and endoscopic improvements as co-primary endpoints. The relationships between clinical symptoms and endoscopic disease severity have not been established. This analysis reports correlations of endoscopic remission and response with clinical outcomes in the CELEST study.

Methods: A total of 220 adult patients, mean ± SD age of 40.7 ± 12.9 years, CD duration of 13.2 ± 10.0 years, a CD Activity Index (CDAI) 302.8 ± 63.4, average daily liquid/very soft stool frequency (SF) 6.3 ± 3.3, average daily abdominal pain score (AP) 1.8 ± 0.5 and Simplified Endoscopic Score for CD (SES-CD) 15.0 ± 3.9, were randomised to induction therapy with placebo (PBO) or UPA 3, 6, 12, 24 mg twice daily (BID) or 24 mg once daily (QD) for 16 weeks. Follow-up ileocolonoscopy was performed at either Week 12 or 16, per randomised schedule. Correlation of CDAI <150, modified clinical remission, enhanced clinical response, SF ≥2.8 and AP not worse than BL, and SF not worse than BL at Week 16 was associated with better clinical outcomes than with endoscopic remission and endoscopic response. The strongest correlation was observed between AP ≤1.0 and SF not worse than BL and endoscopic response (p = 0.61).

Table. Correlation of clinical endpoints at Week 16 and endoscopic endpoints at Week 12 of 16.

<table>
<thead>
<tr>
<th>Endpoints</th>
<th>Endoscopic Remission, p</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDAI &lt;150</td>
<td>0.53</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Modified Clinical Remission</td>
<td>0.40</td>
<td>0.006</td>
</tr>
<tr>
<td>SF ≥2.8 and AP not worse than BL²</td>
<td>0.32</td>
<td>0.048</td>
</tr>
<tr>
<td>AP ≤1.0 and SF not worse than BL¹</td>
<td>0.24</td>
<td>0.257</td>
</tr>
</tbody>
</table>

Endoscopic response: SES-CD ≤ 4 and at least two point reduction versus BL, or no subscore ≥1 in any individual variable.

Conclusions: Overall, clinical endpoints in CELEST correlated more strongly with endoscopic response than with endoscopic remission over a 16-week induction treatment period. Clinical remission (based on stool frequency and abdominal pain), and endoscopic response may be the most appropriate co-primary endpoints for short-term induction studies.

Reference

P534
Spontaneous intra-abdominal abscess in Crohn’s disease: Efficacy of non-surgical management and prognostic factors

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Background: Spontaneous intra-abdominal abscess may complicate Crohn’s disease (CD). Management is multidisciplinary and may include antibiotics alone or associated with percutaneous drainage or surgery. The aim of the study was to evaluate efficacy of non-surgical management of intra-abdominal abscess in CD patients and to identify predictive factors of a favourable response.

Methods: Medical records of CD patients who have been admitted for intra-abdominal abscess between January 2002 and October 2017 were retrospectively reviewed. Patients with postoperative abscess were excluded. Clinical, biological and radiological (CT scan or magnetic resonance imaging) response to non-surgical management of intra-abdominal abscesses were retrospectively assessed.

Results: Fifty patients were included in the study. Mean age was 32 ± 11 years old. Abscess was unilocular in 32 (64%) patients, multilocular in 10 (20%) patients and multiple in 8 (16%) patients. Median size of collection was 34 ± 41 mm. There were 36 (72%) patients who had ileal fistula. Antibiotics were prescribed in all patients during 21 ± 7 days. Imaging guided percutaneous drainage was associated in 5 (10%) patients. Radiological control was performed after a median antibiotic treatment period of 21 ± 7 days. It showed complete regression of abscess in 23 (46%) patients, partial regression in 3 (6%) patients and persistence of abscess in 21 (42%) patients. Twenty-five (50%) patients underwent surgery for medical treatment failure in 21 (42%) patients, peritonitis in 1 (2%) patient and intestinal obstruction in 2 (4%) patients. Predictive factors of favourable response to non-surgical management were: percutaneous drainage (p = 0.02), absence of ileal fistula (p = 0.047), unilocular type of abscess (p = 0.043) and more than 1.5 fold decrease of serum CRP level during the first 10 days of treatment (p = 0.01).

Conclusions: Non-surgical management of spontaneous abscess complicating a CD was effective in approximately half of patients in our series. Percutaneous drainage, unilocular type of abscess, absence of ileal fistula and significant drop of serum CRP level are predictive of favourable outcome.

Poster presentations
Royal College of Nursing IBD Network and gastroenterology special interest group of the UK Clinical Pharmacy Association.

Results: We received 142 responses. Of these, 110 (77%) were complete and were analysed. This included 50 (45%) consultants, 30 (27%) trainees, 25 (23%) IBD CNS, and 5 (5%) gastroenterology pharmacists. Over half (61, 55%) only carry out TDM in non-response. The remainder use TDM routinely, during maintenance therapy for patients in remission. Only 15 (14%) respondents reported being "clear and confident in their understanding of the difference" between drug-sensitive and drug-tolerant assays. Moreover, most (82, 75%) were unsure as to which assay their laboratory uses.

Lower therapeutic thresholds used by clinicians were variable.

What level would you consider the lower therapeutic threshold for infliximab?

Lower therapeutic thresholds used for infliximab and adalimumab.

Consultants, high-frequency TDM users (>3 requests/month) and clinicians with larger anti-TNF cohorts (>100 patients) were significantly more likely to select the 'most appropriate' answer to at least one of the five scenarios.

Conclusions: These results demonstrate quite marked heterogeneity in the practical use, understanding and interpretation of biologic TDM in IBD. Biologic decision making, informed by TDM, should involve consultation with experienced clinicians who are frequent TDM users. Ideally, as part of a multidisciplinary, biologics-focused IBD meeting.

P537
Adalimumab: Relevance of drug trough levels and antibodies assessment in the prognosis of Crohn’s disease

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Background: Monitoring of infliximab therapy in inflammatory bowel disease (IBD) is well established. As for adalimumab, there is less consolidated data. This study aimed to evaluate the usefulness of adalimumab trough levels (ATL) and serum anti-adalimumab antibodies (AAA) in the control of Crohn’s disease (CD).

Methods: This is a retrospective study assessing patients with CD treated with adalimumab followed in a tertiary hospital. Remission