had not increased after the approval; 37 (2006), 37 (2007) and 28 (2008). AZA or 6-MP had been stopped in 36 patients (30 due to the recommendations and 6 due to tolerance). The withdrawal did not affect the disease activity in 25 patients whereas in 9 the activity had increased moderately, in 2 significantly. Only one of 36 patients had restarted AZA while 7 patients had been started on methotrexate.

Conclusion: The recommendations to withdraw AZA and 6-MP had very little negative effect on the disease activity. The guidelines for the usage of IFX in paediatric patients were implemented to a high degree.

P108 INTRAVENOUS IRON SUCROSE IN CHILDREN WITH INFLAMMATORY BOWEL DISEASES

E. Toporowska-Kowalska1 *, B. Gebora-Kowalska1, A. Plociek1, J. Kudzin1, E. Biernacka1, K. Wąsowska-Królikowska1. 1Department of Pediatric Allergology, Gastroenterology and Nutrition, Medical University of Lodz, Lodz, Poland

Anemia is a common extraintestinal manifestation of inflammatory bowel diseases (IBD). Several types of anemia are associated with IBD, but iron deficiency anemia accounts for the majority of cases.

The aim of the study was to evaluate the effectiveness and tolerability of treatment with iron sucrose in children with IBD with concomitant iron deficiency anemia or iron deficiency alone.

Materials and Methods: Intravenous iron supplementation was performed in 7 children with IBD: Crohn’s disease (CD, n=2) and ulcerative colitis (UC, n=5). Intestinal disease activity was moderate in 4 and severe in 3 children. All children fulfilled the criteria for iron deficiency (serum ferritin <100 µg/L, 3 of them had anemia according to WHO). The indications for iron sucrose were poor response and/or intolerance to oral iron. Patients received 7 mg/kg/week of iron sucrose (Venofer) intravenously up to calculated cumulative dose. Clinical assessment was performed on day 1 and 10.

Results: All children responded to intravenous iron therapy by means of Hb, ferrum and ferritin increase. The average increase in hemoglobin concentration was 0.7 g/dL. Treatment with iron sucrose led to median rise of ferrum 34.4 µg/dL and ferritin 133 µg/L. No side-effects were observed after intravenous administration of iron in patients.

Conclusion: Intravenous supplementation is a well tolerated route of iron administration in children with IBD and is effective in children with inappropriate response to oral iron.

P109 EFFICACY AND SAFETY OF INFlixIMAB THERAPY IN CHILDREN WITH INFLAMMATORY BOWEL DISEASES - OWN EXPERIENCE

E. Toporowska-Kowalska1 *, B. Gebora-Kowalska1, A. Plociek1, K. Wąsowska-Królikowska1. 1Department of Pediatric Allergology, Gastroenterology and Nutrition, Medical University of Lodz, Lodz, Poland

Infliximab (INF) was registered for inflammatory bowel diseases treatment in children in 2004. Data indicate for its high efficacy (remission 50-70%). Aim: Evaluation of efficacy and safety of INF therapy in children with Crohn disease (CD) and ulcerative colitis (UC).

Materials and Methods: Analysis included 8 children qualified to biological therapy (medium age-14.7 years): 4 with severe CD (PCDIA 67-72); 4 with UC (9-10 points in Truelove-Witts scale). 2 patients with CD had active fistulas. INF was given in the typical scheme and dose. Examinations were performed every 2 months, efficacy of therapy was evaluated at week 26 and 52.

Results: Time from diagnosis to introducing of INF ranged from 4 to 96 months (average 31, median 28). Totally 56 infusions of INF was administered during the period of 2 to 58 weeks (average 41; median 52). Concomitantly patients were treated with azathioprin. After 6 months remission achieved 5 patients (drop off PCDIA average 48 points; Truelove-Witts <4). 2 patients with UC were qualified to colectomy. Fistula closed in 1 child, partially in 1. Colonoscopy after 52 weeks of INF treatment revealed mucosal healing in 4 patients with pseudopolyps formation in 2 cases. In 4/5 patients GCs were discontinued after 9 weeks, 1 child remains on small dose. No side effects during INF infusions were observed, except of one episode of hyperglycemia.

Conclusion: 1). INF therapy enables to achieve clinical remission and mucosal healing in children with severe CD and UC, unresponsive to conventional treatment. 2). The infusions of INF are well tolerated in children.

P111 BIOLOGICAL THERAPY FOR PAEDIATRIC IBD IN SCOTLAND 1/00–12/08: A NATIONWIDE ‘REAL LIFE’ EXPERIENCE

D.C. Wilson1 *, M.L. Wilson 1, N. Basheer 1, A. Jamison 2, D. Goudie 3, G. Mahdi4, R.K. Russell5. 1Child Life and Health, University of Edinburgh, Edinburgh; 2Paediatric Gastroenterology, Royal Hospital for Sick Children, Glasgow; 3Paediatrics, Raigmore Hospital, Inverness; 4Paediatric Gastroenterology, Royal Aberdeen Children's Hospital, Aberdeen, United Kingdom

Background and Objective: Biologicals are increasingly used for paediatric IBD (PIBD), yet the evidence base is limited and there are safety concerns. We evaluated clinical pattern of usage and safety using a Scottish national framework.

Methods: An audit of use of the biologicals infliximab (IFX) and adalimumab (ADA) for treatment of PIBD (aged <18 years of age) from 1/1/99 to 31/12/08 in Scottish PIBD units.

Results: 92 children of median (IQR) age of 14.2 (12.1–15.7) years had IFX and/or ADA; 41 were female 83 had Crohn’s disease (CD), 9 had ulcerative colitis or indeterminate colitis. 15 (16%) had 2 biologicals; total follow up from 1st biological was 174.2 patient years. 90 children (81 CD) had IFX, with a median (range) of 4 (1–25) infusions. 43 entered remission, 33 responded, and 14 had no response. 41 had maintenance with median (range) 5 (1–19) doses. 11 of 41 required escalation of therapy. There were 34 adverse events with 5 SAE. 13 proceeded to ADA. 15 children (all CD) had ADA, with a median (range) of 20 (4–38) doses. 8 entered remission, 6 responded, and 1 had no response. All proceeded to maintenance and 6 required escalation of therapy. None had reactions leading to discontinuation. 2 had SAE, with no deaths.

Conclusion: Biologicals are effective in severe IBD but there are safety issues and significant need for dose escalation and multiple biologicals.