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.

PMO-36 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–

Abstract PMO-36 Table 1 infection aetiology and severity

	Aetiology	Number of patients (%)
Severe	Pneumonia	3 (4.3)
	Line infection	2 (2.9)
	Covid-19	1 (1.4)
	Biliary	1 (1.4)
	Epididymo-orchitis	1 (1.4)
	Shingles	1 (1.4)
Non-severe	Lower respiratory tract	9 (12.9)
	Urinary	6 (8.6)
	Coryzal	4 (5.7)
	Pneumonia	1 (1.4)
	Diarrhoea	1 (1.4)
	Line infection	1 (1.4)
	Soft tissue	1 (1.4)

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.

PMO-37 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-

prednisolone; thiopurines; biologics). Rates are expressed as counts per 1,000 clinical events.

Results Comparing Apr-Jun 2020 (post-COVID) to Apr-Jun 2019 (pre-COVID): Total clinical event fell (9975 to 8208; -18%), with a sharp drop in F2F OPD (3436 to 1203; -65%) accompanied by a compensatory rise in non-F2F (1777 to 3161; +78%). Rate of new diagnoses fell (49 to 13 *per 1,000 events*; -74%). Prescription rates reduced sharply for thiopurines (26 to 5; -81%), with lesser reductions for biologics (89 to 55; -38%) and oral prednisolone (25 vs 20; -20%) but with a rise for non-prednisolone steroids (5 vs 8; +60%). No change in relative proportion of different biologic classes.

Conclusions Records of patient contacts were reduced in the immediate post-COVID period with a rapid shift from F2F to non-F2F. The drop in new patient records may reflect delayed pathways. Prescribing trends suggest a selective reduction in thiopurine and some shift from systemic to more topically-acting steroids. Longer term trends will be presented.

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PMO-38 CONCOMITANT 5-AMINOSALICYLATE USE IN INFLAMMATORY BOWEL DISEASE PATIENTS ON BIOLOGIC THERAPY: A PRELIMINARY COST ANALYSIS

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Introduction Despite the rapidly evolving therapeutic armamentarium for inflammatory bowel disease (IBD), 5-aminosalicylates (5-ASAs) are still widely utilised as induction therapy and in maintenance of remission. Emerging data advocating the withdrawal of 5-ASAs in patients receiving biologic therapy¹⁻⁴ presented an opportunity for us to evaluate local practice in honing a value-based healthcare model.

Methods IBD patients receiving biologic therapy from December 2019 to December 2020 were identified via the Blueteq High Cost Drugs system. A retrospective analysis was then carried out, aided by a pre-designed proforma. Data on patient demographics, IBD subtype, type of biologic therapy and concomitant 5-ASA use including the brand name, daily dose and subsequent annual cost were collected.

Results 382 patients were on biologic therapy over the 12-month period, consisting of 204 males (53.4%) and 178 females (46.6%). A significant proportion were treated for Crohn's disease (n=245, 64.1%), followed by ulcerative colitis (n=131, 34.3%) and IBD-unclassified (n=6, 1.6%). Adalimumab therapy was encountered in 151 cases (39.5%), Vedolizumab in 93 cases (24.3%), Infliximab in 79 cases (20.7%), Ustekinumab in 46 cases (12%), Tofacitinib in 9 cases (2.4%) and Golimumab in 4 cases (1.1%).

90 patients on biologic therapy were on concomitant 5-ASAs (23.6%). The vast majority suffered from ulcerative colitis (n=65, 72.2%), followed by Crohn's disease (n=23, 25.6%) and IBD-unclassified (n=2, 2.2%). The total annual cost of 5-ASA therapy in this cohort was estimated at £73000.

Conclusions In a pressing economic landscape, discontinuation of 5-ASAs on escalation to biologic therapy may yield significant cost savings which could be reinvested into other aspects of patient care in IBD. Rationalisation of treatment will also

address the issue of non-adherence due to polypharmacy and consequently lead to improved clinical outcomes.

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PMO-39 FACTORS INFLUENCING DELAYS IN BIOLOGIC INITIATION IN INFLAMMATORY BOWEL DISEASE

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Introduction Biologics have transformed the treatment landscape in inflammatory bowel disease (IBD). Biologic initiation a multi-step process often associated with delays. We aimed to describe factors affecting 'decision to needle' (D2N) time in a real-world IBD cohort, identifying barriers to efficient delivery of biologic therapy.

Methods This was a retrospective review of IBD patients commenced on biologic therapy between December 2018 and December 2019 at 2 large IBD centres. Inpatient biologic initiations were excluded. We recorded patient demographics, Harvey Bradshaw Index (HBI)/partial Mayo score (pMayo)/simple colitis activity index (SCCAI) and biochemical markers (faecal calprotectin [FC], C-reactive protein [CRP]). Dates were gathered on decision to treat, screening, blueteq approval and first dose. We used 21 days from decision to treat as a cut-off for determining D2N delay. Logistic regression examined associations between variables and D2N. Multivariate analysis was performed including variables with p < 0.1 from univariate analysis.

Results We included 204 patients (mean age 45 years; range 18-82 (Table 1)) and median disease duration of 6 years. Mean Charlson comorbidity index was 1 (range 0 -7). Adalimumab was initiated in 93 patients (46%), ustekinumab:44 (22%), vedolizumab:34 (17%), infliximab:32 (16%) and golimumab(1). Median D2N time was 44.5 days overall, for intravenous (IV) drugs (n=110) 39.5 days (range 1-264), and subcutaneous (SC) drugs (n= 94) 50 days (range 8-362). There were no significant associations in D2N time with age (p=0.24), gender (p=0.777), comorbidities (p=0.908), employment (p=0.478) or IBD diagnosis (p=0.739). SC initiation was significantly associated with D2N delay in comparison to IV initiation (p=0.004); OR 3.951 (CI 1.359 to 11.489 p= 0.016). Screening duration was significantly associated with D2N time on univariate (p=0.007), but not on multivariate analysis. Odds of D2N delay were lower with more severe baseline disease activity (OR 0.252, CI 0.080 to 0.790 p=0.018) and baseline CRP>5 (p=0.008).