anastomotic leakage. During a mean follow-up of 3.67 years (range from 1 to 7 years) after the ileostomy reversal, one female patient presented with a pouch-vaginal fistula 14 months after ileostomy closure.

Conclusions: The specificity and negative predictive value of the combined FES and PE in identifying the intact anastomosis is very high. However, pouch leakage was misdiagnosed in the only patient of our cohort with pouch-related fistula. Studies with large number of patients are needed.

P450
Mind the gap: Why do physicians underestimate their patient’s adherence?
E. Broide1,2, A. Ein Dor1,2, A. B Shirir1, N. Ruhimovich1, H. Shirin1,2, F.M. Konikoff4, T. Nafali1,3
1Assaf Harofeh Medical Center, The Kamila Gonczarowski Institute of Gastroenterology Assaf Harofeh Medical Center, Zerifin, Israel, 2Tel Aviv University Sackler School of Medicine, Internal Medicine, Tel Aviv, Israel, 3Tel Aviv University Sackler School of Medicine, Internal Medicine, Tel Aviv, Israel, 4Shaare Zedek Medical Center, Department of Gastroenterology and Digestive Diseases, Jerusalem, Israel, 3Meir Medical Center, Gastroenterology, Kfar Saba, Israel

Background: Adherence to medical treatment can be explored either from the physician’s or the patient’s point of view. The advantages of physician's assessment are long-term acquaintance with the patient and access to the patient’s files. On the other hand, self-reported patients adherence score (Morisky score) is considered a reliable tool to assess patients adherence. The ability of physicians to assess their patient’s adherence was investigated in only a few studies. Therefore, we aimed to investigate the suitability between patients self-report (Morisky score) and physician assessment of adherence. Secondary aim was to evaluate the reasons for the gap, if any, between the two.

Methods: Patients filled questionnaires including: demographic, socioeconomic, clinical features and communication with the medical staff. Patients filled the Morisky 8 question adherence score (MMS8). In case of non-adherence, patients also reported the reasons. Physicians assessed a six item questionnaire regarding patient’s adherence to clinic appointment, treatment, medical procedures and laboratory evaluation.

Results: A total of 264 IBD patients filled the questionnaires. Median age 35.36 years, 168 (63.4%) females, 189 (71.6%) had Crohn’s disease. The suitability between patients and physicians reports is described in Table 1.

Table 1. Suitability between patients and physicians reports.

<table>
<thead>
<tr>
<th>Low Morisky score (group A)</th>
<th>High Morisky score (group B)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low physician score (group 1)</td>
<td>44 (group A1)</td>
<td>32 (group B1)</td>
</tr>
<tr>
<td>High physician score (group 2)</td>
<td>60 (group A2)</td>
<td>128 (group B2)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>104</strong></td>
<td><strong>160</strong></td>
</tr>
</tbody>
</table>

Patients with high physician score had more non-intentional non-adherence (45, 76.3%) compared with patients with a low physician score (14, 23.7%, p <0.001). Patients with low physician score had more intentional non-adherence (9, 69.2%) compared with patients with high physician score (4, 30.8%, p = 0.036).

Conclusions: The gap between physicians and patients adherence assessment might be explained by different categories of non-adherence. When the reason for non-adherence is intentional, it is easier to identify than when the reason is unintentional. Intervention in intentional non-adherence should be totally different from intervention when non-adherence is unintentional, hence the importance of identifying intentional vs. unintentional non-adherence.

P451
Long-term surgical outcome of ileal pouch-anal anastomosis when used for well-defined Crohn’s disease
D. Mandel, K. Zaghiyan, P. Fleshner*
Cedars-Sinai Medical Center, Los Angeles, USA

Background: Crohn’s disease (CD) is considered a contraindication to ileal pouch-anal anastomosis (IPAA). A preliminary study from our group in 17 patients showed the intentional use of IPAA in CD compared with ulcerative colitis patients was associated with a higher incidence of postoperative recurrent disease but no significant difference in pouch failure (Le Q et al., Inflamm Bowel Dis 2013;19:30–6). Using a larger sample size, this study sought to extend these findings in a larger patient cohort followed over a longer postoperative time.

Methods: A prospective inflammatory bowel disease registry was queried for patients with pre-operative CD undergoing IPAA. Patients were considered to have CD before surgery based on a history of perianal disease, small-bowel disease, perianal disease, pre-treatment skip lesions or non-crypt associated granuloma. Patients were prospectively assessed for pouchitis or CD. Pouchitis (acute and chronic), postoperative CD (pouch inflammation into the afferent limb or pouch fistula) or pouch failure (need for permanent diversion) were assessed.

Results: Forty patients with pre-operative CD were identified. CD was diagnosed based on perianal disease (n = 13; 32%), small-bowel disease (n = 10; 25%), pre-treatment skip lesions (n = 10; 25%) and noncaseating granuloma (n = 7; 18%). Indications for surgery were medically unresponsive disease (n = 37; 93%) or cancer/dysplasia (n = 3; 8%). After a median follow-up time of 61 (range 2–196) months, pouchitis developed in 11 (28%) patients (acute pouchitis (n = 9), chronic pouchitis (n = 2)). Seventeen (43%) patients developed postoperative recurrent CD in the afferent limb (n = 9), pouch fistulising disease (n = 4) or perianal disease (n = 4). Only one patient (3%) required faecal diversion. The incidence of recurrent CD over time is shown in the figure.

Conclusions: This largest-ever report examining the intentional use of IPAA in well-defined CD has shown a high (43%) incidence of postoperative disease. However, there is a low (3%) incidence of ultimate pouch failure. Highly motivated patients with colorectal CD involving the more proximal and/or distal gastrointestinal tract may wish to undergo IPAA and avoid a definitive end ileostomy.