PWE-027 SELF-MEDICATION WITH ORAL CORTICOSTEROIDS IN AMONGST PATIENTS WITH INFLAMMATORY BOWEL DISEASE

¹Marie Jasim*, ²Richard Pollok. ¹St George's, University Of London, London, UK; ²St George's University Hospitals NHS Foundation Trust, London, UK

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Introduction Corticosteroid (CS) overuse and dependency has been highlighted as a key clinical outcome in the management of inflammatory bowel disease (IBD) in a recent national audit¹. Whilst data regarding clinician prescribed CS is available², little is known about the magnitude of self-prescribed CS amongst IBD patients, and we therefore aimed to investigate self-prescribing habits.

Methods Patients attending the IBD clinic at a teaching hospital between November 2017 and February 2018 were included in the study and invited to complete an 18-item questionnaire, designed to determine CS self-medication in the previous 12 months. The questionnaire defined: patient demographics, disease behaviour, and CS prescriptions in the last 12 months. A pilot questionnaire was initially administered to ensure validity and robustness.

Results 100 patients participated in the survey. In total, 8 (8.0%) reported self-medicating with CS in the last 12 months, with the majority (n=6) having a diagnosis of ulcerative colitis. All these individuals had been diagnosed with IBD for at least 11 years. In most cases (n=7), CS were remaining from previous medical prescriptions, with 1 patient reporting having purchased CS online. Reasons given for self-medicating included difficulty in seeing a clinician (n=3) and a desire for greater control of their own symptoms (n=3). The self-medicating dosage regimen varied significantly between individuals, from 5 mg to 60 mg prednisolone daily, taken for durations between 5 to 21 days. Of the total patients who participated in the survey, 40 (40.0%) had not suffered with a flare-up in the previous 12 months.

Conclusions Nearly one-tenth of the study population reported self-medication with CS over the past 1 year. These findings underscore the importance of enquiring about CS self-medication in the IBD clinic, which may otherwise go undetected. Self-prescribing may indicate refractory disease and a need for treatment escalation.

REFERENCES

1. Selinger CP, Parkes GC, Bassi A, Fogden E, Hayee B, Limdi JK, Ludlow H, McLaughlin S, Patel P, Smith M and Raine T. A multi-centre audit of excess steroid use in 1176 patients with inflammatory bowel disease. *Aliment Pharmacol Ther.* 2017;46(10):964–973.
2. Chhaya V, Saxena SK, Cecil E, Subramanian V, Curcin V, Majeed A and Pollok RC. Steroid dependency and trends in prescribing for inflammatory bowel disease – a 20 year national population-based study. *Aliment Pharmacol Ther.* 2016;44:482–494.

PWE-028 PERSISTENCE OF BIOLOGIC THERAPY AND MAPPING OF SEQUENTIAL BIOLOGICS: RESULTS OF A SINGLE CENTRE COHORT

¹Philip Jenkinson*, ¹Nik Plevris, ¹Cher Siong Chuah, ²Mathew Lyons, ¹Lynne Merchant, ¹Gareth Jones, ¹Ian Arnott, ¹Charlie Lees. ¹NHS Lothian, Edinburgh, UK; ²University of Edinburgh, Edinburgh, UK

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Background Biologic therapy has revolutionised the treatment of IBD in the last 20 years. There is limited data on the patient journey through multiple lines of biologics and

mapping this to outcomes. We aimed to establish the prevalence of biologic use in a single tertiary IBD centre and assess outcomes defined by biologic persistence.

Methods Retrospective review of electronic health records (TrakCare) was performed on all patients who have received infliximab (IFX), adalimumab (ADA), vedolizumab (VEDO) or ustekinumab (UST) in Edinburgh from January 1999 to October 2017. We collected data for demographics, phenotyping details and duration of treatment. Kaplan–Meier survival curves and log-rank analyses were used to compare time to either discontinuation or resectional surgery.

Result 841 patients were identified who have had biologic therapy for IBD. Median interval from diagnosis to biologic was 4.9 years (IQR 1.3–11.0). The multiple combinations of biologics used is displayed in Figure 1. 665 CD patients (79.7% of total) were treated with biologics; 486 received IFX (73.1%), 169 ADA (25.4%) and 10 VEDO (1.6%) as first line therapy. Second line therapy was required in 238 patients and consisted of ADA 189 (79.4%), IFX 25 (10.9%), VEDO 18 (7.6%) and UST 6 (2.5%). Third line therapy was required in 57 patients, VEDO 41 (74.5%) and UST 14 (25.5%). 3 (0.5%) patients received fourth line therapy with UST. In the CD cohort persistence of treatment on ADA was longer than IFX when used as first line treatment; median 2373 vs 1430 days (p=0.0189).

Abstract PWE-028 Figure 1

Conclusion Multiple sequential biologic use is becoming increasingly common and this will accelerate with the increasing use of anti-integrin and anti-IL12/IL23 therapies. Mapping the sequence of biologic use and linking this to outcomes is a priority for IBD research.

PWE-029 COMPARATIVE ASSESSMENT OF THE DIFFERENT MANAGEMENT SUPPORT PROGRAMMES AVAILABLE TO IBD PATIENTS AT A DGH

¹Matt W Johnson*, ²David Wellsted, ^{1,2}Fiona M Pearce. ¹Luton and Dunstable University Hospital, Luton, UK; ²Centre for Health Service and Clinical Research, University of Hertfordshire, UK

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Introduction Since 2012, a supported, self-help and management programme (SSHAMP) at the Luton and Dunstable University Hospital, has allowed over 950 IBD patients with stable symptoms to be managed safely within the community by encouraging self-management. IBD-SSHAMP is supported by consultants and specialist nurses through telephone clinics,

relieving pressures on the hospital based outpatient clinic system. Both IBD-SSHAMP patients and those who continue to be under traditional hospital-based outpatient clinic care, also have access to online support via an IBD web-portal provided by Patients Know Best' (PKB). We were keen to see if the different forms of support provided differences in the perception of their disease control and health-related quality of life (HRQoL).

Method Between 2013 and January 2017, an estimated 575 patients had registered with PKB and 950 were on IBD-SSHAMP. A series of questionnaires were completed anonymously by 260 patients between January – July 2017. Measures included depression, anxiety, health-related quality of life, psychological flexibility and illness perception. Approximately 60% of patients completing the questionnaires receive traditional hospital outpatient care (n=158), with around 30% of those registered for additional online PKB support (n=46) comprising the PKB group and 70% (n=112) not registering for PKB and comprising the control (normal) care group. Of the 40% IBD-SSHAMP patients (n=101), 52% also registered for PKB (n=53) comprising the SSHAMP+PKB group. The remaining patients (n=48) were the SSHAMP only support group. Various univariate comparisons between the normal-care group and the 3 supported groups were undertaken as well as multivariate regression analysis.

Results In this patient cohort, women tended to responded more and there was a higher proportion of Crohn's disease in the females and compared to UC within the men. The proportion of men and women in the different patient groups was similar except that men were slightly over-represented in the normal (OPA)-care group and women in the SSHAMP+PKB group. Women had significantly lower HRQoL scores than men and scored worse on most psychological measures. CD diagnosis correlated with worse overall HRQoL and fatigue measures. The SSHAMP patient group had significantly better overall HRQoL and social-emotional HRQoL scores than the normal-care group. There were no significant psychological differences between PKB web-users and the normal-care group, although high PKB registration was observed amongst the SSHAMP group, particularly by younger female patients with Crohn's disease.

Conclusion High PKB registration by SSHAMP patients and lack of significant difference to the normal-care group by PKB users suggests that SSHAMP patients may be more engaged in their own care and that generally patients, especially women, are effective at seeking additional online support when needed. Psychological differences, including illness perceptions, appear to mediate the relationship between supportive care and HRQoL.

PWE-030 THE NEED FOR REPEATED COURSE OF INTRA-VENOUS IRON IN IBD PATIENTS; A 7 YEAR RETROSPECTIVE REVIEW

Matt W Johnson*, Luke Johnson, Floyd Lourenco. *NHS, Luton, UK*

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Introduction The current prevalence of IBD in UK is said to be 400/100,000 (0.4%), with rates for Crohn's disease ranging between 26 to 199 per 1 00 000 (<0.2%), whilst Ulcerative Colitis (UC) is found more frequently at 37 to 246 per 1 00 000 (0.25%). Anaemia is a common problem in IBD, contributing to tiredness and lethargy, and has multifactorial

causes. Current ECCO guidelines recommend that all patients with IBD should be assessed for IDA and that intravenous iron should be considered first line in patients with active inflammation. We were keen to assess the need for recurrent courses of IV iron in IBD patients.

Method The Luton and Dunstable University Hospital serves a catchment of 3 30 000 and has a database of 3014 IBD patients (0.9%). This is made up of 186 Proctitis, 1447 UC, 1037 Crohn's, 71 Microscopic colitis, 273 Indeterminate colitis patients. We compiled a 7 year retrospective database of all the IBD patients presenting to the L and D with blood tests confirming iron deficiency anaemia (IDA), using the following definition; haemoglobin level of <13 g/L for men and <12 g/L for women with ferritin of <50 ng/ml (although ECCO suggest <100 ng/ml in acutely inflamed patients). We compared this with a database of all the iron infusions that had been prescribed for IBD patients over that same 7 year period. In this way the demand for recurrent iron infusions was assessed.

Results The prevalence of IBD is high in the local area (almost 1%). Over the 7 year review period, 633 (21%) of our local IBD patients were found to have IDA, with a median Hb level of 118 (130–47) g/L and ferritin count of 16.9 (49.8–2.4) ng/ml. Of these, there were 238 infusions in 128 patients (4.2% of total cohort), with 37 patients (29%) requiring 110 repeated infusions (with a range of an additional 1–17, median 2, mean 3.97). The data set was skewed by 7 patients who between them required 71 additional infusions, due to a range of co-morbidities including 1x acute GU bleed, 1x stricture surgery, 1x haemorrhoidectomy and 4x joint care with haematology. If these 7 patients were removed from the data set, just 39 repeated infusions would have been necessary in 30 patients (23%) over the 7 year period.

Conclusion The BSG have previously highlighted that 50% of IBD patients suffering IDA will redevelop it within 1 year post-correction. Our data suggests that if the patients' IDA is predominately due to their IBD (and not other co-morbidities), then IV iron is a highly effective therapy, with only 23% requiring further infusions over a 7 year period.

PWE-031 RE-EVALUATING INVESTIGATION AND MANAGEMENT OF ANAEMIA IN INFLAMMATORY BOWEL DISEASE

¹James Kennedy*, ²Su Su Myat, ²Cara Leung, ³David Tate, ⁴Eleanor Turner-Moss, ²Melanie Lockett. ¹Royal Berkshire NHS Foundation Trust, Reading, UK; ²North Bristol NHS Trust, Bristol, UK; ³Gloucestershire Hospitals NHS Foundation Trust, Gloucester, UK; ⁴Cambridge Institute of Public Health, Cambridge, UK

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Introduction Anaemia is the most prevalent extra-intestinal manifestation of inflammatory bowel disease (IBD), affecting up to 66% of inpatients admitted with a flare of IBD. European guidelines published in 2015 define clear management priorities for such patients.¹ Here we present a re-audit of the practice of a large teaching hospital following introduction of a local guideline based on the European consensus.

Methods We retrospectively identified and analysed the casenotes of all patients admitted to North Bristol NHS Trust between 2015 and 2017 presenting with a flare or new diagnosis of IBD. Data collected included patient demographics, admission haemoglobin (Hb) and ferritin levels, and prescription of oral or intravenous iron during admission. These data were compared to a historical dataset from 2014 prior to the local guideline introduction.