IgA and IgG anti-TTG to increase sensitivity. There is a huge variation in the normal range of IgA TTG with the upper normal limit varying from 2.9 to 19.

The survey results were presented (AH) at the annual regional network meeting generating an active discussion amongst the attending immunologists, paediatricians, dieticians and specialist nurses, with these conclusions.

- The huge variation in normal levels, with lack of standardisation in TTG testing, is an issue in the region, as highlighted nationally.
- The Immunologists highlighted variations even within the same serological test, when using different batches requiring labs to conduct regular quality control checks.
- A network consensus followed with regards to provision of dietary review for all patients (particularly <10X serologic levels), to ensure adequate gluten intake before consideration of biopsy.

Conclusions pCD is a lifelong condition requiring an accurate diagnosis. The clinicians and immunologists continued to be challenged despite following the correct pathways and guidance. This study highlighting the strengths and benefits of a joint regional collaborative approach to help overcome some of these difficulties.

**LONG TERM SAFETY AND EFFICACY OF SINGLE DOSE PARENTERAL IRON IN CHILDREN WITH INFLAMMATORY BOWEL DISEASE IN A LARGE TERTIARY CENTRE**

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**Background** Iron-deficiency anaemia is a common complication amongst children with inflammatory bowel disease (IBD). Although single-dose parenteral iron (PIN) preparations are an easily available treatment for children, there are still concerns surrounding its adverse reactions.

**Aims** The primary aim of this study was to evaluate the safety, side effects and efficacy of IV iron maltoside 1000 (Monofer) at 6 weeks, 3 months, 6 months and 1 year after treatment in children with IBD. Also, to look for any evidence of iron overload.

**Methods** A comprehensive search was performed using the hospital’s IBD database to identify patients who have been given PIN from 2012 to 2016. Primary indication, underlying diagnosis, dose of iron, adverse reactions and laboratory values were among the parameters recorded. Dose calculations were based on the Ganzoni formula. PIN was used only if oral iron therapy is ineffective, not tolerated, not advisable or iron-deficiency anaemia with haemoglobin levels of <100 g/L. Repeated measures ANOVA was conducted for statistical analysis.

**Results** A total of 29 patients were identified. The median age was 14 and median weight was 33.4 kg. Two patients did not have the full data set. Repeated-measures ANOVA conducted on 27 patients showed that mean haemoglobin differed significantly between time points [F (4, 104)=29.416, p<0.001]. Residuals were approximately normally distributed. Post-hoc tests using the Bonferroni correction revealed that mean haemoglobin increased significantly by 6 weeks and remained stable thereafter (p<0.001).

Only one patient had an acute type 1 allergic reactions (not anaphylaxis). Two patients had hair loss at 3 months post-infusion which were unlikely to be secondary to iron overload. None of the patients had dysmetabolic iron overload syndrome (DIOS). All children had normal LFTs and GGTs with no evidence of diabetes, chronic fatigue or hepatosplenomegaly in their follow up.

**Conclusion** PIN appears to have sustained efficacy in the treatment of iron deficiency anaemia in children with IBD. Iron status increased significantly at 6 weeks and sustained till 1 year post-infusion. The immediate reaction rate was 3.7% and none of the remaining patients had any side effects including any evidence of DIOS.