

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

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PTH-108 THE HIDDEN BURDEN OF FAECAL INCONTINENCE IN ACTIVE AND QUIESCENT ULCERATIVE COLITIS: AN UNDERESTIMATED PROBLEM?

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10.1136/gutjnl-2019-BSGAbstracts.167

Introduction Despite advances in Ulcerative Colitis (UC) therapies, 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 8 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 groups 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.

PTH-109 FATIGUE IN PATIENTS WITH CROHN'S DISEASE ON LONG TERM VITAMIN B12

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10.1136/gutjnl-2019-BSGAbstracts.168

Introduction Some individuals with Crohn's Disease who take long term three monthly Vitamin B12 injections complain of lack of energy and tiredness prior to their next B12 injection. Some have persuaded their General Practitioners to give the B12 injection more frequently than 3 monthly.

Methods We wanted to determine if this was a common experience, and also if seen in other causes of B12 deficiency besides Crohn's Disease.

453 patients on long term B12 in the community were invited to complete a questionnaire, 148 agreed. Most of these patients were elderly with a history of pernicious anaemia. 445 patients completed the questionnaire online. Most of these patients had Crohn's disease. 593 questionnaires were analysed.

Results In the period prior to Vitamin B12 injection, the majority reported tiredness, lack of energy, poor concentration and mood. Selected control symptoms were only seen in 1/4, figure 1. Of those noticing fatigue, 65% noticed this in the week prior to B12 injection. The community recruited group and the online group showed a similar pattern of complaints, but the incidence was lower in the Community group.

Following B12 injection there was an improvement in the majority, in energy, concentration, fatigue and mood.

Multivariate analysis to identify factors differing between high and low symptom sufferer, showed only age and treatment interval which predicted greater symptom burden but this only explained a very small proportion of the variation seen (less than 9%)

A small proportion reported worsening of symptoms following B12 injection; the most common symptom was feeling cold in 7%.

Conclusions In summary, fatigue, lack of energy, poor mood, and difficulty in concentration are seen frequently as individuals approach the 3 monthly B12 injection both in Crohn's Disease and pernicious anemia. These improve following injection

PTH-110 COLITIS ON CT – DOES THIS MEAN INFLAMMATORY BOWEL DISEASE?

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10.1136/gutjnl-2019-BSGAbstracts.169

Introduction Cross sectional imaging is commonly used to assess the abdomen for a variety of symptoms. Colitis reported on CT has become a frequent indication for lower gastrointestinal endoscopy. The outcomes of performing colonoscopy for radiology reported colitis is not clearly known.

Methods A retrospective, single centre study of patients referred for a colonoscopy with the indication of 'abnormal imaging'. Data was collected using the endoscopy software

audit tool over a 12-month period (September 2017 to August 2018). Patients who had undergone an imaging modality other than CT and those with an overt colonic polyp or mass on CT were excluded from the analysis. Analyses were performed using chi-square and student t-test.

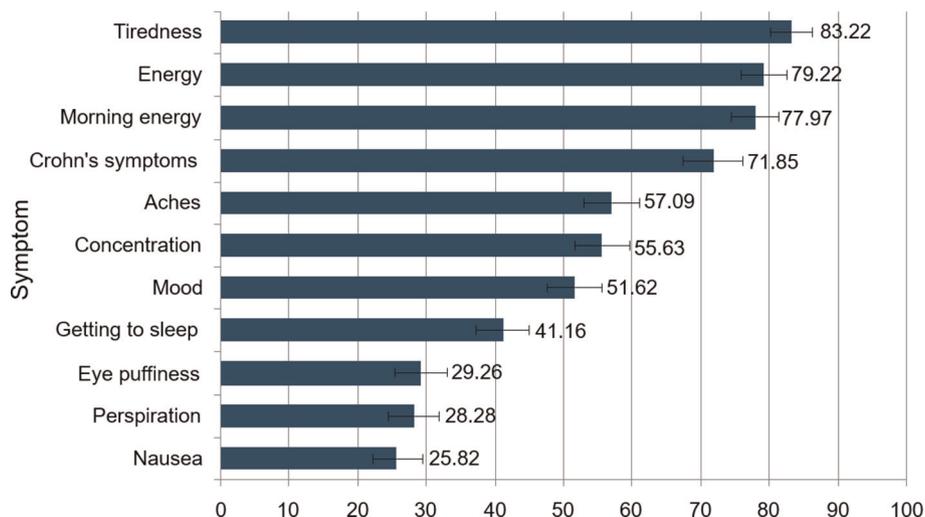
Results 249 patients (183 CT (73.5%), 66 CTVC (26.5%)) underwent a colonoscopy for CT evidence of mural thickening (218 (87.6%)), fat stranding (88 (35.3%)), inflammation (104 (41.8%)) or local lymph nodes (37 (14.9%)); median age 68 (IQR 53 – 79); median time from CT to endoscopy 33 days (IQR 12.5 – 56.5). Initial indication for CT examination: Abdominal pain 112 (45.0%), Change in bowel habit 39 (15.7%), ?Malignancy 32 (12.9%), PR bleeding 13 (5.2%), Weight loss 9 (3.6%) and Other 44 (17.7%).

53 (21.3%) patients had completely normal lower GI endoscopy. 111 (44.6%) had uncomplicated diverticulosis, 11 (4.4%) diverticulitis, 20 (8.0%) haemorrhoids and 37 (14.9%) colorectal polyps.

20 patients (8.0%) had endoscopic evidence of colitis; 14 (6%) histological evidence of colitis. 10 (4%) confirmed IBD at 6 months follow up (4 UC, 6 CD).

Abstract PTH 110 Table 1 Comparison of endoscopic diagnoses according to CT features and blood results

	Normal (n=53)	Colitis (n=20)	Malignancy (n=21)	*p value
Age, mean	63.6	54.4	69.5	<0.02
Time to endoscopy (days), mean	45.3	24.5	24.9	<0.04
Mural thickening (%)	48 (90.1)	19 (95)	20 (95.2)	ns
Fat stranding (%)	14 (26.4)	12 (60)	9 (42.9)	<0.03
Inflammation (%)	16 (30.2)	12 (60)	9 (42.9)	0.06
Lymph nodes (%)	4 (5.7)	8 (40)	11 (52.4)	<0.00006
Haemoglobin (g/L), mean	128.0	123.8	112.2	0.005
CRP (mg/L), mean	29.8	55.5	68.1	0.10, <0.05



Abstract PTH-109 Figure 1