hospital-based ELISA testing were randomly selected. We compared these to 50 random patients who had a home-based FC testing. Patients who were supplied with home testing kits received training from IBD nurses as well as on-line training materials. Data was collated retrospectively. Compliance was recorded if result was documented within 6 weeks of request.

Result Prior to the introduction of home testing, only 52% of the patients' sampled complied with hospital-based testing. This compared to a 70% compliance rate, when home testing was requested. (Figure 1)

Conclusion The improvement in FC testing compliance with rapid home testing kit compared to laboratory based testing illustrates the benefit of adapting home testing as the standard in future. The considerable increase in compliance by home testing may be due less disruption to patient's personal life i. e., ability to undergo testing at home, symptoms such as faecal incontinence preventing patients delivering samples to hospital and COVID pandemic compelling patients to stay at home. Adopting rapid FC home testing as standard provides patients with increased locus of control regarding their care, providing health care professionals with rapid results, thus, will improve management of IBD. The ability for patients to perform home test has obvious advantages during the COVID pandemic.

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PTH-15 ECONOMIC ANALYSIS OF INTRAVENOUS IRON INFUSION IN IBD AND IDA: REAL WORLD DATA FROM UK

^{1,2}Anjan Dhar*, ³Dawa kabiru, ³Matthew Johnson, ¹Frances Maw, ⁴Richard Pollock. ¹County Durham and Darlington Nhs Foundation Trust, Darlington, UK; ²School of Health and Life Sciences, Teesside University, Middlesbrough, UK; ³Bedfordshire Hospitals NHS Foundation Trust, Luton, UK; ⁴Covalence Research Ltd, London, UK

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Introduction Iron deficiency anemia (IDA) is a common symptom of inflammatory bowel disease (IBD), arising from the combined effects of gastrointestinal blood loss and reduced iron absorption. Intravenous (IV) iron is the preferred treatment option in patients with severe anaemia or in patients refractory to treatment with oral iron. Two high-dose, rapid-infusion IV iron formulations are currently available in the UK: ferric derisomaltose (FDI) and ferric carboxymaltose (FCM), differing in the nature of the carbohydrate with which the iron is complexed and the approved posology; FDI can be dosed up to 20 mg/kg bodyweight, while FCM can be dosed up to a maximum of 1,000 mg.

Aims and Methods The aim of the study was to evaluate the resource utilization and cost associated with treating IDA or hypoferritinemia with FDI versus FCM in patients with IBD in the United Kingdom (UK).

Data from 91 patients with IBD and either IDA or hypoferritinemia having received IV iron treatment at two UK gastroenterology services were pooled and analyzed using R. Of the included patients, 28 received FDI and 63 received FCM. Baseline age, bodyweight, hemoglobin, ferritin, and calculated iron need were compared between the FDI and FCM

treatment groups, and the total number of infusions administered to address the iron need was calculated. The average cost of treatment was then modeled using two approaches: healthcare resource group (HRG) tariffs from a national Department of Health (DoH) perspective and a microcosting analysis from the NHS Trust perspective. The HRG tariff approach utilized a weighted cost based on the 2019-20 tariff values for day cases and ordinary elective spells weighted by the combined day case and elective spell activity from 2018-19. The microcosting analysis captured observation and infusion time based on data from the summaries of product characteristics (SPCs) and the Personal Social Services Research Unit (PSSRU), costs of IV iron from the British National Formulary, and costs of giving sets, cannulas, and dressings from the NHS Business Services Authority and NHS Supply Chain.

Result None of the recorded baseline characteristics significantly differed between the FDI and FCM treatment groups ($p > 0.05$ for baseline hemoglobin, ferritin, and bodyweight). Patients treated with FDI received an average of 1.14 infusions to address the iron need (32 infusions in 28 patients), compared with 1.56 infusions with FCM (98 infusions in 63 patients). The economic analysis based on HRG tariffs showed that this would result in savings of GBP 121 per patient (GBP 334 with FDI versus GBP 455 with FCM), while the microcosted analysis showed cost savings of GBP 23 per patient (GBP 220 with FDI versus GBP 243 with FCM) from the NHS Trust perspective.

Conclusion An analysis of real-world data from two gastroenterology services in the UK showed that using FDI in place of FCM would result in 0.42 fewer infusions per patient to treat either IDA or hypoferritinemia in patients with IBD. In the UK, this reduction would be associated with cost savings of GBP 121 per patient from the national DoH perspective or savings of GBP 23 per patient from an NHS Trust perspective. The reduction in infusions associated with FDI also has the potential to free up infusion suite capacity for other patients, or other IV infusions in the same patient group.

PTH-16 LIFE IN LOCKDOWN: SUPPORTED SELF-MANAGEMENT OF IBD INCREASES DISEASE CONTROL THROUGH MY IBD CARE

¹Rachel Moran, ¹Oliver Miles, ¹Rachel Moran, ²Gareth Parkes*, ³Bu Hayee. ¹Ampersand Health Ltd, London, UK; ²Dept of Gastroenterology, The Royal London Hospital, Barts Health NHS Trust, London, UK; ³Department of Gastroenterology, King's College Hospital NHS Foundation Trust, London, UK

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Introduction MyIBD Care is a mobile phone application delivering digital therapeutics and remote monitoring for patients with inflammatory bowel disease (IBD). The app provides a library of self-management content, direct messaging with clinical teams, and a range of clinically validated disease-measures.

During the first wave of the COVID pandemic many IBD patients were forced to shield due active disease or medication. In response to this we developed situationally relevant behavioral science-based courses to alleviate the increased risk of patients developing anxiety or depression due to isolation. Our two courses focussed on maintaining healthy relationships and exercise. The courses were created using the same behavior-change framework as existing courses in the app.

Methods Fifteen MyIBD users participated in a study designed to evaluate the effectiveness of the 'Life in Lockdown'