Predictive models comprising combinations of clinical parameters, blood results, and endoscopy findings were ranked by AIC with a final model selected with an emphasis on simplicity and ease of implementation. This model was validated in 110 patients admitted to GCUH, Australia between 2015-20 and 62 patients admitted to AIIMS, India between 2015-8. The Oxford cohort were compared with data from the same unit in 1992-3 (Travis et al, Gut 1996; 38: 905-10).

**Results** Admission CRP albumin, and UCEIS scores predicted steroid non-response at day 3 (FDR p=0.00066, 0.0066, and 0.015). A 4-point model was developed involving CRP ≥100mg/L, albumin ≤25g/L, UCEIS ≥4, or ≥7. Scoring 0 or 4 was 100% accurate in all cohorts. 19.5% of patients scored 3 or 4 of whom 83% in Oxford, 85% in GCUH and 80% in AIIMS failed steroid treatment. In the combined validation cohorts the PPV for steroid failure was 0.84 (0.70-0.98), OR 11.9 (10.8-13.7), with the number needed to screen 8.2 (5.8-13.7).

In the current Oxford cohort 54% of patients received rescue therapy (27% ciclosporin, 27% anti-TNF), increased from 27% ciclosporin in 1992-3, p=0.0015. Colectomy during admission halved (15% vs 29%, p=0.033), but an eight-fold increased risk of colectomy in the following year is still seen after a partial steroid response.

**Conclusions** Our model identifies on admission a subset of patients very unlikely to respond to steroid treatment and allows stratification for early intensification of management. In 25 years colectomy rates for ASC have halved while second-line therapy use has doubled. Long-term outcomes remain poorer in patients who do not clearly respond to steroids.

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**OMO-2** **FILGOTINIB EFFICACY IN PATIENTS WITH ULCERATIVE COLITIS BY LINE OF THERAPY: PHASE 2B/3 SELECTION RESULTS**

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**Introduction** Filgotinib (FIL) is a once-daily, oral, Janus kinase 1 preferential inhibitor. We assessed the efficacy of FIL in biologic (bio-naïve) and bio-experienced patients with UC, and in bio-experienced patients with failure of 1 or ≥2 biologics or 1 or 2 mechanisms of action (MoAs).

**Methods** SELECTION (NCT02914522) was a phase 2b/3 double-blind, randomised, placebo-controlled trial comprising two induction studies and a maintenance study. Adults (18–75 years) with moderately to severely active UC were randomised 2:2:1 to FIL 200 mg, FIL 100 mg or placebo (PBO) once daily for 11 weeks in Induction Study A (bio-naïve) and B (bio-experienced). Patients in either clinical remission or Mayo Clinic Score (MCS) response at week 10 (responders) could enter the Maintenance Study. Responders who received induction FIL were re-randomised 2:1 to continue their induction regimen or PBO through week 58. Responders who received induction PBO continued PBO. We assessed clinical remission and MCS response at weeks 10 and 58 in bio-naïve patients and bio-experienced patients with failure of 1 or ≥2 biologics and 1 or 2 MoAs (TNF antagonists and vedolizumab). All p values for subgroup analyses are nominal.

**Results** Week 10 clinical remission was achieved by a significantly higher proportion of bio-naïve and -experienced patients treated with FIL 200 mg than PBO. A higher proportion of bio-experienced patients with 1 biologic or MoA failure treated with FIL 200 mg than PBO achieved clinical remission.