

At week 14, VDZ was continued in 50 (87.7%) of the patients; in 6 patients (5 – UC, 1 – CD) VDZ was discontinued for primary non-response and in 1 patient (UC) for an adverse effect (tinnitus). Three patients required hospitalization during the induction, of them 2 were referred to colectomy and one was treated for *Clostridium difficile* infection

**Conclusions:** VDZ was effective for induction of clinical response in anti-TNF naïve patients with both UC and CD. CRP was reduced by week 14 in a vast majority of patients. Response and remission rate in anti-TNF naïve patients were substantially higher than the rates reported for anti-TNF experienced patients in current RWE series.

### P367

#### The availability of infliximab trough levels in IBD patients on maintenance therapy deeply impacts therapeutic decision-making

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**Background:** Infliximab (IFX) trough levels (ITL) have emerged as a promising tool for the management of inflammatory bowel disease (IBD) patients. However, its real usefulness in clinical practice is still controversial.

**Methods:** Observational study where IBD patients on maintenance IFX therapy were prospectively included from June 2015 to June 2016. At each IFX infusion, patients were visited by their physician and the actual clinical decision (ACD) was taken regarding clinical and biological data (C-reactive protein (CRP) levels). At this time, blood samples for ITL were collected. Our aim was to compare the ACD with the decisions of 3 experts' based on the same data plus the results of ITL (ITL-guided decision –TLGD-). The decisions between experts were also compared. Both comparisons were calculated by the linear Cohen's Kappa ( $\kappa$ ) index.

**Results:** A total of 235 infusions were analyzed among 77 IBD patients. Concordance between ACD and TLGD was poor ( $\kappa=0.10$  [95% CI: 0.01–0.20]/ $\kappa=0.11$  [95% CI: 0.01–0.21]/ $\kappa=0.10$  [95% CI: 0–0.21]) for experts A/B/C, respectively. This “disagreement” was mainly due to a higher proportion of dose-escalations according to the TLGD as compared to the ACD. Among the 215 infusions where no action was taken according to the TD, 85 (40%), 43 (20%) and 59 (28%) patients would have been dose-escalated according to the TLGD for experts A, B and C, respectively. Despite this “disagreement”, most patients remained in clinical and biological remission during the follow up, since only 28% of events were recorded as loss of response defined as clinical relapse and/or CRP  $\geq 5$  mg/L. Moreover, concordance between experts was moderate ( $\kappa=0.55$  [95% CI: 0.41–0.71]/ $\kappa=0.40$  [95% CI: 0.26–0.55]/ $\kappa=0.30$  [95% CI: 0.21–0.40]) for experts A-B/B-C/A-C respectively).

**Conclusions:** ITLs significantly change the therapeutic decision making on IBD patients treated with IFX, mainly towards dose-escalation of IFX. Both the clinical and economical impact of such a potential change in the management of IBD patients needs to be evaluated in future cohorts.

### P368

#### Treatment of inflammatory bowel disease in the elderly

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**Background:** Data on efficacy and safety of inflammatory bowel disease (IBD) treatment in the elderly is sparse as they are often excluded from clinical trials. We aimed to analyse treatment options and adverse events in elderly IBD patients.

**Methods:** Retrospective study including 345 IBD patients followed in our outpatient clinic from January 2008 to October 2016. Demographic and clinical data was analysed. Elderly was defined as patients over 60 years of age.

**Results:** 173 (50.1%) Crohn's disease, 168 (48.7%) Ulcerative colitis and 4 (1.2%) Indetermined colitis patients were included, 56.2% were female and the median follow-up was 13 years (IQR 8–19). Mean age at diagnosis was 33.0 years (IQR 23.0–45.5), 36 (10.4%) patients had elderly-onset IBD and 106 (30.7) were  $\geq 60$  years at the time of the study analysis. Charlson comorbidity index ( $4.1 \pm 1.4$  vs.  $0.8 \pm 1.3$ ,  $p < 0.001$ ) and total number of daily medications ( $4.3 \pm 3.5$  vs.  $1.6 \pm 1.6$ ,  $p < 0.001$ ) were significantly higher in patients  $\geq 60$  years. This group received more frequently sulfasalazine or 5-aminosalicylates (84.6% vs. 72.0%,  $p = 0.001$ ) and less frequently azathioprine (19.8% vs. 51.5%,  $p = 0.000$ ) or tumor necrosis factor inhibitors (13.2% vs. 36.0%,  $p = 0.000$ ). There was no significant difference concerning the use of metotrexate or surgery. When comparing elderly with non-elderly, global incidence of adverse events was not significantly different (16.0% vs. 21.3%,  $p = 0.253$ ), neither was the sub-analysis of patients under sulfasalazine or 5-aminosalicylates ( $p = 0.233$ ), azathioprine or 6-mercaptopurine ( $p = 0.786$ ) or tumor necrosis factor inhibitors ( $p = 0.549$ ). Infection was not more frequently diagnosed in the elderly ( $p = 0.784$ ).

**Conclusions:** One in each 10 patients has elderly-onset IBD. Although immunosuppression was used less frequently in this population, there was no significant differences in its safety profile.

### P369

#### Safety and lymphocyte-lowering properties of etrasimod (APD334), an oral, potent, next-generation, selective S1P receptor modulator, after dose escalation in healthy volunteers

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**Background:** Etrasimod is an oral, potent, next-generation S1P modulator with an optimized S1P receptor activity profile that is in Phase 2 clinical development for ulcerative colitis.

**Methods:** Two randomised, double-blind studies evaluated safety and pharmacodynamics of etrasimod, administered orally as single dose (Study 001; dose-escalation design) or repeat once daily (QD) dosing (Study 002; multiple ascending-dose design) in healthy adults. In Study 001, up to 8 subjects per cohort were randomised to etrasimod

mod (n=6) or placebo (n=2), starting at 0.1mg. Following screening (21 days), single doses were administered on Day 1 and observations undertaken until at least Day 7. In Study 002, up to 12 subjects in each of 3 cohorts (0.7, 1.35 and 2.0mg) received etrasimod (n=10) or placebo (n=2) for 21 days. Dosing in Cohorts 4 and 5 started at 0.35 and 0.5mg for 7 days with titration to 2.0 and 3.0mg, respectively.

**Results:** In single doses, etrasimod was well tolerated at 0.1, 0.35, 1 and 3mg. Mild-to-moderate headache (1/6–3/6 of subjects) and contact dermatitis (1/6–2/6) were the most commonly reported AEs, occurring with similar/lower frequency to placebo (2/3 each). In the 5mg cohort, 4 events of first or second degree AV block, with and without bradycardia, occurred in 3/6 subjects; although asymptomatic, further dose escalation was stopped. Dose-related declines in blood pressure and heart rate from baseline (vs placebo) were statistically significant with 3.0 and 5.0mg doses only ( $p<0.05$ ); all resolved without intervention. With multiple dosing, common AEs with etrasimod versus placebo included contact dermatitis (1/10–7/10 of subjects vs. 6/10), constipation (2/10–3/10% vs. 0), headache (1/10–3/10% vs. 4/10) and diarrhoea (2/10–3/10% vs. 1/10). These were mild-to-moderate, and not dose related. Small asymptomatic declines in blood pressure and heart rate were noted. 3 subjects developed first degree AV block (placebo: 1; 2mg: 1; 0.5/3mg: 1). No serious AEs or deaths were reported. Single etrasimod doses of 3mg and 5mg decreased total peripheral blood lymphocyte counts to 52.5% and 35.9% of baseline and with time to nadir of ~15 hours and ~11 hours post-dose, respectively. With multiple dosing, etrasimod had a dose-dependent effect on lymphocyte lowering, plateauing at 2mg QD. Median reduction in lymphocyte counts was ~67% for the higher doses (2 and 3mg QD for 21 days). For both studies, mean counts returned to baseline levels within 7 days of dosing discontinuation.

**Conclusions:** In Phase I studies, etrasimod was well tolerated and modulated lymphocyte levels when administered orally at dose levels  $\leq 3$ mg in healthy volunteers. These findings support further evaluation of this S1P modulator in clinical studies.

### P370

#### A randomised controlled trial of acceptance and commitment therapy for the treatment of stress in inflammatory bowel disease

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**Background:** The inflammatory bowel diseases are associated with high levels of psychological stress. Acceptance and commitment therapy (ACT) is a psychological intervention that comprises acceptance and mindfulness procedures along with commitment and behaviour-change strategies to increase psychological flexibility and reduce stress. The aim of this study was to determine the effect of ACT on stress in IBD patients.

**Methods:** Ninety five patients (mean age 40 years; 42 male) with quiescent or mildly active IBD were randomly assigned to an eight week ACT course (n=47) or to a control group (n=48) stratified by disease type and gender. Clinical, demographic, disease activity, biochemical (including CRP and faecal calprotectin) and psychological data were collected at i) baseline, ii) post-intervention (8 weeks) and iii) 20 weeks. Patients on antidepressants, those with psychiatric disorders or those who had received steroids over the previous three

months were excluded from study. Stress symptoms and reaction to stress was measured using the DASS-21 and perceived stress using the stressometer. Intervention and control groups were well matched for age, gender, social variables, disease activity, CRP and calprotectin levels.

**Results:** ACT was associated with a 42% and 37% reduction in DASS-21 stress scores at 8 and 20 weeks respectively, in comparison with control patients whose DASS-21 stress scores remained stable over the study period (ANOVA,  $p<0.05$ ) (see Figure 1).

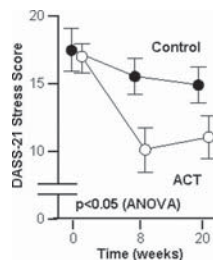


Figure 1. DASS stress scores in ACT and control groups.

ACT was also associated with a reduction in perceived stress scores at 8 and 20 weeks when compared with control patients ( $p<0.05$ ). No changes were found in clinical or biochemical disease activity, nor in other psychological parameters, in either group over the 20 week study period.

**Conclusions:** An 8 week course of ACT is an effective treatment for reducing stress in IBD patients. If it is true that stress is causally associated with subsequent IBD activity, future therapeutic paradigms may include appropriate psychological treatments to favourably impact on stress and, perhaps, long term disease activity.

ClinicalTrials.gov Registration No: NCT02350920

### P371

#### Healthcare maintenance in inflammatory bowel disease patients: need for a top down approach

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**Background:** Patients with inflammatory bowel disease (IBD) often depend on their gastroenterologist for IBD related healthcare maintenance. In our institution, we provide verbal advice to the patient and written guidance to the primary care physician on issues including vaccinations, bone health and cancer/dysplasia surveillance. Furthermore, we hold quarterly education days for newly diagnosed IBD patients and offer chronic disease self-management courses.

**Aims:** To capture adherence to ECCO healthcare maintenance guidelines and to identify factors contributing to poor compliance.

**Methods:** We administered an anonymous written survey to patients attending the IBD clinic and the infliximab infusion suite. The survey contained fourteen questions pertaining to the IBD diagnosis, medications, duration of disease, influenza and pneumonia vaccination status, smoking status, sun avoidance and sunscreen use and bone density scanning.

**Results:** One hundred and twenty-seven patients completed our survey, 59 (46%) were male, ages ranged from 17 to 78. Sixty-five patients had Crohn's, 51 ulcerative colitis, 1 indeterminate colitis and 9 patients did not know their diagnosis. Duration of disease, gender or age were not significantly associated with knowledge of disease. Patients who did not know their disease were more likely not to know what medications they took ( $p=0.002$ ) but it did not influence smok-