treatment to 40 mg adalimumab (ADA) every other wk (EOW) to 40 mg ADA every wk (EW) to 40 mg ADA EW +2.5 mg/kg azathioprine (AZA)/day at 12, 24, and 36 wks after randomization based on failure criteria (CD Activity Index [CDAI]=200 or decrease <70 points [1 wk pre-randomisation] or <100 points versus baseline [at wk 11, 23, 35] and prednisone use for the CMG; CDAI=150, C-reactive protein=5 mg/L, faecal calprotectin=250µg/g, and prednisone use for the TCG). At 24 and 36 wks, if failure criteria were not met, patients de-escalated ADA EW dose to 40 mg ADA EOW. Pts re-escalated if failure criteria were met at the next visit. The primary endpoint (mucosal healing [CD Endoscopic Index of Severity <4] and no deep ulcers at 48 wks post-randomisation) was evaluated in pts who de-escalated treatment. Analyses were performed in pts who completed the study and did not move to rescue therapy. Non-responder imputation was used for missing data.

Results 15 pts in the CMG and 31 pts in the TCG de-escalated treatment during the study. Of those, 2 pts in the CMG and 8 pts in the TCG re-escalated to 40 mg ADA EW. Overall, 54% of pts in the CMG and 61% of pts in the TCG who de-escalated to 40 mg ADA EOW ± AZA achieved the primary endpoint (table 1). Of the pts who re-escalated to ADA EW, 0% in the CMG, and 75% in the TCG achieved the primary endpoint (table 1). The overall adverse event rates have been previously reported (Colombel, 2018)

Conclusions Our data suggest that repeated dose optimization based on tight control is a more refined approach resulting in mucosal healing compared with clinical management. Larger data sets are needed to confirm our observation on repeated dose optimization.

Abstract PTH-077 Table 1 Proportion of patients who reached the primary endpoint who de-escalated and/or re-escalated treatment

	CM n/N (%)	TC n/N (%)
De-escalated and remain de-escalated		
40 mg ADA EW to ADA EOW	7/13 (53.8)	7/13 (53.8)
40 mg ADA EW +2.5 mg/kg AZA/day to ADA EOW +2.5 mg/kg AZA/day	0	7/10 (70.0)
Re-escalated		
40 mg ADA EW to ADA EOW to ADA EW	0/2	6/8 (75.0)

REFERENCE

- Colombel, *et al.* *Lancet* 2018;**390**:2779–89.

PTH-078 VEDOLIZUMAB POST RESECTION FOR CROHN'S DISEASE: A 4 YEAR REAL WORLD EXPERIENCE

Johanne Brooks*, Mark Tremelling. *Norfolk And Norwich University Hospital, Norwich, UK*

10.1136/gutjnl-2019-BSGAbstracts.137

Introduction Vedolizumab is a gut specific anti integrin biologic therapy that NICE guidance indicates can only be used only in moderate to severe Crohns disease if an anti-TNF has failed, cannot be tolerated or is contraindicated and should be given as a planned course of treatment until it stops working or surgery is needed. There is no documentation regarding vedolizumab post resectional surgery. This audit utilises 4 years of data of using vedolizumab in a tertiary centre and assesses response rates, the use of vedolizumab post surgery

and observations regarding TNF naïve and patients with a history of prior cancer on vedolizumab.

Methods Utilising the vedolizumab database from the IBD department, the last 4 years of data was analysed, specifically identifying those who had resectional surgery with vedolizumab post surgery for prevention of recurrence or confirmed anastomotic recurrence. Data included indications for vedolizumab and Rutgeerts scoring at the anastomosis for those who had TI surgery.

Results 81 patients' data were on the vedolizumab database and their clinical notes were audited by the IBD team. Clinical remission was achieved in 49% of patients in our cohort, with the other 51% having a loss of response, side effects or primary non responders.

37% of those whose Crohns was in remission post vedolizumab were anti-TNF naïve compared to 12% of anti-TNF naïve patients in whom vedolizumab failed.

21 out of 81 patients had surgery for Crohns disease. Clinical remission was achieved in 66% (n=14) of patients started vedolizumab post resectional surgery due to being high risk of recurrence, or a Rutgeerts score of i2 or greater. This is compared to 33% of patients (n=7) who failed vedolizumab treatment post surgery. There was no statistical difference between Rutgeerts scoring (when appropriate) in those who went into clinical remission and those who did not.

On a further observational note; indications for vedolizumab differed between the patients in remission and those who had failed vedolizumab. 40% of the patients in remission had either cancer or a contraindication to an anti-TNF e.g. cardiac failure, or severe opportunistic infection on infliximab (PCP or mycobacterial infection). Only 9% of patients who failed vedolizumab treatment had cancer.

Conclusions Over 4 years, we achieved clinical remission in 49% of patients with Crohns disease using vedolizumab. 34% of these patients had had resectional surgery for their Crohns disease and were in remission. This real world data indicates that vedolizumab is a useful biological therapy in maintaining remission in patients post resectional Crohns surgery. The data also suggest, in concordance with the current literature, that being anti-TNF naïve affords a better prognosis with vedolizumab, than having failed treatment with an anti-TNF prior to vedolizumab.

PTH-079 IBD VS IBS REFERRAL PATHWAY : OUTCOMES FROM THE IBD NURSE LED RAPID ACCESS CLINIC

Rachel Campbell*. *Stockport Nhs Foundation Trust, Stockport, UK*

10.1136/gutjnl-2019-BSGAbstracts.138

Introduction The role of the IBD nurse in reviewing suspected new patients is evolving with the onset of more rapid access clinics. The purpose of the study was to evaluate how reliable the use of a specific pathway from primary care was in identifying IBD patients vs IBS using the IBD nurse to reduce the referral to diagnosis time.

Methods A retrospective examination of data from a nurse-led rapid access clinic was used to determine if the use of an IBD vs IBS pathway was successful in reducing referral to treatment times but also to highlight if improvements to the service enabled a more satisfying patient experience?

Over an 18 month period, 400 patients (M=140, F=260) between the ages of 16–45 were reviewed in the rapid access