patients continued to take oral CsA as maintenance therapy. The endpoint of maintenance therapy was defined as disease recurrence, addition of other treatment or withdrawal of CsA by adverse events. Non-recurrence rate was analyzed by Kaplan-Meier estimate.

**Results:** In induction therapy, mean dosage of CsA was 4.2mg/kg body weight/day in oral group and 2.9mg/kg body weight/day in intravenous group. Two weeks after CsA induction therapy, mean DAIBD score was decreased from 92.5 to 43.0 and a response rate was 70.0% (60.0% in oral CsA group and 80.0% in intravenous CsA group). Even in patients with failure to biologics therapies, a response rate was high (80.0%). The endoscopic findings of all of 6 patients, who could examine in both baseline and week 2, showed partially to significantly improvement. In maintenance therapy, mean dosage of peroral CsA was 4.1 mg/kg body weight/day. Non-recurrence rate of CsA maintenance therapy was 67.5% in 26 weeks, 33.8% in 52 weeks, and 22.5% in 78 weeks. Adverse events associated with CsA therapy were pyomyositis, nephropathy, hyperkalemia, tremor, and hypertrichosis.

**Conclusions:** CsA induction therapy is effective to active intestinal BD which is refractory to the conventional therapies including biologics. Yet, the efficacy and the safety of CsA maintenance therapy remain controversial. Further controlled study is needed.

**P524**

Could histological lesions predict reactivation in ulcerative colitis patients with mucosal healing?

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**Background:** Mucosal healing (MH) is a potential target in the treatment of patients with ulcerative colitis (UC), reducing the need for surgery and the risk of colorectal cancer. MH lowers the risk of disease reactivation, but some patients relapse in spite of the presence of MH. It is reasonable to think that the microscopic disease activity beyond MH could explain these cases. Our aim is to assess how many patients with MH have a microscopic disease activity and what kind of lesions are associated with mid-term reactivation (after 6 and 12 months).

**Methods:** We retrospectively enrolled UC patients showing MH, expressed as Mayo 0 at colonoscopy, and undergone multiple biopsies during the same exam. We reviewed the corresponding histological lesions evaluating the presence of the typical histological lesions associated with UC, such as acute or chronic inflammatory infiltrate, basal plasmacytosis, basal lymphoid aggregates, stromal changes, lamina propria eosinophils, crypt branching, crypt distortion, crypt atrophy/depletion, cryptitis, crypt abscesses, surface irregularity, mucin depletion, erosions and Paneth cell metaplasia. We evaluated the number of clinical reactivation 6 and 12 months after baseline colonoscopy.

**Results:** Among 50 enrolled patients, only 3 showed no histological lesions. The most common lesion was chronic inflammatory infiltrate (82%) followed by basal lymphoid aggregates (58%), acute inflammatory infiltrate (42%) and crypt distortion (28%). After 6 and 12 months, 19% and 30% of patients relapsed, respectively. The most prevalent lesion in patients relapsing after 6 months was chronic inflammatory infiltrate (100% of relapers vs 70% of non-relapers), followed by acute inflammatory infiltrate (71% vs 37%), basal lymphoid aggregates (57% vs 50%), basal plasmacytosis (43% vs 17%) and lamina propria eosinophils (43% vs 17%). After 12 months, chronic inflammatory infiltrate was found in 82% of relapers vs 81% of non-relapers, basal lymphoid aggregates in 73% vs 46% and acute inflammatory infiltrate in 45% vs 42%, respectively.

**Conclusions:** A microscopic disease activity persists in the majority of patients with MH. Some lesions are associated with disease reactivation. Further studies are required to assess if these microscopic features can predict mid- and long-term reactivation.