Results Themes identified are summarised:

Abstract PTH-096 Table 1

Themes	Sub-themes (* most frequently occurring themes)
Facilitators in shared decision-making (SDM) and decision confidence	<p>Feeling well informed:</p> <ul style="list-style-type: none"> • Give balanced & accurate information* • Explain all alternative options • Address patient priorities: effect on quality of life, family, career • Allow time for independent research • Personalised risk prediction allows rational decision-making • Joint medical/surgical clinics <p>Good relationship with clinical care team:</p> <ul style="list-style-type: none"> • Trust in experience & peer consensus* • Patient-centred & supportive* <p>Address emotional and psychological wellbeing:</p> <ul style="list-style-type: none"> • Social media reduces stigma • Positivity increases confidence • Prepare for potential colectomy early • Provide counselling and patient support network <p>Education may dispel fears (preferred formats: patients, video, leaflet)</p> <p>Suboptimal relationship with clinical team:</p> <ul style="list-style-type: none"> • Lack of options* • Feeling rushed • No continuity in care • Not patient-centred • Making wrong assumptions <p>Internet and social media can be unrealistic and irrelevant</p> <p>Avoidance of reality:</p> <ul style="list-style-type: none"> • Youthful naivety • Over-optimism • Fear
Barriers in SDM	<p>Dying from cancer is not an option*</p> <p>Changing priorities with age</p> <p>If segmental colectomy was an option</p> <p>Reasons to accept a stoma:</p> <ul style="list-style-type: none"> • Allows more control • Uncertainty about pouch function impact on lifestyle • More acceptable in older age <p>Reasons to accept a pouch</p> <ul style="list-style-type: none"> • It's closer to normality • Can go back to stoma if it doesn't work <p>I feel fine, why risk my quality of life?</p> <p>Surveillance is reassuring enough</p> <p>Uncertainty in dysplasia prognosis</p> <p>Negative patient stories</p> <p>Concerns about stomas:</p> <ul style="list-style-type: none"> • Not normal • Disrupts life • Body image • Leaks, smell and pain <p>Concerns about pouches:</p> <ul style="list-style-type: none"> • Pouch frequency disrupts life* • Peri-operative complications • Risk of cancer in pouch/cuff <p>Faith in alternative therapies and lifestyle changes</p> <p>Fear of being a burden on family</p>
Reasons to accept colectomy	
Reasons to decline colectomy	

Conclusions This is the first in-depth qualitative study to our knowledge exploring the barriers and facilitators for shared decision-making in IBD dysplasia management. These findings should guide clinicians to embrace a more patient-centred approach.

PTH-097 DIETARY ANTIOXIDANTS AND THE RISK OF DEVELOPING ULCERATIVE COLITIS: A NESTED-CASE-CONTROL STUDY WITHIN EPIC-NORFOLK

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Introduction Oxidative stress may be involved in ulcerative colitis (UC) aetiology. Here we investigate, for the first time using a prospective study design, whether the dietary antioxidants vitamins C, E and zinc are associated with a decreased risk of developing UC, using 7-day food diaries, the most accurate dietary methodology.

Methods A cohort of 23,658 participants, aged 40–74 years, enrolled in the European Prospective Investigation of Cancer-Norfolk between 1993–1997. At recruitment participants completed 7-day food diaries that recorded food intake including frequency, brands and portion sizes. Nutrient intakes were computed using a specifically designed nutrient database of 11,000 food items. The cohort was monitored to 2004 to identify incident UC cases. Conditional logistic regression analysis calculated odds ratios (OR) of developing UC across tertiles of intake. Adjustments were made for smoking status and energy intake.

Results During follow-up 26 individuals (42% female) developed UC, 35% of whom had left-sided disease. Multivariable analyses showed no associations between any of vitamin C, vitamin E and zinc and the odds of UC, with no trends across tertiles (For vitamin C: 3rd vs 1st tertile OR=2.03, 95% confidence interval (CI)=0.67–6.20; trend OR=1.42, 95% CI=0.82–2.45; For vitamin E 3rd vs 1st tertile OR=1.04, 95% CI=0.27–4.07; trend OR=1.10, 95% CI=0.57–2.14; For zinc 3rd vs 1st tertile OR=2.00, 95% CI=0.42–9.53; trend OR=1.38, 95% CI=0.69–2.78).

Conclusions The data does not support a role for any of vitamin C, vitamin E and zinc in preventing UC. Further follow-up of the cohort is continuing to make estimates with better precision.

PTH-098 MINIMALLY INVASIVE ENDOSCOPIC APPROACHES TO MANAGE COMPLICATED IBD PATIENTS AT A TERTIARY CARE CENTER

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Introduction Patients with complicated IBD have a higher risk of recurrent surgeries, prolonged hospitalizations, morbidity and mortality. We aim to review endoscopic stenting for management of strictures and/or fistula as primary or rescue interventions in these complicated IBD patients.

Methods All IBD patients with endoscopic stent placement between 2011 and 2018 were included. Relevant demographic and clinical data were abstracted from the electronic medical record and presented using descriptive methods.

Results Fifteen patients (mean age 46.7; 59.75% females) including eight with refractory Crohn's disease and seven with IPAA failure were assessed for average of 257 days after index endoscopy. Patients with refractory Crohn's disease presented with stenotic/stricturing disease (n=3, Antroduodenal, duodenal, and ileocolonic anastomosis), fistulizing disease (n=2, colovesicular, biliary-duodenal), leak (n=1, pelvic leak/abscess) or both stenotic as well as fistulizing disease (n=2 ileal, colorectal anastomosis). Patients with IPAA failure presented with pouch strictures (n=2 pre-pouch ileum, at the ileal-pouch anastomosis), leak/fistula (n=2 pre-pouch ileum, tip of the J pouch) or stricture and a fistula (n=3). Four of the IPAA failure were attributed to undiagnosed Crohn's disease.

20% patients were current smokers, 26.6% on steroids, and 46.7% on immunosuppression. 46% patients were rescue cases and had previous surgeries or interventional radiology procedures prior to index endoscopy. Types of stents used: Niti-S (5), Solus double pigtail biliary (1), ureteral double-pigtail stent (2), WallFlex (1), Axios (2), Viabil (5) and ALI-MAXX-ES (1); stent diameter ranged from 3.33–20 mm and length from 10–200 mm. Ten required adjunct therapy in addition to stent: APC (2), hemoclip (1), OVESCO (3), endo-stitch (3), dilation (3), Glue(1). 100% had immediate clinical success (defined as ability to deploy the stent along with recanalization or no contrast leakage). On final follow up for average of 257 days, 33% patients had a sustained endoscopic response and 20% are currently responding to ongoing endoscopic management while endoscopic intervention served as an effective bridge to successful surgery in 33% patients. 14% patients failed both endoscopic and surgical interventions and are currently palliated with drains. None of the patients during endoscopic follow-up developed acute complications that could be attributed to endoscopic intervention.

Conclusions Minimally invasive endoscopic management of complicated IBD is a safe and alternative management option for otherwise high-risk for adverse outcome patients.

PTH-099 SURGERY FOR RECURRENT DISEASE FOLLOWING RIGHT-HEMICOLECTOMY IN CROHN'S DISEASE: ANALYSIS OF HOSPITAL EPISODE STATISTICS

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Resectional surgery is common in patients with Crohn's Disease (CD). However, it is not curative and most develop endoscopic recurrence within a year, with the potential to develop stricturing at the anastomotic site. We examined the proportion of Crohn's patients undergoing further surgical intervention following right hemicolectomy at a national level. **Methods** Hospital Episode Statistics were examined to establish a cohort of all CD subjects who had undergone right hemicolectomy between 2007–2013 in England. Subjects were followed up for 4 years and resectional surgery at the same site

was analysed. Multivariable logistic regression assessed factors associated with further surgery at the same site.

Results 7491 adult patients with CD had a right hemicolectomy between 2007–2013. 45.1% were male, median age was 34 (IQR 25–44) and 88.6% were White. Most subjects had no comorbidities based on Charlson score (96.7%). Right hemicolectomies for CD increased year on year across England from 987 in 2007 to 1140 in 2013. 60% of these initial operations were elective. 9% of subjects had further resectional surgery at the same site within the 4 year follow up period. Median time to further surgery was 472 (IQR 263–945) days. 52% of subsequent surgery was performed on subjects whose initial surgery was an emergency. When factors associated with subsequent surgery were analysed, only an initial *emergency* right hemicolectomy was found to be associated (OR1.78 (95%CI 1.51–2.09) $p<0.001$) (table 1). If initial hemicolectomy was during an emergency admission, there was a 12.1% chance of needing surgery for recurrent disease at the same site.

Conclusions Right hemicolectomy for CD increased in England during the study period. 9% of subjects will have further surgery and an initial emergency surgical procedure was associated with the need for later surgery. Future research will focus on the indication for further surgery and examine intervention requirements over a longer follow up period.

Abstract PTH-099 Table 1 Multivariable logistic regression: factors associated with further surgery after right hemicolectomy for CD

Demographic		OR	Lower 95% CI	Upper 95% CI	P value
Sex	Male	Base			
	Female	0.89	0.76	1.04	0.148
Age	18–24	Base			
	25–30	1.01	0.79	1.29	0.957
	31–38	1.13	0.89	1.44	0.307
	39–47	1.01	0.79	1.30	0.914
	48–60	0.97	0.75	1.25	0.809
Ethnicity	White	Base			
	Asian	1.00	0.61	1.61	0.985
	Other	0.91	0.57	1.46	0.704
Deprivation	1 (Most Deprived)	Base			
	2	0.96	0.76	1.22	0.757
	3	0.98	0.77	1.26	0.891
	4	0.82	0.63	1.07	0.145
	5	0.79	0.60	1.04	0.089
	Emergency	1.78	1.51	2.09	<0.001
Index Surgery	Elective	Base			
Admission Method					
Charlson Score	0	Base			
	1–4	1.18	0.65	2.11	0.590
	5+	1.49	0.88	2.54	0.139
Index Surgery Year	2007	Base			
	2008	1.14	0.83	1.56	0.423
	2009	1.23	0.91	1.67	0.179
	2010	1.12	0.82	1.52	0.492
	2011	0.93	0.68	1.28	0.650
	2012	1.26	0.93	1.70	0.131
	2013	0.97	0.71	1.32	0.828