myelosuppression and 7 (2%) developed pancreatitis (consistent clinical presentation and raised amylase). Of the 182 patients who stopped AZA, 67 (37.8%) had an escalation of therapy – 20 started methotrexate, 18 started biologics and 29 underwent surgery.

Of the 152 who continued AZA, 138 (90.8%) were in a clinical remission based on clinical assessment supported by normal C-reactive protein in 126 (91.3%), Harvey Bradshaw Index in those with CD 55 (40%) patients and endoscopic findings in 22 (15.9%). 112 (73.6%) patients had blood monitoring (FBC and LFTs) at least quarterly and 147 (96.7%) at least bi-annually.

Conclusions: A significant number of patients stop AZA due to side effects. This study highlights these so that patients can be accurately informed. It also shows that AZA when tolerated is a very effective maintenance medication. Alternative prescribing strategies, such as low dose AZA with allopurinol, may limit side effects and maintain efficacy.

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Long-term benefit of one year infliximab administration for the treatment of chronic refractory pouchitis

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Background: Infliximab administration is currently recommended for the management of chronic refractory pouchitis, following ileo-pouch anal anastomosis (IPAA) for ulcerative colitis (UC). However, the optimal time that it needs to be administered is not known. Our study aimed to identify the long term benefit of one year infliximab administration for the treatment of chronic refractory pouchitis.

Methods: Seven patients (4 females, 3 males) with chronic refractory pouchitis were included in an open study. Pouchitis was diagnosed by clinical plus endoscopic and histological criteria. Three patients had also fistulae (pouch-bladder in 1 and perianal in 2). Extraintestinal manifestations were also present in 4 patients (erythema nodosum in 2, arthralgiae in 2). All patients were refractory to antibiotics, while 3 patients were refractory to azathioprine as well. Crohn’s disease was diagnosed by clinical plus endoscopic and histological criteria. Three patients had also fistulae (pouch-bladder in 1, rectovaginal in 2). Extraintestinal manifestations were also present in 1 patient (erythema nodosum in 1 and sarcoidosis in 1). All patients were refractory to antibiotics, while 1 patient was refractory to azathioprine as well. During infliximab administration, six patients had blood monitoring (FBC and LFTs) at least quarterly.

Results: After 1 year of infliximab administration all patients improved clinically. Six out of the 7 patients had a complete clinical response and 1 patient a partial clinical response, while 2 out of the 3 patients with a fistula had complete fistulae closure. The median PDAI dropped from 62 (baseline) (range, 10–14) to 5 (range, 3–8). Extraintestinal manifestations were in complete remission as well. Three years after completion of therapy, all patients remained in remission and no one needed any kind of additional treatment for pouchitis during this 3-year follow-up period.

Conclusions: One year infliximab administration is associated with a long term benefit in patients with chronic refractory pouchitis, complicated or not by fistulae, following IPAA for UC.

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Long-term remission among Crohn’s disease patients on immunosuppressive therapy after infliximab withdrawal: a retrospective, monocentric study comparing induction alone to a 1-year maintenance therapy

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Background: Maintenance of remission in patients with Crohn’s disease (CD) on immunosuppressive therapy after infliximab (IFX) therapy was stopped is still a debated issue. Induction course alone (induction group) is associated with a high risk of relapse. The benefits of scheduled maintenance therapy every 8 weeks (maintenance group) before IFX withdrawal have not been demonstrated. The aim of this study was to compare remission and tolerance with those two regimens.

Methods: Between January 2000 and June 2012, IFX therapy was stopped in 106 times in 93 patients (58 female, median age 32.4 [IQR = 24–43] yrs) in our centre, after induction therapy alone (n = 59) or followed by maintenance therapy for at least 1 year (n = 47). All patients were in clinical remission (HB score < 4) before IFX withdrawal. Immunosuppressants were continued during follow-up. Patients’ characteristics were compared using Chi2 and Wilcoxon–Mann–Whitney test. Steroid-free remission was studied with Kaplan–Meier method, log-rank test and Cox regression model.

Results: Median follow-up-time was 6.8 (IQR = 4.6–9.0) yrs. Patient’s characteristics were identical in the two groups. At the end of the follow-up, 77 relapses had been observed, 44 (75%) in the induction group and 33 (70%) in the maintenance group (p = 0.62). Actuarial probabilities of steroid-free remission were 78%, 68% and 51% at 6 mo, 1 and 2 yrs, respectively. Stratification based on gender was made due to statistical differences between male and female. In the female group, relapse was associated with a CRP level >5 mg/L (HR = 4.82 [95% CI= 1.93–12.06], p = 0.001) and a leucocytes count >6000/mm3 (HR = 1.96 [95% CI= 1.03–3.72], p = 0.04) at time of IFX withdrawal. In the male group, relapse was associated with active smoking (HR = 2.81 [95% CI= 1.14–6.88], p = 0.02) at time of IFX withdrawal, immunosuppressive therapy failure stratum (HR = 3.20 [95% CI= 1.37–7.48], p = 0.01) and induction group (HR = 0.37 [95% CI=0.14–0.97], p = 0.04). After relapse, 58 (75%) patients were retreated with IFX. Seven infusion-related reactions were observed in which 6 of them occurred in the induction group (p = 0.10). After IFX retreatment, free-steroid clinical remission was observed in 44 (86%) patients at week 10.

Conclusions: One-year maintenance therapy is not superior to induction therapy alone to maintain remission in CD patients on immunosuppressive therapy after infliximab withdrawal. Retreatment with IFX was safer in the maintenance group. Interestingly, disparities relative to gender were observed in this study.

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Long-term increase of serum cholesterol level in ulcerative colitis patients treated with cyclosporine: an underdiagnosed side effect frequently associated with other drug-related complications

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Background: Cyclosporine is one of the recommended therapeutic choices in severe ulcerative colitis (UC) refractory