histopathological data were recorded. Lower GI findings in this cohort were also analysed.

Results We reviewed 40 OGDs performed in our unit for melanoma patients who developed diarrhoea after starting treatment with ICPI patients. In all cases flexible sigmoidoscopy or colonoscopy was also performed. Inflammatory changes were common, including gastritis (40%) and duodenitis (17.5%). Importantly, even in the absence of macroscopically visible mucosal injury, there was a significant burden of microscopic inflammation, especially in the duodenum. In patients with a normal duodenoscopy, significant microscopic changes were present in 28% of patients. Significant histological abnormalities included chronic inflammation and/or increased intraepithelial lymphocytes (86%) and villous atrophy (71%), consistent with pathologically relevant mucosal immune activation. Abnormalities in the oesophagus were also common (32%), but were dominated by candidiasis (15%), likely secondary to high-dose steroids used to treat this challenging condition. All patients in this cohort of ICPI-induced diarrhoea patients investigated with OGD additionally underwent lower GI endoscopy, which confirmed the presence of colitis in 65% of patients. Importantly, upper GI disease was just as common in patients with a normal lower GI investigation (57%) as those with overt colitis (54%).

Conclusions There is a significant burden of upper GI pathology, including macroscopic and microscopic mucosal injury and excessive immune accumulation, most notably in the duodenum, in patients with diarrhoea secondary to ICPI therapy. Additional findings that altered management included oesophageal candidiasis (likely a side-effect steroid therapy, which is usually rapidly initiated as soon as patients present with diarrhoea). Importantly, upper GI pathology is just as common in patients without colonic disease. OGD should be part of diagnostic work up of patients developing diarrhoea in the context of ICPI therapy.

PTU-010 PREVALENCE AND PHENOTYPE OF IBD ACROSS PRIMARY AND SECONDARY CARE: IMPLICATIONS FOR COLORECTAL CANCER SURVEILLANCE

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Introduction Patients diagnosed with colonic IBD have increased risk of colorectal cancer (CRC). Colonoscopic surveillance reduces the risk of CRC-associated death through early detection; national/international guidelines recommend chromoendoscopy. We aimed to assess the burden of IBD in primary care unknown to our service and to identify patients eligible for surveillance.

Methods We conducted a population-based observational study across primary and secondary care to evaluate the incidence/prevalence of IBD in our catchment. We identified cases from primary care using searches of practice databases and in secondary care using searches of hospital records. Case inclusion required a specialist diagnosis of ulcerative colitis (UC), Crohn's disease (CD) or IBD unclassified. IBD was phenotyped according to the Montreal Classification and patients under the age of 75 years, who had been diagnosed with IBD

with colonic disease involvement for more than 10 years, were deemed eligible for colonoscopic surveillance.

Results Patients from 48/49 GP practices within our catchment were included. We identified 3690 patients with IBD living within our catchment of which 12% (875/3,690) were unknown to any local secondary care service. Overall, UC prevalence was 453/100 000 people (95% confidence interval 433–474), Crohn's disease prevalence was 311/100 000 (95% CI 293–327), and IBD unclassified prevalence was 44/100 000 (95% CI 38–51). Patients managed solely in primary care, compared with those in secondary care, were older (mean age 60.9 vs 56.2 years, $p<0.0001$) and had longer disease duration (20.3 vs 14.2 years, $p<0.0001$). The proportion of UC out of total IBD was higher in primary care (69% vs. 58%, $p<0.0001$). A higher proportion of IBD patients in primary care than secondary care had undergone a colectomy (17% vs 5%, $p<0.0001$). Overall, 13% (388/2,815) patients known to secondary care and 29% (257/875) of patients unknown to any secondary care services were eligible for colonoscopic surveillance, equivalent to approximately one colonoscopy list per week.

Conclusions We report one of the highest prevalence rates of IBD in Western Europe (1 in 124 patients). 12% of patients living in our immediate catchment area were unknown to our service; a third of these were eligible for colonoscopic colorectal cancer surveillance. Effective colorectal cancer surveillance programmes in IBD must target primary-care populations and not just known secondary care populations.

PWE-001 EFFECTS OF EBV NAIVE STATUS ON TREATMENT DECISIONS IN IBD

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Introduction Thiopurines, through an association with Epstein Barr Virus (EBV), confer an increased risk of GI lymphoma when used to treat Inflammatory Bowel Disease (IBD), with EBV naïve individuals carrying a higher risk.

Current European Crohn's and Colitis Organisation (ECCO) guidelines recommend considering EBV screening in individuals prior to initiating immunomodulator therapy.

This audit identifies the impact of EBV naïve status on subsequent treatment decisions and the resulting cost expenditure at the Royal Wolverhampton NHS Trust (RWHT).

Methods We conducted a retrospective analysis of IBD patients undergoing EBV screening between June 2015 and June 2017 and extracted relevant data from electronic records.

Results Overall 359 patients underwent EBV screening in the specified period with 43 (12%) patients being identified as EBV naïve. The EBV naïve sample consisted of 27 (63%) males and 16 (37%) females, with a mean age of 40.

Of these 43 patients, 5 were excluded from further analysis as their EBV status was tested for reasons unrelated to IBD management and 4 were excluded as their treatment was altered for reasons other than their EBV status. Table 1 shows the breakdown for the remaining 34.

Table 1 Number of patients undergoing EBV screening for initial thiopurine or biologic therapy and the resulting number of patients in whom therapy was switched and the subsequent cost expenditure. *Calculated based on the cost of 12 months