implementing TDM with anti-TNF’s was collected. Logistic regression was used to predict factors influencing TDM use.

Results 243 respondents participated (51.6% male) of which 237 respondents met inclusion criteria; treating >5 IBD patients and at least 1 with an anti-TNF per month. Of the total respondents, 45% were Consultant Gastroenterologists (GI), 40% IBD Nurse Specialists (CNS) and 15% GI Specialist Registrars (SPR). Of these 237 respondents, TDM was used by 95.7% for secondary loss of response; 71.4% for primary non-response and 53.6% used TDM proactively. Barriers for TDM use were time lag in receiving results (27.1%), lack of awareness of guidelines (15.6%), and cost (11.9%).

Clinicians working at a teaching hospital were more likely to use TDM compared to a district hospital (OR 2.6, 95% CI 0.71–9.8). IBD CNS and GI SPR used TDM more often, when compared to Consultant GI (OR 2.6, 95% CI 0.69–10 & OR 1.5, 95% CI 0.3–7.2 respectively). Clinicians practising for >20 years were more likely to check TDM than less experienced clinicians (OR 4.1, 95% CI 0.4–41.8). Clinicians with large volume IBD practice (>50% IBD patients per month) were more likely to check TDM than those seeing fewer IBD patients (OR 45.6, 95% CI 7.5–275). Proactive TDM was more likely to be used by clinicians working in a tertiary care setting (OR 2.25, 95% CI 0.84–6.05), IBD CNS (OR 1.2, 95% CI 0.6–2.1), clinicians managing large volume IBD practice (OR 10.8, 95% CI 1.2–90) and clinicians with 5–9 years of experience in practice (OR 2.6 & CI 1.04–6.42).

Conclusions Large volume IBD centres with more experience of treating IBD patients are more likely to employ treatment-optimising strategies with TDM. Significant barriers to TDM implementation in the UK are time lag from test to result, lack of awareness of current guidelines and evolving knowledge, cost and less experience. Validation of point of care testing, lower cost assays, and wider dissemination of current evolving paradigms with updated recommendations may further optimise treatment with anti-TNF therapies.

REFERENCE

PTH-108 THE HIDDEN BURDEN OF Faecal INCONTINENCE IN ACTIVE AND QUIESCENT UC: AN UNDERR ESTIMATED PROBLEM?

1Gaurav B Nigam*, 1Jimmy K Limdi, 2Shaheen Hamdy, 3Dipesh H Vasant. 1Pennine Acute Hospitals; 2Salford Royal Foundation Trust, 3Manchester University Foundation Trust

Introduction Despite advances in Ulcerative Colitis (UC) therapy, many patients suffer refractory defaecatory symptoms in the absence of active inflammation. For this group, treatment remains challenging, with a paucity of research and limited therapeutic options. In this prospective, ongoing study, we aim to determine the prevalence of faecal incontinence (FI) in patients with quiescent UC.

Methods In a cross-sectional study, consecutive patients with UC attending Inflammatory Bowel Disease (IBD) clinics were invited to participate. Patients completed a series of validated questionnaires; including an IBD-specific FI questionnaire (ICIQ-IBD questionnaire), Hospital Anxiety and Depression Scale (HADS), the Rome IV diagnostic questionnaire, and the IBD-control questionnaire. Participants were requested to return a Faecal Calprotectin (FCP) within 2 weeks of completing questionnaires. Quiescent UC was defined as IBD-control score ≥13 and IBD-control-VAS ≥85, and/or FCP levels ≤250 (where available, FCP data were used in preference to IBD-control to classify UC activity). Data were compared between active and quiescent using chi-square and non-parametric tests.

Results Overall, n=97 UC patients (n=50 males, mean age 48 (range 18–82) participated. ICIQ-IBD data revealed that most patients experience FI (84/97 (87%) during ‘relapses’. Interestingly, 58/97 (60%) reported FI when in ‘remission’, and this group had higher median HADS depression (P=0.0002), poorer QoL scores (P<0.0001), and trend towards higher HADS anxiety (P=0.09) scores, compared to those without FI. Disease activity data (IBD-control and/or FCP) were available for all patients, and based on these 61/97 (63%) had quiescent UC. The prevalence of FI based on ICIQ-IBD did not differ between those with active (22/36, 61%) and quiescent UC (36/61, 59%), P=NS. In those with FI on ICIQ-IBD, median IBD-FI symptom scores, IBD-FI QoL scores and HADS anxiety (P=0.47), depression: P=0.18 did not differ between disease activity groups. However, within the quiescent group, patients that met the more stringent Rome IV criteria for FI (n=13) had higher median IBD-FI symptom scores (P=0.007) and HADS-depression scores (P=0.05), a trend to worse IBD-FI QoL (P=0.07), but similar HADS-anxiety (P=0.68).

Conclusion This study is one of the first to identify that regardless of disease activity, FI affects most patients with UC, detrimentally impacting patients’ psychological wellbeing, impairing their QoL, and should therefore routinely be screened for in clinics. There is an urgent need for further research in the often neglected area of FI and quiescent disease.