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

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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

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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

clinic within 7 days of the referral. Previously the referral to diagnosis/treatment time was around 30 weeks, with patients waiting up to 18 weeks to be seen in secondary care. Initially the faecal calprotectin on the referral pathway was set at 50µg/g. Following triage by the IBD nurse the patients referred with a faecal calprotectin between 50–100µg/g (N=100) were asked to repeat the stool sample.

Results The patients were reviewed and sent for investigation within 6 weeks of consultation with 56.5% of patients having endoscopic evaluation and only 28% of those patients received any diagnosis. When the faecal calprotectin cut off was raised to 100µg/g the result then increased to 32% for IBD, with a further 17% with a differential diagnosis. The differentials included 3 colorectal cancers (not on 2WW), gynaecological problems, mesenteric panniculitis and 12.5% had microscopic colitis.

Conclusions The referral to diagnosis time was reduced from 30 weeks to on average 9 weeks. There were around 25 new referrals a month with patients being seen within 7 days. The IBD nurse is perfectly placed to triage and review suspected new patients improving patient experience as the waiting times are reduced and the IBD nurse was capable of identifying and managing differential diagnoses.

The challenge has been finding an optimum cut off for the faecal calprotectin so to eliminate low sensitivity and specificity for aiding diagnosis of IBD but also engaging with primary care colleagues to support the referral pathway.

It is recommended that the referral pathway is a suitable method for suspected IBD patients to be seen but that more education within primary care is required to improve patient experience and increase appropriate patient referrals.

PTH-080 CLOSTRIDIUM DIFFICILE INFECTION IN PRE-EXISTING INFLAMMATORY BOWEL DISEASE: A CASE SERIES

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Introduction Inflammatory bowel disease (IBD) is a risk factor for clostridium difficile infection (CDI), and It is known that CDI in an IBD patient is associated with higher morbidity and mortality. It is thought that factors including alterations in the gut microbiome, mucosal disruption and immunosuppression provide a synergistic environment for CDI to complicate an IBD flare, yet there is no agreed consensus on best management of these patients.

Our aim is to examine a series of recent cases to assess our own practice and subsequent outcomes.

Methods A retrospective analysis was carried out of all cases of CDI in IBD patients in NHS GG&C during 2018. Patients were identified via the regional CDI database; those with co-existing IBD were extrapolated.

Data collected included demographics, IBD subtype, and presence of other CDI risk factors. Severity of symptoms was assessed using Truelove & Witts Criteria. Initial management, and any changes following the diagnosis of CDI were noted. Outcomes were measured by length of stay, survival to discharge and whether surgical intervention was required.

Results 14 patients in total were identified. 10 had a diagnosis of ulcerative colitis, 3 of Crohn's disease and 1 IBD unclassified. 11 of the 14 were on immunosuppressive therapy at the time of CDI (2 anti TNF; 1 thiopurine; 1 steroid; 7 5ASA) –

Abstract PTH-080 Table 1

Patient	Initial	Change 1	Change 2
1 – 3	Metronidazole 400 mg TDS		
4 – 5	Vancomycin 125 mg QDS		
6 – 8	Metronidazole 400 mg TDS	→ Vancomycin 125 mg QDS	
9	Vancomycin 125 mg QDS	+ IV Metronidazole 500 mg TDS	
10	Vancomycin 125 mg QDS	Vancomycin to 500 mg QDS	+ Metronidazole 500 mg TDS
11	Vancomycin 125 mg QDS	→ Fidaxomicin 200 mg BD	
12	Metronidazole 400 mg TDS	→ Vancomycin 125 mg QDS	
13	Metronidazole 400 mg TDS	→ Vancomycin 125 mg QDS	Vancomycin to 500 mg QDS
14	Metronidazole 400 mg TDS	→ Vancomycin 500 mg QDS	

this was continued in all cases. 9 of the patients presented with acute severe colitis based on Truelove & Witts Criteria.

Once the diagnosis of CDI was established metronidazole was given in 9 cases, and vancomycin in 5 (doses and any subsequent alterations shown in table 1).

Assessment with Travis criteria on day 3 indicated high chance of colectomy in 7 patients however none required surgical intervention. No patients received rescue biologics or faecal transplant. Median length of stay was 19 days (range 3–169). One patient did not survive to discharge. Since index admission 4 were readmitted, and 6 have subsequently had their IBD therapy escalated.

Conclusions Managing CDI in those with co-existing IBD is clinically challenging. This case series highlights the lack of consensus on how this should be approached, even within a single health board. This suggests that a wider body of work is required to establish guidance and provide better outcomes.

PTH-081 USTEKINUMAB TREATMENT STRATEGIES IN REFRACTORY CROHN'S DISEASE: REAL-WORLD EFFECTIVENESS DATA FROM A UK IBD CENTRE

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Introduction Ustekinumab (UST) is a human IgG1 kappa mAb to the shared p40 subunit of IL-12 and IL-23 which are involved in TH1 and TH17 mediated pathways of Crohn's disease (CD) pathogenesis. NICE approved UST for CD in April 2017, but there is limited UK data on real-world effectiveness. We present clinical effectiveness, safety and drug persistence data from a complex UK cohort.

Methods This was a retrospective observation cohort study of all CD patients treated with UST outside clinical trials in a single UK IBD centre. Physician's global assessment (PGA) was recorded at baseline, post induction and 1 year. Primary