or fistulae at MRI was associated with higher risk of surgery (p \(< 0.001\)). In multivariate analysis, perianal disease (OR = 5.7, p = 0.02) and detection of fistulae in MRI (OR = 10.5, p = 0.003) were associated with higher risk of surgery, whereas anti-TNF treatment during follow up slightly decreased the risk of surgery (OR = 0.9, p = 0.002).

Conclusions: Presence of fistulae at MRI or perianal disease is associated with an increased risk of surgery in CD patients, whereas anti-TNF treatment slightly reduces this risk. Under current therapeutic strategies, presence of ulcers at baseline colonoscopy or MRI is not a predictor of surgery in CD.

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Predictive value of early restoration of quality of life in Crohn’s disease patients receiving anti-TNF agents

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Background: Crohn’s disease (CD) impairs patients’ health related quality of life (HRQOL), therefore a goal of treatment is to improve their health. Recently, a more ambitious therapeutic target has been proposed, to reestablish the quality of life of patients to normal standards. Effective treatment with anti-TNF agents is related to the restoration of health. However, there is no information on long-term prognostic value of restoring the health of patients with CD. Our aim was to determine if early restoration of HRQOL in patients with CD and anti-TNF agents is associated with long-term remission.

Methods: Retrospective longitudinal study in patients with active CD treated with an anti-TNF agent, either infliximab or adalimumab. Patients completed the IBDQ-36 questionnaire at baseline (prior to the start of anti-TNF) and at weeks 2, 6, 14, 28 and 52. Early restoration of health was defined according to an IBDQ-36 score <209 at week 14, and long-term clinical remission as a CDAI (Cohn’s disease activity index) score <150 at week 52.

Results: Ninety-four patients were included in the study. Sixty-three patients (67%) maintained long-term remission, with forty-seven (75%) of them achieving an early restoration of HRQOL. Of the 31 patients (33%) who did not maintain clinical remission, only 4 (13%) restored the HRQOL (p < 0.01), OR: 8.19, 95% CI 5.51–12.65. There was a strong negative correlation between the global value of IBDQ-36 at week 14 with CDAI values when we received: r = -0.64, n = 94, p < 0.01), with lower CDAI scores when HRQOL score was better. Ninety-two percent of patients with early restoration of HRQOL maintained long-term remission vs 37% who did not reach early reestablishment of HRQOL (p < 0.01). To predict long-term remission, the cutoff point of 209 of the IBDQ-36 at week 14 had an area under the ROC curve of 0.81, with a sensitivity and specificity of 0.75 and 0.87 respectively.

Conclusions: Achieving early restoration of HRQOL with anti-TNF agents was associated with sustained long-term remission. This could be a therapeutic goal of treatment both in clinical trials and in daily practice.

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Predictive factors of the course of Crohn’s disease – can we treat in anticipation?


Background: The course of Crohn’s disease (CD) is highly variable and difficult to predict on the basis of information at the time of diagnosis. However it would be useful to categorize patients at the onset of disease in low and high risk on the basis that treating severe CD with “top-down” strategy might change the natural history of CD.

The aim of this study was to evaluate factors at presentation that might predict the severity of CD.

Methods: Retrospective, single-center study including 146 patients with CD diagnosed between June 1983 and December 2011. We defined aggressive CD as need for more than 2 steroids courses required after diagnosis, need for surgery after diagnosis (except surgery for perianal disease or ileocecal resection as first choice of treatment) and need of admission for flare after diagnosis. The variables studied at diagnosis were smoking status, family history of inflammatory bowel disease, extraintestinal manifestations, Montreal Classification (age, location of CD, involvement of the upper gastrointestinal tract, phenotype, perianal disease), need for corticosteroids, admission and surgery on the first flare.

Statistical analysis was performed with SPSS vs 18.0 and a p value of less than 0.05 was considered statistically significant.

Results: 146 patients with CD were included, 55.5% female, with mean age 37.6 ± 11.9 years and mean follow-up of 86 ± 60 months. 80 patients presented at follow-up with non aggressive CD (55%) and 66 (45%) with aggressive CD. Independent factors present at diagnosis and significantly associated with aggressive CD were smoking status (p = 0.02), stenotic and penetrating phenotype (< 0.001) and corticosteroids and admission on the first flare (p = 0.001). Given the results of the univariate analysis, in our cohort, the presence at diagnosis in an individual patient of 2 or more out of the 4 factors was associated with a high risk of aggressive disease with an accuracy of 0.73 (sensitivity of 88%, a specificity of 61%, a positive predictive value of 65% and a negative predictive value of 86%).

Conclusions: At diagnosis of Crohn’s disease predictors of subsequent aggressive course are the initial requirement for corticosteroids and admission, smoking status and penetrating and stenotic disease. The combination of 2 or more variables is highly associated with aggressive disease and may be a useful way to make therapeutic decisions at diagnosis.

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Predictive factors for chronic inflammatory bowel disease in patients presenting with new onset diarrhea

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Background: The diagnosis of chronic inflammatory bowel diseases (IBD) requires chronic changes over time (colonoergic inflammatory changes lasting at least 6 months with chronic histological inflammation). The onset of IBD may mimic acute diarrhea (defined as having sudden onset and lasting less than four weeks); on the other hand, acute diarrhea may be mistaken with a new case of chronic IBD. Our aim was to find clinical or biological predictive factors for the diagnosis of chronic IBD.

Methods: A prospective study was conducted on all cases of new onset diarrhea which presented in our Gastroenterology Unit during 2012. Their initial evaluation included clinical exam, complete biological picture and colonoscopy. All cases of new onset diarrhea with uncertain etiology were followed and the final diagnosis was established at least 6 months after the onset, by repeating colonoscopy with biopsy. The final diagnosis was correlated with clinical and biological parameters evaluated at the first presented.

Results: A total of 120 patients with new onset diarrhea presented to our unit in 2012. After the initial work-up, 82 patients had a positive diagnosis (infectious colitis, colorectal cancer, radiation colitis, ischemic colitis). The remaining 38 patients, including both patients with inflammatory changes at colonoscopy and patients with normal colonoscopy were...