other inflammatory markers. While the medical management primarily now targets control of inflammation and long term prevention of complications, there is a substantial Unmet Need in relation to symptoms and in a broader term "concerns", that are not linked to inflammatory activity.

**P118**
Vitamin D status and bone mineral density in patients recently diagnosed with ulcerative colitis

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**Background:** Introduction: Inflammatory bowel diseases (IBD) are associated with an increased prevalence of decreased bone mineral density. One of the risk factors for the low bone mineral density is the inadequate level of 25 OH vitamin D. The aim of this study was to evaluate bone mineral density and level 25 OH vitamin D in patients recently diagnosed with UC.

**Methods:** A prospective study was performed in The Center of Gastroenterology and Hepatology and included patients recently diagnosed with UC. We noted demographic and clinical data (age, sex, extent of lesions, the degree of disease activity and treatment). 25 OH vitamin D level was measured in all patients and dual-energy X-ray absorptiometry (DEXA) was performed at lumbar level and femoral neck.

**Results:** 134 patients with UC were included; they had an average age of 46.21 years and were mostly men (59.7%) with an average evolution of the disease about 4 years (65% with an evolution <1.5 years or recently diagnosed). Most patients had extensive forms of the disease (56% left colitis, pancolitis 25.4%). In terms of disease activity: 29.9% had severe activity, 32.8% moderate, 23.9% mild and 13.4% were in clinical and biological remission. 29.1% of patients required treatment with oral or intravenous corticosteroids for about 4 months. Based on the lumbar and femoral neck osteodensitometry: 33.58% had normal BMD, 48.5% osteopenia and 17.91% osteoporosis. 25 OH vitamin D level was insufficient (<30 ng/ml) in 47% patients, normal in 31.34% patients, and 29 patients (21.64%) presented severe deficiency of 25 OH vitamin D (<20 ng/ml). Decreased bone density occurs early after the diagnosis of Crohn’s disease. Hypovitaminosis D is induced by large lesions located mainly in the jejunum and ileum and also by the inflammatory activity. Vitamin D deficiency and the use of corticosteroids represent important risk factors in the development of bone demineralization in patients recently diagnosed with Crohn’s disease.

**Conclusions:** Decreased bone density occurs early after the diagnosis of Crohn’s disease. Hypovitaminosis D is induced by large lesions located mainly in the jejunum and ileum and also by the inflammatory activity. Vitamin D deficiency and the use of corticosteroids represent important risk factors in the development of bone demineralization in patients recently diagnosed with Crohn’s disease.

**P119**
Vitamin D status and bone mineral density in patients recently diagnosed with Crohn’s disease

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**Background:** Introduction: Crohn’s disease is associated with an increased prevalence of low bone mineral density. One of the risk factors for the low bone mineral density is the inadequate level of 25 OH vitamin D. The aim of this study was to evaluate the bone mineral density and the level of 25 OH vitamin D in patients recently diagnosed with Crohn’s disease (CD).

**Methods:** A prospective study was performed in The Center of Gastroenterology and Hepatology Iasi and included patients recently diagnosed with CD. We noted demographic and clinical data (age, sex, extent of lesions, the degree of disease activity and treatment). 25 OH vitamin D level was measured in all patients and dual-energy X-ray absorptiometry (DEXA) was performed at lumbar level and femoral neck.

**Results:** 46 CD patients were included in the study. They had an average age of 41.72 years, were mostly men (54.3%) with an average evolution of the disease about 3.8 years (70% had an evolution <1.5 years or were recently diagnosed). Most patients had colonic involvement (45.7%) or ileo-colonic (37%); and in terms of disease activity: 26.1% were in clinical and biological remission, 30.4% had mild-moderate activity, 37% moderate-severe activity, and 6.5% severe activity. 45.7% patients required treatment with oral or intravenous corticosteroids for about 2–3 months. Based on the lumbar and femoral neck osteodensitometry: 13 patients (28.3%) had normal BMD, 26 (56.5%) osteopenia, and 7 patients (15.2%) osteoporosis. 25 OH vitamin D levels was insufficient (<30 ng/ml) for 43.47%, normal for 19.56% patients and 17 patients (36.95%) presented severe deficiency of 25 OH vitamin D (<20 ng/ml). Conclusions: Decreased bone density occurs early after the diagnosis of Crohn’s disease. Hypovitaminosis D is induced by large lesions located mainly in the jejunum and ileum and also by the inflammatory activity. Vitamin D deficiency and the use of corticosteroids represent important risk factors in the development of bone demineralization in patients recently diagnosed with Crohn’s disease.

**P120**
Vitamin D deficiency is common in Crohn’s disease but also in healthy controls: a prospective case-control study

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**Background:** Vitamin D deficiency is described in a wide range of medical conditions, among which Crohn’s Disease (CD). This could be due to different mechanisms, including malabsorption, intestinal loss, decreased dietary intake, or insufficient sunlight exposure. We aim to assess whether CD patients have decreased vitamin D levels compared to healthy controls, and to determine risk factors for vitamin D deficiency.

**Methods:** We prospectively included CD patients visiting our outpatient clinic in the Netherlands immediately after summer (October and November 2012). Patients with functional oesophageal disorders and healthy hospital employees served as controls. Demographic data, sunlight exposure, dietary vitamin D intake, comorbidities and medication were recorded using validated questionnaires. In CD patients the Harvey-Bradshaw Index, Montreal classification and resections were also evaluated. We measured serum concentrations of 25(OH)D, CRP, calcium, phosphate, alkaline phosphatase and albumin. Based on literature data, we considered 25(OH)D levels >75 nmol/L normal; 50–75 nmol/L suboptimal, 25–50 nmol/L insufficient and <25 nmol/L deficient. Serum 25(OH)D was measured by Chemiluminescent immunoassay technology (DiaSorin Liaison).

**Results:** 76 CD patients (mean age 42.6, IQR 31–52, 35% male) and 35 controls (mean age 35.3, IQR 25–40, 14% male) were included. Mean 25(OH)D level was 54 nmol/L in CD, and 62 nmol/L in controls (p = 0.18). Similar proportions of low 25(OH)D levels (<75 nmol/L) were seen in CD patients and controls (58/76 (76%) vs 25/35 (71%), p = 0.64), also when considering 50 nmol/L as lower limit of normal (39/76 (51%) vs 16/35 (46%), p = 0.68). A few other variables were associated with vitamin D levels, as shown in Table 1. In multivariate linear regression analysis, not visiting solarium, azathioprine use, and ethnicity (Caucasian) were strongly correlated with vitamin D level (R >0.56, p = 0.013, 0.03 and 0.014, respectively).