Table. Summary of efficacy endpoints in OCTAVE Induction 1 & 2, and OCTAVE Sustain, using the Mayo score and the mMayo score

<table>
<thead>
<tr>
<th>Placette (N=224)</th>
<th>Tofacitinib 10 mg BID (N=205)</th>
<th>Difference from placebo (95% CI)*</th>
<th>Placette 10 mg BID (N=197)</th>
<th>Tofacitinib 10 mg BID (N=197)</th>
<th>Difference from placebo (95% CI)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remission, n (%)</td>
<td>14 (6.3)</td>
<td>59 (27.6)</td>
<td>45.3 (21.2)</td>
<td>40 (20.6)</td>
<td>29.3 (14.7)</td>
</tr>
<tr>
<td>Modified remission, n (%)</td>
<td>18 (7.7)</td>
<td>224 (104)</td>
<td>25.9 (15.7, 36.1)</td>
<td>82 (42.1)</td>
<td>30 (28.7)</td>
</tr>
<tr>
<td>Symptomatic remission, n (%)</td>
<td>10 (4.5)</td>
<td>102 (43.1)</td>
<td>32.6 (8.8, 56.5)</td>
<td>55 (26.9)</td>
<td>19 (12.3, 27.0)</td>
</tr>
<tr>
<td>Modified symptomatic remission, n (%)</td>
<td>10 (4.5)</td>
<td>102 (43.1)</td>
<td>32.6 (8.8, 56.5)</td>
<td>55 (26.9)</td>
<td>19 (12.3, 27.0)</td>
</tr>
<tr>
<td>Clinical remission, n (%)</td>
<td>14 (6.3)</td>
<td>60 (27.6)</td>
<td>46.3 (22.1, 69.3)</td>
<td>81 (41.1)</td>
<td>30 (28.7)</td>
</tr>
<tr>
<td>Modified clinical remission, n (%)</td>
<td>24 (12.1)</td>
<td>71 (32.9)</td>
<td>23.9 (15.3, 32.5)</td>
<td>84 (42.6)</td>
<td>30.3 (22.3, 38.5)</td>
</tr>
</tbody>
</table>

Remission was defined as a total Mayo score of ≤5 with no individual subscore >1; and at least an RB subscore of 0. Modified remission was defined as an endoscopic subscore of ≤1, no subscore >1, and no active bleeding. Remission within the ACR subset 6. Symptomatic remission was defined as a total Mayo score of ≤5 with at least an individual subscore >1. Modified symptomatic remission was defined as an endoscopic subscore of ≤1, and at least an RB subscore of 0. Clinical remission was defined as a total Mayo score of ≤5, with no individual subscore >1. Modified clinical remission was defined as an endoscopic subscore of ≤2, with no individual subscore >1.

**p<0.001** Data are analyzed with non-responder imputation; endoscopy was based on central read

Conclusion: A novel sweat-based biosensor for duplex detection of cytokine markers has been demonstrated. The developed biosensor can detect pro and anti-inflammatory cytokines that can aid in the prognosis or recovery of inflammation.

P114

PERIANAL EXAMINATION AT TIME OF COLONOSCOPY - A MISSED OPPORTUNITY FOR IBD ASSESSMENT

Rajan Patel, Sina Jamei-Oskoei, Renate Forstrom, Emma Routledge, Emma Johnson, William Blad, Voishim Wong

Introduction: The subtype of inflammatory bowel disease (IBD) is often not known at diagnosis and is often discovered and confirmed by endoscopy. Identification of disease can assist in establishing the diagnosis. PAD is common in Crohn’s disease (CD) but can also be seen in patients with ulcerative colitis (UC) in the form of fissures, abscesses and fistulae. Absence of perianal symptoms does not exclude PAD. Performing a routine perianal examination in a busy outpatient setting is not ideal and the endoscopy suite may be more appropriate. We hypothesise that perianal examinations are being omitted during IBD assessment colonoscopy.

Methods: Unisof Gi Reporting Tool was used to identify the last 70 consecutive CD and UC assessment colonoscopies performed over a 12 month period (August 2018 and July 2019) at a London-based district general hospital. Data was collected on demographics, known PAD, previous imaging and performance of perianal examination at colonoscopy.

Results: 140 patients undergoing colonoscopy for IBD assessment were included in this study (70 CD, 70 UC). Median age 42 (IQR 32-55), Female 66 (47.1%), 15 (10.7%) had known perianal disease. Pelvic MRI had previously been performed in 20 (14.3%), Perianal examination was performed in only 3 (2%) patients at the time of their last clinic consultation. Although digital rectal examination (DRE) was performed in 132 (93.6%) of patients at the time of colonoscopy, only 9 (6.4%) had a perianal examination documented.

Conclusion: About 10% of patients in our cohort undergoing IBD assessment colonoscopy were known to have PAD but perianal examination was performed in only 2% of patients during clinic consultation and 6% during colonoscopy. Perianal examination at time of endoscopic assessment is an ideal setting to perform an intimate examination as you have an exposed, sedated and chaperoned patient. The omission of perianal examination during colonoscopy is a missed opportunity and improvement in this key element of disease assessment is required.

P115

RELATIONS BETWEEN DISEASE STATUS AND BODY COMPOSITION IN PEDIATRIC INFLAMMATORY BOWEL DISEASE

Saurabh Talathi, Pooja Nagraro, Traci Jester, Jeanine Maclin, Taylor Knight, Margaux Barnes

Objective: To evaluate the effect of remission status on physical activity, and body composition in pediatric patients with inflammatory bowel disease (PIBD) and healthy peers.

Methods: Single center cohort study including 54 PIBD patients and 33 healthy peers. During initial study visit, a brief demographic questionnaire, physical activity questionnaire completed by participants and instructions on recording dietary intake were given. Physicians completed the Physician Global Assessment (PGA), Physician Global Assessment; BMI, body mass index; SSI, stov flow index; Ws, work.

Results: IBD patients were older than controls, reported lower quality of life (73.9 vs 80.9) and engaged in less MVPA (195.4 versus 361.1). IBD-Remission group had a significantly lower percentage of body composition in pediatric patients with inflammatory bowel disease (PIBD) and healthy peers.

Conclusion: Our study demonstrates that perianal examination during colonoscopy is a missed opportunity and improvement in this key element of disease assessment is required.

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PASSIVE ECCRINE SWEAT SENSING FOR DUPLEX TEMPORAL DETECTION OF CYTOKINES

Badrinath Jagannath, Siriram Muthukumar, Shalini Prasad

Introduction: Sweat based wearable sensors have shown a lot of promise in the recent years due to the ability of tracking the biomarkers in real-time. Among the various biomarkers present in sweat, cytokine concentrations have been shown in comparable range to the blood cytokines. Detection of sweat cytokines can help in monitoring of inflammation in real-time. In this work, we demonstrate a duplex cytokine sweat based sensor for real-time monitoring. The developed sensor can detect interleukin-6 (IL-6) and interleukin-10 (IL-10) in real-time that can aid in the prognosis or recovery of inflammation.

Materials and Methods: The sweat based sensor was developed with semiconducting electrode on porous polymeric substrate. Electrochemical impedance measurements technique was used to detect the interaction between the specific antibody and target analyte. The impedance response based on the binding interaction was used to quantify the sensor response. Calibration dose response based on the binding interaction was used to quantify the sensor response. Calibration dose response based on the binding interaction was used to quantify the sensor response. Calibration dose response based on the binding interaction was used to quantify the sensor response.

Conclusion: A novel sweat-based biosensor for duplex detection of cytokine markers has been demonstrated. The developed biosensor can detect pro and anti-inflammatory cytokines that can aid in the prognosis or recovery of inflammation.

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SMALL BOWEL INVOLVEMENT IN CHRONIC GRANULOMATOUS DISEASE COLITIS

Sumona Bhattacharya, Sonia Taneeja, Christa Zerbe, Suk See DeRavin, Harry Malech, Steven Holland, Christopher Koh, Theo Heller

Chronic granulomatous disease (CGD) is a rare disorder caused by genetic mutations of the nicotinamide adenine dinucleotide phosphate oxidase complex (NADPH), occurring in approximately 1/200,000 individuals. These mutations decrease residual reactive oxygen species (ROS) levels, leading to dysregulated inflammation. Inflammatory manifestations can be widespread, including severe and recurrent infections. The gastrointestinal tract is the most commonly affected organ with resultant inflammatory bowel disease, termed CGD colitis. Manifestations include abdominal pain, diarrhea with or without blood, nausea/vomiting, obstructions, and fistulas which can occur in a perianal distribution. Patients are often misdiagnosed with Crohn’s disease or ulcerative colitis, especially in the absence of extensive infectious history. We aimed to characterize the small bowel involvement in CGD.

Data is presented from a combined retrospective and ongoing prospective observational study of patients with genetically-confirmed CGD who underwent wireless video capsule endoscopy (VCE) at the National Institutes of Health Clinical Center (n = 8). VCEs were performed for clinical indications including abdominal pain (88%), diarrhea (75%), bloody stools (38%), and/or nausea/vomiting (25%). One patient (13%) underwent VCE for otherwise unexplained high inflammatory markers. Laboratory evaluation was significant for leukopenia/leukocytosis (75%), anemia (63%), and elevated C reactive-protein levels (63%). Seven patients (88%) had prior small bowel imaging, however none showed evidence of any abnormality in this organ. The most common VCE findings were ulcers and/or erosions (88%). Most patients also displayed other mucosal changes consistent with inflammation such as erythema and/or edema (88%). There was also evidence of blood or hematin on 63% of the endoscopies.

While therapies for CGD colitis are targeted towards colonic involvement, our findings show that the vast majority of symptomatic patients also have active small bowel disease including ulcers, erosions, evidence of bleeding, and other signs of inflammation. These findings, however, are not specific to CGD. Given that certain biologic medications used for Crohn’s disease and ulcerative colitis have been shown to increase the risk of life-threatening infections in patients with CGD, it is important to keep other forms of IBD, especially CGD-related IBD, in mind when interpreting small bowel capsule endoscopy in patients with suspected IBD. Lastly, in patients with confirmed CGD colitis, small bowel disease should be rigorously investigated, and therapy should also seek to address small bowel involvement. Of note, our patients did not display any radiographic abnormalities of the small bowel. Due to our small sample size, we aim to study additional patients in the future to augment our data.