severity. Patients completed RFIPC (a 25-item questionnaire about frequently reported worries/concerns in IBD) at each visit (6-month intervals). Responses are scored on a 10-cm visual analogue scale (0='no concerns' to 10='a great deal'; total score=mean of all items). Data are reported using descriptive statistics at baseline (BL, visit 1 [V1]), 1-year (V3), and 2-years (V5) and scores stratified by physician-assessed disease severity (in remission, mild, moderate, severe) at BL.

**Results** 63 patients were included (37 [59%] female; mean ±SD age 43.4±15.7 years; median time since diagnosis 126 days; physician-assessed severity: in remission 16 [25%], mild 18 [29%], moderate 18 [29%], severe 11 [17%]). Mean±SD total RFIPC scores for all patients were 2.9±2.3 (n=63) at V1, 2.7±2.5 (n=40) at V3, and 2.2±2.0 (n=35) at V5. At BL, mean±SD RFIPC total scores by disease severity were: in remission 1.8±1.7, mild 3.2±1.9; moderate 2.6±2.6; severe 4.8±2.4. The changes from BL to V5, stratified by disease severity at BL, were: in remission -0.2±1.0, mild -1.2 ±1.4; moderate -0.7±1.7; severe -2.2±2.7. The specific concerns with the highest scores (mean RFIPC score >4.0) at BL were 'energy level', 'having an ostomy bag' and 'effects of medication'; the mean total scores for these items decreased between V1 and V5 for all patients. Of 5 UK sites, all had established multidisciplinary teams (MDTs) and 4 had a psychologist *in situ*.

**Conclusion** Despite all centres having MDTs and most having onsite psychologists, this subanalysis from ICONIC demonstrated a high burden of worries and concerns in early UC patients with more severe disease. Concerns were most notable at BL, appearing to decrease over time. The greatest concerns were with treatment and complications of UC, including energy levels, indicating fatigue remains an unmet need for UC patients.

## P166 FIRST-LINE AZATHIOPRINE- ALLOPURINOL WITHOUT METABOLITE MONITORING IS AN EFFECTIVE AND SAFE LONG-TERM THERAPY FOR IBD

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**Introduction** The number of IBD patients experiencing a beneficial response from the first-line, low-cost immunosuppressive azathioprine (AZA) is too low due to high rates of adverse events. Co-administration with allopurinol has been reported to improve tolerability and might be an option as first-line therapy.

**Methods** The long-term efficacy, side-effects and safety of low-dose azathioprine with allopurinol (LDAA) was compared with AZA monotherapy (AZAm) in thiopurine-naïve IBD patients unguided by metabolite levels. Medical records of patients (identified from pharmacy dispensing records and an IBD database) were reviewed retrospectively. The primary outcome 'clinical benefit' was defined as: ongoing use of therapy without initiation of steroids, biologics or IBD-surgery. Secondary outcomes included disease activity scores, endoscopic findings, withdrawal of concomitant therapy (including steroids), CRP and adverse events.

**Results** 166 LDAA and 118 AZAm patients (≥ 90% having active disease) were included with a median follow-up of 25 and 27 months, respectively. Clinical benefit was higher in the LDAA cohort at both 6 months (74% vs 53%, p=0.0004) and 12 months (54% vs 37%, p=0.01). The overall median duration of beneficial response since commencement of therapy was 17 months (95%-CI 9 – 25) for LDAA therapy compared to 6 months (95%-CI 1 - 11) for AZAm. The lower efficacy of AZAm was explained by the median dose tolerated of 1.83 mg/kg (73% of most effective dose) and high percentage (45%) of patients discontinuing due to intolerance. Although elevated liver function tests and leukopenia were relatively commonly observed in the LDAA cohort, they only led to treatment withdrawal in 2% for both. Increasing allopurinol dosage from 100 to 200 – 300 mg/day significantly lowered liver enzymes in the majority (83%) of patients who had developed hepatotoxicity on LDAA.

**Conclusions** Optimisation of AZA therapy for IBD is mandatory as poor outcomes were observed in our AZAm cohort. LDAA without metabolite monitoring should be considered standard first-line immunosuppressive therapy, as we demonstrated a safe and effective profile in the long-term.

## P167 RULING OUT INFLAMMATORY BOWEL DISEASE WITH FAECAL CALPROTECTIN: THE SOUTH AND WEST DEVON EXPERIENCE

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**Introduction** Faecal calprotectin (FC) testing in UK primary care is informing the diagnostic process where inflammatory bowel disease (IBD) is suspected but functional disease is likely (irritable bowel syndromes, IBS). Uptake of the regional IBD/IBS clinical pathway prompted laboratory adoption of an assay platform (Phadia 250 ELiA; ThermoFisher Scientific) offering more suitable batch sizes and facile sample preparation compared with ELISA while delivering similar analytical precision and range. Eighteen months later, comparison is made of FC diagnostic performance in the regional population *vs* published data, the clinical decision limit is reviewed and useful audit criteria established.

**Methods** Retrospective analysis of FC results (µg/g stool; analytical range 4–6000 µg/g; imprecision [2xCV] 12% at 20µg/g, 17% at 198µg/g) diagnostics reports and gastroenterology clinic letters. Letters were reviewed for all patients with results ≥100µg/g or ≥3 tests. Inclusion criteria: primary care patients 18.0–46.0y when tested, March 2018-November 2019. Exclusion criteria: known IBD, incomplete results or follow-up. Outcome measure: IBD diagnosis.

**Results** 2,962 FC results considered from 2,771 patients; of those with multiple results, 99% had only one repeat. 75% of tests in age range. 1,741 eligible results with complete follow-up. At 100 µg/g (95% CI) PPV 36% (32–40%); NPV 100% (93–100%); sensitivity 95% (88–100%) specificity 92% (85–99%.) ROC AUC 0.970 (0.957–0.982). IBD prevalence 4.1%. One false negative identified (isolated ileal Crohn's revealed by video capsule endoscopy.) 191 results 46–99 µg/g indicated repeat; 27% repeated, 60% normalized