classification criteria demonstrated similar sensitivity to SLICC-2012 (84.4%, $p=0.29$) and were superior to ACR-1997 ($p<0.05$). However, 10.9% of patients met no classification criteria at diagnosis.

The following results describe the 87.0% of patients meeting at least one of ACR-1997 and/or SLICC-2012 at diagnosis. The median age at diagnosis was 13.9 years. The majority of patients were female (7:1), and this ratio was maintained in the youngest patients. Non-Caucasian children were over-represented (63%). Median time to diagnosis was 4.0 months but wide variation was seen with diagnosis taking over 12 months in 21.1%. Most patients were diagnosed by rheumatology (66.1%) but a significant proportion by general paediatricians (15.2%). Presenting features were consistent with previous literature. Multisystem involvement was assessed using the domains described in the paediatric adaptation of the British Isles Lupus Assessment Group index. Multisystem involvement was common as expected (median number of systems involved was 4). Fatigue affected most patients (84.2%). 23.3% of patients had damage on the SLICC damage score at diagnosis and 12.5% of patients had acquired damage within the first year following diagnosis. All patients received systemic immunomodulatory treatment. The majority of patients (88.6%) received systemic glucocorticoids at diagnosis, with 69.9% of patients continuing to receive glucocorticoids at one year.

Conclusions Challenges in classifying patients with JSLE remain but this study supports the use of SLICC-2012 classification criteria as the best available system. The significant burden of JSLE is clearly exemplified by the high number of patients accruing disease damage within one year of diagnosis, and the significant ongoing glucocorticoid use. Further work will describe the minimum incidence of JSLE and diagnostic delay.

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AUDIT OF THE THERAPEUTIC DRUG MONITORING OF INFlixIMAB IN PAEDIATRIC INFLAMMATORY BOWEL DISEASE

Charles Bovenizer. Newcastle University

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Background Biologics have emerged as new treatment options for IBD, targeting the immune system and its products. This has revolutionised the way that IBD is managed. It is important that serum drug levels are monitored regularly to ensure the biologics are administered at therapeutic doses. If levels are not regularly tested, they may be sub-therapeutic. This increases the risk of a flare up or development of anti-infliximab antibodies.

Objectives Guidance for therapeutic drug monitoring varies between different centres. Local guidance indicates monitoring should be done pre 3rd or 4th dose. The aim of the audit was to compare practice at the GNCH to the guidance.

Methods Information regarding the timing of therapeutic drug level sampling was analyzed retrospectively, using data from electronic records, for all patients receiving Infliximab at

GNCH. Levels were judged to be 'on time', according to trust guidance, if they were taken before the 3rd or 4th doses of infliximab administration. This process would reset once serum infliximab levels were taken. Trust guidance has been determined by specialist discussion between other sites that use and monitor infliximab in paediatric IBD. This has been influenced by advice from ESPGHAN and the PANT study.¹

Results 87 patients have started on Infliximab between 2012 and 2019, aged 4 to 17 years old. 5/87 started too recently to have 4 doses, thus were excluded. Overall, 34% of patients had all their levels taken accurately, with 53% of total levels taken accurately (table 1). The improvement in accuracy coincides with the introduction of a specialist pharmacist to oversee biologic application.

Additionally, patients who started infliximab prior to 2018 had poorer accuracy in their 2019 testing with accuracies of 36, 43 and 53% in patients started in 2015, 2016 and 2017 respectively. Compared to 65% accuracy in 2018 and 71% in 2019 (table 2).

To comment on 'early' levels, although this clinically does not lead to poorer care, according to the guidelines it is over testing and an unneeded use of resources.

Of all the levels taken, 56.2% showed serum level lower than was deemed therapeutic, thus showing how important regular testing is.

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	Accuracy of levels taken between 2013–2017 (total 86)	Accuracy of levels taken between 2018–2020 (total)	Accuracy of all levels taken
On Time	35%	59%	53%
Early	34%	20%	23%
Late	31%	21%	24%

Conclusions While infliximab monitoring in GNCH has improved over the time it has been conducted there is still room for improvement. Part of this should come from further guidance from the specialist pharmacist.

My suggestions for making further improvements are:

- Increased awareness of the importance of infliximab monitoring in patients and healthcare providers.
- A messaging system, similar to the one used for Azathioprine, to remind patients and day case units when they require a blood test.
- Infliximab blood test forms should be made electronic, like other blood tests, in order to improve accessibility.

In further audits it may be informative to explore how these levels were used, compared to algorithms/recommendations set by studies like that conducted by Vaughn *et al.*²

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