Results: In total, 67 patients (45 CD, 22 UC) were analysed. Median treatment duration was 78 weeks (IQR 48–101). Drug survival was comparable between CD and UC patients (p = 0.180). Twenty out of 67 patients (16 CD, 4 UC) discontinued vedolizumab treatment of which 90% within the first year. Reasons for discontinuation were lack of response (n = 15; 13 CD, 2 UC), extra-intestinal manifestations (n = 2), patient wish (n = 1), anaphylactic reaction (n = 1) and death (n = 1, unrelated to vedolizumab). Clinical activity scores could be compared with baseline in 68.9% and 64.4% of CD patients and 54.5% and 50.0% of UC patients at 6 and 12 months respectively. Clinical response and remission rates were 48.3% and 32.3% at 6 months, and 41.4% and 31.0% at 12 months in CD patients and clinical response and remission rates were 66.7% and 41.7% at 6 months, and 50.0% and 33.3% at 12 months in UC patients. Baseline and follow-up endoscopy were available in 26/67 (38.8%) patients (15 CD, 11 UC), with a median time to endoscopy of 40 weeks (IQR 27–64). Endoscopic response was seen in 8/15 (47%) CD patients, and 1/15 (7%) CD patients was in endoscopic remission. Endoscopic response was seen in 9/11 (81.8%) UC patients, and 5/11 (45.5%) UC patients were in endoscopic remission.

Conclusions: Approximately 30% of IB patients that started vedolizumab reached clinical remission after 1 year and 27% of patients had discontinued treatment within the first year. The success rate of vedolizumab appears to be low in this therapy refractory cohort of IB patients.

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Complications related to varicella zoster virus infection in patients with inflammatory bowel disease in the pre-JAK inhibitors era: A prospective study
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Background: Retrospective studies performed with databases have shown that herpes zoster infection (HZ) is more frequent in patients with inflammatory bowel disease (IBD) than in the general population. To know the risk of this infection and its complications is important, especially before the introduction of JAK inhibitors into the therapeutic arsenal for IB patients. Our aim is to know the seroprevalence of varicella zoster virus (VZV) infection, and prospectively evaluate the complications associated to this infection (varicella and HZ) in adults with IBD.

Methods: Prospective and single centre study in IB patients attended at an IBD Unit between 2007 and 2017. Seroprevalence of VZV infection was assessed using IgG serological assays. Varicella cases are described. Incidence and risk factors for HZ were analysed.

Results: 96.1% of 1737 IBD patients were VZV IgG positive (seroprevalence). Among 68 seronegative patients, 32 could have been vaccinated. During follow-up 9 subjects presented a varicella (7 under immunosuppressive and/or biological treatment) and 4 of them required hospitalisation. There were no deaths associated with this acute infection. After 10,805 patient-years of follow-up, 110 cases of HZ were diagnosed; the incidence of HZ was 1.02 cases/100 patient-years (95% CI, 0.83/100 patient-years–1.21/100 patient-years). Risk factors for HZ were age (p = .008), diagnosis of Crohn’s disease (p = .001), tumours (p = .005) and the use of immunomodulators (p = .001), biologics (p = .001) and corticosteroids (p = .006). At the diagnosis of HZ, 36 patients were not receiving immunosuppressants, 53 were receiving immunomodulators, biological or steroids, and 21 were receiving ≥2 immunosuppressants. Ninety patients received antiviral treatment. In 17 patients HZ affected the trigeminal nerve, and there were no cases of visceral involvement. As complications there were 27 postherpetic neuralgia, 3 patients with ocular involvement and 1 case of Ramsay-Hunt syndrome. No patient required hospitalisation.

Conclusions: Our study shows that the risk of HZ in real life is greater than the risk described in retrospective studies. The immunosuppressants that we currently use are associated with the risk of HZ.

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Immunisation practices for hepatitis B and response to vaccination in Greek patients with inflammatory bowel disease
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Background: Low vaccination rates against hepatitis B virus (HBV) and sub-optimal response to vaccination are reported in patients with IBD. We initiated a multi-centre study in the metropolitan area of Athens, to assess: a)the percentage of IB patients with protective anti-HBs levels and b)the response to vaccination.

Methods: We reviewed the clinical records of all IB patients with regular follow-up at 4 tertiary hospitals in Athens. All patients were tested for HBsAg, anti-HBs and anti-HBc antibodies. Patients with negative tests for both HBsAg and anti-HBc were managed as follows: a)negative anti-HBs without history of vaccination: 3-dose vaccination(0,1,6mo) with 20µg b)history of vaccination: anti-HBs levels >100 IU/l; annual follow-up of anti-HBs levels; anti-HBs 10–100 IU/l, 1–3 20µg doses with anti-HBs measurement after each dose; undetectable anti-HBs, 1–3 20µg doses with anti-HBs measurement after each dose. Vaccination was considered complete when anti-HBs >100 IU/l were detected. In patients with negative anti-HBs levels after 3x20µg doses, vaccination was repeated with a double dose(40µg) with anti-HBs measurement after each dose.

Results: Our study population consists of 686 IB patients. Among those, 575 patients had recent HBV serology(84%). In our cohort we identified 8 cases of chronic HBV infection(HBsAg+) and 38 patients with previous exposure to HBV(HBsAg-, anti-HBc+). Protective immunity due to previous vaccination(HBsAg+, anti-HBc-, anti-HBs=>100 iu/l) was detected in 24%(n = 140). Sub-optimal anti-HBs levels were seen in 12%(n = 70). The majority of patients were negative for all three markers, indicating lack of effective vaccination(n = 319, 56%). Vaccination has been commenced in 243 patients. 206 patients completed their regimens. Response
has been assessed in 177 patients: 106(60%) demonstrated sufficient response while 71 failed to develop immunity to HBV. Among non-responders, 39 received repeat vaccination, with 22 having achieved protective anti-HBs levels and 17 failing to respond again. There was a significant correlation between “low-tier” (only 5-ASA or no treatment) therapy at time of vaccination and successful response (p = 0.015). There was also strong association (p < 0.001) between age and presence of protective immunity, probably due to the application of HBV vaccination in the last 2 decades in Greece.

Conclusions: A significant percentage of Greek IBD patients lack protective immunity against HBV. Classical vaccination regimen often fails to induce adequate levels of anti-HBs antibodies especially in cases that are receiving “high-tier” treatment (immunomodulation and/or immunosuppression). Increased awareness, intensified vaccination protocols and frequent testing of response may be required in this population.

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Infliximab or adalimumab: Which should be used first for Crohn’s disease? A multicentre retrospective observational study

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Background: We have debated which of the anti-TNF agents we should use first for the biologic-naive Crohn’s disease (CD) patients; infliximab (IFX) or adalimumab (ADA). There are few multicentre studies to compare the efficacy between those agents. The aim of this study was to clarify the long-term efficacy of those agents in the treatment of CD patients.

Methods: We enrolled 263 biologic-naive CD patients [median age, 39 years [IQR 30–48]] from 13 institutions in Japan and performed retrospective analysis of their characteristics and clinical courses. All the CD patients were administered IFX (n = 183) or ADA (n = 81) as a first biologics between June 2002 and March 2016, and followed for more than one year. Sixty-seven (26%) patients received an immunomodulator concomitantly at the initiation of anti-TNF agents. The primary endpoints were steroid-free remission at 32 weeks and at one year.

Results: Steroid-free remission rates at 32 weeks and at 1 year were 46.6% and 54.1% on IFX monotherapy, 66% and 74% on IFX combotherapy, 52.4% and 61.9% on ADA monotherapy, and 52.9% and 60.5% on ADA combotherapy, respectively. Significant differences were observed between IFX monotherapy and IFX combotherapy at 32 weeks and at 1 year (p = 0.021, and p = 0.018, respectively). On the other hand, there were no significant differences between ADA and IFX, and between ADA monotherapy and ADA combotherapy. Adverse events leading to drug discontinuation were observed in 12% on IFX and 5% on ADA, respectively (p = 0.11).

Conclusions: In this retrospective, multicentre, observational study, similar long-term efficacy was observed in biologics-naive CD patients between IFX first and ADA first. The efficacy of combination with an immunomodulator was observed in patients with IFX first, but not observed in patients with ADA first.

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Risk factors for poor postoperative outcome in patients with Crohn’s disease undergoing ileocecal resection

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Background: The postoperative outcome of intestinal resection in Crohn’s disease (CD) patients may be affected by multiple perioperative factors. The objective of this study was to identify risk factors of 30-day postoperative complications in CD disease patients who underwent ileocecal resection.

Methods: An observational retrospective monocentric study including CD patients who underwent ileocecal resection between January 1, 2008 and September 30, 2017 was conducted. Epidemiologic, clinical, biologic, and therapeutic characteristics were abstracted from medical records.

Results: We have colligated 89 patients of mean age of 32.8 years old. Indications for ileocecal resection was strictureing disease (n = 52; 57, 8%) and penetrating complications (n = 38; 42, 2%). Preoperative medical therapy included steroids (n = 14; 15.6%), immunosuppressants (n = 13; 14.4%), and biologics (n = 4; 4.4%). Laparoscopic ileocolic resection was performed in 55 (61, 1%) patients, while 34 (37, 8%) patients underwent an open ileocolic resection. Postoperative complications have been observed in 7 patients (7, 8%) after a median period of 11.7 days (5–21). The rates of intra-abdominal abscess, anastomotic leak and enteric fistula were 44%, 1.1% and 2.2%, respectively. Postoperative complications were associated with no preoperative blood transfusions (p = 0.016) and a low preoperative cholesterol level (<1g/l) (p = 0.016). Intra-abdominal abscess discovered during surgery (p = 0.018) and laparotomic surgery (p = 0.03) were correlated with longer postoperative stay in hospital. Other potential risk factors, such as age, gender, low preoperative haemoglobin or albumin levels, and the use of steroids or biologics were not associated with the occurrence of postoperative complications in our patients.

Conclusions: In CD patients undergoing ileocecal resection, no blood transfusion and low preoperative cholesterol level were associated with unfavourable postoperative outcome. Intra-abdominal abscess discovered during surgery and laparotomy were correlated with longer postoperative stay in hospital.