No differences were found in starting with IFX (HR 1.31; 95% CI 0.68–2.54) or ADA (HR 0.74; 95% CI 0.40–1.39) There were 8 adverse events that forced the stopping of treatment: 3 in Group A, 3 in Group B and 2 in Group C ($p = 0.12$). No infections that required hospitalisation were observed.

Conclusions: The interval of time between the first and the second anti-TNF had no influence on either the rates of failure to treatment, the rates of adverse events or the rates of infections.

P493

Inflammatory sticturing Crohn's diseases: results of medical treatment

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Background: Stricture is the most common complication of CD. Treatment of stricturing CD depends on the inflammatory or fibrotic character of the stricture. However, therapeutic management of stricturing CD remains a complex situation as it has been shown that inflammatory and fibrosis are two overlapping entities. The aim of our study was to assess the short- and long-term impacts of medical treatment in inflammation stricturing CD and to identify predictors of therapeutic failure and lead to surgery.

Methods: A retrospective study over a period of 15 years (2001–2016) including all patients with CD receiving medical treatment for symptomatic inflammatory stricture was performed. The inflammatory nature of stricture was mainly identified by cross-sectional imaging examinations showing signs of active inflammation. Therapeutic failure was defined as symptomatic recurrence leading to hospitalisation or endoscopic dilation or surgery. Short andlong-term medical therapy failure were defined by occurrence of cited above events within respectively 6 and 24 months after initiation of medical therapy.

Results: Fifty-one inflammatory strictures were collected in 43 CD patients who received medical treatment. Medical therapy was based on a full-dose of oral corticosteroids in 37 cases (73%) and anti-TNF agents in 14 cases (27%). Azathioprine was prescribed in maintenance for patients who received corticosteroids in 21 cases (63%) and in combination with anti-TNF (combotherapy) in 12 patients (85%). The short-term therapeutic failure rate was 22% ($n = 11$) and the long-term therapeutic failure rate was 45% ($n = 23$). Nineteen patients (37%) needed surgery within an average of 11 months (7–18 months). In multi-variate analysis, only the presence of fistulas was associated with short-term medical therapy failure ($p = 0.014$). Active smoking (HR 3.46, 95% CI [1.129–10.821], $p = 0.009$), age at diagnosis (A1 according to the Montreal classification) (HR 2.02, 95% CI [0.613–6.715], $p = 0.036$) and presence of enteroenteric fistulas (HR 7.188, 95% CI [1.804–28.634], $p = 0.001$) were independent predictors of long-term medical therapy failure and surgery requirement.

Conclusions: Despite the identification of inflammatory nature of intestinal stricture, medical treatment fails in half of the cases and nearly 40% of patients are operated on after 2 years. This emphasises the fact that the two entities, inflammation and fibrosis, cannot be dissociated. Identify predictors of therapeutic failure, may allow us to select from the outset patients at high risk of surgery.

P494

Regional survey on satisfaction with healthcare in inflammatory bowel disease patients

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Background: Inflammatory bowel diseases (IBD) are chronic and lifelong conditions that can have a major impact on patients' lives. Due to chronic nature of the disease, patients are in constant interaction with the healthcare system. Therefore, it is of great importance to constantly question patients' needs and satisfaction to provide better and more patient-oriented care. Aim of this study was to survey IBD patients' opinion on their overall care.

Methods: We created an anonymous questionnaire and posted it to the web-based IBD patient group that gather patients from our geographical region (Croatia, Bosnia and Hercegovina, and Serbia). Besides general information, such as gender, age and diagnosis, patients were asked about their disease activity, general satisfaction with the healthcare received, access to IBD doctor, their knowledge about the disease and changes they would take to make healthcare system better. We received 387 responses between November 2017 and November 2018, and analysed them by descriptive statistics and chi square test.

Results: A total of 193 patients with Crohn's disease and 194 patients with ulcerative colitis filled the questionnaire, of which 268 (69.3%) were female. Median age was 35 years (min. 13, max. 70 years). A majority of patients ($n = 286$, 73.9%) were satisfied with their overall care. According to their opinion, important changes that would improve patient care are: better access to IBD doctor ($n = 129$, 33.3%), more educational materials ($n = 100$, 25.8%), more interaction with other IBD patients ($n = 62$, 16.0%). Twenty-one patient (5.4%) had other suggestions, and 75 patients (19.4%) would not make any change. IBD doctor's availability was of great importance, as 91.6% of patients ($n = 219$) that could easily reach to their gastroenterologist were satisfied with healthcare received compared with only 45.3% ($n = 67$; $p < .001$) of patients whose doctor was not available. Even among patients whose disease was active, IBD doctor's availability was considered important, as 83.3% ($n = 65$) of them were satisfied with healthcare if their doctor was available compared with 25% ($n = 16$; $p < .001$) of those whose doctor was not easily reachable.

Nearly half of patients considered to be excellently or well informed ($n = 193$) about the disease, 36.7% ($n = 142$) were satisfied with their level of knowledge. Major source of information about the disease was internet, IBD doctor and patient advocacy groups.

Conclusions: Most of the patients think that better access to IBD doctor would improve patient care. Therefore, improving access to the IBD service should be of special interest to us. Our aim should also be a better education of our patients by improving educational materials and promoting patient advocacy groups.

P495

Spacing the administration interval of anti-TNF agents: a valid strategy for patients with inflammatory bowel disease?

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Background: Patients with psoriasis and rheumatologic diseases are eventually treated with biological agents using treatment schedules with more spaced administrations than those approved. These schedules are cheaper and they even might reduce the risk of adverse events. However, these treatment strategies are scarcely used in inflammatory bowel disease (IBD).
Methods: Aim: Two evaluate the clinical course of IBD patients treated with anti-TNF agents by means of a spacing strategy (administration interval greater than 8 weeks for infliximab or 2 weeks for adalimumab). Using the local databases from two referral centres, all the patients with IBD who were treated with infliximab or adalimumab by means of a spacing strategy, were identified. Patients with ostomy or ileoanal pouch, indication of anti-TNF therapy for perianal disease, or adverse events as the main cause for spacing strategy, were excluded. The spacing strategy success was considered if at the end of the follow-up the patient remained in clinical remission with the same spaced schedule or without biological therapy and if no return to the conventional schedule, dose-escalation, switch, swap, a course of systemic corticosteroids or surgery were required.
Results: Eighty-five patients were included (58 Crohn's disease, 27 ulcerative/IBD unclassified). Sixty were treated with infliximab (49 every 10 weeks and 11 every 12 weeks) and 25 patients with adalimumab every 3 weeks. Prior to the index course of anti-TNF, 38% of patients followed a previous course of anti-TNF, and 7% required dose-escalation. The spacing schedule was initiated after the median of 25 months of anti-TNF treatment (IQR 14–49). Thirty-seven per cent had ileocolonoscopy (3% with endoscopic activity) and 17% MRI enterography (29% with RM activity) within 6 months before spacing began. 60% of patients were on concomitant immunomodulatory treatment at the beginning of spacing. The median time on spacing schedule was 15 months (IQR 12–25). Thirty-seven per cent of patients returned to a conventional schedule and 9% required dose-escalation. In 22 patients (26%) the anti-TNF was stopped because of sustained remission (9/22), clinical relapse (3/22), adverse events (2/22) or for other reasons (3 pregnancy, 3 neoplasia, 2 other). At the end of follow-up, 50 out of 85 patients (59%) met the success criteria of the spacing strategy. No baseline characteristics were found to be associated with success.
Conclusions: Anti-TNF administration at longer intervals than the ones provided in the data sheet of the drug can be a convenient, safe, useful and cheaper alternative for IBD patients, even though, at this time, we do not have predictors of success.

P496

Impact of ulcerative colitis on costs, work productivity and quality of life: a prospective study in a single referral centre

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Background: Ulcerative colitis (UC) is a chronic condition with a heavy economic burden for the health system and the society. Previous reports are available, but few data have been published in Italy, especially in the south.
Methods: Our aim was to evaluate prospectively, in a 1-year period, the costs of UC in a consecutive cohort of Sicilian patients, and to assess their correlation with diseases activity (evaluated by Mayo Score), disease location, Work Productivity (WPAI-RCU) scoring and quality of life. Patients were asked to fill questionnaires on Quality of life (Eq5D), Cost of Illness (COI) and use of health resources (HRU). Data on demographic, hospitalisations, surgery, visits to the treating physician and to the emergency room, laboratory tests, radiological and endoscopic examinations, drugs.
Results: We recruited 77 consecutive patients with UC coming to our IBD clinic from May 2017 to November 2017. At baseline mean age was 46.8 ± 13.6 years, 40 were males. Disease location was pancolitis in 31 patients. Twenty-four patients were in clinical remission, 24 had mild disease and 19 moderate activity. In 1-year observation period, mean cost/patient was €2898.8 for drugs, €3076.4 if we included the cost of diagnostic tests. Cost of drugs was higher in patients with pancolitis (€4142.6) than those with a limited disease (2599.7 €) and proctosigmoiditis (€2112.9) ($p = 0.004$). A relationship was also observed between drug therapy and disease activity ($p < 0.05$). There was a statistical difference among patients on biologics (€6395.5), when compared with thiopurines (€368.7) and other conventional treatments (€554.6) ($p < 0.001$). Disease activity was significantly related with work productivity ($p = 0.05$) and quality of life ($p < 0.001$).
Conclusions: Our preliminary results confirm that in Southern Italy, UC has high direct costs mainly related to drug therapies and in particular to biological therapy. Mean cost/patient/year is €3076.4 and it is significantly associated with disease activity and extent of disease. Disease activity impacts significantly on work productivity and quality of life. These preliminary results will provide useful information to health authorities to guide resource allocation and physicians to improve disease management.

P497

IL-33/ST2 levels and gut microbiota characterisation can predict mucosal response to anti-TNF therapy in ulcerative colitis

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Background: IL-33/ST2 axis and gut microbiota are important factors in the pathogenesis of IBD. Anti-TNF are able to modulate the IL-33/ST2 axis as well as gut microbiota in inflammatory conditions and are effective in inducing mucosal healing in patients with moderate-to-severe ulcerative colitis (UC). The aim of our study was to explore the potential role of the IL-33/ST2 axis and gut microbiota in the mucosal healing process mediated by anti-TNF therapy in UC.