PO56
Autologous Stem Cell Transplantation For Crohn’s disease (ASTIC) trial: early report of toxicity and efficacy
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Introduction: Some patients with Crohn’s disease are resistant to available treatments, none of which is curative. By resetting immune responses and by other mechanisms, autologous stem cell transplantation has the potential to cure Crohn’s disease. Case reports suggest this is the case for some but not all patients.

Aims and Methods: The ASTIC Trial randomises patients with poor quality of life despite ≥3 immunosuppressive agents to undergo stem cell mobilisation followed by high dose immunoablation and autologous hematopoietic stem cell transplantation immediately or after 1 year, and compares the number in drug free clinical and endoscopic remission at the end of the first year. Patients only enter the study after systematic scrutiny by a Steering Committee.

Results: As at November 4 2008, eighteen patients have been considered by the Steering Committee. Eight have been approved unconditionally and five subject to specific improvements in health or management. Nine patients who have entered the study are shown in the Table. Four patients did not proceed to trial entry because of spontaneous improvements.

<table>
<thead>
<tr>
<th>Age</th>
<th>Sex</th>
<th>Dura-</th>
<th>Montreal</th>
<th>Surg-</th>
<th>Isotro-</th>
<th>Trial status</th>
</tr>
</thead>
<tbody>
<tr>
<td>23</td>
<td>M</td>
<td>9</td>
<td>A1,L3,L4,B1p</td>
<td>0</td>
<td>Recurrent herpes</td>
<td>Transplant Aug 08</td>
</tr>
<tr>
<td>23</td>
<td>F</td>
<td>12</td>
<td>A1,L3,L4,B1p</td>
<td>9</td>
<td>Pancreatitis</td>
<td>Transplant Dec 08</td>
</tr>
<tr>
<td>33</td>
<td>F</td>
<td>7</td>
<td>A2,L1,L4,B2</td>
<td>0</td>
<td>Hepatotoxicity</td>
<td>Withdrawn</td>
</tr>
<tr>
<td>39</td>
<td>M</td>
<td>17</td>
<td>A2,L3,B1p</td>
<td>2</td>
<td>Anaphylaxis</td>
<td>Transplant Aug 08</td>
</tr>
<tr>
<td>36</td>
<td>M</td>
<td>15</td>
<td>A2,L1,B1</td>
<td>0</td>
<td>Veno-occlusive disease</td>
<td>Mobilised Oct 08</td>
</tr>
<tr>
<td>29</td>
<td>F</td>
<td>1.5</td>
<td>A2,L2,B1</td>
<td>0</td>
<td>Psoriasis</td>
<td>Baseline</td>
</tr>
<tr>
<td>22</td>
<td>F</td>
<td>3</td>
<td>A1,L3,B1</td>
<td>0</td>
<td>Lost response</td>
<td>Baseline</td>
</tr>
<tr>
<td>44</td>
<td>F</td>
<td>15</td>
<td>A2,L3,L4,B1p</td>
<td>4</td>
<td>Neuropathy</td>
<td>Anaphylaxis</td>
</tr>
<tr>
<td>26</td>
<td>F</td>
<td>10</td>
<td>A1,L3,L4,B2</td>
<td>2</td>
<td>Anaphylaxis</td>
<td>Mobilisation Dec 08</td>
</tr>
</tbody>
</table>

Four serious adverse events (3 infective) have been reported (3 serious, 1 SUSAR) see Table. Data on efficacy will be summarised in February 2009 and will be presented.

Conclusions: There are a significant number of patients with Crohn’s disease for whom stem cell transplantation is an appropriate course of action. The main risks are related to infection.

PO57
Usefulness of the Quantiferon TB Gold Test in assessing the necessity for TB prophylaxis in IBD patients treated with biologicals
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Introduction: Screening for latent tuberculosis is required prior to commencement of anti-TNF-alpha therapy in patients with IBD. However, the protein purified derivative (PPD) test is of low sensitivity and specificity in populations with high frequency of immunosuppressive treatment and previous BCG vaccination.

Aims and Methods: We aimed to evaluate the usefulness of the Quantiferon TB Gold test in assessing the true necessity for TB prophylactic treatment. We performed an investigation on a group of our IBD patients by performing the screening for PPD with all three tests: tuberculin skin test (PPD), chest X-ray (CXR), and Quantiferon TB Gold test (QTB). The primary goal of this study was to look at results of QTB in patients with slightly positive PPD (induration 5–15 mm), in whom the TB prophylaxis with isoniazide (INH) is recommended. In case of QTB negativity, this potentially hepatotoxic agent may be avoided, provided the CXR is also normal.

Results: One hundred and thirty four patients with both Crohn’s disease (CD) and ulcerative colitis (UC) were enrolled. Among them, 24 (18%) had slight positivity of the PPD, i.e. they had induration between 5–15 mm. Of these 24 subjects, 19 (79%) were QTB negative, 4 (17%) indeterminate, and 1 (4%) was QTB positive, respectively. None of 19 QTB negative patients was advised by the pneumologist to be prophylactically treated with INH. On the other hand, there were 3 QTB positive patients among subjects with normal PPD (induration below 5 mm), all of them had also normal CXR. Despite this, they were given INH according to pneumologist’s recommendation. Relatively more patients with QTB negativity were seen among those with normal PPD (96/104, 92%), as compared with group with slight PPD positivity (19/24, 79%). There was no positive QTB seen in patients with high PPD positivity (induration above 15 mm).

Conclusion: Using the Quantiferon TB Gold test, the prophylactic INH administration could be avoided in almost 80% of patients with slightly positive PPD test. To the contrary, some 3% of PPD negative patients were identified to be at higher risk for TB, and therefore treated with INH.

PO58
Small intestine contrast ultrasonography (SICUS): an alternative to radiology in the assessment of small bowel disease in pediatric patients with Crohn’s disease
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Radiological assessment, with either small bowel follow-through (SBFT) or enema is the reference standard in Crohn’s disease (CD), for the diagnosis of lesions located in the small bowel (SB) (1) that is not accessible to routine endoscopy. However the radiation exposure limits the use of radiology in the follow-up of CD patients. In adult subjects SICUS, performed after distension of small bowel lumen with a macrogol solution is comparable to radiological examination in detecting presence, number, extension and site(s) of SB lesions [2,3].

Aim: To evaluate the diagnostic accuracy of SICUS to assess presence, number, site and extension of SB CD lesions in pediatric patients.

Subjects and Methods: Twenty-seven consecutive patients (F 11; age range 11–23 yrs) 21 of whom with the diagnosis of CD (5 previously submitted to ileal resection/stricturoplasty) and 6 with the suspect of CD were evaluated after the ingestion of 375 ml of macrogol solution. SICUS findings were compared with those of ileocolonoscopy, SBFT, wireless capsule endoscopy (WCE) and surgery. SICUS was performed by a sonologist, unaware of radiological and endoscopic findings.

Results: SICUS was well tolerated by all patients. In undiagnosed patients CD was ascertained at SICUS in 5/6 patients confirmed at endoscopy, at SBFT and/or WCE. In 1 patient with diagnosis of IBS no lesion was found at SICUS, endoscopy and WCE. According to Montreal classification CD patients had 12 B1, 11 B2, and 3 B3 behavior (3 with p); 23 pts with ileo-terminal (L3) location, 3 with upper GI involvement (L4), 2 with ileo-terminal and upper location
Terminal/neoterminal lesions were detected at SICUS in 23 patients, confirmed at ileo-colonoscopy in 22 and at surgery in 1. Terminal/neoterminal lesions were excluded at SICUS in 1 patient with CD of the colon and in 2 operated patients with no recurrence and confirmed at ileo-colonoscopy. SICUS detected additional jejunal/proximal ileum lesions in 7 pts confirmed at radiology and/or WCE or surgery. At SICUS the extension of the proximal and distal SB lesions was 26±22.8 cm and 17±10 cm respectively. Furthermore SICUS detected extra-luminal CD findings, namely nodes enlargement and mesenteric involvement, in 21/26 patients.

**Conclusions:** These findings indicate that the non invasive procedure SICUS: 1) has a high accuracy for diagnosing Crohn’s lesions of the SB, 2) is comparable to endoscopic, radiological and WCE examination, in detecting presence and site of SB lesions, and 3) furthermore enables to assess the extension of the SB lesions. These findings support the use of non-invasive SICUS as a first choice examination in the diagnostic work up and follow up of CD pediatric patients.

**Reference(s)**

**P059**
**Incidence of pre-malignant lesions in patients with long standing ulcerative colitis**

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**Hospital Universitari Germans Trias i Pujol, Badalona, Spain**

**Introduction:** Ulcerative colitis (UC) has an increased incidence of colorectal cancer (CRC). Endoscopic surveillance should be performed depending on the extent and duration of the disease. The incidence CRC and pre-malignant lesions in the Mediterranean area has not been accurately assessed, and recent studies suggest a reduction in CCR/dysplasia risk in UC in the last years.

**Aims:** To evaluate the incidence of CRC/dysplasia/adenomas and associated risk factors in long standing UC.

**Patients and Methods:** We registered from databases of two referral centres all screening endoscopies of patients with long-standing UC (>10 years for left-sided and >15 years for extensive UC). We collected the results of endoscopy, and biopsies, risk factors, clinical and treatment data.

**Results:** 187 patients (51% males, 61% extensive UC) were included. The age at onset of the disease was 34.3±13.2 years, the median time of evolution of UC was 21.7±6.9 years at the end of follow-up. We performed a total of 503 colonoscopies (median per patient 2, IQR:1–4), 84% were full colonoscopies. We did not find any CRC but we found 8 cases of dysplasia (5 low-grade, 3 indeterminate dysplasia). Only two cases had been on immunosuppressive therapy (thiopurines for steroid-dependency). 5 out of these 8 patients had surveillance colonoscopies after the detection of dysplasia and this was confirmed only in one of them. The cumulative probability of detecting dysplasia was 0%, 2.4% and 9.5% at 10, 20 and 30 years of disease, respectively. We detected adenomatous polyps in 15.5% of patients in some of screening colonoscopies. Predictive factors for dysplasia were not identified.

**Conclusions:** In our geographical area, long standing UC appears to have a lower incidence of dysplasia/CRC as compared to other areas. These patients could present an smaller incidence of adenomas as compared to the general population.

**P060**
**The role of MR enterography for detection of enteral fistulas in Crohn’s disease, correlation with radiological and surgical findings**

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**Purpose:** Crohn’s disease (CD) is a lifelong disease arising from an interaction between genetic and environmental factors. Crohn’s disease pathogenesis is characterized by to main mechanisms, causing transmural lesions of the bowel wall and an excessive fibrogenic response. CD is a chronic inflammatory disease of the gastrointestinal tract characterized by aphthous ulceration, cobblestoning, strictures, and fistula formation. CD is accompanied by fistulas in 40–50% of the patients during the course of illness. The aims of this study are to evaluate the diagnostic value of MR enterography (MREG) in detection of enteral fistulas.

**Material and Methods:** 30 patients with known CD were enrolled in the study. All patients had histopathologic proof of Crohn’s disease. All of them were suspected of fistulating CD, 15 patients underwent previous operation.

The MREG was performed at 1.5T after the oral administration of 6% mannitol solution. The MREG protocol included TrueFISP, HASTE sequences before intravenous contrast administration and Gd-enhanced T1-weighted fat-suppressed Flash 2D i 3D and VIBE sequences.

The results of clinical examination and fluoroscopy after administration of barium were used as references. In 9 cases results were compared with surgical findings.

**Results:** Two radiologists determined presence of fistula, localization and size of tract. Interobserver agreement for detection, localization and etiology for each fistula was calculated (p < 0.05).

The most useful sequence for detection and localization fistulas were appointed T1-weighted Gd-suppressed images (Flash 2D i 3D).

38 fistulas were found in twenty eight patients in MRI: ileoileal (n = 10, Figure 1), ileocolic (n = 8, Figure 2), ileovesical (n = 9, Figure 3), rectovaginal (n = 1, Figure 4), ileocutaneous (n = 10, Figure 5, Figure 6). In 4 cases were found abscess (n = 4, Figure 7).

Interobserver agreement between two radiologist for detection of fistula was 0.8 (kappa).

The MRI results were correlated with surgical findings. Overall sensitivity, specificity and accuracy for fistula detection was 76.5%, 71.2% and 75.2% respectively. Sensitivity and specificity for correct localization was 74.1% and 75.6% respectively with visualization of the fistulas tract in all cases.

**Conclusion:** MREG is an accurate tool for detection of enteral fistulas in CD. Gadolinium-enhanced T1-weighted fat-suppressed imaging, provides the greatest conspicuity for delineation of the fistulas tract.

MREG is the most accurate preoperative technique for complete evaluation and classification of enteral fistulas.