Results: Among 887 patients, a subgroup of 439 CD and 173 UC were included with a mean follow-up of 19 and 15 years respectively. One year after the diagnosis 147 CD patients had NS CD. At 5 years and at the maximum follow-up respectively, 83/147 (56%) and 15/147 (10%) patients still had NS CD. Complications were strictures (29%), fistulizing disease (18%), perianal disease (37%). Immunomodulators and anti-TNF were required in 79% and 54% of patients respectively. Prognostic factors for persistent NS CD were older age at diagnosis (38 vs 26 years, p = 0.005), no corticosteroid during the first year (p = 0.036). In UC, 142 patients had NS disease one year after the diagnosis. 102/142 (72%) and 62 patients (44%) had NS UC after 5 years and at the maximum follow-up respectively. Surgery occurred in 19 patients (13%) after a mean time at 164 months. Immunomodulators were needed in 66 patients (47%) and anti-TNF in 37 patients (26%). NS UC was associated with absence of hospitalization for active UC over the first 5 years (p = 0.009) and during the total course of UC (p = 0.0001), no intake of corticosteroid during the first year (p = 0.03).

Conclusions: In our cohort representing referral centre recruitment, nearly all CD patients and 2/3 of UC with NS disease at diagnosis became severe with time. Older age at diagnosis was associated with NS CD outcome while absence of hospitalisation during the first year was associated with NS UC outcome. Absence of steroid use during the first year was associated with NS outcome in both diseases.

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Multiparametric evaluation of Crohn’s disease: possible role of intestinal healing beyond mucosal healing

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Background: Mucosal healing (MH) is a challenging endpoint in Crohn’s Disease (CD) therapy, even if inflammation often involves the whole intestinal wall. A more complete evaluation of disease activity (DA) may offer a basis for a tailored therapy. Our aim is to evaluate if a combined (clinical, endoscopic and radiological) disease assessment could predict the relapse rate, after 12 and 36 months.

Methods: We enrolled 57 patients, who underwent a colonoscopy and a CT Enterography (CTE) within 1 month (t0). Each patient was clinically assessed after 12 months (t1), a subgroup (n = 20) even after 36 months (t2). Harvey–Bradshaw Index (HBI), SES-CD and the radiological DA, based on the qualitative evaluation of an expert radiologist, were defined at t0 and used to stratify patients according to clinical, endoscopic and radiological DA. HBI, hospitalizations, surgery, therapeutic changes (TC), exits were evaluated at t1 and t2. An additional analysis was made on the basis of the agreement between clinical, endoscopic and radiological evaluations.

Results: A complete agreement between clinical, endoscopic and radiological DA was found in 15.79% of patients. Patients with moderate–severe clinical DA (HBI > 8) at t0 had an higher rate of TC at t1 than those with mild–moderate clinical DA (5 ≤ HBI ≤ 7) or remission (HBI < 4) (p = 0.019), while in patients with endoscopic (SES-CD > 13) or radiological moderate–severe DA the higher rate of TC was not significant. Patients with moderate–severe clinical DA at t0 had a higher rate of hospitalization at t2 (p = 0.0005). Patients with a moderate–severe radiological DA at t0 had a higher rate of hospitalization at t1 (p = ns) and t2 (p = 0.0005). At t2, the rate of hospitalization was higher when at t0 all the evaluations agreed in indicating DA (p = 0.0474). Between patients with MH at t0 (n = 23), only 22% had a radiological remission, while 69% and 9% had a mild–moderate and a moderate–severe DA at CTE; patients with radiological DA seemed to have higher rate of TC, hospitalization and surgery.

Conclusions: Clinical, endoscopic and radiological assessments seem to offer complementary informations in CD. MH without transmural healing could be associated with a poorer prognosis. A multiparametric evaluation of CD might suggest a more aggressive therapy in high risk patients.

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Multidisciplinary approach in IBD patients with arthralgias: usefulness of a combined rheumatologic and gastroenterologic assessment in a prospective study

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Background: The prevalence of Enteropathic-related Spondyloarthritis (SpAe) in IBD shows marked variations (18–45%). Controlling “joint pain” in IBD is a relevant clinical issue, and the real prevalence of rheumatologic abnormalities may be underestimated by gastroenterologists. In a prospective study, we aimed to evaluate the prevalence and characteristics of articular manifestations in IBD patients (pts) with arthralgias, as assessed by a dedicated rheumatologist. Therapeutic changes after the combined assessment were evaluated.

Methods: From December 2012 to November 2013, all IBD pts referring articular pain to the IBD-dedicated gastroenterologist were referred to an experienced rheumatologist. Assessment was made according to current guidelines and data recorded in a common database. Statistical: paired T test. Data expressed as median (range).

Results: During the 12mos follow up, 1275 pts were assessed as outpatients in the IBD Unit. Arthralgias were referred by 93/1275 (7.3%) IBD pts, referred to the rheumatologist for proper assessment. Ulcerative colitis (UC) group included 38 pts: 11M, age 46 yrs (18–77), UC duration 10 yrs (0–47), UC inactive in all pts (Partial Mayo score <3). UC extent was total (n = 18; 47%), left-sided (n = 15; 40%) and distal (n = 9; 24%). Among the UC pts, 9 (21%) were smokers, 11 (29%) ex-smokers, 4 (11%) had familial history of IBD. Crohn’s disease (CD) group included 55 pts: 18M, age 49 yrs (20–89), CD duration 17 yrs (range 1–40), CD was inactive in 49 (89%), mildly active (CDAI 150–220) in 6 (11%). Montreal CD classification: B1 31 (56%), B2 22 (40%), B3 2 (4%), P5 (9%); L1 24 (44%), L2 8 (14%), L3 23 (42%), L4 2 (4%). In CD, 19 (35%) were smokers, 5 (9%) had familiar history of IBD. Crohn’s disease (CD) group included 55 pts: 18M, age 49 yrs (20–89), CD duration 17 yrs (range 1–40), CD was inactive in 49 (89%), mildly active (CDAI 150–220) in 6 (11%). Montreal CD classification: B1 31 (56%), B2 22 (40%), B3 2 (4%), P5 (9%); L1 24 (44%), L2 8 (14%), L3 23 (42%), L4 2 (4%). In CD, 19 (35%) were smokers, 5 (9%) had familiar history of IBD. Among the 93 IBD pts with arthralgias, rheumatologic assessment diagnosed rheumatologic diseases in 33 (88%) UC and in 44 (80%) CD pts. In particular, a diagnosis of SpAe was made in 50 (54%) IBD pts (54% peripheral SpA, 24% axial SpA, 22% both), 24 (26%) Osteoarthritis, 6 (7%) Fibromyalgia, 3 (3%) Gout, 3 (3%) Rheumatoid Arthritis, 2 (2%) Psoriatic Arthritis, while diagnosis was inconclusive in 5 (6%) pts. After rheumatologic assessment, a higher percentage of IBD pts were treated with disease-modifying anti-rheumatic drugs (including anti-TNFs) (5.3% vs 15%, p = 0.03, RR 1.6) and/or with anti-COX2 (6.4% vs 27%; p < 0.0001; RR 2.3). Anti-TNFs use also significantly increased (19% vs 34%, p = 0.009; RR 1.8).

Conclusions: Multidisciplinary IBD care including rheumatologists may facilitate the diagnosis and management of arthralgias in IBD. A combined multidisciplinary approach may