known small bowel (SB) Crohn's disease; first assessment for presence of SB disease in IBD; & investigation for SB disease in patients without a known diagnosis of IBD. Obesity, complicated surgical history (>1 resection or strictureplasty involving different segments, or stoma), & known proximal SB disease were deemed unsuitable.

Results 105 MREs were performed in January 2018. 59 (56%) were deemed suitable for IUS instead of MRE. Most common reasons for unsuitability included complex surgical history (n=17, 37%), obesity (n=14, 30%), non-appropriate indication (n=12, 26%) & known upper gastrointestinal disease (n=10, 22%).

Of suitable cases, 32/59 (54%) had active inflammation detected including 17 (53%) isolated ileal, 8 (25%) ileocolonic, & 6 (19%) isolated colonic. In one case performed as first assessment for SB disease, both ileal & jejunal disease were found, the latter likely to be missed with IUS. No cases of isolated upper gastrointestinal inflammation were found. Regarding non-gastrointestinal findings in potential IUS patients, there were two cases of pancreatic cysts necessitating further investigation with serial MRIs & endoscopic ultrasound, yielding a side branch intraductal papillary mucinous neoplasm & a benign serous cyst adenoma. One case of multiple high T2 skeletal lesions was deemed clinically insignificant following further investigations. No other significant extra-intestinal findings not expected to be seen on IUS were identified.

Conclusion >50% of MREs could have been performed as IUS instead, with a potential annual cost saving of >£110,000. No instances of inflammation would have been missed based on distribution, although in one case the full extent of disease may not have been identified on IUS. Incidental non-gastrointestinal findings resulted in multiple investigations but were of limited clinical significance.

PMO-25 AGE MAY NOT IMPACT BIOLOGIC TREATMENT FAILURE IN IBD: A RETROSPECTIVE SINGLE CENTRE COHORT STUDY

¹Sonika Sethi*, ¹Jayesh Patel, ²Jonathan Bruce, ¹Duaa Dhafer, ¹Mohammed Suleman, ¹Suneha Verma, ¹Amy Thompson, ¹Shyam Menon, ¹Hari Padmanabhan, ¹Matthew James Brookes. ¹The Royal Wolverhampton Nhs Trust, Wolverhampton, UK; ²University of Birmingham, UK

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Introduction Research of age-related treatment failure with biologics for inflammatory bowel disease (IBD) is limited. Previous studies have suggested a higher failure risk for Adults >60 years (>60), but focused on anti-TNF α agents. Newer biologics are revolutionising treatment for Adults with IBD, but to date treatment failure or intolerance in the >60 is poorly understood.

RAB-IBD (Retrospective analysis of biologic treatment failure in IBD) at Royal Wolverhampton NHS Trust, is a real-life, longitudinal retrospective single-centre study comparing failure rates for biologics/biosimilar agents. These include anti-TNF α 's, integrin-inhibitors, interleukins-inhibitors and JAK-inhibitors. The primary outcome was to evaluate whether treatment failure at 12 months was impacted by age (>60s versus <60s). The secondary outcomes were to analyse if failure to complete 12 months of therapy were a result of the; type of biologic used, use of concomitant drugs, or demographic factors.

Methods 632 patients were identified from the Trust IBD database, who were initiated on biologics from January 2015 to December 2019. 465 matched our inclusion and exclusion criteria. Baseline characteristics, such as gender, biologic, type of IBD and number of biologics used previously, were matched to produce two cohorts, each of 98 participants comprising >60s and <60s.

Results Adverse effects, hospitalisation and need for emergency surgery was seen in 5.1% of under 60s (n=5) and 13.3% of over 60s (n=13). There was no significant difference in the proportion of patients who failed to complete 12 months of biologic treatment from the >60s (n=20, 20.4%) versus <60s (n=12, 12.2%) (OR 1.838, $p=0.126$). A larger proportion of biologic failure was seen in those on anti-TNF α vs. non-anti-TNF α biologics, but this was not significant (OR 2.35, $p=0.051$). IBD type (Crohn's vs. Colitis) was not a predictor of biological failure (OR 1.856, $p=0.176$), nor was previous biologic use (OR 0.644, $p=0.118$); concomitant thiopurines/methotrexate (OR 0.46, $p=0.134$); co-morbidities (OR 0.834, $p<0.752$); smoking status (OR 0.956, $p=0.888$); severity score (OR 0.939, $p=0.420$); baseline CRP (OR 1.024, $p=0.250$); faecal calprotectin (OR 1.00, $p=0.746$). Risk of biological failure at 12 months was greater in women than in men (OR 2.5, $p=0.023$).

Conclusions Age is not an independent predictor of pooled biological failure at 12 months post-initiation. This finding may be factored in when personalised treatment approaches are sought for >60s who are not respondent to conventional therapy. However, more research is required in a higher-powered study to investigate whether treatment failure is influenced by various demographic factors and by biologic type.

PMO-26 INTESTINAL ULTRASOUND INSTEAD OF ENDOSCOPY: LARGE POTENTIAL ROLE AND COST SAVINGS

¹Raphael Luber*, ¹Bianca Petri, ¹Sebastian Zeki, ²Krisztina Gecse, ¹Nyree Griffin, Peter Irving. ¹Guy's and St Thomas' Hospitals, St Thomas' Hospital, Westminster Bridge Rd, Lambeth, UK; ²Amsterdam University Medical Center, Amsterdam, The Netherlands

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Introduction Transabdominal intestinal ultrasound (IUS), best capable of detecting intestinal inflammation & associated complications proximal to the rectum, can potentially obviate the need for endoscopy in certain clinical scenarios. It is non-invasive, able to assess disease extent, can be performed at point-of-care enabling immediate therapeutic decisions, and, costing £24 at our centre, is also less expensive than both colonoscopy (£528) & flexible sigmoidoscopy (£395).

We aimed to establish the proportion of lower gastrointestinal endoscopy cases in which IUS could have been used instead, the potential cost savings, & the predicted pathology miss-rates.

Methods All colonoscopies & sigmoidoscopies performed at a single UK tertiary centre in January 2018 for either assessment of inflammatory bowel disease (IBD) activity or investigation of gastrointestinal symptoms (specifically diarrhoea, alternating diarrhoea or constipation, or abdominal pain) were retrospectively reviewed. Among patients being investigated for symptoms, only those aged <40 without: calprotectin >250 μ g/mg; CRP >5mg/L; anaemia; per rectal bleeding; or documented family history of colorectal cancer, were deemed IUS appropriate. Among IBD patients, need for dysplasia surveillance or stricture dilatation, consideration of treatment