scoring systems, the risk of ACN was significantly different in low, moderate and high-risk tier ($p < 0.001$, table 2). When compared with average risk subjects, those in the high-risk tier had a 3.06 (95% confidence interval (CI) 1.22, 7.68) and 4.07 (95% CI 1.48, 11.20) fold increased risk of ACN for the APCS and modified APCS system, respectively. The C-statistics of APCS and modified APCS were 0.645 (95% CI, 0.598, 0.683), and 0.648 (95% CI, 0.640, 0.696), respectively.

Conclusions Both the APCS and modified APCS scores were similarly efficient to identify those subjects with high risk of can. Their feasibility and acceptability in different population groups should be further explored.

Abstract IDDF2018-ABS-0134 Table 1 Participant characteristics and colonoscopy findings (n=2,813)

	Total	Percentage (%)
Gender (male)	1463	52.0
Ever smoking	931	33.1
Alcohol drinking	823	29.3
Family history in FDR	390	13.9
Hypertension	1004	35.7
Diabetes	293	10.4
Heart disease	156	5.5
COPD	19	0.7
Stroke	18	0.6
Cirrhosis	5	0.2
Fatty Liver	135	4.8
Personal cancer history (rather than CRC)	64	2.3
NSAID use	101	3.6
Normal	1755	62.4
Hyperplastic polyp	379	13.5
Non-advanced adenoma	537	19.1
Advance colorectal neoplasia	142	5.0
Cancer	29	1.0
Colorectal neoplasia	679	24.1

Chronic Obstructive Pulmonary Disease; CRC: colorectal cancer; FDR: first degree relative; NSAID: non-steroid Anti-Inflammatory Drug

Abstract IDDF2018-ABS-0134 Table 2 The discriminatory capability of APCS and modified APCS in Chinese asymptomatic subjects (n=2,813)

Scoring System	Categories	Case number	ACN prevalence	OR (95% CI)	p-value
APCS (age, gender, smoking, family history as predictors)	Average (0–1)	177	5 (2.8)	Referent	<0.001
	Moderate (2–3)	1742	64 (3.7)	1.31 (0.52,3.30)	0.564
	High (4–7)	894	73 (8.1)	3.06 (1.22,7.68)	0.017
Modified APCS (age, gender, smoking, family history, BMI as predictors)	Average (0)	214	4 (1.9)	Referent	<0.001
	Moderate (1–2)	1253	35 (2.8)	1.51 (0.53,4.29)	0.440
	High (3–6)	1333	96 (7.2)	4.07 (1.48,11.2)	0.006

APCS: Asia-Pacific Colorectal Screening, ACN: advanced colorectal neoplasia, OR: odds ratio, CI: confidence interval, BMI: body mass index

IDDF2018-ABS-0135

OBESITY AND ADVANCED COLORECTAL NEOPLASIA IN CHINESE ASYMPTOMATIC SUBJECTS

¹Martin Chisang Wong*, ¹Liwen Huang, ²Ping Chen, ²Xiaoqin Yuan, ³Shanjuan Wang, ⁴Wei Huang, ⁵Ming Hu, ⁶Tiansheng Huang, ⁷Xiaogang Li, ⁸Yinbing Tan. ¹JC School of Public Health and Primary Care, CUHK, Hong Kong; ²Ruijin Hospital North, Shanghai Jiaotong University, China; ³Hospital of Jiading District, Shanghai, China; ⁴Li Qun Hospital, Shanghai, China; ⁵Nan Xiang Hospital, Shanghai, China; ⁶Traditional Chinese Medicine Hospital of Jiading District, Shanghai, China; ⁷Dachang Hospital, Shanghai, China; ⁸Huaqiao Hospital, Kunshan, Jiangsu, China

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Background Obesity is recognised as a risk factor for advanced colorectal neoplasia (ACN). Body mass index (BMI) is used for obesity, while waist circumference (WC) for abdominal obesity. Several criteria exist for diagnosing obesity in subjects of different races and ethnicities, yet it is unclear which measure of obesity is a better predictor of ACN in colorectal cancer (CRC) screening.

Abstract IDDF2018-ABS-0135 Table 1 Univariate regression for risk factors of ACN

	overall(n=2813) (95% CI)	P value
age	2.350 (1.678–3.291)	0.000
age category		0.000
age(<55)	1	
age(55–64)	1.997 (0.960,4.153)	0.064
age(≥65)	3.313 (1.657,6.625)	0.001
gender	2.206 (1.530,3.181)	0.000
BMI(continuous)	1.047 (1.007,1.043)	0.083
BMI(23 as cutoff)	1.532 (1.058,2.218)	0.024
BMI(25 as cutoff)	1.441 (1.011,2.053)	0.043
Waist circumference(continuous)	1.025 (1.007,1.043)	0.006
WC(male 100 cm, female 90 cm)	0.910 (0.523,1.582)	0.738
WC(male 90 cm, female 85 cm)	1.392 (0.958,2.024)	0.083
WC(male 85 cm, female 80 cm)	1.463 (0.999,2.143)	0.051
Family history in FDR	1.880 (1.248,2.830)	0.003
Smoking status	1.813 (1.291,2.546)	0.001
Diabetes	1.916 (1.222,3.004)	0.005
Heart disease	1.310 (0.674,2.545)	0.425
Fatty liver	0.415 (0.131,1.320)	0.136
NSAID use	1.196 (0.515,2.779)	0.677

BMI: body mass index; WC: waist circumference; FDR: first degree relatives; NSAID: non-steroid aspirin inflammatory drug; CI: confidence interval

BMI: body mass index; WC: waist circumference; FDR: first degree relatives; NSAID: non-steroid aspirin inflammatory drug; CI: confidence interval

Methods In 2016 and 2017, we performed a prospective, multiple-centre, colonoscopy study that consecutively recruited asymptomatic subjects in seven endoscopy units across North Shanghai, China. Self-reported questionnaires for risk factors of CRC were collected in the study sites. All participants' body weight, height, and WC were measured by research assistants using standardised methods. All the colonoscopies were completed by senior endoscopists. Taking ACN as the outcome, we conducted univariate binary regression to identify the additional risk of ACN conferred by BMI/MC. We then used their different cut-off levels, comparing separate

Abstract IDDF2018-ABS-0135 Table 2 Multivariate binary regression for risk factors of ACN

Obesity indexes	Adjusted odds ratio(95% CI) with age, gender, family history CRC in FDR, diabetes	p-value
BMI $\geq$ 23	1.60 (1.08,2.36)	0.018
BMI $\geq$ 25	1.44 (1.01,2.10)	0.044
WC(male 90 cm, female 85 cm)	1.33 (0.91,1.95)	0.140
WC(male 85 cm, female 80 cm)	1.52 (1.03,2.24)	0.035

multivariate regression results to select the one with a highest odds ratio (OR) as the best predictor. The risk scores of all predictors and C-statistics was reported for the regression model with obesity index having the highest OR.

Results A total of 2813 subjects were enrolled (mean age 58.7 ± 8.4 years, 52.0% male), of which 142 (5.0%) was diagnosed with ACN. In univariate regression, several BMI/WC criteria were significant, with age, gender, family history, smoking status and diabetes (table 1). The Asian criteria for overweight (BMI $\geq$ 23) attained the highest adjusted OR (1.60, 95% confidence interval (CI) 1.08, 2.36), when compared with international criteria for overweight (BMI $\geq$ 25) (OR 1.46, 95% CI 1.01, 2.10) and Asian criteria for abdominal obesity (male $\geq$ 85 cm, female $\geq$ 80 cm) (OR 1.52, 95% CI 1.03, 2.24) (table 2). The C-statistics of the new model with BMI $\geq$ 23 as the predictor for ACN was 0.648 (95% CI 0.600, 0.696).

Conclusions The Asian criteria for obesity had the most discriminatory performance to predict ACN as compared to other obesity measures in this asymptomatic Chinese cohort. These findings imply BMI $\geq$ 23 may be most suitable 'obesity-predictor' of ACN in risk algorithms.

IDDF2018-ABS-0136 A SCORING SYSTEM FOR OUTPATIENT IMPROVEMENT IN THE DIAGNOSTIC YIELD OF UPPER GASTROINTESTINAL ENDOSCOPY

Nitin Agarwal*. Postgraduate Institute of Medical Education and Research, Dr. Ram Manohar Lohia Hospital, Delhi, India

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Background With the widespread availability of diagnostic procedures, it has become necessary to evaluate the efficacy and appropriateness, especially with regard to gastrointestinal endoscopy (upper and lower). Many centres have adopted an open-access referral policy, resulting in increased costs, waiting times and clinical workload. Attempts have been made to rationalise resources, by using limited indications. Diagnostic accuracy for dyspepsia is only 40%–50%. We planned to develop a scoring system which would help in differentiating disease from non-diseased and improve the diagnostic yield of upper gastrointestinal endoscopy.

Methods A total of 150 patients from the outpatient and inpatient departments of a tertiary care hospital in north India

over 2 years were included. The clinical history and examination of the patients were recorded on a performa. The examination was undertaken by a standard forward-viewing fibre optic endoscope using topical anaesthesia by the consultant. The outcome of the endoscopy was categorised as positive if there was a significant finding. Less severe and equivocal findings such as gastritis, duodenitis were not considered positive for this study. Logistic regression (forward LR score) was used; the *coefficient of regression* was used to assign a score for each symptom.

Results Pain was the most common symptom; in 110 patients (77.3%) the endoscopy showed no significant findings. Significant findings were seen in 34 patients; diagnostic yield=22.7%. Clinical features like weight loss, hemeaemesis, malena, dysphagia, anaemia, abdominal distention, ascites and abdominal lump significantly discriminated and pointed towards a positive endoscopic finding. The pain was not a good discriminating factor; dysphagia, the presence of ascites and the presence of abdominal lump independently predict significant endoscopic findings. At a total score of 4 or less we can avoid doing endoscopy in 75 (50%); as the score increase the sensitivity decreases while the specificity increases. At a score of 5 the sensitivity=82% and specificity=71%. All 11 malignancies had a score=5 or more.

Conclusions Our findings suggest how the selection of patients for endoscopy can be improved. It also provides a basis for prospective studies which can lead to better use of resources in future.

IDDF2018-ABS-0141 AN ANALYSIS OF THE EFFICACY AND SAFETY OF INFLIXIMAB IN THE MANAGEMENT OF REFRACTORY ULCERATIVE COLITIS AND ULCERATIVE COLITIS WITH EXTRA-INTESTINAL MANIFESTATIONS

Hui Su*, Yan Jia, Yuanming Pan, Xiaojuan Lu, Ruying Fan, Xin Fan, Yilin Wang, Shirong Li, Jianqiu Sheng. Department of Gastroenterology, PLA Army General Hospital, Beijing, China

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Background To evaluate the efficacy and safety of Infliximab (IFX) in the management of refractory ulcerative colitis (UC) and UC with extra-intestinal manifestations.

Methods The clinical data for 36 cases including refractory UC patients and UC patients with special extra-intestinal manifestations, who all accepted treatment with IFX, were analysed retrospectively.

Results Among all the 36 cases, 33 were refractory UC (5 with extra-intestinal manifestations) and another 3 with special extra-intestinal manifestations (2 with perianal abscess and 1 with ankylosing spondylitis). After treatment with IFX, 13 patients achieved clinical remission, of whom 3 achieved mucosal healing, 15 achieved clinical response and 8 failed to respond. The total effective rate of IFX treatment was 77.78%, remission rate 36.11%; Among 8 cases with extra-intestinal manifestations, 5 patients' extra-intestinal manifestations improved and the efficacy rate was 62.5%. No serious adverse events occurred during observation.

Conclusions IFX is effective and safe in the management of refractory UC and extra-intestinal manifestations.