Conclusions High rates of sustained clinical response were observed to occur following a BI switch supported by the use of pre and post switch TDM. TDM dose escalation resulted in a statistically significant increase in TLs, this may account for the rates of continued clinical response

REFERENCE

1. Papamichael K. *Frontline Gastroenterol.* 2016 Oct;7(4):289–300.

PTH-134 EXPERIENCES OF USING VEDOLIZUMAB IN THE TREATMENT OF INFLAMMATORY BOWEL DISEASE IN THE EAST MIDLANDS

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Introduction Randomised controlled trials have demonstrated efficacy of vedolizumab in Ulcerative Colitis (UC) and Crohn's Disease (CD). Further data in the real-world setting is needed to inform future practice.

Methods A multicentre retrospective observational chart review study was conducted with all pts initiated on vedolizumab across 7 UK hospitals between 1/11/14–30/11/16. The Health Research Authority approved the protocol (19/HRA/0008). Clinical disease activity was assessed at baseline, week 14, 30 & 52 using the Harvey Bradshaw Index (HBI) and partial Mayo Score (pMS). Clinical remission was defined as HBI≤4 or pMS <2 with a combined stool frequency and rectal bleeding subscore of ≤1. Clinical response was defined as ≥2-point decrease from baseline in pMS and ≥3-point decrease from baseline in HBI. The primary objective was to describe corticosteroid-free and clinical remission. Secondary objectives included effect on disease activity scores, biochemical markers, concomitant drug use, mucosal healing, hospital admissions and adverse effects.

Results 192 patients were included: 100 CD, 87 UC and 5 IBD unclassified (grouped with CD in this analysis). 46% of UC and 10% of CD patients were anti-TNF naïve. Median age was 44 (range 18–79) years; 49% male and median BMI was 25.7 (IQR 22.5–31.4). Exposure time was 38.0 (23.7–56.7) for UC and 30.9 (21.3–49.6) weeks for CD. Corticosteroid-free remission rates for UC and CD were 46% and 45%, while clinical remission rates were 52% and 44% respectively. Clinical response rates for UC was 49% and CD was 53%. The median time to corticosteroid free remission for UC and CD was 17.6 (8.7–29.6) and 14.1 (6.0–21.7) weeks and clinical remission was 15.1 (7.4–24.9) and 10.1 (3.1–21.0) weeks respectively. Time to clinical response for UC was 9.4 (5.7–15.4) and CD was 9.5 (6.1–18.2) weeks. Disease activity decreased from baseline at 14 weeks: pMS 5 (4–6) vs 3 (1–5) p=0.025 and 30 weeks pMS 5 (4–6) vs 2(1–5.5) p=0.032. Concomitant corticosteroid and immunomodulator use decreased in UC (48% vs 15% and 41% vs 18%) and CD (27% vs 10% and 26% vs 7%), respectively. The overall rate of IBD-related hospital admissions per patient per year was 1.3 (0–18.1). Adverse events were reported in 5.2% of patients.

Conclusions Results in our predominately anti-TNF experienced vedolizumab cohort mirror other published real-world data and demonstrate good clinical effectiveness and safety profile.

PTH-135 AN INFLAMMATORY BOWEL DISEASE-SPECIFIC NUTRITION SCREENING TOOL (IBD-NST) FOR BETTER OUTPATIENT CARE

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Background Patients with inflammatory bowel disease (IBD) can have hidden nutrition risks that generic malnutrition screening tools, which place too much emphasis on body mass index (BMI), are not able to identify, therefore some IBD patients that would benefit from dietary interventions are missed. By identifying nutrition risk using an IBD-specific screening tool, early detection of nutrition risk may be able to prevent development of malnutrition and improve clinical outcomes.

Aim This study aimed to develop and test an IBD-specific nutrition self-screening tool (IBD-NST).

Methods IBD patients were recruited prospectively to independently complete IBD-NST and Malnutrition Universal Screening Tool (MUST). Subjective global assessment (SGA) and hand grip strength (HGS) were completed by a dietitian. The IBD-NST scored nutrition risk as low (0), moderate (1) or high (≥2), including questions on BMI, unintentional weight loss, and a combination of active disease and nutrition concerns. Scores were compared to sub-optimal (15% below the mean) HGS, mid-upper arm muscle circumference (MAMC), BMI, weight loss >5% and SGA. Chi² compared dichotomous outcomes and Receiver Operator Characteristic curves were used for prediction assessment with a cut off of AUC<0.7 for poor prediction.

Abstract PTH-135 Table 1 Patients identified at nutrition risk by IBD-NST and MUST

		MUST			
		Low	Moderate	High	Total
IBD-NST	Low	60	4	4	68 (67%)
	Moderate	0	9	0	9 (9%)
	High	12	1	11	24 (24%)
	Total	72 (71%)	14 (14%)	15 (15%)	101

Results 101/116 patients (87%) were recruited, 54 (53%) were female, 61 (60%) had CD, 33 (33%) had UC and 7 (7%) had IBD-U. Mean (SD) age was 40 (14) years and BMI was 24.6 kg/m² (4.3). SGA identified 11/91 (12%) with malnutrition and IBD-NST and MUST identified a similar number of patients at nutrition risk (table 1). Twelve patients were low risk for MUST but high risk for IBD-NST due to having a flare and concerns about their nutrition. Unlike SGA and MUST, IBD-NST nutrition risk was not predicted by BMI (AUC=0.286 (SE 0.06) (95% CI 0.17, 0.40)). No significant difference in suboptimal HGS was seen across BMI categories