detected on random biopsy, none were detected with dyespray. Adherence to the 2010 guidelines in these patients was 85%.

1289 individuals with 2256 colonoscopies were identified. Low/moderate/high risk groups were 78 (60%)/382 (29%)/125 (9.7%) respectively. Interval adherence in this cohort was 82%. 20 patients were selected for case notes review. The mean age was 52 (range 31–72). Three patients had colectomy (2 refractory colitis, one DALM) and one patient moved out of area during the studied period. 72 colonoscopies were performed with 52 intervals recorded. Seven (13%) intervals were scheduled over the recommended time (mean 333 days). These were all at the patient's request. 30 intervals (58%) were performed before their intended date (mean –347 days). The most common reason for this was inappropriate yearly surveillance.

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.

PWE-059 TRAVELLING WITH INFLAMMATORY BOWEL DISEASE (IBD): BARRIERS, FEARS, CONCERNS AND SUGGESTIONS FOR SUPPORT

Anet Soubieries*, Varun Philip, Andrew Poullis. *St Georges Hospital NHS Trust, London, UK*

10.1136/gutjnl-2018-BSGAbstracts.191

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 prescription for their journey, 75% wanted specific management advice, 68% a written management plan. 68% felt a doctor's note could help them secure health insurance. 38% of patients who travelled abroad were suffering/recovering from a flare and 18% travelled despite being within a week of a flare. 92% were unaware that high altitudes could precipitate a flare. 27% travelled to high altitude destinations and of these

46% experienced a flare whilst travelling or within 4 weeks of travel. 72% were unaware of the 'Can't Wait Card' and 96% never heard about the IBD passport website.

Conclusion IBD has a big impact on travel for a broad range of reasons. Refusal of health insurance, coupled with higher premiums could explain why many IBD patients travel abroad uninsured. Providing a doctor's note confirming fitness to travel was a popular solution chosen by patients. A majority were interested in doctors providing written management plans and prescriptions prior to their travel. Despite over half of the study being on immunosuppressant therapy, most were unaware of avoiding live vaccines whilst taking them. Better advice from health care professionals makes this entirely avoidable. Most IBD patients were unaware that high altitudes may precipitate flares. A large 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.

PWE-060 BASELINE CALPROTECTIN PREDICTS STEROID FREE REMISSION WITH BIOLOGICAL THERAPY IN ULCERATIVE COLITIS AT 1 YEAR

¹Sreedhar Subramanian*, ²Rebecca Davies, ²Susie Dodd, ¹Daniel Storey, ¹Alan Steel, ¹Martyn Dibb, ¹Paul Collins, ¹Ed Derbyshire, ²Chris Probert, ²Paula Mcparland. ¹Royal Liverpool University Hospital, Liverpool, UK; ²University of Liverpool, Liverpool, UK

10.1136/gutjnl-2018-BSGAbstracts.192

Background Response to the anti-tumour necrosis factor (TNF) agents and the anti-integrin- $\alpha_4\beta_7$ antibody, vedolizumab, in ulcerative colitis (UC) is variable. There are few clinical predictors of long term efficacy to biological therapy apart from prior exposure to anti-TNF therapy. Identification of readily available clinical and biochemical predictors will enable better utilization of these expensive drugs. We sought to evaluate the role of clinical factors and faecal calprotectin prior to initiation of therapy in predicting steroid free remission at 1 year.

Methods The case records of all patients who commenced biological therapy for UC were examined. Baseline clinical factors including disease extent, duration, smoking status, body mass index, concurrent immunomodulatory or steroid therapy and biochemical factors including C-reactive protein and faecal calprotectin were recorded. Patients with acute severe colitis were excluded. Remission was defined as simple clinical colitis activity index of <3. A multi-variate logistic regression was performed to assess the role of baseline variables in predicting steroid free remission at 1 year.

Results A total of 150 patients commenced biological therapy during the study period (2014–2017). Eighteen patients (12%) were excluded from the final analysis (Adverse reactions, N=5, 3.3%, Surgery, N=6, 8%, and data unavailable, N=7, 4.6%). After exclusion, a total of 98 patients commenced anti-TNF therapy (37 infliximab, 14 golimumab and 12 adalimumab) and 34 commenced vedolizumab. Twenty-three (23.5%) of the anti-TNF treated and 16 (47%) of vedolizumab treated patients were in steroid free remission at 12 months. Forty-seven patients had extensive colitis and 4 patients were active smokers. A baseline calprotectin of >500 $\mu\text{g/g}$ was associated with a lower probability of remission to vedolizumab (OR 0.23, 95% CI 0.05 to 0.98, $P<0.047$) and anti-TNF therapy (OR 0.39, 95% CI 0.14 to 1.07, $P=0.067$) at 12 months. None of the other clinical variables examined (BMI, disease

extent, duration, concurrent immunomodulatory therapy) predicted steroid free remission at 12 months.

Conclusions A raised basal calprotectin was associated with a lower probability of steroid free clinical remission with both anti-TNF and anti-integrin biological therapy in UC. None of the other clinical variables including BMI at baseline predicted steroid free clinical remission at 1 year.

PWE-061 PREDICTORS OF REMISSION TO VEDOLIZUMAB THERAPY IN A COMBINED INFLAMMATORY BOWEL DISEASES COHORT

¹Sreedhar Subramanian, ²Paula Mcpartland, ²Susie Dodd, ¹Daniel Storey, ¹Alan Steel, ¹Martyn Dibb, ¹Paul Collins, ²Chris Probert, ¹Ed Derbyshire, ²Rebecca Davis*. ¹Royal Liverpool University Hospital, Liverpool, UK; ²University of Liverpool, Liverpool, UK

10.1136/gutjnl-2018-BSGAbstracts.193

Introduction The response to the anti-integrin- $\alpha_4\beta_7$ antibody, vedolizumab, is variable in both Crohn's disease and ulcerative colitis. Apart from prior exposure to anti-TNF agents, there are very few clinical predictors of response to vedolizumab therapy. Previous studies have shown that clinical and biological variables such as body mass index (BMI), baseline disease activity and concurrent immunosuppression influence response to anti-TNF agents but such data are not available for vedolizumab. We sought to evaluate the role of clinical and biological variables as predictors of response to vedolizumab.

Methods We conducted a retrospective single centre retrospective cohort study of all patients commencing vedolizumab therapy. Clinical response was defined as a reduction of 3 points from baseline for Harvey-Bradshaw index (HBI) and 2 points for simple clinical colitis activity index (SCCAI). Clinical remission was defined as HBI <5 and SCCAI <2. Response and remission was evaluated at 6 and 12 months. A multi-variate logistic regression was performed to analyse the effect of BMI, baseline calprotectin, prior anti-TNF exposure, disease type (UC or CD) and concomitant IS on response and remission to vedolizumab.

Results A total of 95 patients commenced vedolizumab therapy during the study period (2014–17). Of these, 11 patients (11.5%) had recently commenced therapy and a further 20 patients (21%) were excluded (Surgery, n=4, adverse reaction, n=4, primary non-response, n=5 and insufficient data, n=7). Of these, 64 patients had disease activity data at 6 months and 45 patients at 12 months. The pooled steroid free remission rates at 6 and 12 months were 45% and 32% respectively. Baseline clinical factors including BMI, smoking status, concurrent immunomodulatory or steroid therapy were not associated with steroid free remission at 6 and 12 months. Prior anti-TNF failure did not influence clinical remission at 6 months (OR 0.7, 95% CI 0.26–1.88, p=0.4) or 12 months (OR 1.24, 95% CI 0.44–3.46, p=0.6). Patients with UC were more likely to be in steroid free remission at 6 (OR 2.45, 95% CI 0.89–6.74, p=0.08) and 12 months (OR 3.5, 95% CI 1.2–10.6, p=0.02). Neither baseline calprotectin nor a reduction in calprotectin at 2 months predicted steroid free remission at 6 or 12 months.

Conclusions In a mixed IBD cohort treated with vedolizumab, patients with UC were more likely to be in steroid free remission at 6 and 12 months. None of the other clinical and biological variables were associated with steroid free remission.

PWE-062 FIRST CLINICAL EXPERIENCE OF PANENTERIC CAPSULE ENDOSCOPY USING THE PILLCAM CROHN'S CAPSULE

¹David Tai*, ¹Victoria Thurston, ¹Ailish Healy, ²Sara Koo, ²Clare Parker, ²Simon Panter, ¹Melissa Hale, ¹Reena Sidhu, ¹Mark McAlindon. ¹Sheffield Teaching Hospitals NHS Trust, Sheffield, UK; ²South Tyneside NHS Foundation Trust, Tyne and Wear, UK

10.1136/gutjnl-2018-BSGAbstracts.194

Introduction Guidelines support endoscopic assessment of mucosal healing in Crohn's disease before a change in therapy. [Gomollon, J Crohn's Colitis 2016] A recent study has shown that the PillCam Crohn's (PCC, Medtronic, Dublin, Ireland) has a better diagnostic yield than ileocolonoscopy [Leighton, Gastrointest Endosc 2017] and that colon capsule (for which the same bowel preparation is used) is better tolerated [Ojida, European J Gastroenterol Hepatol, *in press*]. We report the first experience of PCC in routine clinical practice.

Methods Data was collected prospectively in Sheffield and South Tyneside hospitals. Montreal classification was used (ileal:L1; colonic: L2; ileocolonic: L3; upper GI: L4; B1: non-stricturing/penetrating; B2: stricturing; B3: penetrating). All patients passed an Agile patency capsule (Medtronic).

Results Eighteen patients (median age 35 years, 38.9% male, known Crohn's in 83%) had PCC. Indications were: symptom assessment (77.8%), assess response to treatment (11.1%), consideration of stepping down therapy (16.7%). Patients with established Crohn's had L1 (53.3%), L2 (13.3%), and L3 disease (33.3%) which was uncomplicated (40%), stricturing (46.7%) and penetrating (13.3%). Patients were on medical treatment in 73.3%. PCC changed staging of disease in 33% of cases (L1 to L3 n=1, B2 to B1 n=3 and B1 to B2 n=1). One of three patients with suspected Crohn's disease subsequently had endoscopic confirmation (L3 B1). PCC was normal (5/18), revealed L1 disease alone (8/18), L2 disease alone (1/18) and L3 disease (5/18). There were three incomplete procedures, all with an otherwise normal visualised colon. No capsule retentions occurred. Follow up data was available in 11 patients. Of eight patients with symptoms, five had active disease and three no or minimal activity. Of the five, three had a step-up in treatment, one had adalimumab temporarily suspended due to a perianal abscess and management continues to be discussed in one patient on maximal medical therapy. Other causes of symptoms were sought in the patients with inactive disease. Three patients had no symptoms, one had active disease and a step up in treatment, two had no or minimal activity of whom one continued therapy due to poor prognostic factors and one was already on no treatment (PCC being performed to provide supportive evidence of a diagnosis made in childhood). No patient known to have Crohn's has been referred for further small bowel imaging or colonoscopy.

Conclusion PCC provides a single visit assessment of both small and large bowel which was useful in guiding patient management without complications.

PWE-063 ALTERATIONS IN CORTICAL THICKNESS AND GREY MATTER VOLUME IN PATIENTS WITH ACTIVE CROHN'S DISEASE

¹Gordon Moran*, ^{1,2}Gita Thapaliya, ²Sally Eldeghaidy, ¹Shellie Jean Radford, ¹Melanie Lingaya, ¹Yirga Falcone, ²Sue Francis. ¹Nottingham Digestive Disease Centre, University of Nottingham, Nottingham, UK; ²Sir Peter Mansfield Imaging Centre, University of Nottingham, Nottingham, UK

10.1136/gutjnl-2018-BSGAbstracts.195