and IBDU patients. 2.5% were off medication. 55 patients (33%) were in remission on monotherapy [5-erythromycin;ASAs n = 16, Azathioprine/6-MP n = 28 (27/1), Methotrexate n = 5, Infliximab n = 3 and Adalimumab n = 3]. 107 (64%) were on combination therapy [Azathioprine/6-MP and 5-ASA n = 45 (42/3), Azathioprine and Infliximab n = 15, 6-MP and Infliximab n = 1, Azathioprine and Adalimumab n = 5, Methotrexate and Infliximab n = 1, Methotrexate and Adalimumab n = 3, Methotrexate and 5-ASA, Azathioprine and Infliximab n = 11, 5-ASA, Azathioprine and Adalimumab n = 6]. 17/107 (16%) children were on other combinations.

Conclusion: Overall 80.5% of our patients were in clinical remission, of whom one third were on monotherapy only. Our ICN database is a very valuable tool in capturing our remission rates on mono- and combination therapies, alerting us on treatment failures.

P-033 Data on surgery in paediatric IBD (pIBD) over a 4 year period using the ImproveCareNow (ICN) collaboration data base
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Introduction: The natural history pIBD is multifactorial, colectomy rates (CR) up to 20% are reported. Previous data on UC patients (P) at this center were 3.6%. After joining ICN clinical outcomes were benchmarked against 66 other pIBD centres.

Aim: Our aim was to review surgical outcomes in pIBD patients since joining ICN.

Methods: All surgical procedures performed were captured from our ICN database over a 4 year period in 270 patients (154 male, range 0.4–16 y, median 9.7 y).

Results: All patients received standard pIBD treatment, escalating to monoclonal treatment (MT) on relapse. This aggressive approach lead to 5 (1.85%) of 270 IBD patients requiring surgery. P1 (15 y) had intractable fistulating Crohn’s disease (CD) requiring a laparoscopic total colectomy/terminal ileum (TI) resection, developing peristomal fistulae, requiring further revision. P2 (13 y) with Crohn’s-like pIBD had spontaneous perforation, needing defunctioning ileostomy. P3 (11 y) had intractable ulcerative colitis (UC, 1/66, 1.6%) requiring subtotal colectomy (STC). P4 (14 y) had IBD unclassified (IBDU) with CD-like features with transfusion dependence, requiring STC/ileostomy formation. P5 (8 y) had intractable right-sided/TI CD requiring right hemicolectomy/loop ileostomy formation. Due to on-going small bowel inflammation, stoma ulcers and rectal prolapse, stem cell transplant treatment was given and restoratory surgery at our centre was performed one year later achieving continuity.

Conclusion: In our institution only 1.85% of patients identified within the ICN database required surgical interventions after having received aggressive immunomodulatory and immunosuppressive treatment.

O-13 Fecal markers in IBD: ready for primetime!
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There is methodological sound evidence that consecutive fecal calprotectin levels below 250 μg/g indicate that IBD patients are in stable control. Clinicians should move away from single calprotectin measurements that are read in isolation, but instead shift their focus to monitoring, which is periodic calprotectin testing to guide the management of IBD.

The main objective in treating patients with IBD will be to keep fecal calprotectin levels in the target range. This involves setting up a schedule of regular calprotectin measurements to detect a drift from the target range. When a deviation is detected, the patient can be optimized. If the calprotectin level does not move toward the target range on the next occasion, the clinician should decide to increase the drug dosage, to add another therapy, or to change to another therapy.

This ‘close monitoring’ strategy should incorporate a method to avoid overdiagnosing relapse in patients with infectious diarrhea or nonsteroidal anti-inflammatory drug use, as these conditions may give an abnormal result for fecal calprotectin. If monitoring strategies as described above prove to be beneficial for patients in a randomized trial, close monitoring will be an important step forward in IBD care.

O-15 ImproveCareNow (ICN) as a quality improvement (QI) tool in a paediatric inflammatory bowel disease (pIBD)
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Introduction: ImproveCareNow (ICN) a QI program benchmarking patient visit outcomes against currently 66 pIBD centres, monitoring 18 000 pIBD patients in a live database. Agreed outcomes include Clinical Remission, Steroid-free remission, Nutrition and Growth, Disease Classification and Treatment.

Aim: To report improvements from adoption of ICN quality improvement tool benchmarking ourselves against agreed international standards.

Methods: 270 IBD patients (154 male, 0.4mo–16 yrs, median age at diagnosis 9.7 y) were registered. Data was collected prospectively with each clinic visit and entered into the database. This included diagnosis, nutrition, anthropometrics, results, medication and physicians global assessment (PGA). The QI tool required pre-clinic planning meetings and results were stratified allowing implementation of approved treatment plans. Monthly QI meetings set/review 90 day goals enabling service development.

Results: Overall remission rates increased from 60% to 77%. Steroid-free remission increased from 50% to 71%, patients off steroids increased from 60% to 92%, satisfactory nutritional status increased from 82% to 97%, satisfactory growth from 92% to 96% and nutritional failure decreased from 9% to zero.

Conclusion: By adopting the ICN standards and utilising the QI tool, we achieved measurable improvement of pIBD outcomes, using accurate collection and monitoring of data (24-hourly updated reports) and benchmarking against set standards, allowing us timely intervention. Patient care was standardised. Overall ICN has dramatically improved patient outcomes.