Introduction Psychological distress is highly prevalent in patients living with inflammatory bowel disease (IBD). Identifying and managing psychological distress can improve IBD symptoms and quality of life and reduce interaction with secondary care¹. IBD standards have long emphasised the importance of psychological support, particularly at the time of diagnosis, in patients experiencing pain or fatigue or in patients being considered for surgery².

This project aimed to improve screening for psychological distress in outpatients living with IBD at a large district general hospital, whilst also increasing the number of patients signposted or referred to support services if indicated.

Methods Outpatient letters from 167 consecutive IBD consultations between October 2019 and November 2020 were retrospectively reviewed to see if psychological distress was discussed and, if indicated, whether patients were referred for support. A three question screening tool was then developed to identify patients suffering from psychological distress, with a clear referral pathway if required to either the clinical health IBD psychology service or the local Improving Access to Psychological Therapies service. The tool was promoted to healthcare professionals seeing patients with IBD. 66 post-intervention clinic letters were then reviewed. The second cycle involved saving the tool as a template to the patient record prior to an appointment to act as a prompt for screening.

Results Psychological distress was discussed in significantly more consultations post-intervention than pre-intervention (32.8% vs 15.6% $p=0.004$). The bespoke screening tool was used in 23% of consultations post-intervention. Of those screened 21.4% reported psychological distress. The intervention increased the frequency of signposting and referral of patients with psychological distress from 35.7% to 87.5% ($p=0.019$). There was no significant difference in rate of screening between cycle 1 and 2 (44.4% vs 41.4% $p=0.766$); demonstrating the change was sustained.

Conclusions Clinician education and a simple outpatient screening tool can significantly improve screening for psychological distress and subsequently identify and refer on those patients with the greatest need. We intend to increase awareness of our screening tool and our next intervention involves digitising the tool; enabling patients to complete it prior to their clinic appointment. We will also evaluate the impact of our service on health-related quality of life in our patient population.

REFERENCE

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PMO-12 REAL-WORLD OUTCOMES AFTER VEDOLIZUMAB DISCONTINUATION IN A TERTIARY IBD COHORT

¹Gregory Sebeos-Rogers*, ¹Konstantinos Fragkos, ¹Hajeena Saravanapavan, ¹John Barragry, ²Hui Fen Koo, ²Ho Juen Ko, ¹Ioanna Parisi, ¹Edward Seward, ¹Sara McCartney, ¹Stuart Bloom, ¹Shameer Mehta, ¹Farooq Rahman. ¹Dept. Gastroenterology, University College Hospital, London, UK; ²University College London Medical School, London, UK

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Introduction Vedolizumab (VDZ) is an $\alpha 4\beta 7$ integrin antagonist licensed to treat moderate to severe ulcerative colitis (UC) and Crohn's disease (CD). We provide long-term real-world data on outcomes after VDZ discontinuation.

Methods A consecutive cohort of 193 adult IBD patients initiated on VDZ between May 2015 and June 2019 was retrospectively reviewed up to June 2020. Primary outcomes were post-VDZ relapse, biologic and surgical event rates. VDZ discontinuation for remission was classified as treatment for at least 6 months with 3 months corticosteroid-free clinical remission pre-discontinuation. Statistics: Continuous variables

Abstract PMO-12 Table 1 Post vedolizumab treatment options in CD (n=67) and UC (n = 59)

	Infliximab	Adalimumab	Ustekinumab	Tofacitinib	Vedolizumab re-use	Golimumab	Surgery
CD (n = 67)	3 (4.5%)	4 (6%)	44 (65.7%)	1 (1.5%)	4 (6%)	0 (0%)	26 (38.8%)
Persistence	2 (67%)	3 (75%)	30 (68%)	0 (0%)	2 (50%)	0 (0%)	
Surgery	1 (33%)	2 (50%)	14 (32%)	0 (0%)	2 (50%)	0 (0%)	
Number of previous biologics							
0	0 (0%)	2 (3%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
1	2 (3%)	0 (0%)	15 (22.4%)	0 (0%)	2 (3%)	0 (0%)	5 (7.5%)
2	1 (1.5%)	0 (0%)	26 (38.8%)	1 (1.5%)	1 (1.5%)	0 (0%)	16 (23.9%)
3	0 (0%)	2 (3%)	3 (4.5%)	0 (0%)	1 (1.5%)	0 (0%)	5 (7.5%)
χ^2 p-value	0.473	<0.0001	<0.0001	0.775	0.700	–	0.184
Disease Location							
Ileal	1 (1.5%)	0 (0%)	8 (11.9%)	0 (0%)	2 (3%)	0 (0%)	2 (3%)
Colonic	2 (3%)	4 (6%)	36 (53.7%)	1 (1.5%)	2 (3%)	0 (0%)	24 (35.8%)
χ^2 p-value	0.418	0.361	0.59	0.655	0.062	–	0.125
UC (n = 59)	16 (27.1%)	11 (18.6%)	5 (8.5%)	11 (18.6%)	4 (6.8%)	1 (1.7%)	16 (27.2%)

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Persistence	5 (31%)	2 (18%)	2 (40%)	7 (64%)	3 (75%)	0 (0%)	
Surgery	4 (25%)	3 (27%)	2 (40%)	3 (27%)	0 (0%)	0 (0%)	
Number of previous biologics							
0	15 (25.4%)	5 (8.5%)	1 (1.7%)	5 (8.5%)	3 (5.1%)	0 (0%)	6 (10.2%)
1	0 (0%)	6 (10.2%)	2 (3.4%)	3 (5.1%)	1 (1.7%)	0 (0%)	6 (10.2%)
2	1 (1.7%)	0 (0%)	2 (3.4%)	3 (5.1%)	0 (0%)	1 (1.7%)	4 (6.8%)
χ^2 p-value	<0.0001	0.042	0.424	0.954	0.422	0.195	0.592
Disease Location							
E1	2 (3.4%)	0 (0%)	0 (0%)	2 (3.4%)	1 (1.7%)	1 (1.7%)	1 (1.7%)
E2	9 (15.3%)	6 (10.2%)	1 (1.7%)	5 (8.5%)	3 (5.1%)	0 (0%)	7 (11.9%)
E3	5 (8.5%)	5 (8.5%)	4 (6.8%)	4 (6.8%)	0 (0%)	0 (0%)	8 (13.6%)
χ^2 p-value	0.282	0.324	0.295	0.644	0.142	0.023	0.717

(median, interquartile ranges (IQR), Mann–Whitney U- test); categorical variables (frequency, percentages, chi-square test).

Results Data from 90 CD and 103 UC patients was analysed. Prior biologic exposure (Adalimumab 57.5% (111/193); Infliximab 46.6% (90/193); Ustekinumab in CD 42.2% (38/90)) was high overall.

Total all-cause VDZ discontinuation rate was 74.4% (67/90) in CD and 56.3% (58/103) in UC with the majority discontinuing within year 1 (CD: $n = 44$; UC: $n = 35$) as compared to years 2, 3 or greater (CD: $n = 13, 8, 2$; UC: $n = 11, 6, 7$). Of these patients, 77.6% (52/67) with CD and 63.8% (37/58) with UC required another biologic. A majority with CD persisted on subsequent Ustekinumab (68%; 30/44) or anti-TNF (71%; 5/7) by the end of the study period. In UC, 26% (7/27) persisted on an anti-TNF and 64% (7/11) on Tofacitinib (Table 1).

17 patients were retreated with VDZ having discontinued it for remission (CD: $n = 7$; UC: $n = 10$). The median duration of VDZ retreatment was 164 [IQR: 87–189] weeks for CD and 165 [IQR: 126–205] weeks for UC (duration follow-up from first VDZ discontinuation for CD: 46 [IQR: 30–56] weeks; UC: 46 [IQR: 16–77] weeks). Of this larger cohort, there was no significant difference in relapse rate on VDZ retreatment between CD and UC (14% ($n = 1$) vs. 30% ($n = 3$), $p = 0.6029$).

A large minority of patients underwent subsequent surgery (CD: 38.8% (26/67); UC: 29.3% (17/59) with the median interval to surgery greatest in UC (CD: 21 [IQR: 9–71] vs. UC 63 [IQR: 12–84] weeks, $p = 0.2409$). Most CD patients who had surgery post VDZ (61.5%, 16/26) had had 2 prior biologics as compared to none who had VDZ first line ($p = 0.184$) whereas in UC, biologic exposure had less impact on surgery rate ($p = 0.592$).

Conclusions Our data suggests VDZ recapture for relapse following discontinuation of therapy for remission, sequencing Ustekinumab after VDZ in complex/refractory CD and anti-TNF therapy before or after VDZ in UC are options in the management algorithm of IBD.

PMO-13 ESTABLISHING TRENDS IN LUMINAL INFLAMMATION TOWARDS THE END OF LIFE IN PATIENTS WITH LONGSTANDING IBD

Alexander Robertson*, Gareth-Rhys Jones. Edinburgh IBD Unit, Western General Hospital, Edinburgh, UK

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Introduction Inflammatory bowel disease (IBD) is a chronic condition characterised by unpredictable mucosal inflammation which can severely impact a patient's quality of life. Due to compounding prevalence and an aging population, more people are dying with IBD. This study aims to describe IBD activity in a prevalent cohort in the years before death using faecal calprotectin (FC).

Method The NHS Lothian IBD registry is a rigorously validated, prevalent IBD cohort that has been shown to be circa 95% complete for the approximate one million population of the Lothians, Scotland. Data on >11k patients on date of diagnosis, death, IBD subtype, and serial FC measurements are held since 2003.

Patients with disease duration ≥ 8 years who had died and had ≥ 1 FC in the 5 years preceding death were identified. FC was correlated to patient demographics, IBD subtype, time before death and cause of death.

Results 261 deceased individuals (136 ulcerative colitis (UC) and 125 with Crohn's disease (CD)) were identified. 28 were excluded, having died of small bowel or colonic disease (16 with UC and 12 with CD).

Mean age at death was 74.47 (SD 13.6) years in UC cohort (49.2% female) versus 70.47 (SD 14.3) in CD cohort (57.5% female).

The median FC decreased in those with UC (from 705 to 438ug/g) but rose in those with CD (210 to 310ug/g) in the 5 years prior to death, (Figure 1).

Deaths from acute illness/accident, chronic disease (or acute on chronic illness) and malignancy were compared. FC measurements remained constant for those dying from both acute illness and chronic disease, although in both UC and CD an

Abstract PMO-13 Figure 1 Median FC levels in the years prior to death