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, ¹Sunenah 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

withdrawal, acute severe ulcerative colitis, isolated proctitis, or performance as part of a trial were features deemed inappropriate for IUS. In either indication, obesity (BMI>30) or complex surgical history were considered unsuitable for IUS.

Results 260 endoscopies were performed for the specified indications, of which 73 (28.1%) met criteria to be performed as IUS instead (55 of 220 colonoscopies [25%] & 18 of 40 flexible sigmoidoscopies [45%]). By indication, 46 of 108 [42.6%] cases performed for IBD assessment & 27 of 152 [17.8%] for symptoms met criteria.

Among potential IUS patients, one case each of adenoma (<5mm) & sessile serrated lesion (<5mm) were found; no other significant pathology that would be expected to be missed with IUS was encountered. Further, there were no cases of isolated proctitis found among IBD patients deemed suitable for IUS. In contrast, among IUS unsuitable patients, 4 malignancies, 19 cases of adenomatous polyps (6 cases of 5-10mm & 1 case of >10mm), & 8 new cases of IBD were diagnosed, supporting the proposed criteria.

Conclusion Using conservative criteria, almost 30% of endoscopies for IBD assessment or symptoms could have been performed as IUS instead, with a potential annual cost saving of >£400,000. No cases of significant non-inflammatory pathology would have been missed with IUS using the proposed criteria.

PMO-27 SWITCHING TO SUBCUTANEOUS VEDOLIZUMAB IN INFLAMMATORY BOWEL DISEASE DURING COVID-19 PANDEMIC – COUNTY DURHAM EXPERIENCE

^{1,2}Frances Maw, ¹Mei Yen Chan, ¹Susan Ritchie, ¹Victoria Fletcher, ¹Helen Dallal, ^{1,3}Anjan Dhar*. ¹Department of Gastroenterology, County Durham and Darlington Nhs Foundation Trust, Darlington, UK; ²Department of Clinical Pharmacy, Darlington Memorial Hospital, Darlington, UK; ³School of Health and Life Sciences, Teesside University, Middlesbrough, UK

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Introduction The COVID-19 pandemic resulted in the need for significant adaptations to an intravenous biologics infusion service. Patients were reluctant to come to a Biologics Infusion Unit in an acute hospital due to the fear of exposure to SARS-CoV-2 virus and also due to the UK governmental advice on strict isolation and shielding. Based on the VISIBLE-1 and -2 Study data, we decided to switch our IBD patients from IV Vedolizumab to SC vedolizumab in a phased manner. We report on our experience and short term outcomes.

Methods During the COVID-19 pandemic, we decided to switch patients with Ulcerative colitis and Crohn's disease from IV Vedolizumab to Subcutaneous Vedolizumab in a phased manner. In the first Phase (July – Sep 2020) all patients with Ulcerative colitis (UC) in clinical remission of their disease beyond 16 weeks of Vedolizumab treatment were invited to switch. In phase 2 (October –Dec 2020) additional UC and Crohn's Disease (CD) patients on maintenance were switched and in Phase 3, new patients with UC and CD entering the Vedolizumab treatment programme were included for IV induction followed by SC maintenance. 6 month outcomes were assessed for clinical response, faecal calprotectin, and for short term patient experience.

Results A total of 31 patients were switched in the 6 month period of COVID-19 adaptation. 19 patients had UC (13

pancolitis, 6 distal colitis) and 12 patients had CD (1 Crohn's colitis, 5 ileocolonic, 5 small bowel and 1 complex). Over the 6month period, 1 patient flared on SC Vedo and switched back to escalated IV, 1 developed abnormal LFTs and switched out of class. All remaining patients were doing well, and had mean SCAI score of 0, HBI score of 1. Mean FCP in UC patients was 197 ug/g (range 25-561), and in CD patients was 248ug/g (range 213-283). Patient experience indicated that all patients on SC Vedo felt that they were safer during the pandemic.

Conclusion A COVID-19 adaptation of managed switching of patients with ulcerative colitis and Crohn's disease from IV to SC Vedolizumab is safe and does not result in any adverse outcomes. Long term data on maintenance of remission and endoscopic healing is awaited.

PMO-28 EFFICACY OF SUBCUTANEOUS INFlixIMAB IN PERIANAL CROHN'S DISEASE

Philip J Smith*, Daniel Storey, Belle Gregg, Lisa Critchley, June Stenson, Ashley Bond, Alan Steel, Martyn Dibb, Paul Collins, Edmund Derbyshire, Christopher Probert, Sreedhar Subramanian. Royal Liverpool Hospital, Department of Gastroenterology, Liverpool University Hospitals Foundation NHS Trust, Liverpool, UK, Liverpool, UK

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Background A new subcutaneous (SC) formulation of infliximab has recently been approved for the management of inflammatory bowel diseases (IBD). In the registration clinical trial, the efficacy of SC IFX was comparable to intravenous (IV) IFX (1) but specific data regarding the efficacy of SC IFX in perianal Crohn's disease (pCD) is lacking. We aimed to investigate the efficacy of SC IFX in patients with pCD who were switched from IV IFX.

Methods We conducted a single centre observational, retrospective study of pCD patients who were maintained on IV IFX and switched to SC IFX. Elective switching was at the discretion of the treating physician. In patients with active pCD at treatment initiation, the success of SC IFX was defined by clinical success at 6 months assessed by the physician's judgment without additional medical or surgical treatment for pCD. In patients with inactive pCD, the pCD recurrence-free survival was calculated. Treatment persistence rates were calculated at the end of 6 months. Safety and adverse events of interest were recorded. Data was analysed using SPSS for Windows with p<0.05 being significant.

Results We included 18 patients with a mean age of 36 (SD 12) and a M:F ratio of 5:4. Eleven (61%) patients were on concomitant thiopurines with a mean 6-thioguanine level of 258 (SD 155). The majority (n=13, 72%) had an inter-sphincteric fistula, 1 patient had a supra-sphincteric fistula (5.6%) and 2 patients (11.1%) each had trans-sphincteric and extra-sphincteric fistulae respectively. None of the patients had active, draining fistulae at the time of switching and 1 patient had an examination under anaesthesia (EUA) in the 6 weeks prior to switch. The mean IFX level at baseline was 9.9 µg/ml (SD 4.1). Two patients (11.1%) had recurrence of symptoms after switching to SC IFX and required further antibiotic therapy and EUA. These two patients also switched back to IV IFX after a median of 2.25 months. The mean IFX levels at 3 and 6 months after switch were 15.6 µg/ml (SD 0.2) and 15.5 µg/ml (SD 1.4) respectively (P<0.01). The treatment