PTU-074 OPTIMISING CROHN'S DISEASE TREATMENT BASED ON THE RUTGEERTS' SCORE 12 MONTHS AFTER ILEO-COLIC RESECTION IMPROVES CLINICAL OUTCOMES AT 3 YEARS COMPARED TO STANDARD PRACTICE

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Introduction Clinical relapse of Crohn's Disease (CD) occurs in 20–30% of patients at 1 year following intestinal resection, increasing by 10% per year without treatment.[1] Work by Rutgeerts' *et al*.[2] within a tertiary centre supports the practice of ileo-colonoscopy 12 months post-resection to assess endoluminal recurrence, however the validity of this practice is unclear in a general hospital setting. The European Crohn's and Colitis Organisation (ECCO) recommend the use of the Rutgeerts' score at 12 months following ileo-colic resection to guide treatment decisions. This is not supported by the current BSG guidelines. The aim of this study is to assess the utility of the 12-month Rutgeerts' score to improve clinical outcomes at 3 years following ileo-colic resection.

Method Prospective analysis of 50 patients with CD requiring ileo-colic resection and primary anastomosis in a District General Hospital (DGH) between 2005–2011. Thirty eight of fifty patients underwent endoscopic appraisal of the pre-anastomotic ileum by a single expert observer (AWH) 12 months following resection. Patients with high risk lesions (≥ i3) were offered a step-up in treatment. Patients with low risk-lesions (i0-i1) had their treatment stopped completely or continued on their current regimen. Clinical outcomes at 3 years were compared between these 38 patients and 12 of 50 patients who refused 12 month endoscopic appraisal and received standard care. Fisher's Exact Test was used to compare groups.

Results Thirty six of thirty eight patients whose treatment was guided by 12 month endoscopic appraisal remained in steroid and symptom-free remission at 3 years. In comparison 5 of 12 patients receiving standard care suffered recurrence. The difference in clinical outcomes at 3 years between groups was significant (P = 0.0059, OR 12.86 (95% CI 2.064–80.09); Fisher's Exact Test). There was trend towards higher Rutgeerts' scores (≥ i3, $n = 20$) being associated with a higher risk of disease relapse at 3 years as compared to low Rutgeerts' scores (i0-i1, $n = 17$) but this did not reach statistical significance (P = 0.0606, OR 10.00 (95% CI 0.993–100.7)).

Conclusion In comparison with standard practice, optimising treatment paradigms guided by the Rutgeerts' score 12 months following ileo-colic resection improves clinical outcomes at 3 years in DGH practice.

Disclosure of interest None Declared.

REFERENCES

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2 Rutgeerts P, *et al*. *Gastroenterology* 1990;**99**(4):956–63

PTU-075 UTILITY OF MEASURING ADALIMUMAB DRUG LEVELS AND ANTI-DRUG ANTIBODIES IN CLINICAL PRACTICE: A LARGE IBD REFERRAL CENTRE EXPERIENCE

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Introduction The development of adalimumab (Ada) drug and antibody testing has allowed a personalised approach to complex inflammatory bowel disease (IBD) treatment. We present our 2-year experience at a tertiary IBD referral centre.

Method All Ada drug and antibody levels carried out at Guy's and St. Thomas' Hospital were analysed. The indications for carrying out levels, the subsequent changes in management and the long-term patient outcomes were evaluated.

Results 143 levels were carried out on 105 patients from October 2012 to October 2014. The median value was 5 μg/ml (range 0- >8 μg/ml).

74 levels (52%) were done on patients who had symptoms indicative of loss of response (LOR). 13 patients, all with no detectable antibodies had their dose increased, 10 of these patients had low levels (<5.0 μg/ml), 6 of whom responded. 1 patient had high levels of antibodies and therefore Ada was stopped. A further 8 patients had their Ada stopped and were referred for surgery or switched to infliximab.

5 levels (4%) were measured after induction (week 12–14) resulting in 1 patient with a low level (3.5 μg/ml) and clinically active disease escalating to 40 mg weekly with good response.

38 levels (27%) were done as part of annual reassessment resulting in only 2 changes in management: 1 patient had dose de-escalation from weekly to every other week due to levels >8 μg/ml and the other had their dose increased to weekly due to low levels (1.4 μg/ml).

The remaining levels were done to aid decisions regarding discontinuation of concomitant immunosuppressant (1%), dose de-escalation (11%) and discontinuation of Ada (2%), or to assess response to dose escalation (3%).

39 (27%) of the levels were sub therapeutic in 32 patients. In the 30 patients that did not have antibodies to Ada, 13 patients underwent dose escalation. Ada antibodies were detected in only 2 patients (1%). 1 patient, who had previously had a reaction to infliximab continued on Ada with minimal improvement in her symptoms. The other patient was lost to follow-up shortly after the levels were tested.

Conclusion Measuring Ada levels in our cohort resulted in a change of management for 25% of patients, a percentage similar to that seen for infliximab. The majority of patients with LOR who had sub therapeutic levels responded well to Ada dose escalation. Antidrug antibody development is infrequent in our cohort of patients.

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PTU-076 IS FAECAL CALPROTECTIN (FC) A RELIABLE MARKER OF ISOLATED SMALL BOWEL CROHN'S DISEASE (CD) ACTIVITY?

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Introduction The measurement of FC is considered an important investigation in both the diagnosis and assessment of activity in CD. However, it's accuracy in isolated small bowel disease (Montreal classification L1) compared to colonic (L2) and ileocolonic (L3) remains undetermined. This study aims to establish