should be conducted focussing on patients presenting to secondary care, to measure the true effect of Instagram influence.

PWE-66 COMORBID IRRITABLE BOWEL SYNDROME AND HYPERMOBILE EHLERS-DANLOS SYNDROME: A DISTINCT CLINICAL PHENOTYPE?

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Introduction Several studies have demonstrated a high prevalence of Functional Gastrointestinal Disorders (FGID), particularly irritable bowel syndrome (IBS) in patients with Hypermobile Ehlers-Danlos Syndrome (hEDS) and hypermobility spectrum disorders (HSD). However, no studies have identified if those with overlap IBS and hEDS/HSD form a distinct phenotypic profile to those with IBS alone.

Methods Case-Control study consisting of females with overlap IBS and hEDS/HSD and IBS alone. The overlap group consisted of females with an established diagnosis of hEDS/HSD referred to Neurogastroenterology clinics. Patients underwent telephone interviews assessing for IBS using ROME IV criteria. Those who met the criteria were included ($n = 50$). IBS alone group consisted of females with an established diagnosis of IBS who had seen a hospital gastroenterologist. Patients underwent a video call to assess for the presence of IBS using ROME IV criteria and exclusion of hEDS/HSD using the Beighton scoring system (≤ 3) and 5-point joint hypermobility questionnaire (< 1) ($n = 50$). Both groups were issued with the following questionnaires: Irritable Bowel Syndrome Symptom Severity, Gastrointestinal Symptom Rating Scale, Visceral Sensitivity Index Score (reverse scored to measure GI symptom specific anxiety), Patient Health Questionnaire Adjusted, Hospital Anxiety and Depression Scale, Quantitative measure of autonomic symptoms, and Health related Quality of Life.

Continuous variables were summarised by mean and standard deviation and analysed using an unpaired t-test; significance set at $p < 0.05$.

Results Patients with overlap IBS/hEDS had an increased IBS symptom severity (341.02 vs. 279.86; $p = 0.001$), increased

non-GI related somatization scores (16.16 vs. 8.6; $p = < 0.0001$), higher prevalence of autonomic symptoms in all domains (42.12 vs. 26.14; $p = < 0.0001$), and worse quality of life (46.80 vs. 65.86; $p = < 0.0001$) than those with IBS alone. However, patients with IBS alone had an higher visceral sensitivity index score than those with overlap IBS/hEDS (54.4 vs. 45.24; $p = 0.004$). Whilst there were no significant differences in general anxiety disorder between the two groups ($p = 0.126$), those with overlap IBS/hEDS demonstrated a trend towards increase in depressive symptoms (8.26 vs. 6.80; $p = < 0.059$).

Conclusions These results suggest that the overlap hEDS/IBS cohort may be a distinct phenotype governed by marked autonomic symptoms, a lot of chronic pain and lower visceral sensitivity index. These patients are more complex and have more multicomorbidity than those with IBS alone and may benefit from multidisciplinary treatment managing autonomic aspects as well as GI issues.

Gastroenterology service

PTH-14 IBD PATIENT COMPLIANCE WITH FAECAL CALPROTECTIN HOME TESTING KITS COMPARED TO LABORATORY BASED HOSPITAL TESTING

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Background Faecal calprotectin (FC) testing has become a standard non-invasive tool to monitor disease control in Inflammatory Bowel Disease (IBD)(1). Reported patient compliance with submitting samples for hospital testing has been as low as 35% (2). We aimed to evaluate patient compliance with rapid home faecal calprotectin testing kits compared to hospital based testing in our university teaching hospital.

Method 100 patients with a diagnosis of IBD for at least 1 year and attended IBD clinic between January 2019 and August 2020 were selected. Our laboratory ceased performing FC testing in late March and we introduced home testing (BÜHLMANN IBD doc). 50 patients who were, pre-pandemic, requested to bring a stool sample to the laboratory for

Abstract PTH-14 Figure 1 Comparison of percentage of compliance between hospital and home faecal calprotectin test request