improvement in median FC levels was seen in those dying from malignancy (1130 to 250ug/g in UC and 588 to 490ug/g in CD).

When stratified by age of death the FC measurements were similar between age groups.

Conclusions Serious and fatal non-IBD related disease does not seem to lead to spontaneous improvement or deterioration in luminal inflammation prior to death, with no significant 'burn out' of IBD activity seen. For patients approaching the end of their life the aim of treatment focuses on maximising quality of life, but there remains variation in practice around stopping or continuing IBD therapies, and further research in this area is required. This study suggests that for patients with IBD an individualised approach is required, and for many, good palliative care will include active and aggressive management of their IBD.

PMO-14 USE OF NON-INVASIVE SURROGATE MARKERS TO MONITOR VEDOLIZUMAB THERAPY IN INFLAMMATORY BOWEL DISEASE

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Introduction We provide long-term data on the effectiveness of Vedolizumab (VDZ) in the management of inflammatory bowel disease (IBD) by reviewing the response of surrogate markers of disease activity to VDZ therapy, including Harvey-Bradshaw Index (HBI) for Crohn's disease (CD) and Simple Colitis Clinical Activity Index (SCCAI) for ulcerative colitis (UC), c-reactive protein (CRP), and faecal calprotectin (FCP).

Methods A consecutive cohort of 193 adult IBD patients (90 CD and 103 UC/IBD-unspecified) who commenced VDZ between May 2015 and June 2019 at a tertiary IBD centre was retrospectively reviewed. Markers of disease at baseline, 1 year (n = 193), 2 years (n = 157) and 3 years (n = 104) were assessed. Statistical analyses were performed using SPSS 25.0, with significance assigned to a p-value of <0.05 in bootstrap t-testing.

Results Overall, 77.8% and 93.2% of patients with CD and UC respectively had undergone more than one baseline assessment modality prior to VDZ therapy. At baseline for CD and UC patients respectively; a) median disease activity index (DAI) score was HBI 5 (interquartile range (IQR): 2-8) and SCCAI 5 (IQR: 3-8), b) median CRP was 9.9 mg/L (IQR: 3.73-22.5 mg/L) and 4.8 mg/L (IQR: 1.5-10.5 mg/L), c) median FCP was 656.5 µg/g (IQR: 301-1472 µg/g) and 1190 µg/g (IQR: 386.5-2639 µg/g).

Following initiation of VDZ therapy, DAI scores indicated a favourable response in patients with colonic CD disease and all UC disease subtypes from visit 2 onwards compared to baseline (p<0.05, Figure 1A,B). There was a significant fall in CRP in colonic but not ileal CD patients (p<0.05 at multiple timepoints after visit 4 in Year 1), a trend that persisted during year 1 and extended up to year 3 (Figure 1C). In UC patients, a significant fall was present from visit 3 in Year 1 and persisted in E1 and E2 UC patients compared to baseline (p<0.05, Figure 1D). There was a significant reduction in FCP over time in patients with colonic CD and E3 UC (P<0.01, Figure 1E,F).

Abstract PMO-14 Figure 1

Conclusion In our single centre retrospective cohort analysis of 193 adult IBD patients, we observed a clinically and statistically significant improvement in markers of disease activity, including DAI scores, CRP and FCP. These surrogate markers allow non-invasive monitoring of VDZ response, particularly in patients with colonic CD and UC.

PMO-15 TRANSITIONING FROM INTRAVENOUS TO SUBCUTANEOUS VEDOLIZUMAB IN PATIENTS WITH INFLAMMATORY BOWEL DISEASE (TRAVELESS)

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Introduction In May 2020, subcutaneous (SC) vedolizumab was approved for use in Inflammatory Bowel Disease (IBD). Patients with IBD have a number of risk factors for a poor outcome from SARS-CoV-2 infection and managing this risk by reducing hospital visits is crucial. Currently there is no information on the process or outcomes of transitioning patients established on intravenous (IV) vedolizumab to SC.

Methods This is a prospective service evaluation of adult patients who are either stable on IV vedolizumab or have