Results: All patients demonstrated a pronounced reduction in their colitis activity index within 1 week following a single intracolonial dose of DIMS0150. Further improvements were evident at week 4 resulting in a clinical response and remission rate for the single dose treatment of 71% (8/11) and 27% (3/11) respectively. By week 12, the clinical response and remission rates had reached 91% (10/11) and 73% (8/11) respectively. Endoscopic remission rates in the single dose group were 27% (3/11) at week 4 and 45% (5/11) at week 12. Marked histological improvement was observed in 64% (7/11) of the single dose treated patients at week 12. Those patients who received three doses of DIMS0150 demonstrated an improved response to the measured parameters when compared to those patients who received a single dose of DIMS0150.

A follow-up period of over 3 years post treatment indicated that 85% (12/14) of the treated patients had avoided the need for colectomy giving a colectomy rate of <10% per year with the longest patient being in symptom free remission for over 40 months.

Conclusions: DIMS0150 has the potential to be an effective agent for treatment refractory chronic active ulcerative colitis patients with the prospect to avoid colectomy on a long term basis and is currently the subject of a clinical phase III study (EudraCT number: 2011–003130–14).

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Long-term outcome of treatment with infliximab in patients with steroid-dependent ulcerative colitis

A. Armuzzi1*, D. Pugliese1, S. Danese2, G. Rizzo1, M. Marzo1, C. Felice1, G. Andrisani1, G. Fiorino1, O.M. Nardone1, I. De Vitis1, A. Papa1, G. L. Rapaccini1, L. Guidi1, 1Internal Medicine and Gastroenterology Unit, Complesso Integrato Columbus, Catholic University, Rome, Italy, 2IBD Unit, Istituto Clinico Humanitas, Rozzano, Italy

Background: Up to 40% of ulcerative colitis (UC) patients need steroids during their course and 20% of them become steroid-dependent. Thiopurines are recommended in steroid-dependent UC, but their efficacy is debated. We recently reported more than 30% of steroid-free clinical remission and mucosal healing for UC patients after 1 year of infliximab (IFX) treatment [1]. Aims of our study were to describe the long-term outcome of IFX treatment in active steroid-dependent UC and to investigate if predictors of sustained clinical response and colectomy could be identified.

Methods: Consecutive patients with active steroid-dependent UC treated with IFX were studied. Co-primary outcomes were 1) sustained clinical response in patients who achieved clinical remission (no diarrhoea, no blood) or response (clinical improvement, despite persistent blood loss) after induction and 2) colectomy free-survival. Sustained clinical response was defined as a persistent clinical improvement during the follow-up.

Results: 126 steroid-dependent UC patients were included. 45% of them were naive to thiopurines and 56% were started on concomitant thiopurines. The median duration of follow-up, without need of a course of steroids was 2.6–14) was identified as independent predictor of sustained clinical response.

Conclusions: IFX long-term treatment is effective in this large cohort of steroid-dependent UC patients. The severity of endoscopic lesions at baseline and a persistently high CRP after induction are associated with higher rates of colectomy. Thiopurine naive status is protective from colectomy. Combination therapy is predictive of sustained clinical response.

Reference(s)


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Local infliximab treatment followed by endoscopic dilation reduces ileocolonic anastomotic Crohn’s disease recurrence

M. Mastronardi1*, P. Giorgio1, G. Di Matteo1, G. Sisto2, F. Pezzolla3, 1IRCCS “S. De Bellis”, Gastroenterology and Digestive Endoscopy, Castellana Grotte, Italy, 2IRCCS “S. De Bellis”, Chirurgia Gastroenterologica, Castellana Grotte, Italy

Background: Strictures are a common cause of morbidity in patients with Crohn’s disease and often occur at the site of the ileocolonic anastomosis. Bowel-conserving procedures have emerged as valuable tools to limit repeated intestinal resections: intraslesional steroid injection, endoscopic balloon dilation and incision of stricture of the anastomotic recurrence. Some studies showed that infliximab (IFX) tissue levels are predictive of mucosal healing, so intraslesional injection in active disease could be more effective than sistemic administration.

Methods: From August 2007 to December 2008 we studied prospectively 23 consecutive Crohn’s disease patients with ileocolonic anastomotic, symptomatic strictures alternatively attributed to these two interventions: (1) per-endoscopic infliximab injection (100 mg) in the ileocolonic ulcerated stricture followed, six week later, by endoscopic balloon dilation and incision of stricture of the anastomotic recurrence. Clinical: Therapy and observation S187
Conclusions: In this pilot study the complete or partial mucosal healing of anastomotic lesions induced by local infliximab injection shows better and more durable pneumatic dilation of the ileocolonic anastomotic stenosis, with no surgical resection in any of the patients treated.

P444
Low-dose thiopurine and allopurinol co-therapy results in significant cost savings at a district general hospital

H. Johnson1*, H. Dewhurst1, S. Weaver1, S. McLaughlin1, 1Royal Bournemouth Hospital, Gastroenterology, Bournemouth, United Kingdom

Background: Thiopurines are used for maintenance of remission in IBD. In England and Wales biologics are approved by NICE (National Institute for health and Clinical Excellence) for Crohn’s disease (CD) but not ulcerative colitis. Adalimumab is recommended in preference to infliximab in patients over 65 kg due to cost. Published data report >50% of patients stop thiopurines due to therapeutic failure, hepatotoxicity or side effects. In this situation most UK clinicians start biologics in CD patients. This has significant cost implications. An alternative treatment strategy is low dose thiopurine and allopurinol (LDTA) co-therapy which is effective in most patients who fail standard dose thiopurines. Some patients require liquid thiopurine to achieve the correct (low) dose – this formulation is significantly more costly than tablets. We report the annual cost savings from adopting this strategy at our centre.

Methods: We maintain a prospective IBD database. Patients with CD treated with LDTA in preference to biologic therapy were identified. The annual drug costs of their treatment with LDTA compared with biologic therapy (adalimumab for patients over 65 kg. Infliximab for patients >65 kg) were calculated including the cost for the formulation of thiopurine used (liquid/capsules/tablets) and the dose prescribed. Costs of attending the day unit for an infusion were not included.

Results: 17 CD patients who failed standard thiopurine and were eligible for biologics were identified over a 1-year period (September 2011 to September 2012). Of these, 4 (24%) failed LDTA and progressed to biologics, 13 (76%) entered a sustained clinical remission. Mean weight of patients = 77.3 kg (range: 53.5–105), 6 (46%) patients required liquid thiopurine. Mean calculated costs were: thiopurine €559.96 (range: €60.06–1,667), biologics: €14,039.18 (range: €13,083.91–19,924.47). Mean cost saving per patient: €13,479.15 (range: €11,417.44–18,765.99). Total cost saving: €175,229.03.

Conclusions: We have previously reported that low dose thiopurine and allopurinol co-therapy is safe and effective. In the present study we have identified significant annual cost savings can be made when this treatment strategy is used to prevent escalation to biologics. These cost savings are likely to be even more significant in the long term since a significant proportion of patients treated with biologic therapy require dose escalation. We believe adopting this strategy more widely could lead to significant health-care savings.

P445
Looking for predictive factors of clinical response to adsorptive granulocyte and monocyte apheresis in patients with ulcerative colitis

M. Kawai1*, Y. Yokoyama1, K. Fukuina1, T. Ogawa1, K. Kamikoizumi1, K. Nagase1, K. Tozawa1, N. Hida1, T. Matsumoto1, 1Hyogo College of Medicine, Department of Lower Gastroenterology, Nishinomiya, Japan

Background: Adsorptive granulocyte and monocyte apheresis (GMA) with an Adacolumn in patients with ulcerative colitis (UC) has been applied as a non-pharmacological treatment strategy, but the efficacy has been encouraging as well as discouraging, depending on patients’ demography at entry. In this study, we looked for predictive factors for clinical response to GMA.

Methods: In a retrospective setting, 43 outpatients who had been treated with GMA for active UC were evaluated. Patients were divided into remission group (RG) and non-remission group (NRG) based on Lichtiger’s clinical activity index (CAI) before and after 10, once a week GMA sessions. Patients with CAI ≤5 were classified as having active disease, while CAI ≥6.4 meant clinical remission. The efficacy was analysed in relation to patients’ demographic variables.

Results: After 10 GMA sessions, clinical remission rate was 53.5% (23/43). Among the 23 responders, 9 patients (39.1%) had steroid-free remission. At baseline, the duration of UC was significantly shorter in the remission group compared with the non-remission group, 27.3±31.0 days vs. 57.7±54.4 days, respectively (P<0.05). Multiple logistic regression analysis showed that the interval between relapse and the first GMA session was significantly shorter in the remission group compared with the non-remission group, 6.2±7.3 vs. 8.6±6.8 (P<0.05). Likewise the mean interval between relapse and the first GMA session was significantly shorter in the remission group than in the non-remission group. 6.2±7.3 vs. 8.6±6.8 (P<0.05).

Conclusions: In this study, patients with a short duration of UC seemed to respond well to GMA. However, we found that the best responders were patients who received GMA immediately after a relapse. Additionally, GMA was effective in patients with active UC while on AZA. The data from this study should spare medical cost and reduce morbidity time for many patients, relevant for decision making in clinical settings.

P446
Long term outcome of azathioprine therapy in 353 consecutive IBD patients

H. Johnson1*, K. Smith2, N. Jarrett1, S. McLaughlin1, S. Weaver1, 1Royal Bournemouth Hospital, Department of Gastroenterology, Bournemouth, United Kingdom, 2Yeovil District Hospital, Department of Gastroenterology, Yeovil, United Kingdom

Background: Thiopurines are the mainstay of therapy in inflammatory bowel disease (IBD). However they have a wide range of side effects which can limit their use. To assess how effective AZA was in IBD, and what its limitations were, the outcome of 353 consecutive IBD patients started on AZA with at least one year follow up was assessed.

Methods: Since 2005 all patients started on AZA for IBD have been recorded and monitored. These data were then used to assess the outcome of patients where there had been at least one year of follow up. Outcomes recorded were whether AZA was still being taken or not. If still being taken information about the disease activity was recorded. If AZA therapy had been discontinued then the reason for this was recorded and subsequent therapeutic interventions noted.

Results: 353 patients had started AZA and had at least one year of follow up. TPMT status was checked in all patients. Dosing was as follows: low TPMT: AZA 50 mg and increased as tolerated. Normal TPMT: 2.5 mg/kg. Of the 353 patients, 204 had Crohn’s Disease (CD), 141 had Ulcerative Colitis and 8 had IBD-unclassified. The male:female ratio was 184:169 (52.1% male). Average range was 16–86 years (mean; 46). 322/353 (91%) remain under follow up. 127 (36%) of patients had stopped taking AZA at one year. After six years 152 (43.1%) remained on AZA, 182 (51.6%) had stopped and in 19 (5%) the outcome was unknown. Nausea and myalgia were the main reasons for stopping AZA. 40 (11.3%) patients developed hepatitis (ALT rise ≥2×ULN), 6 (1.7%) developed...