as were patients who ceased smoking prior to Dx c/w patients who quit at Dx (p = 0.045). B2/B3 disease was more likely if iv steroids (p = 0.004), IS (p < 0.0001) were required or if there was perianal disease (p < 0.0001). 558 patients required intestinal surgery and modelling with smoking status as a predictor showed that smoking was significant (p = 0.044). Multivariate analysis showed surgery was more common with TI (p < 0.0001) and perianal (p = 0.01) disease, while smoking lost significance. 186 patients underwent a 2nd intestinal resection. A greater proportion of smokers underwent a 2nd surgical resection (40%) than patients who quit at, or before, the 1st surgical resection (29%) and NS (28%) but was not significant. There was a general trend in disease behaviour change and the need for 1st and 2nd surgery with increasing numbers of cigarettes/day smoked. Regression analysis identified cigarettes/day smoked as significantly associated with B2/B3 disease change (0.01).

Conclusions: Smoking is a modifiable risk factor. Cessation at Dx reduces the rate of complicated disease as does reducing the number of cigarettes/day smoked. This supports the need for CD patients to be strongly encouraged to cease or at least reduce their smoking.

P366 Skin pathology associated with anti-tumour necrosis factor (anti-TNF) therapy – a single UK IBD centre experience

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Background: With the increasing use of biologic therapy in the treatment of inflammatory bowel disease (IBD) there has been a reported increase in dermatological conditions associated with therapy in patients with IBD. We carried out a prospective audit to identify the proportion of IBD patients at The Royal Free Hospital on anti-TNF therapy developing therapy related inflammatory skin pathology.

Methods: 141 IBD patients on anti-TNF therapy (either infliximab or adalimumab) were sent a postal questionnaire to identify patients who had experienced identifiable and associated skin conditions. The questionnaire included information regarding the body site affected, dermatology opinion and whether therapy had to be stopped. Data for infliximab and adalimumab were analysed.

Results: Of 141 patients, 105 replied (71 (74%) infliximab and 34 (74%) adalimumab). In both groups 32% of patients described new skin complaints attributable to anti-TNF therapy (n = 23 in infliximab group, n = 11 in adalimumab group). Sites of skin inflammation were common to both groups; face (29%), trunk (21%), legs (14%) and arms (14%). Combined data showed only 44% of patients were reviewed by a dermatologist and received a formal diagnosis. No patients on adalimumab stopped treatment, while 3 stopped therapy in the infliximab group (9% overall).

Conclusions: Although IBD is itself associated with skin pathology, recent studies have demonstrated that patients on anti-TNF therapy develop inflammation of the skin [1], and our data support the concept that paradoxical skin inflammation related to anti-TNF therapy is a class effect. In our cohort few patients had to stop therapy which is similar to some [1], but not all reported studies [2,3]. Less than half of affected patients received consultant dermatological review.

Reference(s)

