Conclusion The survey indicates some variation in steroid prescribing for IBD patients. The majority prescribe an 8 week regime with a starting dose of 40mg daily for 7 days and a taper of 5mg every week thereafter. 2nd generation steroids were more frequently prescribed in CD than in UC with the majority agreeing that these preparations should be offered before conventional steroids. Whilst steroid prescribing is not underscored by a firm evidence base it is reasonably consistent. Further research is needed to define the optimal tapering regime.

PMO-6 IMPACT OF CONSULTATION FREQUENCY AND TIME TO DIAGNOSIS ON SUBSEQUENT INFLAMMATORY BOWEL DISEASE OUTCOMES

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Introduction The impact of length of time between the point of initial contact, at symptom onset, with a health-care provider and diagnosis of inflammatory bowel disease (IBD) on subsequent disease outcomes is unclear. Diagnosis can be challenging and delay common, with an excess of gastrointestinal (GI) symptoms reported 3 years before diagnosis of IBD compared to the background population.¹

We describe the impact of time to diagnosis and frequency of consultation amongst individuals with GI symptoms who later go on to develop ulcerative colitis (UC) and Crohn's disease (CD).

Methods Using the Clinical Practice Research Datalink, a nationally representative research database, incident cases of IBD were identified between 2003 and 2016. GI symptoms were defined as abdominal pain, diarrhoea or rectal bleeding. Proportion of individuals consulting for incident GI symptoms within 3 years prior to IBD diagnosis was identified. Using a multivariable regression model we evaluated the association between time to diagnosis from incident consultation and consultation frequency for GI symptoms on disease outcomes (corticosteroid (CS) and thiopurine (TP) use, hospitalisation and major abdominal surgery) 5 years after IBD diagnosis.

Results 6,967 incident cases of IBD were identified during the study period. Within 3 years prior to IBD diagnosis, 2,645 (38%) patients had an incident presentation with GI symptoms in primary care (782 CD, 1,863 UC). Presentation with GI symptoms occurred >3 years before IBD diagnosis in 2,842 (41%) of patients. There was no recorded primary care consultation for 1,480 (21%) patients.

Time to diagnosis from initial consultation was not associated with worse subsequent disease outcomes. However, amongst patients later diagnosed with UC, ≥ 3 prior consultations for GI symptoms was associated with an increased subsequent risk of CS use (HR 1.19, 95% CI 1.05 -1.36), CS dependency (HR 1.50, 95% CI 1.10 -2.05), TP use (HR 1.60, 95% CI 1.22 - 2.11) and colectomy (HR 1.91, 95% CI 1.21 - 3.04). Amongst patients with CD, ≥ 3 prior consultations was associated with an increased subsequent risk of major abdominal surgery (HR 1.75, 95% CI 1.22 -2.5) and hospitalisation (HR 1.58, 95% CI 1.18 -2.11)

Conclusion Frequent primary care consultation with GI symptoms, but not symptom duration prior to IBD diagnosis, was

associated with worse subsequent disease outcomes. Steps are needed to expedite IBD diagnosis to reduce the risk of adverse disease outcomes.

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PMO-7 PATIENT-REPORTED OUTCOMES ON THE IMPACT OF ORAL STEROID TREATMENT IN ULCERATIVE COLITIS

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Introduction Corticosteroids (CS) have formed the main stay of therapy for the treatment of acute flares of ulcerative colitis (UC).¹ Data regarding the optimal tapering regime however is lacking. Since the introduction of CS it became apparent that their use is often associated with short and long-term side effects.² Likewise rapid discontinuation of CS may also cause withdrawal symptoms. There remains a gap in the evidence base defining the optimal oral CS tapering regime to ensure adequate efficacy while minimising undue side effects

We aimed to explore patient perspective on the general impact, benefits and side effects, associated with the use of oral CS and discover views on a short course tapering regime to manage mild to moderate flares of UC.

Method Patient views were assessed quantitatively and qualitatively via a Crohn's and Colitis UK led 'Patient involvement in research' event. The UC Steroid Questionnaire (UCSQ) poll 1 and 2 was developed based on patient and clinical input. Participants completed both UCSQ's online. Poll 1 was by the option of multiple choice and poll 2 indicating the degree of agreement with individual statements on a 10 point Likert scale. Further debriefing interviews with the same group of patients were conducted online evaluating the content, clarity, and relevance of the items.

Results Forty patients responded to UCSQ 1 and 49 to UCSQ 2. Approximately two-thirds (68%) of patients had experienced significant side effects from oral CS use. Sleep disruption, mood disturbance and bone thinning were of highest concern (60% vs 55% vs 55%). Overall only 53% were satisfied with the use of oral CS in managing a UC flare. Ninety-five percent of patients said they would consider participating in a trial comparing a 1 month short course to a longer 2-3 months course of oral CS to manage a mild to moderate flare, whilst 5% mentioned that they would not. The risk of suboptimal response and disease flare were amongst the main concerns elicited amongst those who were uncertain or said no.

Conclusion Significant side effects experienced by the majority of patients following oral CS use impacted on the opinions of many towards considering a shorter CS tapering regime to manage a mild to moderate flare of UC. With better understanding of patient experiences to steroid use, we highlight the need in defining the optimal oral CS tapering regime to reduce the risk of potentially avoidable disease progression.

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