(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.

P99 ROUTINE IMAGING OF CROHN’S DISEASE WITH ULTRASOUND AND MR ENTEROGRAPHY: THE PATIENT PERSPECTIVE
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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=36/56) 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 test, the mean score was 10 for SBUS patients versus 0 for MRE (0=not given opportunity to speak to someone, 10=indicating most satisfied with quality of information provided). Free text responses commented specifically on the ability to see and understand their disease with SBUS.

60% (n=29) of the SBUS cohort scored 10 for overall experience (median 10) versus 19% of the MRE group (median=8). Most participants would undergo the same examination again (96% and 100% of the SBUS and MRE cohorts respectively).

Abstract P99 Figure 1 Patient responses to ‘How uncomfortable was 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

P100 OUTCOMES OF A CLINICAL PSYCHOLOGY INTERVENTION IN A UK IBD SERVICE
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Introduction Patients with IBD experience significant psychological distress. A variety of interventions to ameliorate this distress have been studied. However, no European study has assessed the impact on patients of a clinical psychologist embedded within the IBD team. Clinical psychology is uniquely characterised by its use of a patient/therapist collaborative formulation to guide and select from a variety of evidenced based psychological therapeutic treatment options. Such an approach is likely to be particularly beneficial for patients with IBD who may present with a wide range of needs from adjustment at diagnosis to coping with symptoms, adhering to treatment protocols and managing an on-going relationship with a medical team.

Methods A novel clinical psychology service was established within an existing IBD service at a large UK tertiary centre. Patients were referred either by a gastroenterologist, IBD