been newly started and opted for SC administration. Between October and December 2020, all suitable patients attending our infusion centre for vedolizumab were offered the option to switch to SC. Initially, the aim was to offer a SC dose to patients in place of their IV infusion with injection training by IBD specialists. This proved to be a challenge as it left a narrow window of time for homecare deliveries to be arranged for subsequent doses. Therefore, the remaining patients who agreed to the switch received an IV infusion at their baseline review, with the aim of administering the first SC dose in place of the next scheduled IV dose.

Outcomes include reasons for consenting or declining to switch, patient experience with using SC injections and time saved by not needing to travel to the infusion centre. Data on factors associated with poor outcomes from SARS-CoV-2 infection were collected, including co-morbidities, smoking status, concomitant medication and age.

Clinical baseline data collected as part of routine care included disease activity (modified Harvey-Bradshaw Index or Simple Clinical Colitis Activity Index), biochemical results including C-reactive protein, albumin, haemoglobin and platelet count, faecal calprotectin and quality of life using IBD-Control. Trough vedolizumab levels were measured in patients who had had at least 3 IV doses previously. Patients will be reviewed after 12 weeks as part of the switching programme.

**Results** 179 patients were offered the opportunity to change to SC vedolizumab (54.2% CD, 44.1% UC, 1.7% IBDU), of which 125 (70%) (64 (51.2%) CD, 58 (46.4%) UC and 3 (2.4%) IBDU) agreed to the switch. The mean (SD) was 55 (19.4). 11 patients were new to vedolizumab or reloading. The median time taken by patients (leaving home to returning home) to receive their infusions was 180 minutes (IQR 45 to 360).

The main reasons for agreeing to switch were patient preference to manage their treatment at home (70.4%), concerns about contracting an infection at the infusion centre (15.7%) and difficulty attending the infusion centre (15.7%). Reasons for patients declining included not wanting to self-inject (28.3%), needle phobia (15.2%), and current instability of symptoms (15.2%). There have been no major adverse events to date.

**Conclusions** This is a description of a service evaluation design to monitor outcomes in patients who have consented to transition from IV to SC vedolizumab at one IBD tertiary referral centre.
Methods A consecutive cohort of 90 adult CD patients treated with VDZ were retrospectively reviewed over a 3-year period. Primary end-points were clinical response (CR) as defined by Harvey-Bradshaw Index (HBI) reduction of ≥3 and clinical remission (CRM) defined as HBI<5. Corticosteroid-free remission (CFRM) was analysed at weeks 14, 54, 106 and 162. VDZ persistence was a secondary-end point. Predictors of CR, CRM and CFRM were examined with logistic regression. Predictors of time to CR and VDZ persistence were analysed with Cox Regression. Statistical analyses were performed using Statistical Package for the Social Sciences software (SPSS Inc v.26, Chicago, IL).

Results Median age at CD diagnosis and VDZ initiation were 19 (IQR 13-28) and 28 (IQR 23-42) respectively. Concomitant corticosteroid use (42.2%), immunomodulator use (53.3%) and prior biologic exposure (63.3% Infliximab, 84.4% Adalimumab, 42.2% Ustekinumab) were high. 54.4% were exposed to 2 anti-TNF agents whilst 27.8% had 3 biologics.

Duration between CD diagnosis and VDZ initiation predicted CR at week 14 and 54 with OR=0.94 (0.89-1.00), p=0.057 and OR=0.92 (0.85-0.99), p=0.037, respectively. For every year increase in duration of disease prior to VDZ, the risk of not responding to VDZ at 14 and 54 weeks decreased by 6% and 8% respectively. Prior adalimumab use was the only significant predictor of time to CRM (HR=0.52, 95% CI [0.29,0.95], p=0.034) and was associated with a 50% reduction in likelihood of achieving CRM with VDZ.

The rate of VDZ persistence was 50.0%, 28.9% and 13.5% at 1, 2 and 3 years, respectively with a median duration of 12.7 months (95% CI 9.2-21.4). Colonic CD was a significant moderator of persistence and increased as compared to ileal CD (HR=0.42, 95% CI [0.22-0.83], p=0.012). Prior Ustekinumab was a predictor of VDZ persistence (HR=0.36, 95% CI [0.21, 0.61], p=0.0001) whilst every 100 unit rise of faecal calprotectin (FC) at baseline was associated with a 3% risk of VDZ cessation (HR=1.03, 95% CI 1.106, p=0.036).

Conclusion Late VDZ use after CD diagnosis, anti-TNF naïvety, colonic disease, prior Ustekinumab use and low baseline FC are predictors of good clinical outcome and VDZ persistence. These factors are relevant in biologic selection and sequencing decisions to tailor bespoke patient therapy.

Abstract PMO-18

Intestinal failure in Crohn’s disease: a systematic review and meta-analysis of surgical risk factors

Introduction Intestinal failure (IF) is a rare but serious complication of Crohn’s disease (CD). However, to date, surgical risk factors remain poorly characterised and data from individual studies can be difficult to interpret or limited. We reviewed the existing literature, to identify surgical factors for IF in CD patients.

Methods According to PRISMA guidelines, a systematic review of PubMed for IF and CD was conducted through a series of advanced searches. To identify risk factors, articles related to IF and CD were analyzed according to demographics and CD characteristics, surgical characteristics, and nutritional and medical management. Study quality was assessed using the Item Bank for Assessment of Risk of Bias and Precision for Observational Studies of Interventions or Exposures. Where applicable, a meta-analysis with a random-effects model was performed in R. Results are presented as mean ± standard deviation.

Results 7 original articles were included with a total of 438 CD patients diagnosed with IF; 6 (85.7%) were retrospective studies and 1 was a prospective study (14.3%). The majority of studies were considered to be of low risk of bias (57.1%), and the remainder had a medium risk of bias (42.9%). From 3 or more studies, the mean age at CD diagnosis from meta-analysis was 28.2 yrs (95% CI: 24.0-32.5, P<0.01, I²=92%), the proportion of males was 42.7%, and the mean proportion...