cuff. These patients have IPS (AJG 2002;97:972–7). Clinical features and QOL have yet to be studied.

Methods: We prospectively assessed 45 consecutive symptomatic UC patients with IPAA. Age-matched diarrhea-predominant IBS patients were included as controls. Pouchitis was defined as Pouchitis Disease Activity Index (PDAI) score ≥ 7. Cuffitis was defined as presence of symptom and endoscopic and histologic inflammation of the rectal cuff. IPS was diagnosed in symptomatic patients (a total of 12 wks in a 12-mo period) with the absence of endoscopic and histologic inflammation of pouch and cuff. Crohn's disease was excluded. We used disease-specific QOL instruments, the 3-item Cleveland Global Quality of Life (CGQL, scale 0–1.0, from the worst to best QOL) designed for patients with IPAA, and the 34-item IBS-QOL (scale 34–170, from the best to worst QOL) designed for patients with functional bowel disorders.

Conclusions: 1) IPS, similar to IBS, had a significantly negative impact on patients' QOL, as did pouchitis and cuffitis; 2) Bleeding is almost exclusively seen in patients with cuffitis; 3) Bloating, abdominal pain relieved with defecation, and symptoms associated with stress/food, are most often seen IPS and IBS, suggesting a common pathophysiology of these two disease entities.

	Nl Pouch (N=14)	Cuffitis (N=7)	Pouchitis (N=11)	IPS (N=13)	IBS (N=10)
PDAI sx score (± SD)	0.3 ± 0.5	3.5 ± 1.6*	3.5 ± 1.7*	3.3 ± 0.7*	N/A
Bleeding (n, %)	0**	7 (100%)	1 (9%)**	0**	0**
Sxs a/w food/stress (n, %)	N/A	1 (16%)	8 (73%)**	12 (92%)**	10 (100%)**
Abd pain relieved by defecation (n,%)	N/A	0	2 (18%)	11 (85%)***	10 (100%)***
Bloating	1 (7%)	1 (14%)	3 (27%)	12 (92%)****	8 (80%)****
CGQL (mean±SD)	0.8 ± 0.2	0.6 ± 0.2*	0.6 ± 0.1*	0.6 ± 0.2*	0.6 ± 0.2*
IBS-QOL (mean±SD)	63.6 ± 17.9	94.0 ± 16.2*	87.5 ± 30.2*	110.2 ± 31.2*	83.4 ± 29.5*

* P< 0.05, vs nl pouch;** P < 0.026, vs cuffitis; *** P < 0.003, vs pouchitis & cuffitis; P<0.014, vs nl pouch, cuffitis, & pouchitis

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INFLAMMATION VS. FIBROSIS: EVALUATION OF SMALL BOWEL NARROWING IN CROHN'S DISEASE WITH CT ENTEROGRAPHY

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Terminal ileal narrowing due to Crohn's disease often presents a clinical dilemma: is the narrowing due to inflammation that will be responsive to medications, or is it due to fibrosis that will necessitate surgery? Currently available imaging is unable to answer this question. CT Enterography (CTE) using a 16-slice Multidetector CT scanner has high resolution and allows 3-D reconstruction. Oral water contrast provides excellent luminal detail and is well tolerated by patients. Arterial and venous phase imaging with an iodinated contrast bolus can identify areas with increased blood flow expected in active inflammation. Sixteen patients with small bowel Crohn's disease and symptoms of cramping abdominal pain suggestive of small bowel narrowing were evaluated with CTE. A review of patient bowel movements, blood in stool, sedimentation rate, white blood cell count, and endoscopy results prior to CTE were used by an experienced gastroenterologist blinded to the CTE result to make a clinical judgement of whether inflammation was present or not. Bowel wall thickening, mucosal contrast enhancement, increased bowel vascularity, fat (identified by CT densitometry with Hounsfield Units) in the layers of the bowel wall, and soft-tissue stranding in fat in the tissue surrounding the bowel wall were determined to be present or absent by a radiologist blinded to the clinical results. These radiologic findings were used to calculate a CTE inflammation score (CTEIS range: 0 to 5). One patient's results were discarded because the CTE revealed a small bowel leiomyosarcoma. The average CTEIS for the 8 patients with clinically-defined inflammation was 4.38 ± .74. The average CTEIS for the 7 patients without clinically-defined inflammation was 2.29 ± 1.25. The p-value for this difference was 0.002. Using a cutoff of 3.5, the CTE has a sensitivity of 88% and a specificity of 86% for active inflammation. This study shows that findings on CTE may identify active inflammation in Crohn's disease. The data from this cohort will be used to develop a predictive model that will be validated in a propspective cohort. CTE may prove valuable for distinguishing small bowel narrowing due to inflammation from small bowel narrowing due to fibrosis.

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ALCOHOL IS WELL TOLERATED IN IBD PATIENTS TAKING EITHER METRONIDAZOLE OR 6-MERCAPTOPURINE

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Purpose: 6-Mercaptopurine and metronidazole are commonly used agents in patients with Crohn's disease and ulcerative colitis. Pharmacists and/or physicians caution most patients not to ingest alcohol when taking these medications due to the adverse reactions that may occur. The existence of such reactions has been poorly documented. This study is aimed at assessing the presence of adverse events in patients taking chronic metronidazole and/or 6-mercaptopurine in combination with alcohol.

Methods: A total of 207 patients were identified from a random chart review of a private gastroenterology practice specializing in IBD. They were divided into three groups – patients on 6-mercaptopurine, patients on metronidazole and a control group of patients that were not taking either drug. Symptoms of adverse reactions to alcohol consumption were assessed in all three groups using a phone survey.

Results: All of the patients consumed less then four alcoholic beverages per day. The percentages of patients experiencing any clinically significant symptoms are as follows: metronidazole group 16.3%, 6-mercaptopurine group 14.5%, control group 8.97%. While there is a trend towards more side effects in the study groups, no statistically significant difference was observed (2-tailed p-value of 0.47 for 6-mercaptopurine vs. controls and 0.33 for metronidazole vs. controls). One-tailed p-values to test for the positive association between ethanol and either of the drugs were also non-significant (0.23 for 6-mercaptopurine vs. controls and 0.17 for metronidazole vs. controls).

Conclusions: Our study does not indicate any significant interactions between alcohol and either metronidazole or 6-mercaptopurine. A cautious trial of alcohol is advisable in patients that are starting and will be taking either of the medications on a chronic basis.

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DOES ELEVATED BODY MASS INDEX AFFECT THE CLINICAL COURSE OF CROHN'S DISEASE?

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Purpose: It is generally perceived that Crohn's disease (CD) patients are unlikely to have an elevated body mass index (BMI). Excess TNF production in adipose tissue is well documented, and TNF production has been shown to correlate with disease activity. Given this association, we hypothesized that patients with increased adipose tissue may have a more severe clinical course of CD.

Methods: A retrospective search of the University of Pennsylvania database from 1997-2002 was performed to identify patients with CD. Patient charts were reviewed and standardized telephone surveys performed prospectively. IRB approval was obtained, as was informed consent from all participants. BMI was measured in kg/m^2 for all patients. Overweight was defined as BMI ≥25 prior to, or at diagnosis with CD. Primary endpoints