was better in patients with extensive colitis (E3) than left-side colitis (E2) (p < 0.05).

Conclusions: Infliximab therapy is effective for long term clinical remission and mucosal healing in patients with steroid-dependent UC, but an important number of patients need dose intensification of IFX. Results seem to be better in extensive colitis than in left-side colitis.

P109
Factors associated with failing of enteral nutrition in treatment of active paediatric Crohn’s disease

Objective: According to present guidelines [1], enteral nutrition could be the first therapeutic choice for the treatment of active disease in paediatric patients with Crohn’s disease (CD). EN induces remission, corrects malnutrition which is common in children with CD, and has better safety profile compared to steroids. However, data are scarce, and more studies are needed [2]. The aim of our study is, therefore, to investigate risk factors associated with failing of EN in paediatric patients with CD.

Methods: Data of all newly diagnosed CD patients (n = 47) treated in Children’s Hospital Zagreb from 1997 to 2007 were retrospectively analyzed (27 male and 20 female, age range 9–17.8 years). As a first line therapy for remission induction, EN was introduced in 30 (63.8%) of all treated patients. EN consisted of polymeric formula, given exclusively for 5–6 weeks. In all of the patients, either mesalamine (N = 8; 26.7%) or azathioprine (N = 8; 26.7%) or both (N = 16; 47.7%) were concomitantly introduced with the aim of maintaining the remission.

Results: Remission was achieved in 21 patients (70%) treated with EN. Once established, duration of remission varied from 4 months to 5 years (mean 17.6 mo). To explore the risk factors for failing of EN, patients were divided in two groups: group A – patients in which treatment with EN was successful and group B – patients who failed EN. Group A and B differed in: (a) Location of disease: ileocolonic disease was present in 100% (group B) vs 28.57 % (group A) of patients. Disease location for other group A patients was: ileocecal (61.9%) and ileal disease (group B) vs 28.57 % (group A) of patients. There were no differences in respect to: (a) Duration of illness (6 mo vs 6 mo); and (b) Age at diagnosis (mean 13.8 y vs 13.8 y).

Conclusions: Predominantly colonic disease was significantly more common in children with CD who failed to achieve remission on EN, while perianal disease and the involvement of upper GI tract were associated with a good therapeutic response to EN.

Reference(s)

P110
Multifocal motor neuropathy with conduction block related to infliximab in Crohn’s disease
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Introduction and Objective: anti-TNF therapy is an important treatment for moderate to severe cases of Crohn’s disease (CD). Infliximab (IFX) is a chimeric antibody which binds anti-TNF-alpha, leading to apoptosis and reduction of tissue inflammation. Adverse neurologic events due to this therapy are described, mainly optic neuritis and multiple sclerosis. Peripheral neurologic events secondary to IFX are rare. The objective of this report is a description of a case of multifocal motor neuropathy with conduction block in a CD patient, secondary to IFX infusion.

Case report: this is a report of a 64-year-old female, with a diagnosis of ileal and perianal CD for 6 years, who was treated with corticosteroids and azathioprine, without response. IFX induction therapy was administered in weeks 0, 2 and 6, with complete remission. After week 24, the patient presented with neurologic peripheral motor symptoms, in right ulnar and left posterior tibial territories. An electrophysiological study revealed conduction blocks in these nerves. Despite complete remission, IFX therapy was interrupted and partial improvement was observed after 8 weeks. The patient is in observation, and IV immunoglobulin may be infused in the next months, according to the neurology unit.

Conclusions: neurological events after IFX infusions are rare. Patients in continuous treatment must be monitored, and if any motor symptoms occur, should be referred to neurology for adequate investigation. Electrophysiological studies can confirm the diagnosis. IFX interruption is mandatory, and symptoms usually improve after a few weeks. Refractory cases should be treated with IV immunoglobulin.

P111
Incidence, risk factors and clinical course of gastrointestinal intolerance in inflammatory bowel disease patients treated with azathioprine: the role of TPMT
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Introduction: Azathioprine (AZA) and 6 mercaptopurine (MP) are effective in inflammatory bowel disease (IBD). One of the most frequent adverse effect that requires discontinuation of the drug is the gastrointestinal intolerance. The use of MP in patients previously intolerant to AZA may be considered in order to optimize the treatment.

Aims: to evaluate the incidence of gastrointestinal intolerance in AZA-treated patients, to assess the clinical factors associated with its appearance and to describe in a prospective cohort the utility of MP in this setting.

Materials and Methods: We included prospectively and consecutively all inflammatory bowel disease patients who received thiopurines. All patients had thiopurine methyltransferase (TPMT) activity levels previously to initiate thiopurines. All patients were treated with AZA according to the same protocol. If gastrointestinal intolerance appeared, we tried the reintroduction of AZA in low doses. When gastrointestinal intolerance appeared again, AZA was stopped and we introduced MP. We collected the cause of AZA-therapy stop, length of time in which adverse effects appeared, concomitant medication and outcome of AZA and MP therapy.

Results: Ninety two patients with IBD were included (58 Crohn Disease and 24 Ulcerative Colitis). The mean age was 36.8 years (SD 10.97). Mean TPMT value was 19.65 (SD 4.6) U/mL (range 6.6–35.7). Adverse effects were reported in 58 patients (63%) after a mean of 3.42 months, the most frequent were gastrointestinal intolerance (33%) and myelotoxicity (9%). Twenty five patients discontinued treatment due to size effects after a mean of 1.5 months (range 0.36 to 6.51 months). Gastrointestinal intolerance appeared after a mean of 2.1 months (range 0.4–12). Factors associated to gastrointestinal intolerance were female sex OR 2.83, 95%CI (1.29–6.2), level of TPMT value (P = 0.04) and concomitant use of infliximab OR 5.8, 95%CI (1.1–32). Fifteen of the 30 patients tolerated the reintroduction of AZA, the others discontinued the treatment. The variables associated with AZA withdrawal were TPMT levels (P = 0.04) and the concomitant use of 5-aminosalicylic acid.