patients were exposed to acetarsol more than once. 76.7% of patients achieved clinical response. 3/35 patients had an endoscopic assessment with two of three patients showing endoscopic improvement. 33.3% patients required treatment escalation following acetarsol exposure with two undergoing subtotal colectomy. Five patients (14.3%) stopped acetarsol due to side effects. One patient experienced vomiting, palpitations and sweating, and the other four experienced headache, vomiting, anal itching and paresthesia. Median serum arsenic level was 728.25 (872) nmol/l (<130 nmol/L). Serum arsenic levels were not correlated with patient clinical response nor the need for treatment escalation.

Conclusions Acetarsol suppositories could be an effective and tolerable option in the management of refractory proctitis. A definitive study is urgently warranted to thoroughly investigate the clinical efficacy and safety of this promising drug.

Conclusions The majority of gastroenterologists surveyed are adhering to the budesonide label recommendation of tapering over a 2–4 week period when prescribing budesonide. The reasons behind 20% of prescribers deviating from the product labels needs further research to be addressed.

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Introducing vedolizumab (VDZ) dosing frequency to recapture response has been shown to be effective in clinical trials but there is limited real-life data from the clinical practice. In this study we assessed whether VDZ dose escalation helped recapture response in a large cohort of patients in a tertiary referral IBD centre.

**Methods** A retrospective cohort study was performed by reviewing prospectively recorded clinical data for patients who received VDZ between November 2014 and October 2017. Patients who had sub-optimal response and had been escalated to 6 or 4 weekly infusions were identified. Data collected for demographics, previous biologic exposure, concomitant immunomodulators (IM), steroid use (SU), clinical disease activity for CD (HBI) and UC (SCCAI), and CRP levels at baseline, 12 and 24 weeks after dose escalation.

Of the total 139 patients on VDZ, 36 (27%) had been escalated to Q4 (30) or Q6 (6), of whom 5 were further escalated to Q4 (72% male, median age 44, previous biologics exposure 81%, 49% concomitant IM and 16% SU at time of escalation). 18 patients had CD (50%), 14 UC (39%), and 4 (11%) IBD-U which were included in the UC group for the purpose of analysis.

Duration of VDZ before and after dose escalation with a median of 7 m (ranges 0–22, 2–25 respectively). Currently 76% remain on VDZ after dose escalation (median 7 m after escalation).

Clinical response was defined as HBI or SCCAI reduction >3. Remission as HBI <5 or SCCAI <3. Paired HBI, SCCAI, CRP values at baseline, week 12 and 24 were compared using Wilcoxon signed-rank test.

**Results** Patients with CD had a median HBI of 4 (range 0–27), 4 (0–29) and 3 (0–8), at baseline, 12 and 24 weeks.

In UC group, the median SCCAI was 6 (range 0–22), 4.5 (1–11), and 4 (0–10), at baseline, 12 and 24 weeks.

CRP for both groups at baseline was a median of 6 (1–23), 5 (1–46) at w12, and 2 (1–17) at w24.

HBI and SCCAI at baseline, 12 and 24 weeks after dose escalation

Statistically significant differences were noted in the UC group between SCCAI at baseline and after 24 weeks (p 0.01) and overall CRP at baseline and 24 w (p 0.04).