mucosal Crohn’s Disease (CD) lesions in the proximal small bowel (SB). How-
over, the frequency and the possible clinical relevance of these findings in
CD is unknown. Aim. Primary endpoint was to assess, in a prospective longi-
tudinal study, the clinical relevance of proximal SB lesions detected by CE in
CD and also the possible correlation of these findings with proximal SB le-
usions detected by CE and small intestine contrast ultrasonography
(SICUS).

Methods: 40 CD patients (22 F, median age 35 yrs, range 19-76) were en-
rolled. NSAIDs use was reported by 7/40 (18%) and smoking habits included:
smokers 16/40 (40%), ex-smokers 5/40 (12%), no smokers 19/40 (48%). Before
CE, in each patient the following parameters were recorded: clinical activity
(CDAI), presence of epigastric pain, laboratory tests (Hb, serum iron, fer-
ritin), and CRP. CE was performed by using Given SB-CE, while SICUS after 375 ml
PEG ingestion performed within 3 months. Findings compatible with CD le-
sions were considered, at CE, erosions, aphthoid or deep ulcers, strictures or
stenosis and, at SICUS, an increased bowel wall thickness (>3 mm). Jejunal and
proximal jejunal lesions were considered as proximal SB lesions.

Results: CE detected previously unknown proximal SB lesions in 18/40 (45%) CD
pts (median age 39 yrs, range 20-65), including aphthoid ulcers in 15/18
(83%), deep ulcer in 3/18 (17%), with the presence of stricture was de-
tected in only 1 pt. Among pts with proximal SB lesions, 3/18 (17%) had epi-
gastric pain, 8/18 (44%) were smokers, 4/18 (22%) NSAIDs users, while 4/18
(22%) showed iron deficiency anemia (IDA). No correlation was observed be-
tween CE findings and clinical parameters including: epigastric pain, age,
smoking habits, NSAIDs use, IDA (p=n.s. for all). SICUS detected proximal SB
lesions in 3/34 (9%) pts, detected also by CE in 3/3 pts. In 6/40 pts (15%) SICUS
was not performed. Considering patients performing both examina-
tions, no correlation between CE and SICUS was observed for proximal SB
lesions (x2 = 0.53; p= 0.46). The only strictured identified by CE was also visu-
alized by SICUS. Findings compatible with CD lesions in the distal ileum were
detected by CE in 38/40 (95%) pts, and by SICUS in 30/34 (88%) pts, and both in
31/34 pts (91%).

Conclusions: CE is a non invasive technique allowing the visualization of mi-
nor proximal SB lesions in CD pts. Although no significant clinical relevance
may be associated with these findings, the use of CE in CD may add clues in
defining the proper extent of the lesions.

P113 INTERFERON-BETA FOR ULCERATIVE COLITIS: LONG-STANDING CLINICAL RESPONSES AND REMISSEIONS IN ACTIVE DISEASE

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Background: Interleukin-13 (IL-13) has been identified as a candidate ef-
fector cytokine driving inflammation in human ulcerative colitis (Fuss et al.
2004). Since type I interferons have been shown to inhibit IL-13 production and
to block its signaling (inducing SOCS1 to inhibit STAT6 activation), we
and to block its signaling (inducing SOCS1 to inhibit STAT6 activation), we

Interferon-beta is able to induce clinical responses and re-
maintain remission. Interferon-beta is a successful novel therapy for active ulcerative colitis that
gained with retreatment. INF β is well tolerated by patients with active UC.
Interferon-beta is a successful novel therapy for active ulcerative colitis that
holds promise for induction and maintenance of remission.

P114 VSL#3 AS MAINTENANCE THERAPY FOR CHRONIC POUCHITIS: EXPERIENCE IN UK CLINICAL PRACTICE

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Introduction: Pouchitis is common following restorative proctocolectomy for
ulcerative colitis. The probiotic VSL#3 is now available in UK pharmacies and
has been reported to be effective in maintaining remission in 85% of patients
with chronic relapsing pouchitis (CRP) who achieved symptomatic and en-
dooscopic remission following antibiotics (pouch disease activity index (PDAI)
<3). Results in clinical practice in the USA have been disappointing. The trial
dose given was 6g of 300 billion bacteria (BB) per gram (1800 BB), however
becaue VSL#3 available commercially is 450 BB per gram in 3g sachets (1
sachet =1350 BB) the trial dose cannot be given. Excess VSL#3 is known to cause diarrhoea which may be important in clinical practice. We report our clinical experience.

Method: Patients with symptomatic CRP without prior history of NSAID use had a flexible panceooscopy before following 4 weeks treatment with ciprofloxacin and metronidazole. The PDAI was calculated. Those with a clinical PDAI ≤3 were treated with VSL#3. 7 patients received VSL#3 1350
BB (3g) per day and 8 patients received VSL#3 2700 BB. 3 patients received both doses.

Results: 25 subjects were studied. 12 (48%) had a reduction of PDAI <3 fol-
lowing antibiotic treatment. 13 of 25 (60%) entered symptomatic remission but had a PDAI >3 (no mucosal healing) following antibiotic treatment. 2 sub-
jects (13%) maintained remission with VSL#3 2700 BB at 3 months following antibiotic treatment.

Conclusion: VSL#3 has only been shown in previous work to be effective in patients who achieve endoscopic and clinical remission (clinical PDAI ≤3) with antibiotics. In this study all achieved clinical remission following antibi-
otics however, only 12 (48%) had concurrent endoscopic remission and were thus suitable for treatment with VSL#3. Of these, 2 maintained remission at 3 months, both were treated with VSL#3 2700 BB (6g). The remainder all relapsed ≤2 months.

Given the low rate of mucosal healing following antibiotic we recommend pancecooscopy should be performed in all patients before considering treat-
ment with VSL#3.

Our results and the experience others suggest that VSL#3 when used in clinical practice may be less effective than originally reported, but should be given at a dose of 6g VSL#3 (2700 BB) per day.

P115 ASSESSMENT OF CROHN’S DISEASE RECURRENCE AFTER ILEO-COLONIC RESECTION: CORRELATION BETWEEN ENDOSCOPIC SCORE AND SONOGRAPHIC FINDINGS

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Background: ileocolonic sclerosis (IC) is the gold standard for assessing Crohn’s Disease (CD) recurrence. Small intestine contrast ultrasonography (SICUS) is able to visualize the bowel wall and extraluminal lesions in small bowel CD, while IC shows mucosal lesions. Whether SICUS and IC provide comparable findings in assessing CD recurrence is unknown.

Aims: To investigate the sensitivity, specificity and accuracy of SICUS in as-
sessing CD recurrence, when using IC as a gold standard. We also aimed to eval-
uate the possible correlation between the bowel wall thickness mea-
sured by SICUS and the endoscopic score of recurrence.

Methods: 68 pts (33 M, median age 44.5 yrs, range 17-75) with ileo-colonic resection for CD requiring IC were enrolled. All 68 pts underwent both IC and
SICUS within 6 mths: 3 pts repeated the 2 procedures. Recurrence was as-
essed by IC performed by the same endoscopist using the Rutgeerts’ score. IC
SICUS was performed after PEG ingestion by the same sonologist, unaware
of the endoscopic findings. Findings compatible with recurrence included:
increased bowel wall thickness (>3 mm), bowel dilatation (lumen diameter
>2.5 cm) or stricture (lumen diameter <1 cm). The sensitivity, specificity,
accuracy of SICUS and the correlation between the 2 techniques in assessing CD recurrence was calculated.

Results: Endoscopy detected recurrence in 34/71 (48%) cases. SICUS de-
tected findings compatible with recurrence in 64/71 (90%) cases (6 N, 5 F, 1 TN, 52 TP). SICUS showed a 91% sensitivity , 17% specificity and 85% ac-
curacy for detecting CD recurrence. When assessing the correlation between