(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% ($n=56/88$) of patients were unsure which examination was more 'accurate'. There was an inclination towards preferencing 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.¹ This 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.

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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, to date 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

Abstract P100 Figure 1 Pre- and post-intervention measures of depression (PHQ-9, A), anxiety (GAD-7, B), work and social adjustment (WSAS, C) and IBD-related quality of life (IBDQ, D). (A) and (B) also show distribution of PHQ9 and GAD7 scores in an unselected background population of IBD patients attending outpatient clinics at our centre.

nurse, or dietician using real world clinical selection (clinical judgement rather than screening/threshold methods). Patients could also self-refer to the service. After an assessment with the clinical psychologist, patients were assigned as either accepted for intervention, referred to other mental health services or did not require intervention. Intervention involved a range of therapeutic modalities delivered by a clinician with considerable experience of working with long-term physical health conditions.

Results Of 42 patients referred, 25 (60%) were accepted for intervention, with completion data currently available for 21. Measures of depression, anxiety, work and social adjustment and health related quality of life were captured for these patients pre-, during and post-intervention, as well as for 93 unselected patients with IBD attending outpatient clinics. Patients selected for intervention recorded moderate to severe scores across these domains that differed significantly from the background population. Post-intervention, patients showed highly statistically significant improvement across all domains with scores that did not differ from the background.

Conclusions Real world clinical selection methods appear adequate in identifying patients with greater psychological need than the baseline population. Although limited by our current small sample size, our results suggest that a clinical psychology intervention, embedded within the IBD team, can reduce patient psychological distress in IBD across a range of outcomes.

P101

DISCONTINUATION OF USTEKINUMAB IN PATIENTS WITH CROHN'S DISEASE: MULTI-CENTRE REAL WORLD DATA

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Intro Ustekinumab is efficacious for treating moderate to severe Crohn's disease (CD). We aim to study real world efficacy of ustekinumab for CD.

Methods A retrospective observational study across 3 London Hospitals with 106 adults with CD started on ustekinumab between 2017–2019. Primary outcome was clinical response (3-point change in the Harvey-Bradshaw index) at week 12.

A secondary outcome was time to treatment discontinuation (drug survival). Predictors of discontinuation were analysed using Cox regression and multivariable Cox regression for joint association.

Results 47.2% were male; median age at time of ustekinumab induction was 35 years (range 20 – 69). 61.3% had ileocolonic disease. The majority (55.7%) had inflammatory phenotype. 47.2% were on concomitant immunomodulators during induction. Only 9.4% were biologic naïve. 41.5% had previous abdominal surgery. Median follow-up was 12 months (range 1 – 33). 58.9% had clinical response at 12 weeks. 72% (95% CI: 62% to 81%) and 67% (95% CI: 55% to 77%) remained on Ustekinumab after 1 and 2 years follow-up respectively. The association between various patient factors

Abstract P101 Table 1

Variable	Category	Discontinued n/N	Hazard Ratio (95% CI)	P-value
Disease duration	≤ 2 years	1/9	1	0.31
	> 2 years	24/94	2.83 (0.38, 20.9)	
Disease behaviour	Non-complicated	15/39	1	0.83
	Complicated	12/47	0.92 (0.43, 1.97)	
Perianal disease	No	14/65	1	0.41
	Yes	13/41	1.37 (0.64, 2.93)	
Immunomodulator	No	15/56	1	0.40
	Yes	12/50	0.72 (0.34, 1.54)	
Previous biologic ^(~)	None	0/10	(>)	0.24
	Anti-TNF only	18/68		
	Anti-TNF + Vedol.	9/27		
	Vedol.			
Primary non-response	None	19/68	1	0.99
	Anti-TNF only	4/14	0.97 (0.33, 2.87)	
	Vedolizumab ^(^)	4/14	0.97 (0.33, 2.85)	
Maintenance frequency ^(&)	Every 8 weeks	12/44	1	0.08
	Every 12 weeks	7/53	0.43 (0.17, 1.10)	

(~) Omitting one patient who received Vedolizumab only

(>) Unable to perform Cox regression due to no discontinuations in one group. Analysis using logrank test

(^) Non-response from Vedolizumab with or without non-response from anti-TNF

(&) Omitting patients not continuing with Ustekinumab