if PEG oral preparation produces a significant change in calprotectin levels in UC patients and healthy subjects.

Methods: Prospective, observational study in UC patients in clinical remission, who required a colonoscopy for surveillance and a group of healthy volunteers. All subjects received an identical PEG bowel preparation. Stool samples were obtained from all subjects 24 h before and after taking PEG. Calprotectin was measured by immunoenzymatic assay. Samples were tested in duplicate and results expressed as μg/g of faeces. Clinical and demographic data of all subjects were collected. Statistical significance was determined with a two-tailed p-value of <0.05.

Results: We included 25 subjects in the study, 13 UC patients and 12 healthy volunteers. Mean age was 37.5 ± 11.4 for UC patients and 37.6 ± 13 in controls (p = ns). The time of evolution of UC was 10.3 ± 7.5 years. Sixty-one percent of UC and 58% of healthy subjects were male (p = ns). In patients with UC, the average value of calprotectin before and after taking PEG was 120 ± 74 μg/g and 159 ± 82 μg/g, respectively, without finding significant differences (p = ns). All patients were in endoscopic remission of UC (Mayo score 0 or 1). One patient presented a post-colonoscopy flare of UC that was controlled with oral corticosteroids. In healthy controls, no significant change was observed between the calprotectin value before and after the PEG intake (42.7 ± 17 vs. 47.5 ± 21 μg/g (p = ns)).

Conclusions: PEG bowel preparation does not significantly affect calprotectin levels in UC patients and healthy subjects.

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Long-term outcome of perianal fistulae treated with anti-TNFα therapy in a cohort of Saudi patients with Crohn’s disease based on Parks classification

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Background: Perianal fistulising Crohn’s disease (PFCD) causes considerable morbidity and remains one of predictor for poor long-term outcomes. Pelvic MRI has a significant role in diagnosing and monitoring response to medical treatment for complex PFCD being clinical assessment alone could miss unhealed tracts. Data looking at deep healing of complex PFCD based on MRI appearances using Parks classification remain sparse. The aim of this study was to assess the clinical efficacy of Infliximab (IFX) and adalimumab (ADA) in the treatment of complex PFCD based on Parks classification and to analyse the risk factors associated with poor response in a Saudi cohort of patients with fistulising Crohn’s disease.

Methods: All patients registered in IBDIS; a national IBD database, diagnosed with PFCD based on pelvic MRI received IFX, or ADA were identified. Data related to demographics, clinical symptoms, laboratory investigations, endoscopic findings and MRI results pre- and post-biological treatment were extracted. Response to treatment was determined based on Parks classification as full, partial, or no response at ≥12 months of treatment. Descriptive statistics for the continuous variables were reported as mean ± standard deviation (SD). The level of statistical significance was set at a p-value of < 0.05. However, this study might be underpowered to detect a difference unless we do reverse engineering to get a sample size calculation that could accommodate this number.

Results: A total of 61 patients with PFCD were included of which 27 of 61 (44.2%) had a full response, 8 of 61 (13.1%) had partial response, while 26 of 61 (42.7%) had no response with a mean disease duration of 6.2 ± 5.8. A statistically significant association was observed between poor fistulae response and anorectal involvement, high CRP, and presence of abscess. No association existed between the fistulae response and gender, smoking history, albumin, disease location, type of fistulae, or treatment with IFX vs. ADA.

Conclusions: According to this longitudinal cohort study, there was no significant difference in the clinical efficacy of adalimumab and infliximab in the treatment of perianal fistulas in CD. However less than half of the patients achieved complete healing. High CRP, perianal abscess and anorectal involvement are predictors of poor response to therapy.

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The impact of a virtual clinic on clinical decision-making and healthcare resource use vs. standard care: The Oxford experience

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