looks at degree of success in implementation of PROMS for IBD patients on treatment with biologics in a sample district hospital of United Kingdom.

Methods: The IBD PROMs questionnaire is filled by patients themselves when treated with biologics. The questionnaire asks overall health status, treatment of bowel condition, effectiveness in controlling bowel condition, satisfaction with quality of treatment, Crohn's and Colitis questionnaire CCQ12 and uses 12 dimensions: sleeping, appetite, energy level, rushing to the toilet, being bloated, incomplete emptying of bowels, blood in stool, generally unwell, faecal incontinence, nocturnal diarrhoea, passing wind and effect on leisure activity. It also has questions for patients with a stoma. We collected data from a sample district general hospital in United Kingdom for one year in retrospect and analysed the implementation of PROMS. We hoped at least 90% of patients would fill the PROMS questionnaire.

Results: 45 patients with IBD who were on biologics were recruited in the study. They had repeated admissions for treatment and we kept check points at 3, 6 and 12 month follow up treatments. There were 21 patients on infliximab, 23 on vedolizumab, and 1 on ustekinumab with overall total number of infusions being 352 due to their recurrent admissions for biologic treatment. A minimum of 45 PROM responses could have been achieved and maximum of 352 for good implementation. In our data only 4 were filled (8.89% of minimum and 1.1 of maximum required). Thus PROMS for IBD was not implemented to any useful extent.

Conclusion: Our study did not look at the outcomes, but simply whether the PROMS was utilised sufficiently for IBD patients on biologics. We demonstrated low uptake by one sample district general hospital of United Kingdom. Further studies to evaluate practice of other IBD units in the country would help to understand the situation better. There can be various reasons for this low uptake including lack of resource, not knowing importance of PROMS or deficient motivation in staff.

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Clinical diagnostics of fecal calprotectin: a comparative study of a semi-quantitative rapid test and a quantitative lab test

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Background: The non-specific and heterogeneous clinical symptoms complicate the diagnosis of Inflammatory bowel disease (IBD). Colonoscopy, the primary method in IBD diagnostics, is costly and invasive, and not optimal for routine disease monitoring. Fast, user-friendly, and cost-effective diagnostic tests facilitate the timely identification of inflammation and disease monitoring. Calprotectin is a pro-inflammatory protein released by neutrophils at the intestinal mucosa, and detectable in feces. Fecal calprotectin (fCal) is a sensitive biomarker that helps to detect IBD, as its concentration is directly proportional to the degree of intestinal inflammation. Furthermore, fCal analysis helps to confirm disease activity in suspected flares and guides decision-making in drug therapy allocation.

Methods: In this study the accuracy of fCal detection by the semi-quantitative Actim Calprotectin rapid test and the quantitative automated LIAISON Calprotectin assay was assessed on a panel of 119 clinical stool samples. Actim Calprotectin is a visually interpreted, semi-quantitative dipstick test that is hygienically performed in a single tube. LIAISON Calprotectin is an automated quantitative chemiluminescence immunoassay (CLIA). Analyses were performed at NordLab Oulu clinical laboratory (Oulu University Hospital, Finland).

Results: fCal testing took only about 15 min of hands-on time with Actim Calprotectin, and 40 minutes with LIAISON Calprotectin. The mean fCal concentration in the 119 analyzed clinical samples was 191.8 µg/g (median 41.9 µg/g; range 0-6,290 µg/g) as quantified by LIAISON Calprotectin. The Actim Calprotectin and LIAISON Calprotectin assays agreed on 94 samples (79.0%) (Figure 1). The fCal concentration range-specific inter-assay agreement was as follows: 81.2% at < 50 µg/g, 65.6% at 50–200 µg/g, and 94.4% at >200 µg/g. The sensitivity of Actim Calprotectin was 94.0% (n=47) for the 50 µg/g cut-off when compared to the quantitative LIAISON Calprotectin. The three samples with fCal concentrations above 50 µg/g in the LIAISON Calprotectin test but interpreted as having fCal concentration below 50 µg/g in the Actim Calprotectin test, had an fCal concentration very close to the 50 µg/g cut-off (< 70 µg/g).

Conclusion: Actim Calprotectin is a suitable method for fCal detection in a clinical setting, supporting fast disease activity and treatment response monitoring in patients with gastrointestinal inflammation. The rapid test can be utilized for the initial differentiation between negative and positive samples in an outpatient setting, thus helping to limit the use of more laborious quantitative methods to positive samples. Future investigations could focus on evaluating the utility of Actim Calprotectin in routine disease monitoring.

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Gastrointestinal ultrasound instead of magnetic resonance enterography: Large potential cost savings with limited clinical downsides

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Background: Gastrointestinal ultrasound (GIUS) is a non-invasive imaging modality capable of detecting intestinal inflammation & associated complications. It has comparable sensitivity & specificity to magnetic resonance enterography (MRE) in detecting ileocolonic disease, however it is less expensive (£24 vs £180) & can be performed at point of care.

We aimed to establish the proportion of MREs that could have been performed as GIUS at a tertiary inflammatory bowel disease (IBD) unit, the potential cost savings, & the predicted pathology miss-rates.

Methods: All MREs performed in January 2018 were retrospectively reviewed. Demographics, scan indication, IBD characteristics, surgical history, & gastrointestinal & non-gastrointestinal findings were collected. Indications deemed suitable for GIUS included: assessment of disease activity of known small bowel (SB) Crohn's disease; first assessment for presence of SB disease in IBD; & investigation for SB disease in patients without a known diagnosis of IBD. Obesity, complicated surgical history (>1 resection or strictureplasty involving different segments, or stoma), & known proximal SB disease were deemed unsuitable.

Results: 105 MREs were performed in January 2018. 59 (56%) were deemed suitable for GIUS instead of MRE. Most common reasons