were no significant differences between groups in terms of gender, age, and IBD diagnosis.

Reasons for stopping azathioprine were drug-related symptoms (33% in LDG v 24% in TDG), abnormal liver function tests (8% in LDG v 3% in TDG), and pancreatitis (3% in LDG v 3% in TDG). Significant leucopenic episodes (defined as white cell count <3.5 × 10⁹/l) occurred in 2 LDG patients and 1 TDG patient. In the TDG patient this was transient and resolved before any dose adjustment was required.

In TDG patients, thiopurine metabolites were checked at week 4 and showed median thioguanine nucleotides level = 379 pmol/8 × 10⁸ cells (range 176 – 520), and median methylmercaptopurine (MMP) level = 2438 pmol/8 × 10⁸ cells (range 794 – 7277). Four patients in this group had their dose adjusted due to high MMP levels.

Conclusions Starting Azathioprine at a therapeutic 2 mg/kg dose, in IBD patients with normal TPMT level, appears to be as safe and well tolerated compared to using a low dose approach with gradual increase. This more direct approach has clear benefits in terms of achieving therapeutic response earlier, reducing the number of patient contacts, and saving IBD nurse or pharmacist time.

**Methods** IBD biologics MDT was initiated along the principles of QI. The aims, drivers and personnel were agreed via driver diagram. The criteria to include patients in the MDT were agreed- Longest wait (Patients who were furthest away from their last clinical review), Clinical Need or Complex Biosimilar switch. The MDT met for 90 minutes twice monthly. At least 3 Consultants were required to make quorate decisions. Outcomes were agreed and recorded, a copy of which would be sent to the GP and the patient. The data was recorded on a new biologics database. The process underwent ‘PDSA cycles’. Patient feedback was received.

**Results** Over the 1st 12 months, of the initial 225 patients on biologics (n) 113 (50%) were discussed (patients on biologics rose to 284, an increase of 26%, during this period). Four different biologics were being used in these patients (Biosimilar infliximab, originator or biosimilar Adalimumab, Vedolizumab and Ustekinumab). The longest waiting time between clinical review reduced from 80 to 31 weeks. The MDT altered management in 60 (53%) of patients it also led to further investigations in 49 (43%). Drug cost savings of £72206 was noted. 74% of patients surveyed were satisfied with MDT discussion, with the remaining 26% indifferent to discussion.

**Conclusions** The Biologic MDT can provide a safe and effective framework for IBD patients on biologic agents.