<46 µg/g. Median time (IQR) to repeat 35d (22–74.) 70 results 100–249 µg/g indicated routine referral; median wait for review 83d (54–160.) 130 results ≥250 µg/g indicated urgent referral; median wait 59d (40–105.) 18% had endoscopy directly ('straight to test.') 16% of results <46 ug/g still referred.

Conclusions This is the largest analysis of UK primary care FC testing to date that considers IBD specifically, as opposed to any organic intestinal disease, *versus* IBS. Comparing favourably to other published work, the assay platform and clinical pathway are fit for purpose in safely and effectively ruling out IBD. A 100µg/g cut-off is optimal based on the sensitivity×specificity product. Those with significantly raised results access secondary care more quickly; direct endoscopy rates appear low but data were incomplete. Repeat tests often normalize and repeats should be mandated for all positive tests. Sensitivity drops precipitously without an appropriate age limit; educating clinical users about pretest probability should minimize false negatives, streamline test workload and reduce unnecessary clinic utilization.

P168 TOFACITINIB IN ULCERATIVE COLITIS: EARLY REAL-WORLD EXPERIENCE IN SOUTHAMPTON

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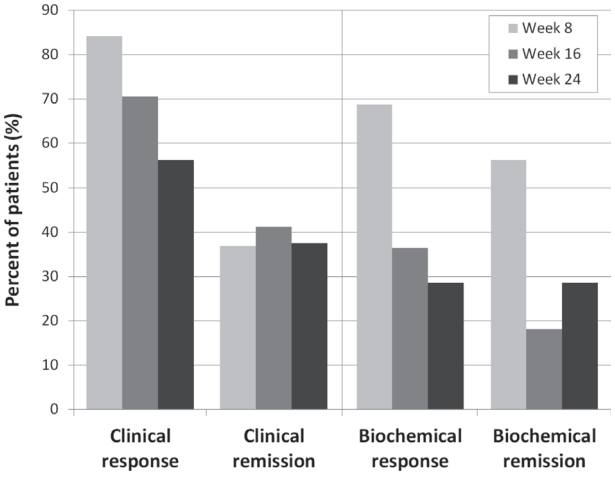
Introduction The landscape of medical therapies for severe ulcerative colitis is widening. Tofacitinib, the first oral therapy and Janus kinase (JAK) inhibitor to be approved for this indication, was licensed in the EU in August 2018 and was approved for use in the NHS by NICE in November of that year. This is a description of the real-world experience of its effectiveness and patient reported outcomes in one IBD tertiary referral centre.

Methods Patients were reviewed every 8 weeks with safety blood monitoring, adverse event recording and effectiveness measured using faecal calprotectin (FC), abbreviated-UCDAI (a-UCDAI) and IBD-Control. A retrospective observational study was conducted using intention-to-treat analysis. A clinical response was defined as a fall of a-UCDAI from baseline or a value of ≤ 2. Clinical remission was defined as a score of ≤ 2. Biochemical response (only assessed where the baseline FC was more than 250µg/g) was defined as a fall of FC of at least 50% from baseline and remission as achieving a value of < 250µg/g.

Results All 22 patients treated with tofacitinib are included in this analysis. The mean age was 46 (SD ± 14) years, 27% were male and the median disease duration was 4.4 years (IQR 3.8–13). Rates of prior exposure to at least one anti-TNFα agent and vedolizumab were 86% and 64% respectively with 59% having received both. At baseline mean calprotectin was 2119µg/g, 14 patients had an a-UCDAI ≥ 7 and 12 patients were taking an oral corticosteroid.

At 8 weeks of treatment, 16 patients (84%) achieved a clinical response and 7 (37%) achieved clinical remission (figure 1). 38% of the 16 patients with 24 weeks follow-up at the time of analysis were in clinical remission at 24 weeks. Patient-reported outcomes showed a rapid improvement with all patients having an improved IBD-Control-8 score at week 8.



Abstract P168 Figure 1 Efficacy outcomes

56% of patients were dosed with greater than 5 mg BD beyond week 8. Tofacitinib has been discontinued in 7 patients (4 primary non-response, 2 secondary loss of response and 1 due to an adverse event).

Tofacitinib was generally well tolerated and there were no venous thromboembolisms reported. There was 1 serious adverse event involving a suspected allergic reaction which resolved on discontinuation of tofacitinib.

Conclusion In this small group, that included a high proportion of complex patients, tofacitinib appears to be efficacious and well tolerated.

P169 LONG TERM ABDOMINAL DRAIN FOR PALLIATION IN ADVANCE LIVER CIRRHOSIS: SURVEY OF RISKS & BARRIERS

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Introduction Ascites is a leading cause of hospital admission in patients with cirrhosis, with up to a third developing refractory ascites (RA.) RA has a median transplant free survival of 6 months,[1] yet palliation remains sub-optimal and practice varies widely. Long term ascitic drains (LTAD) are standard of care in malignant ascites but there is a paucity of data to support this use in advanced cirrhosis. Our aim was to establish current views and practices of gastroenterologists and hepatologists towards LTAD as a palliative intervention in advanced cirrhosis.

Methods An electronic survey of 10 questions was designed by a focus group of four hepatologists with a special interest in palliative management of advanced cirrhosis. The survey included seven questions with fixed quantitative options and three exploratory questions with free text space. The survey was logged on survey monkey and distributed electronically via the BASL website and also to relevant departments in Brighton and North East London, with reminder emails in four and eight weeks.