transcribed and analysed for IBD outcomes elicited by clinicians (or volunteered by patients), including specific items required for Harvey-Bradshaw Index (HBI) and Simple Clinical Colitis Activity Index (SCCAI).

Results Most commonly elicited outcomes are shown in the table 1. HBI or SCCAI were collected in only 4 (8%) of consultations. In the remainder, domains of HBI and SCCAI were discussed in variable detail. Complete HBI coverage: 5/29 (17%); symptom components of HBI (wellbeing, liquid stools, abdominal pain): 16/29 (55%). No Crohn's disease consultation involved specific discussions about symptoms over past 24 hrs (including 2 where HBI was calculated). Complete SCCAI coverage: only 1 consultation. Partial coverage (5 out of 6 SCCAI domains): 8/21 (38%). Symptoms were never specifically defined over past 3 days. Certain symptoms were elicited significantly more often by nurses than doctors ($p<0.05$), and coverage varied by disease severity. Interviews are under way to explore views, barriers and facilitators to standardisation of outcomes assessment.

Conclusions There is high variability in breadth, depth and quantification of outcomes during routine clinical assessments. Most domains for activity indices were elicited but formal scoring and assessment for a fixed time period was rare. Standardised outcomes may be better-captured directly from patients (PROMs) than via clinician-generated indices.

PTH-116 VEDOLIZUMAB IN THE TREATMENT OF CROHN'S DISEASE AND ULCERATIVE COLITIS – NON-TERTIARY REAL WORLD ANALYSIS

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Introduction Vedolizumab is licenced for treatment of moderate-to-severe ulcerative colitis(UC) and Crohn's disease(CD) after failure of conventional or anti-TNF therapy. Clinical trial data from the GEMINI studies reported a Wk 6 response rate of 47% in UC and 31% in CD and Wk 52 response rate of 42–57% (UC) and 39–44% (CD). Data from expert centres report a lower 12-month remission of 26–33%, with endoscopic mucosal healing of upto 63%. Prior anti-TNF exposure pts are likely to have a worse outcome.(VICTORY Study)

Aims This single non tertiary study was designed to compare clinical, biochemical and endoscopic outcomes of Vedolizumab treatment in UC and CD. A secondary aim was to compare outcomes for anti-TNF naïve v. anti-TNF exposed pts.

Methods All IBD pts eligible for Vedolizumab at MDT review between 2016–2018 were included. Pts were grouped into anti-TNF naïve and anti-TNF exposed, the severity of UC and CD classified by Simple colitis index or Harvey Bradshaw Index respectively, extent of disease defined by Montreal Classification. Baseline demographics, serum C-reactive protein, faecal calprotectin, colonoscopic severity (Mayo Endoscopic score and SES-CD) were recorded before starting Vedolizumab treatment and at 12 months. Standard definitions were used for clinical and endoscopic remission.

Results 35 patients (20 UC,15 CD), M:F 21:14(UC13:7, CD8:7) were included. The mean age was 46.15y for UC (22–77) and 49.4y for CD (26–79). 15/20 UC patients and 12/15 CD patients were anti-TNF exposed. **In the UC group:**

disease extent was E1=1,E2=5,and E3=14; mean SCAI 3.15, mean CRP =23 mg/L (range4–202), mean faecal calprotectin 616ug/g (range 4–1684), endoscopic severity mild = 4, moderate = 10, severe = 6. At 12 months, 9/15(60%) anti-TNF exposed and 2/5 anti TNF naïve (40%) were in clinical remission, with endoscopic remission in 4 and 1 pt respectively. Mean CRP was 5 (4–7) and mean FCP 472. 1 pt developed a rash, 1 pt had abnormal LFT, and 2 failed to respond requiring surgery. **In the CD group:** mean Harvey Bradshaw score was 15 (0–30), mean CRP 15.7(4–202), FCP 250 (5–683). Disease extent was L1=2, L2=4 and L3=9. At 12 months 6/12 (50%) anti TNF exposed patients and 2/3(66%) anti TNF naïve pts were in clinical remission with mean CRP 7.8(4–15) and FCP 472(4–1957).

Conclusion In this real world study, we found that both UC and CD patients responded well to Vedolizumab treatment, with 50% TNF exposed pts achieving clinical remission, with 20–30% endoscopic healing rates. Although 20% pts needed surgery, we have shown efficacy of Vedolizumab in CD to be as good as UC, with a better outcome in anti TNF naïve patients.

PTH-117 PRACTICE PATTERN VARIABILITY IN THE MANAGEMENT OF ACUTE SEVERE COLITIS: A UNITED KINGDOM PROVIDER SURVEY

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Introduction Lack of comparative trial data on dosing regimens of infliximab rescue therapy in acute severe ulcerative colitis (ASUC) has resulted in variable use of rescue regimes in ASUC with potential impact on clinical outcomes. We aimed to (i) study variability in practice in management of ASUC and (ii) evaluate physician perspectives in decision making in rescue therapy.

Methodology An internet-based survey of members of the IBD section of BSG was conducted. The non-vignette section evaluated provider characteristics. The vignette-based section with linked questions detailing progress of an ASUC patient failing intravenous corticosteroids (IVCS) evaluated diagnostic and therapeutic practices. Data was analysed by descriptive statistics and using Fisher's exact test for categorical variables.

Results The response rate of the survey was 31% (209/682 IBD section members). The provider characteristics as in table 1. In the scenario of IVCS failure, 82.9% will use Infliximab rescue with only 1.5% favouring colectomy. Of those who chose infliximab rescue therapy, 78.4% favoured standard dose (5 mg/kg) while 37 (21.6%) favoured a higher dose (10 mg/kg) with reasons cited including low albumin and high CRP. IBD specialists chose higher front-loading dose more often compared to other gastroenterologists ($p=0.01$)

Accelerated Induction was favoured by 51.5% of the respondents while 25% preferred standard induction (SI) regime and 19% favoured colectomy. IBD specialists more often favoured AI compared to other gastroenterologists ($p=0.03$). The main factor for favouring AI was the presence of predictors of low infliximab trough levels (73.9%). The reasons cited by those favouring SI ($n=57$) included lack of