methods We conducted a population based study using electronic primary care records in the UK. We identified incident cases of UC between 1989 and 2009 in the CPRD which contains prescribing and clinical data for 8% of the UK population and is a validated research database. Patients were included if registered with a practice for at least 12 months prior to diagnosis. We compared rates of colectomy between TP users and non-users and examined the impact of treatment duration. We performed survival analysis using the Kaplan-Meier method. Independent risk factors for surgery were determined using a multivariable Cox proportional hazards model.

Results Overall, 8673 patient met our inclusion criteria of which 479 (5.5%) went on to have a total colectomy during 21 years of follow up. 51.4% were male and the median age was 46 years (IQR: 32–62 years). Female patients were less likely to undergo colectomy (HR 0.70, 95% CI: 0.58–0.84, p < 0.001). There was a threefold increase in the risk of colectomy amongst TP users compared with non-users (HR 3.48, 95% CI: 2.84–4.37, p < 0.001). Of the TP users, those receiving greater than 12 months of treatment, were least likely to undergo colectomy compared with users for less than 3 months (HR 0.29, 95% CI: 0.21–0.40, p < 0.001). Early steroid users were almost twice as