Clinical Institute. Among them 237 patients had diarrhea: ulcerative colitis (UC) 116 patients, Crohn’s disease (CD) 38, chronic pancreatitis (CP) 58, others 26 (IBS, colic disease, colon cancer). All UC and CD patients received AB in the past three months. Other patients were not treated with AB. Clostridium difficile toxins were detected in 93 patients (39%): in UC group 37% (43 pts), in CD group 31.5% (12 pts), in CP group 36% (21 pts), in others 65% (17 pts). In all patients, after taking vancomycin or metronidazole diarrhea disappeared or greatly diminished in intensity.

Conclusions: Thus, in patients of gastroenterology department a high frequency of diarrhea associated with CD-I (39%) not only due to AB was observed. This fact usually not taken into account when examining patients have pathogenetic mechanisms of diarrhea in the primary disease. We believe that the detection of Clostridium difficile toxins must be mandatory included in the algorithm of examination of patients with diarrhea regardless of the primary diagnosis. Frequency of CD-I was not differed in UC, CD and PC patients (about 31–37%), but was significantly higher in other patients with diarrhea.

P236 Fecal calprotectin as a surrogate marker of acute microscopic inflammation in ulcerative colitis patients with endoscopic remission

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Background: The presence of acute microscopic inflammation (AMI) in ulcerative colitis (UC) patients with endoscopic remission has demonstrated a prognostic value (increased risk of relapse). Fecal calprotectin (FC) has shown a good accuracy to predict endoscopic activity but data on FC ability to predict histological activity in UC patients in endoscopic remission is scarce.

Our aim was to evaluate the ability of FC as a surrogate marker to predict histological activity in UC patients with endoscopic remission.

Methods: 59 UC patients with endoscopic remission (defined as Mayo endoscopic subscore 0–1) were prospectively included between January 2011 and January 2012. 55 complete colonoscopies with biopsies from rectum, left colon, transverse colon and right colon and 4 rectosigmoidoscopies with rectal biopsies were performed.

Histological activity was scored as acute microscopic inflammation (AMI), chronic inflammation or absence of inflammation. For each patient, the biopsy with most severe histological activity was considered.

FC was determined both by an enzyme-linked immunoassay (ELISA, Bühlmann®) test and a rapid quantitative test (Quantum Blue, Bühlmann®).

Results: Correlation between both techniques was very good: interclass correlation index (ICI) of 0.904 (CI 95%: 0.864–0.932; P < 0.001). Results are presented with the ELISA test.

FC levels were significantly higher in patients with Mayo endoscopic subscore grade 1 (n = 31), than in patients with Mayo endoscopic subscore grade 0 (n = 28): median FC levels of 351.60 ± 452.95 vs. 172.86 ± 322.46 (P = 0.002).

AMI was more frequently present in patients with Mayo endoscopic subscore grade 1 than in those with Mayo endoscopic subscore grade 0 (48.3% (16/31) vs. 8% (2/28), P < 0.001).

FC levels were significantly higher in patients with AMI (n = 18) than in patients with chronic or absence of inflammation (n = 41): mean FC levels of 486.02 ± 533.27 vs. 158.59 ± 301.10, P = 0.023).

In the multivariate analysis, after adjusting for the endoscopic activity, FC was an independent predictor of histological activity (P = 0.028).

Clinical activity and the rest of biomarkers (leucocytes, platelets and CRP) didn’t predict histological activity.

Conclusions: Fecal calprotectin predicts acute microscopic inflammation in UC patients with endoscopic remission.

P237 Features of the Japanese clinical practice guidelines for Crohn’s disease with reference to those in the western world


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Background: We have recently developed a set of clinical practice guidelines for Crohn’s disease (CD) [J Gastroenterol, 2012, DOI 10.1007/s00535–012–0673–1]. These guidelines aim to provide appropriate clinical indicators to Japanese practitioners to improve the outcomes of CD patients. These guidelines are based on global literature-based evidence as well as evidence from Japan. The aim of this study is to introduce some distinct features of the Japanese guidelines for CD, which potentially contribute to the clinical practice for CD in the rest of the world.

Methods: We investigated different features of the Japanese guidelines for CD from those published by ECCO, the British Society of Gastroenterology (BSG), and the American College of Gastroenterology (ACG) in terms of developmental process and statements in those guidelines.

Results: The Japanese guidelines were developed based on the existing evidence with integration of consensus of Japanese experts. The criteria for recommendation grade were also determined by the level of evidence as well as the consensus of the experts. It is a distinct feature of the Japanese guidelines to disclose this process explicitly. This recommendation rating of the Japanese guidelines is thus useful to fill the gap between evidence and daily clinical practice. It should also be emphasized that the diagnostic criteria of CD established and widely used in Japan were employed in the Japanese guidelines. The statements in the 4 sets of guidelines mostly reached the same conclusions basically based on the same evidence. However, some statements in the Japanese guidelines reflect Japanese perspectives and evidence: e.g. 1) The Japanese guidelines recommend contrast radiographic examinations for diagnosis of the small intestinal lesions rather than MRI and CT, 2) Elemental diet and cytapheresis are more emphasized in the Japanese guidelines. 3) 5-aminosalicylate is not recommended in the western guidelines because of its minimal effect on CD, but it has a role in the management of CD in the Japanese guidelines because of its safety profile.

Conclusions: Since the Japanese guidelines for CD are primarily based on global literature-based evidence, most of the clinical indicators in them are consistent with those in other guidelines from the western world. Meanwhile, there are some distinctly different statements in the Japanese guidelines reflecting Japanese standard clinical practice, evidence, and the opinions of Japanese experts.