

Prior to switching 23 of the 25 patients were in clinical remission with the other 2 being partial responders. After switching 11 remained in clinical remission, 13 did not have clinical remission and the data was unavailable in 1 patient.

**Conclusion** The revision of NICE guidelines to include adalimumab was associated with a significant percentage of \*non-clinical switches. There was a 52% loss of efficacy in non-clinical switches. Loss of efficacy when switching has been confirmed in prospective trials.<sup>1,2</sup>

#### REFERENCES

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- 2 Van Assche G, Vermeire S, Ballet V, Gabriels F, Noman M, D'Haens G, Claessens C, Humlet E, Vande Casteele N, Gils A, Rutgeerts P. Switch to adalimumab in patients with Crohn's disease controlled by maintenance infliximab: prospective randomised SWITCH trial. *Gut* 2012;61:229–34

**Disclosure of Interest** None Declared.

#### PTU-086 ULCERATIVE COLITIS (UC) AND ANTI-TUMOUR NECROSIS FACTOR (A-TNF) THERAPY; A SINGLE UNIT'S REAL WORLD EXPERIENCE

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**Introduction** Prescription of a-TNF therapy in UC in the UK is limited to acute severe colitis by NICE. Increasingly physicians are under pressure from patients to offer an alternative to the traditional limited therapeutic options and this has resulted in the drug being used in the subacute setting, as it is in other countries.

**Methods** A retrospective review of all patients receiving a-TNF for UC up until December 2012.

**Results** Twenty-one patients have received a-TNF therapy for UC. Five are currently on a-TNF treatment, 4 of whom commenced in the last 12 months. Twelve were discontinued for non-response, 1 for funding, 1 for remission, 2 for side effects and 1 at the patient's request. Two were switched. Response to the agents are shown in Table 1.

Thirteen received infliximab as first agent, eight had adalimumab. Seven were on other immunomodulators at the time of commencing a-TNF and 11 were intolerant to immunomodulators. Three had a-TNF for acute colitis, 15 for subacute colitis and data unknown for 3 patients.

Currently 3 patients are in clinical remission, 11 had surgery and 7 have active disease (with 2 strongly recommended to have surgery). Twelve patients had steroids while on a-TNF. Mean time on a-TNF was 4.7 months.

**Conclusion** a-TNF use in UC does not appear to be very effective in this context, with 62% having or requiring surgery and 60% requiring concurrent steroids. To make this therapy more

cost effective in this patient group more work is needed to identify patients likely to be responders.

**Disclosure of Interest** None Declared.

#### PTU-087 INDETERMINATE AND INCONCLUSIVE RESULTS ARE COMMON WHEN USING INTERFERON GAMMA RELEASE ASSAY AS SCREENING FOR TB IN PATIENTS WITH IBD

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**Introduction** Anti-TNF treatment is widely used in inflammatory bowel disease (IBD) but has been linked with reactivation of tuberculosis (TB). Screening for active and latent TB prior to initiation of anti-TNF therapy is therefore mandated. ECCO recommends interferon gamma release assays (IGRAs) as, unlike tuberculin skin test, positive tests are not caused by previous Bacillus Calmette–Guérin (BCG) vaccine. However, immunosuppressive agents can result in indeterminate or unreportable results[i] and there is no clear guidance on managing them.

We quantified the prevalence of indeterminate or unreportable TB IGRA Elispot results in a large tertiary centre cohort of patients with IBD.

**Methods** A single centre retrospective study of IGRA tests performed on IBD patients prior to commencement of anti-TNF therapy between Oct 2010 and Oct 2013.

**Results** We included 140 patients (median age 34, range 24–86, 50% males). 92% had Crohn's disease, 4% ulcerative colitis, and 4% IBD-unclassified. At the time of IGRA testing, 115 patients were on immunomodulators and 6 on prednisolone.

3 were positive for latent TB and were referred to infectious disease (ID) department prior to anti-TNF therapy.

3 had indeterminate results; all were on immunosuppressants (2=azathioprine, 1=methotrexate). 2 had a lymphocyte count <1. In 2 cases the IGRA was repeated, one was negative and the second was unreportable on 2 occasions. None had TB risk factors and all were started on anti-TNF. To date, none have developed TB (follow up range 6–18 months).

10 had unreportable results, 9 of whom were on azathioprine. On repeat testing, 4 were negative, and the remainder were still unreportable, one of whom had risk factors for TB and was treated with isoniazid chemoprophylaxis on the advice of the ID team. The remaining 5 patients started anti-TNF based on the absence of risk factors for TB. No patient had reactivation of latent TB at follow up (range 1–18 months). Lymphopaenia was found to be associated with non-reportable cases as compared to the reported cases (median lymphocyte count unreportable = 0.4, reportable = 1.2;  $p = 0.015$ ).

**Conclusion** Our results demonstrate TB IGRA is a useful test to screen for latent infection before initiating anti-TNF therapy. However, a minority of results are indeterminate or unreportable. In such cases repeat testing can produce definitive results. Low lymphocyte counts in association with immunosuppression may contribute to unreportable and indeterminate results; clinical risk stratification appears to be a safe way of managing such cases in this small cohort.

#### REFERENCE

- 1 Papay P *et al.* Predictors of indeterminate IFN- $\gamma$  release assay in screening for latent TB in inflammatory bowel diseases. *Eur J Clin Invest*. 2011

**Disclosure of Interest** None Declared.

Abstract PTU-086 Table 1

Remission	Clinical	Radiological	Histological	Biochemical
Yes	4	0	0	7
No	16	1	6	13
Not assessed	0	19	14	0
Incomplete	1	1	1	1
Total	21	21	21	21