followed by colon in 19 (25%) and rectum in 4 (6%). Urinary tract lesions were located in the bladder in 69 (92%) patients. The indication for surgery was EUF alone in 35 (47%), abdominal indication alone 6 (8%), and both in 34 (45%). In 12 (16%) patients, laparoscopic surgery was attempted, with 4 (33%) requiring switch to open surgery. Other intraoperative findings included abscesses (17 [23%]), pseudotumoural masses (44 [59%]) and other fistula (24 [32%]). Most patients (n = 70 [93%]) underwent one-stage surgery with intestinal resection and closure of the bladder defect. In 5 (7%) patients, temporal ostomy (3 ileostomy, 2 colostomy) was required. Mean (SD) duration of hospital stay was 14 (9) days for open surgery and 7 (3) days for laparoscopic access (p < 0.001). Mean time to oral feeding was shorter for laparoscopic surgery (3 vs 5 days, p < 0.001). Early post-surgical complications occurred in 9 (12%) patients (4 abdominal abscesses, 2 anastomotic leakages, 3 haemorrhages). Two patients (3%) had late post-surgical complications (1 abscess and 1 intestinal obstruction). No deaths or EUF recurrences were reported. After surgery, patients received an immunomodulator (33 [44%]), anti-TNF therapy (3 [4%]) or both (21 [28%]). At the last follow-up visit, all patients were in sustained remission (median [IQR] follow-up from surgery 114 months [49–162]).

Conclusions: Surgical treatment for EUF is a safe and effective procedure, with no recurrences and a low rate of complications. All patients had achieved remission at the last follow-up visit. Mean times to oral feeding or hospital discharge were significantly shorter for laparoscopic surgery, with no differences for other outcomes.

P397 Outcomes after dose escalation of infliximab in Japanese patients with Crohn’s disease
M. Sako*, T. Kawaguchi, A. Hirayama, G. Fukushi, K. Hayama, T. Fujiwara, N. Yoshimura, M. Takazoe, Social Insurance Central Hospital, Centre for Inflammatory Bowel Disease, Tokyo, Japan

Background: The scheduled maintenance therapy of infliximab (IFX) for Crohn’s disease (CD) may require dose escalation due to secondary loss of efficacy. There are limited data on the response to an intensified infliximab regimen for Japanese patients with CD.

Methods: We performed a retrospective survey of 35 patients with CD who had received IFX 5 mg/kg every 5–7 weeks and has begun infusion of IFX 10 mg/kg. They received IFX therapy in extended intervals if duration period of the drug get longer. We analyzed the proportion of the patients who could extend the intervals of IFX therapy.

Results: Rapid clinical response was observed in 15/35 patients (42.9%) and they could extend intervals of infusion in one year. Among 29 patients followed over 24 months, 20.7% (6/29) were maintained in clinical remission with IFX given every 8 weeks at 12 months and 34.5% (10/29) at 24 months after the dose adjustment. 57.1% (20/35) of the patients had no change in duration of response to IFX. 7/20 patients stopped IFX therapy because of the need for surgical resection (5 patients, 4 of them continued IFX 5 mg/kg every 8 weeks after surgery), or symptoms of intestinal stenosis, no response (one patient, respectively). Two patients experienced gradual loss of efficacy. Azathioprine was used concomitantly in 5/20 patients who showed poor response to escalation, yet in responders, there was no concomitant treatment with immunomodulatory agents. Patients who could get longer intervals of IFX had started dose escalation earlier compared with those who had showed poor response (15.5±10.2 months vs. 42.1±18.7 months from the beginning of initial IFX therapy, p < 0.05). The CDAI of the patients achieving response were relatively lower (158±96.1) at the beginning of dose intensification than the poor responders (181±63.4). There was no disparity between them in C-reactive protein at dose escation (1.5 mg/L vs. 1.7 mg/L).

Conclusions: 42.9% of the patients successfully extended duration of efficacy of IFX within 2 years after dose escalation. Early intensification of IFX might lead higher rate of early remission induction.

P398 Outcome of treatment with biological agents in Crohn’s disease: 117 patients in 5 years from a tertiary referral center

Background: Over the past decade, biological agents as anti-TNF antagonists (aTNFa) have become available as effective treatment for inducing and maintaining clinical remission in luminal and fistulising Crohn’s disease (CD). Several large trials have demonstrated its efficacy and safety but just during a limited follow-up period. However, few data are available regarding clinical practice and the use of aTNFa. The aim of this study was to evaluate the efficacy and safety of aTNFa during a 5 years-period in a single center.

Methods: All consecutive CD patients receiving aTNFa between January 2007 and December 2012 were retrospectively reviewed until June 2013. Data regarding time from diagnosis, site of disease, previous medication and indication of aTNFa were collected. Initial and sustained clinical response was evaluated at 3–6 month and at the end of follow-up. Rate of corticosteroids use, hospitalizations and surgery during and after aTNFa were registered.

Results: A total of 117 CD patients (60M/57F, mean age 40.3 years; Infliximab [IFX] n = 86, Adalimumab [ADA] n = 31) were included. The main indication for aTNFa was corticodependency (40%), associated to immunomodulators (89%). Median follow-up length was 40.3 months (±12). Five patients received only induction therapy. Mean time of aTNFa treatment was 25 months (±21). Initial clinical response were showed in 72% and 75% of patients at 3 and 6 months, respectively. Significative reduction of PCR levels was determinated after 1 year (23.4±34 vs 8.4±20; p < 0.001). aTNTa was discontinued in 62 (53%) patients (55IFX/7ADA); 11% due to side effects (12 anaphylaxias and 1 tuberculosis-no mortality reported), 13% for loss of response and 21% (25) for clinical remission. Twenty-four patients changed biological agent and maintained clinical efficacy. After aTNFa discontinuation for clinical remission, the rate of relapse and new indication of aTNFa was 16% (4/25) after a follow-up time of 19±13 months.

Conclusions:
- In our series, aTNFa therapy was very efficacious to obtain clinical response during the first year of treatment (75% ± 6 months).
- Clinical remission determined biological discontinuation in 20% of patients, requiring new indication of aTNFa in 16% of these cases after 19 months.
- Use of aTNFs was safe in our population after a follow-up of 40 months.