TDM is a strategy to help achieve this, through the measurement of drug and anti-drug antibody concentrations. The Building Research in IBD Globally (BRIDGe) groups ‘Anti-TNF Optimizer’, an online tool that helps interpretation of TDM and clinical decision-making.

**Methods**
We performed a retrospective study of IBD patients on infliximab (IFX) or adalimumab (ADA) at our institution, undergoing TDM between Jan 16-Mar 17. TDM was performed using a drug-tolerant ELISA (IDKmonitor, Immunodiagnostics). Disease activity was defined by the combination of clinical symptoms and evidence of biochemical (CRP >10; FCP >150), endoscopic or radiological activity. Clinical decision-making was compared to recommendations made by the BRIDGe ‘Anti-TNF Optimizer’ tool, which suggests that objective evidence should be sought in all cases of suspected primary non-response (PNR) and loss of response (LOR). Subsequent disease course was evaluated using a Physicians Global Assessment (PGA), which took into account clinical, biochemical, endoscopic and/or radiological activity and the need to progress to surgery. Outcomes were described as ‘favourable’ or ‘unfavourable’. Groups were compared using Fisher’s exact test (GraphPad Prism V7.0a).

**Results**
60 patients were included: 30 IFX and 30 ADA. Indications for TDM: LOR 45 (75%), PNR 8 (13%), routine monitoring during remission 7 (12%). Objective evidence of inflammation was sought in all 53 cases of LOR/PNR and found present in 42 (79%). Two patients were lost to follow up and were not included in the final analysis. Of these 40, subsequent clinical management was in keeping with BRIDGe recommendations in 19 (48%).

Of the 19 LOR/PNR patients managed as per BRIDGe recommendations, 15 (79%) achieved a subsequent favourable outcome. The rate of subsequent favourable outcome in the group who were not managed in accordance with BRIDGe was significantly lower at 3/21 (14%, p<0.0001).

**Conclusions**
The rate at which objective evidence of inflammation was sought amongst our patients with symptoms suggestive of PNR/LOR was good. However, clinical decision-making deviated from BRIDGe recommendations in majority of cases and this appeared to adversely impact disease course. Results therefore, suggest that using an evidence-based, expert consensus, online tool to guide biologic decision-making with the results of biologic TDM provides benefit in IBD outcomes.

**Abstract PWE-057 Figure 1**

![Image](image-url)
TRAVELLING WITH INFLAMMATORY BOWEL DISEASE (IBD): BARRIERS, FEARS, CONCERNS AND SUGGESTIONS FOR SUPPORT

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Introduction IBD can act as a barrier to overseas travel due to concerns about travel related morbidity. This study aims to identify barriers, fears and concerns of IBD patients with regards to travel and possible areas of support from the IBD team.

Method 136 IBD patients were selected using convenience sampling. They completed a questionnaire focused on travel with IBD and specific travel issues (decision to travel, insurance, pre-trip advice, vaccination, previous flares while abroad, high altitude travel, assistance while overseas).

Result 136 patients completed the questionnaire, 70 were male (51.4%), 73 had Crohn’s Disease, 53 had Ulcerative Colitis (UC), 3 had Indeterminate Colitis and 7 were unsure. 56.6% of patients were taking 5-ASAs, 52.9% were on immunosuppressant therapy and 20.6% receiving biologics. 89% had travelled abroad since their IBD was diagnosed, 30% reported IBD limited their travel and 40% said it affected their choice of destination. 61% worried about healthcare problems abroad. 7% were refused health insurance and 47% had travelled abroad uninsured. 9% travelled uninsured due to their current diagnosis of IBD. Only 64% felt that they had received adequate pre-travel medical advice. 78% wanted advice from their doctor for future travel, 60% were unaware that taking immunosuppressant medication could affect their vaccinations and 63% on immunosuppressant therapy of biologics claimed they were uninformed of the need to avoid live vaccines. 12% received live vaccines prior to travel. Suggestions for travel help: 91% requested a written/electronic pre-trip advice from health care professionals makes this entirely avoidable. Most IBD patients were unaware that high altitudes may precipitate flares. A majority were unaware of the ‘Can’t Wait Card’ and IBD passport services. Pre-emptive discussions around travel plans should be part of the IBD clinic review.

Notes

Conclusions DALMs were detected in 0.5% of IBD patients undergoing colonoscopy. Almost half of these were not detected during scheduled surveillance, which may support the shorter intervals used by some clinicians.