Abstract IDDF2019-ABS-0126 Table 1 Efficacy and adverse effects

Characteristics	Modified sequential therapy (N=266)	Bismuth quadruple therapy (N=267)	P-value
Eradication			
ITT analysis	88.3%(235/266)	88.4%(236/267)	1.000
PP analysis	89.7%(235/262)	92.9%(236/254)	0.195
Any adverse effects	44.1%(83/188)	76.4%(159/208)	<0.001
Dizziness	13.5%(33/244)	29%(71/245)	<0.001
Skin rash	4.1%(10/244)	4.1%(10/245)	0.317
Headache	4.9%(12/244)	12.7%(31/244)	0.008
Taste distortion	9.8%(24/244)	11.6%(28/242)	0.821
Abdominal pain	11.1%(27/244)	10.6%(26/245)	0.567
Bloating	15.6%(38/244)	22%(54/245)	0.187
Nausea	11.5%(28/243)	34.3%(84/245)	<0.001
Vomiting	5.5%(11/244)	21.6%(53/245)	<0.001
Constipation	6.1%(15/244)	2.8%(7/245)	0.320
Diarrhea	9.5%(23/242)	8.6%(21/245)	0.247
Tongue discoloration	0.4%(1/244)	3.3%(8/245)	0.037
Darkened stool	9%(22/244)	35.5%(87/245)	<0.001
Took less than 80% of drugs	0.8%(2/248)	6.9%(17/246)	<0.001

Conclusions Levofloxacin sequential therapy and bismuth quadruple therapy are similarly effective in the second-line treatment for *H. pylori* infection. (Trial registration number: NCT NCT03148366)

IDDF2019-ABS-0129

OPTIMAL CUT-OFF VALUE OF FECAL CALPROTECTIN FOR THE EVALUATION OF INFLAMMATORY BOWEL DISEASE: AN UNSOLVED ISSUE?

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Background There is variability in the fecal calprotectin (FCP) cut-off level for the prediction of inflammatory bowel disease (IBD) activity and differentiation from irritable bowel disease (IBS). We aimed to assess the status of the optimal FCP cut-off value for the evaluation of IBD.

Methods We reviewed the existing literature regarding the optimal FCP cut-off level in patients with IBD for the prediction of disease activity, remission, relapse and differentiation from IBS patients.

Results The study reveals the large quantitative differences in FCP cut-off levels in different study populations (from 50 to918 microgram/gram) (table 1). FCP cut-off value for the initial diagnosis of IBD or active disease status ranged from 50 to800 microgram/gram. A cut-off level of 50–250 microgram/gram differentiated patients of IBD from IBS. Cut-off level of FCP for the prediction of remission ranged from 250 to 918 microgram/gram. Cut-off value for the prediction of relapse ranged from 50 to200 microgram/gram.

Variability in the cut-off level is due to the use of different test kits and different study populations. Gastrointestinal infections and chronic subclinical intestinal inflammation, may explain the higher cut-off FCP levels in underdeveloped populations. Studies have demonstrated high levels of FCP in patients with intestinal tuberculosis and chronic giardia infection.

Abstract IDDF2019-ABS-0129 Table 1 FCP cut-offs level in inflammatory bowel disease patients

Reference	Country	N	Subject/Controls	Cut-off (µg/g)	Sn/Sp	Inference
Garcia Sanchez et al.	Spain	25	IBD/Healthy	**217**	85/-	Diagnosis
Corracio et al	Italy	9	CD/IBS	170	100/95	Diagnosis
von Roon et al.	United Kingdom	5,983	IBD/Healthy	100	95/91	Diagnosis
Dhaliwal et al.	United Kingdom	88	IBD/IBS	100	97/76	IBD V IBS
Jha et al.	India	76	UC/IBS	**188**	98/97	IBD V IBS
D'Incà et al	Italy	77	IBD	80	78/70	Active disease
Xiang et al.	China	66	UC/Healthy	50	79/92	Active disease
D'Haens et al.	The Netherlands	126	IBD/IBS	**250**	71/100 (UC) 60/68 (CD)	Active disease
Schoepfer et al.	Switzerland	228	UC/Healthy	57	91/90	Active disease
Samant et al.	India	32	UC	**800**	96/71	Active disease
Gaya et al.	United Kingdom	35	CD	100	80/67	Active disease
Lobatón et al.[25]	Spain	123	UC	**250**	74/90	Remission
Lin et al.	Taiwan	52(UC)	UC	191	88/75	Remission
Lin et al.	Taiwan	36(CD)	CD	**918**	50/100	Remission
Dhaliwal et al.	United Kingdom	88	IBD/IBS	250	90/76	Remission
Costa et al.	Italy	79	IBD	150	89/83 (UC) 87/43 (CD)	Relapse
Tibble et al.	England	80	IBD	50	90/83	Relapse
D'Inca et al.	Italy	97(UC) 65(CD)	IBD	130	70/70 (UC) 65/62 (CD)	Relapse
Gisbert et al.	Spain	163	IBD	150	69/69	Relapse
Garcia-Sanchez et al.	Spain	69	UC	120	81/63	Relapse
Garcia-Sanchez et al.	Spain	66	CD	200	80/65	Relapse
Yamamoto et al.	Japan	160	UC	55	88/80	Relapse

Conclusions There is a wide variation in FCP cut-off levels in the initial diagnosis of IBD as well as in follow-up post-treatment. The FCP cut-off levels vary from country to country. The FCP test requires validation of the available test kits and finding of appropriate cut-off levels for different study populations.

IDDF2019-ABS-0130 GLOBAL SMOKING TRENDS IN INFLAMMATORY BOWEL DISEASE: A SYSTEMATIC REVIEW OF INCEPTION COHORTS

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Background The effect of smoking on inflammatory bowel diseases (IBD) may be heterogeneous across ethnicity and geography. This is a systematic review of smoking prevalence across global IBD cohorts.

Methods A systematic literature search was conducted on Medline and Embase from January 1st, 1946 to April 5th, 2018 to identify population-based studies assessing the prevalence of smoking at diagnosis in inception cohorts of Crohn's disease (CD) or ulcerative colitis (UC). Studies that did not report smoking data from the time of diagnosis or the year of IBD diagnosis were excluded. Prevalence of smoking in IBD was stratified by geography and across time.

Results We identified 56 studies that were eligible for inclusion. Never-smokers in the newly diagnosed CD population in the West has increased over the last two decades, especially in the United Kingdom and Sweden; +26.6% and +11.2% respectively. Never-smokers at CD diagnosis in newly industrialised nations have decreased over the 1990s and 2000s; China (-19.36%). Never-smokers at UC diagnosis also decreased in China; -15.4%. The former-smoker population at UC diagnosis in China is expanding; 11%(1990–2006) to 34%(2011–2013).

Conclusions There has been a reduction in the prevalence of smoking in the IBD cohort in the West. This is not consistent globally. Although smoking prevalence has decreased in the general population of newly industrialised nations, this remains an important risk factor with longer-term outcomes awaiting translation in both UC and CD.

IDDF2019-ABS-0139 EVALUATION OF NARROW BAND IMAGING FINDINGS IN MICROSCOPIC COLITIS AND TARGETED BIOPSIES

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Background Microscopic colitis (MC) is the cause of chronic diarrhoea which is often missed. Histopathology is a gold standard for diagnosis but colonic biopsy has a variable yield in view of normal endoscopy. We evaluated ileocolonic mucosa in suspected MC cases with narrow band imaging (NBI)and described its findings with outcome of targeted biopsy

Methods 53 adults with chronic diarrhea suspected to have MC were recruited after excluding malignancy, celiac disease, small intestinal bacterial overgrowth and inflammatory bowel disease. Routine blood tests, necessary imaging, stool analysis were done. Colonoscopy was done in all with ileal intubation if possible. HDWLE (high definition white light examination) and NBI finding were recorded. Routine biopsies on white light and targeted biopsies on NBI were taken and analysed by an expert gastrointestinal histopathologist as per statements of the European Microscopic Colitis Group 2012

Results 43 patients were diagnosed to have MC [mean age - 45.83(±15.92), males - 27]. The WLE revealed normal mucosa in all patients. NBI showed type 1 pit pattern and regular vascular pattern in all patients with MC. Mucosal pattern was honey comb type in all. Focal areas of abnormal vascularity with focally obscure pit pattern was noted more frequently in cases than controls {81% vs 12.5% ($p = 0.052$)}. Histologically 25(58.1%) had collagenous colitis (CC), 14 (32.5%) had lymphocytic colitis (LC). Four patients (9.4%) had a mixed picture. The yield of WLE and NBI targeted biopsies was the same ($p>0.05$)

Conclusions Colonoscopic NBI findings in MC revealed a hitherto unreported and distinct focal areas of abnormal vascularity with focally obscure pit pattern. There was no significant difference in yield of NBI vs WLE biopsies

IDDF2019-ABS-0141 PREDICTORS OF FAILURE OF ENDOSCOPIC HAEMOSTASIS IN BLEEDING PEPTIC ULCERS

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Background Bleeding peptic ulcers are the most common cause of non-variceal upper gastrointestinal bleed and are most often amenable to dual modality endoscopic haemostasis. However, a small group of patients fail to respond to endoscopic haemostasis and are often associated with significant morbidity and mortality. We explore the clinical and endoscopic features that predict failure of therapeutic endoscopic haemostasis.

Methods Retrospective case-matched study of consecutive patients who have failed therapeutic endoscopy following bleeding peptic ulcer (N=29) over a five-year period between 2011 and 2016 in Hospital Tuanku Ja'afar Seremban were age and sex-matched with patients who underwent successful therapeutic endoscopy (N=29). Failure of therapeutic endoscopy is defined as an end-point of either mortality or need for surgical intervention after at least one attempt at endoscopic haemostasis. Clinical, biochemical and endoscopic features between the two groups were analyzed using Pearson's chi-squared test.

Results Patients in both groups had similar baseline characteristics. Mean age was 63.9 in the failed endoscopy group and