biosimilar IFX switch (Remicade® to Remsima® to Zessly®), in a real-life IBD cohort.

Methods A retrospective cohort study was carried out, and eligible patients were identified through an in-house database. All patients on treatment with Remsima® were eligible for the switch to Zessly®. The primary aim of the study was to assess the clinical outcomes (in terms of continuation of therapy, loss of response and achievement of remission allowing cessation of biologic therapy) between the two patient groups, over a six month period following their switch to Zessly®. Secondary outcomes measured were infusion reactions and rates of hospitalisation for an acute flare.

Results A total of 147 patients were eligible for and underwent the biosimilar-to-biosimilar switch; median age was 41 (IQR 28-56), 95 (64.6%) were male, and 107 (72.8%) had Crohn’s Disease. Of the total cohort, 96 (65.3%) were undergoing their first biosimilar switch (Remsima® to Zessly®), whereas 51 (34.7%) were undergoing their second biosimilar switch (Remicade® to Remsima® to Zessly®). In those with one versus two biologic switches, there were no differences seen in the number of patients being able to continue Zessly® (79.2% vs 80.4%, p=0.861), loss of response to Zessly® (11.5% vs 5.9%, p=0.273), or achievement of remission on Zessly® resulting in cessation of therapy (1.0% vs 0%, p=0.46%). None of the patients from either group experienced any infusion-related reactions. There was no difference in hospitalisation in the six months following biologic switch (3.1% vs 2.0%, p=0.680).

Conclusions This real-life, single centre, short-term evaluation demonstrated that switching between biosimilar IFX brands appears to be as safe and effective as switching from originator to biosimilar IFX. A larger randomised-controlled study would be needed to confirm both the safety and effectiveness of switching between multiple biosimilar brands to substantiate the results of this evaluation.

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Abstracts

**IBD DISK TOOL FOR EVALUATION OF PATIENT REPORTED OUTCOMES IN PATIENTS SUFFERING FROM RECURRENT POUCHITIS**

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**UK NATIONAL AUDIT ON DIAGNOSIS AND MANAGEMENT OF COLITIS IN PATIENTS WITH PRIMARY SCORING CHOLANGITIS**

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**Reprints**

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**PSC UK National Audit on Diagnosis and Management of Colitis in Patients with Primary Sclerosing Cholangitis**

Introduction The increased risk of colorectal cancer in patients with primary sclerosing cholangitis (PSC) and inflammatory bowel disease (IBD) justifies an enhanced surveillance strategy with annual colonoscopy and dye spray or protocol biopsies. As symptoms are frequently mild in PSC-IBD colitis can be missed unless colonoscopy and biopsies are undertaken at

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**UK NATIONAL AUDIT ON DIAGNOSIS AND MANAGEMENT OF COLITIS IN PATIENTS WITH PRIMARY SCORING CHOLANGITIS**

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Introduction The increased risk of colorectal cancer in patients with primary sclerosing cholangitis (PSC) and inflammatory bowel disease (IBD) justifies an enhanced surveillance strategy with annual colonoscopy and dye spray or protocol biopsies. As symptoms are frequently mild in PSC-IBD colitis can be missed unless colonoscopy and biopsies are undertaken at
diagnosis of PSC. We audited the colitis surveillance against audit standards published in the BSG and UK PSC guidelines.

Methods All UK PSC investigators were invited (March 2019-Jan 2021) to complete an electronic questionnaire encompassing demographics, diagnosis and bowel cancer surveillance data on each patient with PSC under the care of their service.

Results 1,795 patients across 30 centres (liver units n=1548, general gastroenterology units n=247) were included. Median age at diagnosis was 51 years and 56.4% were men.

Concurrent IBD was present in 1264 patients (70.4%) with 256 (20.3%) having had a colectomy. Where classified, colitis was present in 924/939 (98.4%) patients whereas isolated ileal disease was present in 15/939 patients. Pancolitis (Montreal classification E3) was the commonest disease distribution (673/939, 71.7%).

Most patients with IBD were followed up by an IBD specialist (n=616, 48.7%), 266 (21.1%) were followed by a general gastroenterologist, 236 (18.7%) by a hepatologist, whereas 15 (1.2%) patients were followed in a joint IBD/Hepatology clinic.

Among those with colitis without previous colectomy (n=743), 580 (78.1%) underwent annual colonoscopic surveillance; 30 (5.2%) with dye spray, 230 (39.7%) with biopsies and dye spray, and 252 (43.4%) with protocol biopsies alone.

Of those without documented IBD diagnosis, only 303/507 (59.7%) had this excluded by colonoscopy and biopsies.

Age<40 was associated with poorer compliance with colonoscopy surveillance. (P=0.023).

Conclusions IBD screening and colonic cancer surveillance is suboptimal in this large UK cohort of patients with PSC. This highlights the need for awareness of PSC-IBD management to address this unwarranted variation in care of people with PSC in the UK.

SAFETY AND EFFICACY OF USTEKINUMAB FOR CROHN’S DISEASE IN THE ELDERLY POPULATION

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Introduction The rising incidence of inflammatory bowel disease (IBD) worldwide and an ageing population has led to a marked increase in elderly IBD patients. Anti-tumour necrosis factor (TNF) agents are associated with an increased risk of serious infections and treatment discontinuation among elderly IBD patients; little is known about non anti-TNF biologics in this cohort. We aimed to examine safety and efficacy of ustekinumab in elderly Crohn’s disease (CD) patients.

Methods Patients ≥60 years old commencing ustekinumab for CD were included in this retrospective multi-centre cohort study. We gathered data on adverse events, Harvey Bradshaw Index (HBI) and steroid therapy. The primary outcome was serious infections, defined as requiring hospitalisation. Efficacy was assessed by serial HBI measurement and treatment persistence.

Results 70 patients were included, with a median age of 68 years (range 60-87), male:female ratio of 9:5 and median Charlson co-morbidity index of 4 (range 2-9). 44 (62.9%) had prior anti-TNF exposure and 15 (21.4%) previous vedolizumab. Median treatment duration was 12 months (range 2-48), with a total of 84 patient years. 31 patients (41.3%) had steroids at initiation and 33 (47.1%) required a later course of steroids.

7 patients (10%) had a combined 9 serious infections, of which 1 was life threatening requiring organ support. Incidence of serious infections was 0.107 per patient year. A further 18 had a combined 22 non-severe infections (Table 1). The overall infection rate was 0.42 per patient year. Charlson co-morbidity index was numerically higher in those developing severe infections (median 5, range 3-7 vs. median 4, range 2-9, P=NS). 3 patients developed a malignancy; non-Hodgkin’s lymphoma, melanoma and pancreatic cancer.

Mean HBI improved from baseline 8.13 to 4.64 at 6 months and 4.10 at last follow up (both P<0.0001). Treatment persistence rate was 61.4% (N=43) and 36 (51.4%) were steroid-free. Reasons for discontinuation were primary non-response (42%), adverse event (32%), secondary loss of response (10%), malignancy (10%) and lack of funding (5%).

Conclusion Ustekinumab was safe and effective in a cohort of elderly CD patients. Infections were mostly mild and did not result in therapy discontinuation. Risk of serious infection was very low at 0.107 per patient year of treatment.

COVID-19 IMPACT ON CARE AND PRESCRIBING FOR INFLAMMATORY BOWEL DISEASE: DATA FROM THE IBD REGISTRY

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Introduction The first wave of the COVID-19 pandemic saw a sharp rise in UK cases during March 2020. We analysed UK IBD Registry data to investigate changes in contacts and prescribing in the immediate post-COVID period to gain insights into the impact of the pandemic on IBD care.

Methods We aggregated quarterly data (Jan-Mar 2019 to Apr-Jun 2020), extracting counts of clinical events (outpatient contacts and biologics reviews), contact types (face-to-face, ‘F2F’; or telephone/virtual, ‘non-F2F’), new diagnoses and drug starts (oral steroids, further categorised as prednisolone and non-