Abstract P19 Table 1 Patient characteristics

Total	12
Median age, years (range)	**36 (22 – 69)**
Age at diagnosis, n (%)	
16 years or younger (A1)	*3 (25)*
17 to 40 years (A2)	*8 (67)*
Older than 40 years (A3)	*1 (8)*
Median disease duration, years	
Female, n (%)	**5 (60)**
Phenotype, n (%)	
Crohn's disease	**12 (100)**
Location	
Ileal (L1)	*1 (8)*
Colonic (L2)	
Ileocolonic (L3)	*11 (92)*
Upper GI (L4)	**3 (25)**
Perianal	*9 (75)*
Behaviour	
Inflammatory (B1)	*4 (33)*
Stricturing (B2)	*5 (42)*
Penetrating (B3)	*3 (25)*
Stoma	***7 (58)***
Previous luminal surgery, n (%)	*9 (75)*
Prior treatment, n (%)	*12 (100)*
Infliximab	*12 (100)*
Vedolizumab	*12 (100)*
Ustekinumab	*12 (100)*
Adalimumab	
Concomitant immunomodulation n (%)	*2 (17)*
Steroid use at initiation (%)	*2 (17)*

to 9 mg/L (1-20) at week 4 (p=0.13) and to 7 mg/L (1-34) at week 12 (p=0.029). Results are represented in Figure 1. Two patients experienced mild headaches, no other side effects were reported. At baseline two patients were being treated with concomitant steroids; one discontinued following induction and one has remained on steroids. No other patients initiated steroids. No patients discontinued risankizumab during the study period.

Conclusions We present a heterogeneous cohort of patients with refractory CD despite multiple biologic mechanisms. Overall, there was a positive impact of risankizumab induction over a 12 week period with respect to symptoms, quality of life and CRP, showing the effectiveness of risankizumab in this refractory cohort. We will follow up, and at week 24 will objectively assess disease activity with cross sectional imaging and/or endoscopy.

P20 THE EFFICACY OF THERAPEUTIC DRUG MONITORING IN INFLAMMATORY BOWEL DISEASE: A SYSTEMATIC REVIEW AND META-ANALYSIS

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Introduction There is conflicting evidence in the current literature regarding the benefits of therapeutic drug monitoring (TDM) use in providing a target to treat approach for patients with inflammatory bowel disease (IBD). The aim of this systematic review and meta-analysis was to determine whether the use of TDM results improved clinical, endoscopic, surgical and hospitalisation rates in IBD patients on anti-tumour necrosis factor (anti-TNF) therapy.

Methods MEDLINE, EMBASE and EMBASE Classic, PubMed and the Cochrane central databases register of controlled trials and the Cochrane Specialised Trials Register were searched and randomised controlled trials, observational and prospective and retrospective cohort studies between January 1st1978 to July 31st2021 were included. Relevant conference proceedings from United European Gastroenterology, European Crohn's and Colitis Society, British Society of Gastroenterology and Digestive Diseases Week from 2016 - 2021 were also included in the analysis. Results were reported as pooled relative risks [RRs] with 95% confidence intervals [CIs].

Results 11 studies were included in the meta- analysis post screening. When comparing TDM cohort vs non-TDM cohort; 224/379 (59%) vs 203/338 (60%) achieved clinical remission (RR 0.93, 95% CI 0.84 - 1.04), 221/458 (48%) vs. 263/547 (48%) achieved endoscopic remission (RR 0.96, 95% CI 0.50 - 19.85), 400/420 (95%) vs 758/857 (88%) underwent IBD related surgery (RR 1.09, 95% CI 0.99 - 1.12), 287/310 vs 269/345 were hospitalised (RR 1.17, 95% CI 0.97 - 1.14) and 306/412 (74%) vs 407/680 (60%) failed treatment (RR 0.96, 95% CI 0.27 - 3.39).

Conclusions Our results demonstrated that there was no significant improvement with the use of TDM in improving clinical and endoscopic remission, the need for hospitalisation or surgery or the rate of biologic treatment failure. Future studies with larger RCTs and standardised assays are needed to substantiate these results and validate the cost-effective use of TDM.

P21 A COLITIS BUNDLE INITIATIVE TO IMPROVE THE OUTCOME OF ACUTE IBD COLITIS PATIENTS

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Introduction Early detection and assessment of the severity are crucial in the management of an IBD flare-ups. This is so steroid therapy, the initial remission-inducing treatment can be administered at that right time. However, in those with severe colitis where steroid therapy is inadequate, often rescue therapy, either in the form of biologics or surgery is required. Simple measures during flare-ups would help to achieve this and potentially be life-saving.

Methods This project aims to review the current performance against the IBD management NICE guideline and to introduce a trust-wide Colitis bundle to ensure junior doctors and consultants can make important decisions regarding colitis patient care.

A retrospective audit was carried out on 40 In-patients with a diagnosis of an acute flare of ulcerative and Crohn's colitis over the year 2021. A proforma was created based on the latest colitis management guidelines. This reviewed step-by-step management plans over the first 3 days period –

which, if perfectly followed, will ensure deliverance of rescue therapy safely by day 3 or day 4.

Results The results showed a delay in managing acute IBD flare-ups, in which the initial steroid therapy was given to only 82.8% and the VTE prophylaxis was commenced only on 65.7% of the cases. Recognition of colitis severity as defined by Truelove and Witt's score was also poor as it happened in only 20% of the cases. This downplayed the urgency of acknowledging the need for an escalated treatment strategy, which subsequently resulted in a delay in pre-biologics screening test – this happened in 25.7% of cases only within the first 2 days of diagnosis. As this test was essential in those requiring rescue biologic therapies, this resulted in an overall delay in its initiation as demonstrated in Figure 1.

Abstract P21 Figure 1 Time between the biologic therapy decision and its first dose administration

Conclusions The quality improvement project has demonstrated poor recognition and assessment of acute IBD flare-ups as recommended by the NICE guideline. This subsequently led to a delay in initiation of the steroid therapy, pre-biologic screening test, and initiation of rescue biologic therapies in those with severe colitis. This is due to the lack of exposure among junior and senior doctors towards the guideline. As a response, a mass education at a Trust level for the doctors was recommended and a colitis bundle was constructed, which comprised of evidence-based action plans checklist divided into Day 1 to Day 3 to make sure that all the aspects are not missed.

P22 RESPONSE TO TOFACITINIB IN BRITISH ASIANS WITH ULCERATIVE COLITIS; A REAL WORLD TERTIARY CENTRE EXPERIENCE

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Introduction We have previously shown UK South Asians (SA) with IBD are prescribed TNF antagonists earlier in disease course in comparison with white British (WB) patients, but are more likely to stop due to treatment failure (Gadhok 2020). However, it is currently unknown whether there is a similar variation in response to Tofacitinib, a non-selective JAK inhibitor.

We aim to determine whether persistence to tofacitinib varies with ethnicity and evaluate real world efficacy in an inner-city tertiary referral centre.

Methods Patients prescribed Tofacitinib since 2019 were identified from electronic prescribing records. The following data was collected: ethnicity (as per UK standard coding), disease history including Montreal classification of disease extent, prior advanced therapies, persistence on therapy, indication for cessation, side effects, and endoscopic and biochemical markers of disease activity.

Results 30 adults with UC were prescribed tofacitinib, with a median duration of follow up of 833 days (n=31). 11 patients were female, and ethnicity was as follows: SA:11: Black:1:WB:12:Other/unstated:7. The median failure free survival was 447 days, with no significant variation associated with number of prior advanced therapies (1 prior biologic, 303.5 days (n=12) vs >1 prior biologic, 715 days (n=19) p=0.28).

Abstract P22 Table 1

	SA Patients	WB Patients	P Value
Number of Patients	11	12	
Mean Age (years)	41	30	
Montreal Disease Extent E1	9.09%	8.33%	0.95
Montreal Disease Extent E2	18.18%	25.00%	0.71
Montreal Disease Extent E3	54.55%	66.67%	0.57
Montreal Disease Extent Not Stated	18.18%	0.00%	0.13
1st Biologic	0.00%	0.00%	
2nd Biologic	36.36%	50.00%	0.53
3rd Biologic	27.27%	25.00%	0.91
4th Biologic	36.36%	25.00%	0.57
Continuing Treatment	18.18%	25.00%	0.71
CRP Improvement within 6 months	72.73%	66.67%	0.77
No CRP Improvement within 6 months	27.27%	33.33%	0.77
Patients Stopping Treatment at 12 weeks	9.09%	33.33%	0.17
Median Failure Free Survival (days)	304	447	0.81

Comparison between characteristics and response to treatment of South Asian and White British patients, presented in table 1:

There was no difference between median failure free survival of SA and WB patients (304 days vs 447 days, p=0.28). There was a trend towards lower primary non-response in SA patients, with fewer stopping treatment by 12 weeks, although this was not statistically significant (9.09% vs 33.33% p=0.17). No difference in disease duration at first prescription of tofacitinib between SA and WB patients was found (78.75 months vs 86.80 months p=0.78).

2 patients stopped treatment due to side effects, with 1 patient (SA) stopping due to MACE.

Conclusion In contrast to our previous work on TNF antagonists, British SA patients prescribed tofacitinib for UC had failure free survival comparable with WB patients, with a trend towards fewer primary non responders. Although limited by sample size, these findings are reassuring given that SA patients are underrepresented in trials of novel therapies in IBD and warrants a larger study.

P23 COMPARATIVE SAFETY AND EFFECTIVENESS OF USTEKINUMAB AND VEDOLIZUMAB IN ELDERLY CROHN'S DISEASE PATIENTS

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Background Anti-TNF agents are effective in treating elderly Crohn's disease (CD) patients but its use is limited by increased risk of infections and treatment discontinuation. Evidence for safety and efficacy of non-anti-TNF biologics in the elderly is limited. We aimed to compare the safety and