patients (n = 11) had DEXA scans whilst 68% patients (n = 23) had not had a DEXA scan. Out of the 47 patients included in the analysis at Hospital B, 100% (n = 47) patients were exposed to corticosteroids for more than 3 months and out of these only 9% patients (n = 4) had DEXA scans whilst 91% patients (n = 43) had not had a DEXA scan.

Figure: Percentage of patients (on corticosteroids for more than 3 months) offered DEXA scan.

Conclusions: The increased risk of osteoporosis in patients with IBD can be reliably assessed by measuring BMD using a DEXA scan [1]. DEXA scan is a relatively simple, and non-invasive investigation and has good accuracy and precision (measurement error of 5–6%) [2,3]. This study has highlighted suboptimal compliance with BSG guidelines. More concerted efforts are warranted to ensure compliance nationally. Locally we intend to publicise this information in the departments and create a reminder note in clinic rooms to prompt clinicians. We intend to repeat the study in 3 months to ensure change has been implemented.

Reference(s)

P545 Bolus administration of steroid therapy is more favourable than the conventional use in preventing decrease of bone density and the increase of body fat percentage in patients with inflammatory bowel disease

K. Farkas1, A. Bálint1, Z. Valkusz1, Z. Szepes1, F. Nagy1, M. Szücs2, R. Bor1, T. Wittmann1, T. Molnár1. 1University of Szeged, First Department of Medicine, Szeged, Hungary, 2University of Szeged, Department of Medical Physics and Informatics, Szeged, Hungary

Background: The effects of short course of corticosteroids on the metabolic processes and bone formation has not been well studied. No randomized trials have studied and no guidelines have been developed on taper schedules. Our aim was to compare the efficacy, the frequency of side effects and the changes bone and lipid metabolism in IBD patients using bolus or conventional tapering of methylprednisolone for 12 weeks.

Methods: Nineteen IBD patients received intravenous methylprednisolone of 1 mg/kg for 5 days tapered by 4 mg per week. Patients were prospectively randomized in two groups. In “conventional” group (I) steroids were given daily. In “pulse” group (II) weekly dose of steroids were given on special days of the week. The body mass index (BMI) was measured before and after the corticosteroid therapy. Blood samples were collected to assess glucose level, electrolytes, cholesterol and triglycerides levels, inflammatory parameters, cortisol, osteocalcin and crosslaps values. Total body composition analysis was performed at the beginning and at the end of the steroid therapy to determine the fat and fat-free component of the body.

Results: In Group I, BMI increased, total body bone density decreased significantly at the end of the steroid therapy. Body fat percent showed a tendency to be higher at the end of steroid therapy in Group I. Serum cholesterol level increased significantly in Group I patients. The decrease in serum cortisol level was more remarkable in Group I vs. Group II after steroid therapy. Less side-effect occurred in Group II vs. Group I.

Conclusions: Our results suggest that bolus tapering of equivalent doses of methylprednisolone administered in conventional daily doses has equivalent clinical efficacy, but more favourable side effect profile. As no significant difference was detected between the two administration types on the clinical and laboratory parameters of disease activity, it appears that bolus administration of corticosteroids can safely and effectively replace the conventional use of methylprednisolone for active IBD.

P546 Biological therapy in children and adolescents: infliximab and adalimumab, a comparison of their side effects

F. Calzolari*, F. Vincenzi, F. Fornaroli, B. Bizzarri, A. Ghiselli, C. Calzolari, A. Salerno, G. Nervi, G.L. de’ Angelis. University Hospital of Parma, Gastroenterology and Digestive Endoscopy Unit, Parma, Italy

Background: Infliximab (IFX) and Adalimumab (ADA) have recently been approved for the treatment of IBD in children and adolescents (ADA only for Crohn’s disease in pediatric age). The aim of this study was to evaluate and compare adverse events and side effects arising during IFX or ADA therapy in a cohort of 63 pediatric patients affected by IBD in the period between January 2008 and June 2013.

Methods: Forty-five patients were treated only with IFX, 8 only with ADA and 10 with both of them at different times. 801 intravenous IFX infusions were administered to 55 patients (27 M and 28 F, average age 15.46 years); 38 of them were affected by CD, 14 by UC, 2 by indeterminate colitis and one by Behçet’s syndrome. 948 subcutaneous ADA injections were administered to 18 patients (6 M and 12 F, average age 15.02); among them, 15 were affected by CD and 3 by UC.

Results: In our study, the main serious adverse events observed were: infections, acute infusion reactions to IFX and drug-induced psoriasis. Infections were the most severe adverse event reported and involved 9.09% of IFX-treated patients and 27.78% of ADA-treated patients. They were mostly opportunistic (HSV, HPV, VZV and TB). As regards non-opportunistic infections, there was only one case of pneumonia caused by Mycoplasma. All infections were successfully treated, without other complications. The concomitant treatment with azathioprine didn’t increase the risk of infection in our sample. Acute infusion reactions were observed only with IFX, in 18.18% of the patients treated with this drug. The subjects involved were 2 males and 8 females: in our cohort female gender resulted as a risk factor for developing acute infusion reactions (p = 0.04191). No case required resuscitator’s intervention nor ICU admission. In 4 patients it was possible to switch to a slow infusion schedule; in the remaining 6, biological therapy was definitively suspended to avoid more serious subsequent reactions.

Drug-induced psoriasis occurred in 3 males and 7 females. Our experience showed that this adverse event is a class effect, regarding mainly female patients and involving atypical areas