Methods Qualitative interview study with adults living with UC recruited from three Inflammatory Bowel Disease (IBD) services in the North of England, undertaken between 4th June and 31st October 2019. Data were collected during telephone interviews, digitally recorded and transcribed. Inductive thematic analysis was performed by two researchers using NVivo software. Codes were cross-checked and data saturation was confirmed prior to study close.

Results A total of 33 adults participated (51% female, median age 39 years, median time since diagnosis 6 years). Thematic saturation was confirmed. Four key themes were identified in the data. (1) Treatment effectiveness: this was the primary concern of all participants when choosing a new treatment. Participants explained that alleviating symptoms improving quality of life was the most important driver of their treatment preferences. (2) Influence of healthcare professionals: treatment discussions and choices were heavily guided by IBD healthcare professionals (HCPs). Most participants in this study described the valuable relationships that they have with IBD nurses and medics, and how they trust and respect their clinical expertise. (3) Other influences: whilst important to treatment choices, participants placed limited value on the route of administration and side effects relative to treatment effectiveness overall. (4) Changes over time: there was an increased willingness to try alternative treatments, and eventually surgery over time, in accordance with the severity and duration of symptoms, and crucially, as medical treatment options are exhausted.

Conclusion The importance of treatment efficacy and the influential role of HCPs when patients choose treatments for steroid resistant UC has been highlighted in this study. The data provides a qualitative perspective on patient preferences which should be considered in practice guidelines and trial design.
(20.4%) patients had complicated disease behaviour compared to 46 (34.9%) at follow up (p=0.0018). 83 (62.9%) patients had a ‘pan-enteric’ phenotype at diagnosis, however only 55 (66.3%) retained this phenotype at follow-up (p=0.0002). Disease extension was noted in 18.9% of patients and involution in 35.6% of patients, with upper GI disease noted in only 15.9% of patients at follow-up (p=0.0001). There was a high exposure to both thiopurines (91.7%) and biologics (63.6%), with a median time to starting treatment of 0 (IQR 0–1) and 5 (IQR 2–7) years for thiopurines and anti-TNF therapy respectively. The rate of exposure to biological therapy was similar in patients with disease involution (32/47, 68.1%) and disease extension (21/25, 84%). The cumulative probability (95% CI) of surgery was 0.05 (0.02, 0.11) at 1 year, 0.17 (0.11, 0.24) at 3 years and 0.22 (0.15, 0.30) at 5 years respectively. Overall, 56 (42.4%) patients had surgery at the end of follow-up. Neither disease location nor behaviour were associated with need for surgery.

Conclusions Changes in both disease location and behaviour were seen in our PCD cohort as they progressed to adult life. A significant proportion had disease involution, likely related to a high rate of exposure to biological therapy.

Introduction Assess patient understanding, tolerance and preferences with regards to modern imaging techniques of small bowel Crohn’s disease.

Methods Consecutive paper-based questionnaires were obtained from patients referred for diagnosis, assessment or reassessment of Crohn’s disease with MR enterography (MRE) (n=50) and small bowel ultrasound (SBUS) (n=50) at a large teaching hospital. Analysis performed with SPSS as unpaired non-parametric data.

Results 66% (n=56/88) of patients were unsure which examination was more ‘accurate’. There was an inclination towards preferring the examination that patient had attended for i.e. the SBUS cohort thought that SBUS was more accurate than MRE (18% versus 9%) whilst the MRE group favoured MRE over SBUS (33% versus 2%).

Free text responses regarding the cause of discomfort during MRE included: positioning (lying prone), claustrophobia and the volume of oral contrast. 94% (n=47) of MRE patients received oral contrast vs. 10% (n=5) of SBUS patients. Responses in the SBUS group related to probe pressure.

Regarding quality of information provided following the examination? 1=Uncomfortable, 10=Comfortable

45% patients had experienced both MRE and SBUS at some point in their history. Of these, 68% (n=21) preferred SBUS, 16% (n=4) preferred MRE and 16% responded ‘either.’

Conclusions SBUS and MRE both demonstrate excellent sensitivity and specificity in the assessment of small bowel inflammation in Crohn’s disease. Either examination is suitable as a first-line investigation, although MRE is more sensitive than SBUS in diagnosing the extent of disease. A study demonstrates that SBUS is often better preferred by patients as a stand-alone test and compared with MRE. This is secondary to a combination of better patient comfort, the ability to immediately discuss findings with a radiologist following the examination and a perceived similar accuracy.

REFERENCES