

Abstract PTU-106 Table 1 Pregnancy and fetal outcomes with thiopurine and allopurinol co-therapy

| | Case 1 | Case 2 | Case 3 | Case 4 | Case 5 | Case 6 | Case 7 | Case 8 |
|---|---------------------------|--|---|---------------------------|------------------------------|------------------------------|------------------------------|------------------------------|
| Diagnosis | UC | UC | UC | UC | UC | UC | UC | Crohns |
| Dose thiopurine/allopurinol | AZA 50 mg, Allo 100 mg | AZA 25 mg 5d / 50 mg 2d, Allo 10 mg | AZA 25 mg 5d / 50 mg 2d, Allo 100 mg | AZA 50 mg, Allo 200 mg | 6MP 50 mg 5d, Allo 100 mg | 6MP 50 mg 5d, Allo 100 mg | 6MP 25 mg 3d, Allo 100 mg | 6MP 50 mg 6d, Allo 100 mg |
| Duration of pre-pregnancy co-therapy (months) | 6 | 19 | 1 | 12 | 14 | 6 | 15 | 24 |
| Age at pregnancy (years) | 21 | 24 | 34 | 31 | 32 | 36 | 32 | 29 |
| Number of flares in pregnancy | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| Gestation at delivery (weeks) | 41 | 38 +1 | 39 +4 | 40 +3 | 38 | 39 | 34 | 38 |
| Mode of delivery | SVD | C-section | C-section | SVD | SVD | SVD | C-section | C-section |
| Fetal birth weight | 3.5 kg | 2.94 kg | 3.42 kg | 3.95 kg | 3.75kg | 3.0 kg | 2.91 kg | 3.51 kg |

Methods Patients were retrospectively identified at two hospitals in the UK and in Australia, using our local IBD databases. All pregnancies of co-therapy patients were included. TPMT activity and pre-pregnancy weight were used to calculate thiopurine dosing. Data regarding pregnancy and fetal outcomes were collected from patient notes.

Results Eleven females on co-therapy became pregnant, totalling twelve pregnancies with eight live births (Table 1) and four ongoing pregnancies. There were no reported terminations, miscarriages or spontaneous pre-term deliveries (<37 weeks). Four patients gave birth by spontaneous vaginal delivery (SVD); four by Caesarean section (C-section). There were no low birth weight (<2.5kg) babies. The APGAR scores of all babies were normal and no congenital malformations were identified either on fetal ultrasound scans or on neonate checks. The median duration of follow-up of babies was 6.5 months with no indication of morbidity.

Conclusion All twelve cases were treated successfully with co-therapy without any adverse pregnancy related events or adverse fetal outcomes. Intrauterine exposure of the fetus to thiopurine metabolites is not greater with combination therapy compared with thiopurine monotherapy. There are only two reports of congenital malformations with maternal allopurinol use. The case for an association based on two cases is weak, moreover a negative publication bias with respects to successful maternal allopurinol use is suspected. Our study provides support for clinicians and patients wishing to continue thiopurine-allopurinol co-therapy during pregnancy.

Disclosure of Interest None Declared.

PTU-107 COMPARISON OF MORTALITY FOLLOWING HOSPITALISATION FOR ULCERATIVE COLITIS IN SCOTLAND BETWEEN 1998–2000 AND 2007–2009

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Introduction We have previously demonstrated concerning high 3-year mortality following hospitalisation with ulcerative colitis (UC) between 1998 and 2000 in Scotland.¹ We have extended these studies by examining 3-year mortality following hospitalisation with UC in Scotland between 2007–2009, providing an opportunity for comparison with our earlier results.

Aim To compare 3-year mortality, and factors related to mortality, in Scottish patients hospitalised with ulcerative colitis (UC) between Period 1 (1998–2000) and Period 2 (2007–2009).

Methods The Scottish Morbidity Records and linked datasets were used to assess 3-year crude mortality, standardised mortality ratio (SMR) and multivariate analyses of factors associated with 3-year mortality. The 3-year mortality was determined after four admission types: surgery-elective or emergency; medical-elective or emergency. Age-standardised mortality rates (ASR) were used to compare mortality rates between periods.

Results The admission rate with UC increased from 10.6 per 100,000 of the Scottish population per year in Period 1 to 11.6 in Period 2 ($p = 0.046$). Among those admitted with UC, the proportion aged <30yrs increased ($p = 0.009$). Crude and adjusted 3-year mortality fell between time periods (Crude 12.2% [Period 1] to 8.3% [Period 2], adjusted OR 0.59, CI 0.42 to 0.81, $p = 0.04$). Following emergency medical admission, 3-year mortality was reduced in Period 2 (OR 0.58, $p = 0.003$). Within the >65 yrs age group crude 3-year mortality fell (38.8% to 28.7%, $p = 0.02$). The overall SMR in period 1 was 3.04 and 2.96 in Period 2.

Directly age standardised mortality decreased from 373 (CI 309–437) to 264 (CI 212–316) per 10,000 person years. On multivariate analysis, older age and co-morbid remained associated with 3-year mortality in Period 2.

Conclusion Although the mortality associated with admission remains high at 3 years, crude and adjusted rates suggest significant reductions over the last decade.

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PTU-108 CROHN'S DISEASE AND ANOGENITAL GRANULOMATOSIS PRESENTING WITH GENITAL OEDEMA

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Introduction Anogenital granulomatosis (AGG) is a recently recognised cause of genital lymphoedema¹⁻³ an association of CD with AGG has been noted in previous case reports.^{1,3} It presents with genital erythema and swelling, and flares are frequently misdiagnosed as cellulitis. We present a large case series.

Methods Patients were identified from referrals to the regional to the Lymphoedema Service at St George's Hospital after failure of antibiotics and topical steroids to improve symptoms. Demographic, clinical and endoscopic finding were correlated in patients with histological features of AGG in patients.

Results Sixteen patients (15 male, 1 female; aged 34.8 ± 15.0 yr (mean ± s.d.)), were referred with AGG.

14 of 16 patients initially presented with genital swelling whilst 2 others presented with buttock swelling. Swelling of additional sites was noted in several patients (mons pubis – 25% of patients; natal cleft – 25%; peri-anally – 19%; buttocks – 12.5%). Although initially intermittent (15/16 patients), genital swelling was typically well established and irreversible by the time of presentation to the Lymphoedema Clinic. Flares involved erythema and deterioration of swelling which failed to return to baseline. Established swelling was associated with an increased risk of cellulitis in addition to the non-cellulitic flares.

Histological examination of the affected areas demonstrated dermal (and one case of intra-lymphatic) non-caseating granulomas in 12 patients with the remainder diagnosed clinically. Gastroenterology review, including colonoscopy, confirmed a diagnosis of Crohn's disease in 37.5% of patients.

Treatment of AGG has proven difficult. Initial treatment with compression garments and prednisolone showed a reduction (but not elimination) of scrotal and penile shaft swelling in 9/11 patients. Antibiotics reduced the frequency of flares in only 3/11 patients. Steroid-sparing immunosuppression was successful in 4/11 patients. In 6 patients, lymphoedema of the foreskin caused difficulties in micturition and therefore circumcision was successfully utilised to improve urinary flow. Debulking surgery has been used in only a small number of our cases to date.

Conclusion AGG should be considered in all patients (especially male) presenting with isolated genital lymphoedema and may unusually be the presenting feature of Crohn's disease. Early diagnosis allows for prompt initiation of systemic immunosuppression therapy which is currently the treatment of choice. We hypothesise that swelling is precipitated by non-infective granulomas blocking lymphatic vessels, research in this regard is in progress.

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Disclosure of Interest None Declared.

PTU-109 AZATHIOPRINE IN THE ELDERLY – IS IT TOLERATED AND IS IT SAFE?

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Introduction The use of Azathioprine (AZA) for maintenance of remission in Inflammatory Bowel Disease (IBD) is common practice as part of national and international guidelines. Side effects however are common. Of 353 consecutive patients commencing AZA in our organisation, 36% were not taking it at one year.

With an ageing population, IBD is increasingly relevant in those over 75 years old. However there is little data concerning the efficacy and tolerability of AZA in this age group.

Methods We maintain a prospective database of IBD patients. All patients commenced on AZA between June 2005 and October 2012 over the age of 75 were identified. Thiopurine Methyl Transferase (TPMT) levels were checked in all patients and AZA was prescribed at 2–2.5 mg/kg, with 50% dose reduction in those with low TPMT. We monitor full blood count and LFTs weekly for 8 weeks after commencing therapy.

Results 25 patients were identified, (7 CD, 18 UC). The mean age at which AZA was started was 78 (range 75–86), 16 were male (64%). All patients were followed up for at least one year. 12 (48%) were intolerant of AZA. Reasons for stopping AZA were; hepatitis, 2 (8%); vomiting, 5 (10%); pancreatitis, 1 (4%); myelosuppression (1); joint pain (1); infection (1); and general malaise (1). The mean duration of AZA use in these patients was 34 days (Range 3–89). 13 (52%) tolerated the drug well with one of this group having the drug actively withdrawn at 701 days in complete clinical, endoscopic and histological remission. There were four deaths (16%). Two died in the group intolerant of AZA (84 year old died of stroke 888 days after 13 days of AZA; 82 year old died in the community 140 days after 5 days of AZA). Two people died in the AZA treated group (83 year old died in the community on day 1476 of AZA; 79 year old died following cardiac arrest on day 212 of AZA).

Conclusion Our data demonstrate that AZA is an effective treatment in the elderly. It appears to be less well tolerated than in the general population with 48% intolerant of the drug within 3 months. Within the limitations of this study it appears to be safe. The increased incidence of drug intolerance in this population group may suggest that low-dose azathioprine and allopurinol co-therapy should be considered first-line therapy in this group. A further study to clarify this is required.

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Liver I

PTU-110 REDUCTION IN SERUM SODIUM (NA) IN PATIENTS TREATED WITH TERLIPRESSIN FOR VARICIEAL BLEEDING (VB) AND HEPATORENAL SYNDROME (HRS)

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Introduction Terlipressin is used in the management of VB and HRS. Studies have suggested decrease in Na levels on terlipressin, usually in VB.

We set out to report the incidence of fall in serum Na in patients receiving terlipressin for VB or HRS.

Methods Consecutive patients admitted to Gwent Liver Unit who received terlipressin were identified. Main outcome measure was fall in Na level during and up to 5 days post therapy.

Results 60 patients were analysed (32 HRS, 28 VB). Median Na pre-treatment was 133 and 29/60 (48%) had existing hyponatraemia; 16 (27%) had Na <125mmol/l.