Result: Microscopic, NSAIDs-induced and ischemic colitis were the main drug-induced colitides. Microscopic colitis, which included collagenous and lymphocytic colitis, was usually caused by proton-pump inhibitors and non-steroidal anti-inflammatory drugs (NSAIDs). Endoscopic findings were often unremarkable, however histology classically revealed marked lymphocytosis (lymphocytic colitis) and thickening of the sub-epithelial collagen layer (collagenous colitis). Use of anti-hypertensives, statins, ergot alkaloids, and oral contraceptives were associated with ischemic colitis. Colonoscopy revealed severe mucosal erythema and oedema with multiple non-transmural focal ulcerations. Histologically, diffuse mucosal ischaemic injury was seen, without granulomas or lymphoid infiltration. Other drug-induced colitides such as eosinophilic, immune-mediated and DRESS-induced colitis, were also discussed.
Conclusion: Drug-induced colitis represents a diagnostic challenge and may occur concomitantly with IBD. Endoscopy and histology remain the investigation of choice. Drug-induced colitis should be considered in symptomatic patients taking known offending drugs, especially NSAIDs.

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0536: POSTOPERATIVE COLONOSCOPY FOLLOW UP FOR PATIENTS WITH CROHN'S DISEASE

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Introduction: Many patients with Crohn's disease who undergo intestinal resection will suffer from peri-anastomotic recurrence. The European Crohn's and Colitis Organisation guidance (2013) recommends ileo-colonoscopy within the first year of surgery to establish treatment for prevention of recurrence disease. This study was conducted to monitor whether post-operative Crohn's patients have been managed appropriately in our unit.
Method: 93 patients with Crohn's disease who underwent ileocolic resection from 2010 to 2014 were studied retrospectively.
Result: 29 patients (31.2%) underwent postoperative colonoscopy, of which 16 (17.2%) were as a routine follow-up and 6 patients (6.5%) had it within one year. Recurrent disease was detected in 50% of patients after routine colonoscopy. In the 5-year study period, 19 patients (65.5%) had endoscopic recurrence and 12 (13%) patients had required further surgery. Medical treatment was either initiated or upgraded in only 57.9% of patients with recurrent disease detected after endoscopy. No patients compliant with endoscopic surveillance required further surgery.
Conclusion: This study highlighted poor compliance with the guideline, which is multi-factorial including a lack of awareness amongst clinicians and resource issues. This study has a number of limitations. Nonetheless, it suggests the importance of a tailored treatment in a timely manner with pre-emptive colonoscopic surveillance.

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0548: REDUCING ADMISSIONS IN PATIENTS PRESENTING WITH RECTAL BLEEDING

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Aim: Most patients presenting with fresh rectal bleeding require no intervention acutely. We aim to develop an admission algorithm to safely manage patients with rectal bleeding, with a view to reducing hospital stay.
Method: A retrospective study of 92 patients admitted with rectal bleeding was performed. Admission observations and investigations were recorded and an algorithm was developed. This was applied to the study group and the number of potentially avoidable admissions was recorded.
Result: We recorded the admission systolic blood pressure, haemoglobin and anticoagulation status. Ninetytwo patients presented with rectal bleeding, of those 62 were admitted. Among those admitted, we applied the algorithm and identified a further 21 who could have been discharged with 'hot clinic' follow up. Overall the percentage of admissions for patients presenting with rectal bleeding could have been reduced from 67% to 45%.
Conclusion: The application of this algorithm for rectal bleeding could safely avoid unnecessary admissions. Further studies are required to validate the algorithm using a larger prospective cohort in patients presenting with rectal bleeding.

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0632: WHAT HAPPENS TO THE FOLLOW-UP OF PATIENTS WHO UNDERGO INCISION AND DRAINAGE FOR PERIANAL ABSCESS?

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Aim: To conduct a temporal audit in to the follow-up of patients who undergo incision and drainage (I&D) for perianal abscess.
Method: Patients undergoing I&D of perianal abscess between January 2014 and June 2014, and those requiring a 2nd I&D, up to December 2014, were identified through theatre registers. Patient demographics, follow-up appointments, and the use of imaging were recorded from patient databases.
Result: 77 patients were identified of whom 42 (54.5%) were allocated a follow-up clinic appointment. Of these, 18 (43%) were discharged after 1 appointment, and only 5 underwent long-term follow-up. The non-attendance (DNA) rate remained high for all offered appointments (39.7 %), with an estimated cost of £1633 to the department. Median time from I&D to follow-up was 45 days (IQR 35–64). 10 patients had an episode of recurrence, with 80% receiving MRI. Median time to recurrence was 38 days (IQR 16.75–99).
Conclusion: I&D successfully managed 87.1% of patients. Follow-up practice was variable and there were high DNA rates. Recurrence tended to occur before appointed follow-up. We recommend a telephone follow-up policy at 4 weeks, followed by selective clinics to reduce DNA rates and save resources.

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0668: RANDOM COLONIC BIOPSIES FOR CHRONIC DIARRHOEA – A NUMBERS NEEDED TO INVESTIGATE APPROACH

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Introduction: Current guidelines suggest that random colonic biopsies be performed on macroscopically normal mucosa in patients undergoing diagnostic colonoscopy for chronic diarrhoea. We aim to determine the clinical benefit and economic outcomes of diagnosing microscopic colitis at a large District General Hospital.
Method: A retrospective analysis of a prospective database was performed. All patients from January to February 2014 who underwent diagnostic colonoscopy for chronic diarrhoea were included. Endoscopic and histological data was correlated accordingly.
Result: 100 patients underwent colonoscopy. 87 had macroscopically normal mucosa and subsequent biopsies. Microscopic colitis was histologically confirmed in eight patients (9.19%). Only one patient (1.15%) required active treatment (cholestyramine). Cost analysis indicates processing one sample area of random biopsies costs £48.00. On average 3 separate sample areas were taken per patient. Estimated cost to the Trust during this time period was £14,400.
Conclusion: The Number Needed to Investigate for this sample is 87. Taking random colonic biopsies are not without risk to the patient, have a low diagnostic yield and significant cost to the Trust (estimated £90k p.a.). We therefore suggest that there's no overall benefit in performing random biopsies in this cohort of patients. Further research is required to determine which cohort benefits.

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