the time of initial seton placement), intermediate-term (<12 months from the time of initial seton placement), and long-term (>12 months from the time of initial seton placement) outcomes were analyzed.

**Results:** The study cohort included 41 patients. Indication for placement of draining seton alone rather than definitive surgical fistula repair was presence of anal ulceration, stenosis and/or proctitis (n=30; 73%), complex fistulae not amenable to surgical repair (n=8; 20%) or patient preference (n=3; 7%). Concomitant medical therapy using biologics, immunomodulators, and/or steroids was used in 28 (68%), 14 (34%) and 13 (32%) patients, respectively. Median length of follow-up after seton placement was 35 months (range, 8–69).

Over the short-term, 16/41 (39%) patients required additional seton placement for new or persistent fistula after median follow-up time of 2.2 months (range, 0.2–5.5 months). Over the intermediate-term, 6/37 (16%) more patients required additional seton placement for new or persistent fistula after a median follow-up time of 7.7 months (range, 7–11.4 months). Over the long-term, 7/35 (20%) more patients required additional seton placement for new or persistent fistula after a median follow-up time of 16.8 months (range, 14.5–29.5 months). Overall, 29 (71%) patients required additional seton placement also had concomitant medical therapy with a biologic agent (19/29; 66%). Patients who had a family history of CD had a significantly lower incidence of additional seton placement (50%) compared to patients who did not have a family history of CD (90%) (p=0.04). All other clinical factors including concomitant medical therapy were not associated with additional seton placement.

**Conclusions:** Almost 75% of patients with planned long-term seton drainage for PFCD required additional setons. These data suggest that draining setons in PFCD, even in combination with biologic agents, may not have as promising results as previously believed. Progression of PFCD remains high despite biologic therapy and seton drainage.

**P554**

**Impact of real world home based remote monitoring on quality of care and quality of life in inflammatory bowel disease patients: one year results of pragmatic randomized trial**


**Abstract P554** – Figure 2. Interim analysis showing improvement in symptom burden among intervention cohort (p<0.001).
Abstracts of the 12th Congress of ECCO – European Crohn’s and Colitis Organisation

P555
Systematic review of interventions for chronic abdominal pain management in inflammatory bowel disease
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Background: Chronic abdominal pain is frequently reported by adults with inflammatory bowel disease (IBD), even when disease is in remission. Pain is an under-recognised and under-treated symptom. This paper will systematically review evidence on interventions for chronic abdominal pain management in patients with IBD.

Methods: Databases (MEDLINE, EMBASE, PsycInfo, CINAHL, Scopus and Cochrane Library) were searched (February 2016). Two researchers independently screened the retrieved references and extracted data.

Results: Fourteen papers were included: 12 intervention studies and two cross-sectional surveys. A range of pharmacological, non-pharmacological and dietary supplement interventions were tested. Reduction of abdominal pain was reported for: psychologist-lead stress management (p<0.05) and self-directed stress management (p<0.05), interventions with guided relaxation for both groups; relaxation in groups or individually (pain less intensive p<0.002, less frequent p<0.04, greater pain relief p<0.001 and less pain distress p<0.001). Cognitive behavioural therapy focusing on disease-related concerns also showed pain reduction. Provocative dietary supplements resulted in more pain from alcohol with high sugar content compared to ethanol (p<0.05); there was no difference in pain induced by processed and unprocessed cereals. Current and past cannabis users reported less pain with cannabis use. These results need to be treated with caution, as data were derived from predominantly small uncontrolled studies of moderate to low quality.

Conclusions: Few interventions have been tested for IBD abdominal pain. The limited evidence suggests that relaxation and changing cognitions are promising approaches, possibly with some individualised dietary changes. There is a need to develop and test interventions for abdominal pain management in IBD.

P556
Female Crohn’s disease patients and ulcerative colitis patients on biologic therapy are most disabled
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Background: There is limited disability data in the biologic era using Patient Reported Outcomes. The aims of this study were to describe the disability status and identify determinants of disability in a well characterized cohort of IBD patients using the Inflammatory Bowel Disease Disability Index (IBD-DI).

Methods: From June 2015 to September 2016, the IBD-DI was administered to adult IBD patients. Natural history data were available for each patient from time of diagnosis to time of completing the questionnaires. Clinical remission status at time of answering the questionnaire was also recorded.

Results: 250 patients with IBD completed the IBD-DI. The median duration from diagnosis to completion of questionnaire was 45 months. The median age at diagnosis was 30 years. The median IBD-DI was 31.3 (IQR 17.9–41.1). The median IBD-DI score for CD was 32.14 (IQR 19.2–45.1) in CD and 28.71 (IQR 17.4–44.5) in UC. CD females were more disabled than males (IBD-DI score 36.6 vs 27.1, p=0.001). There was no significant gender bias in the UC group (female IBD-DI score 32.6 vs male 30.6, p=NS).

Conclusions: Female CD patients are more disabled than males. The need for biologic therapy (p=0.027) and active disease (p=0.005) in UC. Female CD patients in remission were also more disabled compared with male CD patients (33.9 vs 23.9, p=0.002). There was no difference in disability scores by gender in the UC group adjusted for clinical activity. UC patients on biologic therapy were more disabled than those who were not, despite being in clinical remission (IBD-DI score 36.7 vs 25.9, p=0.03). CD patients who had undergone intestinal resection demonstrated a trend towards reduced disability compared to those who had not (IBD-DI score 30.5 vs 35.3, p=0.059). CD patients with perianal disease were not more disabled than those without, (IBD-DI score 34.0 vs 32.0, p=0.3).

P557
Utility of “trough levels” adalimumab determination in patients with inflammatory bowel disease. Estimation of individual pharmacokinetic parameters through population pharmacokinetic model
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QOL (0.8 vs 0.7; p<0.01), an effect that remained significant in multivariable models.

In a median follow up of 495 days (±135), the proportion of patients meeting all eligible QOC significantly increased in intervention group versus control group (increase of 38% versus 9%, p<0.01) (Fig. 1). Overall QOL started to improve among HealthPROMISE patients within 5 months and has consistently been above the control arm through a median interval of 495 days (Fig. 2).

Conclusions: This is one of the first randomized controlled trials of app-based home monitoring in IBD patients. Fatigue and tension are the top two drivers of poor QOL among IBD patients. We found a significant improvement in QOC and QOL in intervention group. With a move towards value based care, digital medicine technology can play an effective role in tracking and managing patient population in IBD centers. Remote monitoring coordinators can help support proactive care without disrupting physicians’ workflow.