while no cancers were identified in the non-dye spray group. There were no differences in histological dysplasia between these groups (5 vs. 6, respectively, $p = 0.11$). Where withdrawal time was recorded ($n = 139$), median times were significantly different between both groups (dye spray 16 min (IQR: 12–25) vs. no-dye spray 10 min (8–14); χ^2 $p = 3.7 \times 10^{-4}$).

Conclusions: Our data demonstrate that there are delays to elective IBD surveillance in clinical practice. Dye spray colonoscopy is not widely practised across north-west England. Dye spray colonoscopy identified more visible dysplasia and was associated with longer withdrawal time, a recognised surrogate marker for colonoscopy quality. Our data will inform future work in optimising IBD surveillance in England.

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Female gender increases the risk of anxiety and depression in patients with inflammatory bowel disease under anti-TNFα therapy

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Background: Depression and anxiety are significant predictors of worst health-related qualify of life in inflammatory bowel disease (IBD) patients. Nevertheless, the role of anxiety and depression in IBD patients under treatment with anti-TNFα has been poorly investigated. The aim of the study was to evaluate the frequency of anxiety and depression symptoms in IBD patients under anti-TNFα therapy, and the potential factors influencing the development of these symptoms.

Methods: A prospective observational cohort study was designed. All IBD patients older than or with 18 years under treatment with anti-TNFα were consecutively included. Prevalence of anxiety and depression was assessed in IBD outpatients using the Hospital Anxiety and Depression scale (HAD). When using this scale we considered scores of 8 or higher to be abnormal. Relapse was defined in Crohn's disease (CD) as a Harvey and Bradshaw index higher than 4, and in ulcerative colitis (UC) as a Partial Mayo index higher than 2. Patient demographics and disease characteristics were also collected: age, sex, marital status, smoking habit, type of IBD, phenotype included in Montreal classification, extra-intestinal manifestations, clinical activity, prior surgery, perianal disease and steroid or immunosuppresant use. Results are shown as OR and 95% CI, and analysed by logistic regression.

Results: One hundred and nineteen patients were included (50 male, mean age 40 years, range from 20 to 83). Seventy-seven patients (64%) had CD and 42 (36%) UC; 90 of them (75%) were under maintenance treatment with infliximab and 25% with adalimumab. Anxiety and depression symptoms were presented in 38.9% and 25.2% patients, respectively. Females were more likely to have anxiety (OR = 6.13; 95% CI: 2.47–14.63; $p = 0.001$) and depression (OR = 3.32; 95% CI: 1.26–8.73; $p = 0.015$). Patients with active disease were no more likely to have anxiety (OR = 1.001; 95% CI: 0.973–1.029; $p = 0.972$) or depression (OR = 1.013; 95% CI: 0.984–1.042; $p = 0.389$). None of the other socio-demographic and clinical parameters were significantly associated with the development of anxiety or depression.

Conclusions: An important number of IBD patients under anti-TNFα present anxiety or depressive symptoms. Female gender is associated with more anxiety and depression in this group of patients. However, disease activity was not associated with neither anxiety nor depression.

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Real-life clinical and quality of life outcomes collected remotely from patients with moderate to severe active ulcerative colitis during induction treatment with golimumab in GO OBSERVE

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Background: Limited data are available concerning real-life experience with remotely collected patient-reported outcomes (PROs) in ulcerative colitis (UC).

Methods: GO OBSERVE is an ongoing international multi-centre observational trial with golimumab (GLM) in moderate to severe active UC patients naïve to or previously exposed to one other biological therapy. Patients receive standard subcutaneous GLM induction followed by maintenance with 100 mg or 50 mg every 4 weeks (q4wk). Mayo or partial Mayo score is collected at baseline and end of induction visit at either wk6, wk10, or wk14. Patients are asked to self-report their stool frequency score (SFS; 0–3) and rectal bleeding score (RBS; 0–3) q4wk into an electronic data capture system (EDC). Quality of life (QoL) scores are spontaneously reported by Short Health Scale (SHS) at baseline and end of induction. Partial Mayo response is defined as a decrease from baseline with ≥30% and ≥3 points and either a decrease from baseline in the rectal bleeding sub-score ≥1 or a rectal bleeding sub-score of 0 or 1. The use of concomitant UC medications is allowed per investigator's decision. This pre-specified interim analysis reports the results at the end of induction.

Results: In total, 102 patients were included; 88 patients have end-of-induction data for this interim analysis, including 18 patients who discontinued before wk14 due to lack of effect ($n = 12$), adverse event ($n = 3$) or withdrawal of consent ($n = 3$). Clinical response was achieved at either wk6, 10 or 14 in 32/88 (36.4%) patients; in 27/69 (39.1%) and 5/19 (26.3%) bio-naïve and anti-TNF exposed patients, respectively. Baseline and end of induction CRP (mg/l) was 5.20 ($n = 67$) and 2.20 ($n = 36$), respectively ($p = 0.038$). Baseline and end of induction median PRO2 was 4 ($n = 101$) and 2 ($n = 68$), respectively ($p < 0.001$) with a median change from baseline of -1 for both SFS and RBS. SHS scores were self-reported by 39 patients, with only 17 reporting SHS at both baseline and end of induction.

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Per cent improvement of SHS domains was: symptom burden (13%; $p = 0.008$), social function (20%; $p = 0.015$), disease-related worry (10%; $p = 0.030$), and sense of general well-being (10%; $p = 0.167$). Adverse events were reported in 20/102 patients (19.6%), including infections ($n = 4$), lack of efficacy ($n = 9$), and UC ($n = 3$). Serious adverse events were reported in 7 patients (6.9%) including 2 cases of severe UC.

Conclusions: These results from real-life practice confirm the effectiveness of GLM in active UC and show low compliance with self-reporting of PROs in UC, particularly for QoL. There is a gap between current consensus on the role of PROs in IBD and their true adoption for UC monitoring in real-life practice.

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Surgical resection in a tertiary IBD centre in Southeastern Brazil: clinical aspects and associated factors

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Background: Despite the numerous advances in medical treatment, it is estimated that a significant percentage of patients with IBD requires bowel resection at least once. The aim of this study was to evaluate patient characteristics and factors associated to surgical resection in patients with IBD in a tertiary IBD unit in Southeastern Brazil.

Methods: Retrospective analysis of data from 446 patients with IBD in follow-up at the University Hospital, Ribeirão Preto Medical School, from January 2000 up to December 2016. Medical records data comprised age, gender, disease type (Crohn's disease [CD] or ulcerative colitis [UC]), disease location, disease behaviour, disease duration and smoking. Patients were divided into two groups: presence or absence of surgical resection.

Results: Out of the 446 patients, 143 (111 CD and 32 UC) underwent surgical resection (53.2% female, 82.9% Caucasians, mean age: 45.49 ± 13.30 years). Main indications for surgery were: stenosis (10.3%), clinical intractability (6.5%) and massive haemorrhage (2.7%). Smoking ($p = 0.0109$, OR = 2.244; 95% CI: 1.237 to 4.056), stenotic phenotype ($p < 0.0001$, OR = 5.294; 95% CI: 3.073 to 9.1212), ileo-colonic location ($p < 0.0001$, OR = 3.447; 95% CI: 2.061 to 5.698) and longer disease duration (15.17 ± 9.19 vs. 7.94 ± 5.96 years) [$p < 0.0001$] were significantly associated with operations for CD. Longer duration (21.15 ± 21.58 vs. 9.79 ± 7.08 years) [$p < 0.0001$] and pancolitis ($p = 0.0014$; OR = 3.823; 95% CI: 1.698–8.605) were associated with surgical resection in UC. This results are summarised in Tables 1 and 2.

Variable	OR (95% CI)	*p*-Value
Smoking	2.244 (1.237–4.056)	0.0109
Stenotic phenotype	5.294 (3.073–9.1212)	<0.0001
Ileo-colonic location	3.447 (2.061–5.698)	<0.0001
Longer disease duration (mean)	15.17 ± 9.19 years	<0.0001

Clinical factors associated with higher risk of surgery in Crohn's disease

Variable	OR (95% CI)	*p*-Value
Longer disease duration (mean)	21.15 ± 21.58 years	< 0.0001
Pancolitis	3.823 (1.698–8.605)	0.0014

Clinical factors associated with higher risk of surgery in ulcerative colitis.

No significant differences were observed in relation to gender, race, age at diagnosis, and previous use of corticosteroids.

Conclusions: Need for surgical treatment is still frequent in patients with IBD. Smoking (current or past), longer disease time, stenotic phenotype, and ileo-colonic localisation in CD and more extensive disease in UC (pancolitis) were associated with a higher risk of surgery in our IBD Unit. Awareness about factors associated with unfavourable outcome allows these patients to be treated more appropriately.[1]

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Focussing on the future: reducing barriers and improving access to IBD specialty care

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Background: inflammatory bowel disease (IBD) is a chronic, immune-mediated disease that affects approximately two million North Americans. Canada has the highest age-adjusted incidence and prevalence rates of IBD globally. Given its cumulative prevalence, the IBD clinical burden in North America continues to grow. Limitations in accessing specialty healthcare services is not a new issue facing patients and healthcare providers. Despite this persistent problem, no research elucidating the patient perspective using qualitative approaches to compare and contrast the patient experience across diverse geographic regions has been conducted.

Methods: IBD patients (≥18 years of age) were recruited from gastroenterology clinics and communities through IBD specialists and Crohn's and Colitis Canada. Patients were recruited from both urban and rural locales to ensure adequate representation from geographically diverse regions. Focus groups provided a powerful and more naturalistic tool through which a focussed understanding of the patient experience was derived. Co-facilitated by a researcher and a patient research partner, the focus groups were held in Nova

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