the normative values compared to 85% in NF pts (p = 0.049). No differences were found in daily physical activity between F pts and NF pts.

Conclusions: Physical fitness in IBD patients is impaired compared to healthy controls and particularly in fatigued patients whereas their activity level is normal. This suggests that fatigued patients might benefit from individualized fitness programs in order to lower the fatigue burden.

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How frequent are conversions of tuberculosis (TBC) screening tests among inflammatory bowel disease (IBD) patients under anti-TNF treatment?

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Background: Tuberculosis (TBC) reactivation can lead to severe complications in patients treated with anti-TNF. The rate of conversion of tuberculosis screening tests among IBD patients under these drugs is not well known. The usefulness of repeating TBC screening tests in IBD patients under anti-TNF has not been established.

Our aim was to know the PPD conversion rate in IBD patients under anti-TNF therapy. Aim: to evaluate the correlation between PPD and Quantiferon® test in these patients.

Methods: Cross-sectional study in IBD patients under anti-TNF treatment during at least 12 months. In all cases the evaluations recommended for the screening of latent TBC infection prior to the initiation of the anti-TNF drug had been negative. A blood sample was obtained from each patient to perform the Quantiferon-TB Gold In-tube (Cellestis®) and, after that, 2 units of PPD following the Mantoux intradermal method were administered; the skin reaction was evaluated 72 h later. PPD conversion was defined as skin induration ≥5 mm.

Results: 67 patients were included (mean age 41±12 years, 55% women). The booster of the Mantoux had been performed in 67% of patients (who were under immunomodulators) before the initiation of anti-TNF drugs. At the time of the inclusion in this study, the median duration of anti-TNF treatment was 39 months (IQR 21–55), 44 patients on infliximab, 23 on adalimumab, 19% of the patients were receiving an intensified dose, 6% with methotrexate and no patient was on steroids. There was history of previous BCG vaccination in 9% of the patients, risk of exposure at work in 6%, and travel to areas of high prevalence in 1.5%. The cumulative incidence of PPD conversion was 3% (n = 2), and the incidence rate of PPD conversion was 0.9% per patient-years of treatment with anti-TNF drugs. In the two patients with positive skin test, the chest x-ray was normal and they did not have symptoms suggestive of TBC. All Quantiferon tests but one (a patient with an indeterminate result and a negative PPD) were negative. Chemoprophylaxis with isoniazid was administered to the patients with positive PPD.

Conclusions: The incidence rate of conversion of tuberculosis screening tests among IBD patients under anti-TNF treatment seems to be lower than that previously reported. These conversions were diagnosed based on a positive PPD, while Quantiferon was negative in all of them.

P168
Long-term outcome of fistulizing Crohn’s disease treated with infliximab – a 12 years follow up study

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Background: Fistulizing Crohn’s disease is a more aggressive phenotype of Crohn’s disease. In 1999 the introduction of infliximab (IFX) was performed for treatment of this disease. The aim of this study was to study the incidence of fistulizing Crohn’s disease in the IFX era and study the long term clinical outcome.

Methods: Registration of Crohn’s fistula was done by searching from the data files at the University Hospital of North Norway from 1999 to 2011; the patients were identified and outcomes were extracted from the patient records. IFX was given as induction therapy until remission (closure and/or fistula without inflammation), retreatment was given if relapse, and patients who did not obtain remission were offered a combined IFX and surgical treatment (duo therapy).

Results: 50 patients were diagnosed fistulizing Crohn’s disease. An annual incidence of 6/year was observed in the period of 1999–2004 and then the incidence was gradually decreased to 1/year during the observation period. Complete data of long term registration was obtained in 32 patients [14 females/18 males, mean age 31 (range 24–41)]. Perianal fistula was observed in 71%. The total observation time was 61 months (46–76 (95% CI), time with active fistula was 13 months (1–24), in remission 49 months (33–64), total time of remission was 82% (67–97), and finally the number of induction therapies was 1.6 (1.3–1.8). IFX induced remission in 23/32 (71%). Among those 16 (50%) had no relapse after the last induction treatment including 9/32 (28%) with only one induction therapy. In 9/32 (28%) there was a need for duo therapy and additional remission without later relapse was registered in 4/32 (13%). The IFX mono therapy and duo therapy induced a total remission without relapse in 20/32 (71%) patients.

Conclusions: Treatment of fistulizing Crohn’s disease with IFX is Treatment of fistulizing Crohn’s disease with IFX is effective for short and long term. There is an apparent decreasing incidence of newly discovered fistulizing Crohn’s disease since the start of IFX treatment in 1999.

P169
Comparison of Crohn’s disease and intestinal tuberculosis by clinical, laboratory, endoscopic, radiologic and histologic parameters

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Background: In this retrospective study, to we compared clinical, laboratory, endoscopic and histologic findings of patients with Crohn’s disease (CD) and gastrointestinal tuberculosis (GI-TB).

Methods: Between December 1999 and September 2011, 20 patients have been diagnosed as GI-TB and 537 cases as CD. GI-TB was diagnosed either by stool cultures (n = 10) or endoscopic biopsy specimen cultures (n = 10) which were M.tuberculosis. All GI-TB cases were also confirmed by post treatment colonoscopies. We selected 40 CD patients for comparison, by including the patient before and after each GI-TB on the registration list. We surveyed the charts and
Compared the clinical, endoscopic, radiologic and histological findings of CD and GI-TB patients.

**Results:** Gastrointestinal symptoms were similar in the two groups as well as endoscopic and radiological findings. Although all patients presented with prominent intestinal symptoms, and diagnosed initially as GI-TB, radiologic examination revealed some findings of pulmonary tuberculosis in 45% (9/20) of the patients. Six of them had caverns and 3 had paranchimal infiltrations in the chest CT’s. This has not been proved in none of the CD cases. In a binary logistic regression model we found that fever, perforation, granuloma and high CRP levels were important to distinguish GI-TB from CD (Tables 1, 2).

**Conclusions:** GI-TB is indistinguishable from CD regarding endoscopic and radiological findings. Nearly half of GI-TB patients may also have pulmonary TB in a country with a high TB prevalence. Suspicion of GI-TB with or without pulmonary symptoms may rationalise the thorax CT examination before beginning immunosuppressive therapy. In contrast to common belief, non-caseating granuloma in endoscopic mucosal biopsies are more suggestive of GI-TB (85%) rather than CD (10%).

**P170**

Paediatric inflammatory bowel disease in Greece: 30 years experience of a single center

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**Background:** During the last 30 years, significant advances have been made in the care of children with inflammatory bowel disease (IBD). In this study we aimed to describe trends in the clinical presentation, management and outcomes in children with IBD in Greece during the last three decades.

**Methods:** The medical records of children with IBD referred to one paediatric gastroenterology unit from January 1981 to August 2011 were reviewed retrospectively.

**Results:** 483 children with IBD (50.2% male) with a mean age at diagnosis of 9.6 years (range 6m-18y) were included. Ulcerative colitis (UC) was diagnosed in 267 (55.2%), Crohn’s disease (CD) in 167 (34.5%) and IBD unclassified (IBDU) in 49 (10.1%). Children diagnosed with UC and IBDU were younger than those with CD (mean age at diagnosis 9.2y and 8.9y vs 10.5y, p < 0.01 and p = 0.028 respectively). The commonest presenting symptoms were bloody stools (81.3%) and diarrhoea (61.5%). Extraintestinal symptoms were more common in children with CD compared to those with UC (fever 32.3% vs 8.9% p < 0.01, arthritis 12.0% vs 1.5% p < 0.01, weight loss 33.1% vs 17.3% p < 0.01, failure to thrive 10.5% vs 3.7% p = 0.016, anemia 32.2% vs 18.7% p = 0.021). Most of the patients received 5ASA (96.6%) and steroids (77.0%), about half (50.2%) were treated with thiopurines and 14% with biological agents. Steroids and immunomodulators were used more often for the treatment of patients with CD in comparison to those with UC (steroids 94.3% vs 68.8% p < 0.01, thiopurines 76.5% vs 35.5% p < 0.01, biological agents 31.9% vs 3.0% p < 0.01). Ten percent of the children with IBD underwent surgical intervention. In order to assess temporal trends in paediatric IBD, the cohort was divided in three subgroups according to the date of diagnosis; Group A: 1981–1989, Group B: 1990–1999 and Group C: 2000–August 2011. During the last two decades a significant increase of CD (Group A 18.5% Group B 23.8% Group C 48.8% p < 0.01) compared to first decade with parallel decrease of UC (Group A 79.6% Group B 71.9% Group C 33.2% p < 0.001) was observed. A significant decrease of mean age at diagnosis in CD patients during the last decade Group A (11.4y) and Group C (9.9y) p = 0.043 was noticed.

**Conclusions:** More than half of the children with IBD needed treatment with steroids and immunomodulators, a fact indicating the severity of the disease. Patients with UC and IBDU are younger at diagnosis than children with CD. A significant increase of CD with parallel decrease of UC during the last decade in Greece was found.