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eHealth: Individualisation of MMX mesalamine treatment and optimization of disease course via a self-managed web-based solution in active ulcerative colitis
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Background: Treatment with MMX mesalamine to induce remission in patients with ulcerative colitis (UC) with activity has been shown to be efficient as first line therapy. The objective of this study was to individualise treatment with MMX mesalamine treatment and optimise the short-term disease course via a self-managed web-based solution in relapsed ulcerative colitis.

Methods: Observational, open-labelled three months treatment with MMX mesalamine of 95 relapsed UC patients via a web-application. Patients had to fill out weekly during three months the simple clinical colitis activity index scale (SCCAI) and faecal calprotectin (FC) on web application: www.meza.constant-care.dk. We investigated the short-term MMX mesalamine monotherapy efficacy and the feasibility of web-guided therapy in relapsed UC patients.

Results: A total of 95 patients with mild–moderate UC: 59 (62%) females, median age 45 years (19-77) were included in the study and allocated to 4.8g MMX mesalamine. 82 (86%) patients were adherent to web-therapy completing three month self-managed web-guided MMX mesalamine therapy: 72/82 (88%) complete responders and 10/82 (12%) non-responders. At week 12, all patients had a significant reduction (mean week 0 vs. mean week 12) of SCCAI (4.6 vs. 1.6), FC (437 vs. 195) and TIBS (6.7 vs. 2.4) respectively, p < 0.001.

Conclusions: MMX mesalamine is effective in IB patients in remission or mild-to moderate activity, predominantly improving SCCAI and FC values in more than half patients and could be used in cases of non-adherence with and insufficient response on combined oral and topical 5-ASA therapy. Web-guided therapy in colitis individualise the dose and improve adherence to therapy.

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Yield of colon surveillance and clinical outcome after faecal diversion in patients with Crohn’s disease
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Background: Recently, a number of patients with Crohn’s disease (CD) were identified at the gastroenterology outpatient clinic in the University Medical Centre in Leiden with complaints about their (partly) deviated colon after having a stoma construction. Meanwhile, the excluded colon was no longer accessible for surveillance by endoscopy because of stenosis. Aim of this study was to get a better insight into the distal colon after faecal diversion in Crohn’s patients, mainly focussing on the implications for the excluded colon and the risk of developing colorectal cancer.

Methods: A retrospective study was performed in a cohort of patients with CD who received a stoma between 2003–2012 at Leiden University Medical Centre. The patients’ medical records were thoroughly examined and information about the clinical outcome and yield of surveillance of the deviated colon was obtained. A stoma was regarded as permanent when the anal sphincter had been surgically removed; a stoma was regarded as non-permanent when the anal sphincter was in situ and reconstruction of bowel continuity was still an option. Follow-up time was since reconstruction of first stoma till loss of follow-up or till the end of this study; 1 March 2013.

Results: Seventy-four CD patients who had received a stoma were included in the study. The cumulative follow-up time since the first stoma construction was 658.8 years (mean 8.9 years). At the end of follow-up, 27.1% of the patients had bowel continuity, 39.2% had an non-permanent stoma in situ and 32.4% had a permanent stoma. Clinical outcome was unknown in one patient (1.4%). Indications for diversion of the faecal stream were: refractory disease (RD) (28.4%); fistulas and/or stenosis (32.4%); a combination of RD with fistula and/or stenosis (16.2%); dysplasia/malignancy (8.1%); complications after surgery; i.e. suture leakage (8.1%) and other (6.8%). According to the physician, the initial indication for diversion was solved in 54.7% of the patients. The indications ‘RD’ and ‘fistulas’ had the most unfavourable prognosis in our cohort (respectively 52.4% and 33.3% recovery). In 93.3% of the cases, surveillance of the deviated colon was in accordance with the current surveillance guidelines (AGA and BSG). No dysplasia or malignancies in the deviated colon were found in our population (cumulative follow-up time with a stoma in situ: 238.8 years).

Conclusions: In more than half of the patients with CD, the initial indication for the stoma was solved by diversion of the faecal stream. Dysplasia or colorectal cancer did not occur in the excluded (part of the) colon in our series and we are convinced that this is a rare incident in patients with CD and faecal diversion.

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What is our success on complex perianal fistula healing in the clinic? From Antibiotic to combined anti-TNF based treatment, ending with or without ileostomy
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Background: Our aim was to determine overall treatment (Tx) success and factors influencing the medical Tx (MedTx) response in complex perianal fistulas (Cpfis).

Methods: patients’ charts between 1999–13 retrospectively were reviewed. There were 517/705 (7%) CD patients with Cpfis. All patients were treated with different combinations of antibiotics, azathioprine (AZA) and anti-TNFs but our aim was to put them on triple MedTx if there was no drug intolerance. In case of an abscess, drainage and seton was applied remaining between 3 to 6 mo. in case of no recurrence. Tx success was stratified as complete discharge cessation or additional closure of external orifice, and ultimately radiological disappearance by MRI. In case of MedTx failure a diverting stoma was applied. Age, sex, disease duration, location, behaviour, rectal involvement, age at fistula onset, fistula duration, number of fistula, smoking, number of setons, duration of each MedTx, time with seton, total durations of drugs, and type of surgery was noted. Each patient’s fistula status at the last visit was determined and re-opening and re-closing events and closure time after seton removal were noted.