

beneficial. With its diagnostic and therapeutic capability DBE should be contemplated in small bowel disease in the setting of a multidisciplinary approach.

**Disclosure of Interest** None Declared.

**PTU-038 PROLONGED OVERT OBSCURE GASTROINTESTINAL BLEEDING – A “REAL WORLD” EXPERIENCE**

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**Introduction** Prolonged overt obscure gastrointestinal bleeding (OGIB) after an initial normal oesophagogastroduodenoscopy and colonoscopy can be difficult to manage. “Real-world” studies with all of the endoscopic (capsule endoscopy, device-assisted enteroscopy), radiological (radionuclide red cell scan, CT angiography and angiographic embolisation) and surgical interventions or therapies are lacking.

**Methods** We studied the investigation and treatment of such patients, requiring transfusion with ≥1 inpatient stay of 7 days between 2004 and 2012 at St. Vincent’s Hospital and Epworth Eastern Hospital, Melbourne, Australia.

**Results** Twenty-eight patients presented at a median age of 67.5 years. The median blood transfusion requirement per patient from symptom presentation to diagnosis or census was 26 units. Anti-platelet and anticoagulation therapy was taken by 50% patients. Twenty-four had diagnoses made (21 small and 3 large intestinal). These included angioectasias in 8 patients (6 small and 2 large bowel) who were >65 years and six of whom were taking anti-platelet therapy for cardiac disease; portal hypertensive enteropathy/ small bowel varices in four patients who were <60 years; and small intestinal tumours in 5 patients (2 gastrointestinal stromal tumours and 3 carcinoid tumours), the latter of which needed surgery for diagnosis and treatment in all cases. Repeat gastroscopy allowed histoacryl glue injection of peri-anastomotic varices in one case and repeat colonoscopy permitted treatment of angioectasias in two elderly patients. Radionuclide red cell scans had the highest radiological diagnostic yield (51%) but were beneficial only in conjunction with other tests. CT angiography (diagnostic yield 30%) resulted in successful angiographic embolisation in 3/9 cases (a small intestinal angioectasia and bleeding associated with colonic diverticula and a pancreaticoduodenal artery pseudoaneurysm). Capsule endoscopy had the highest endoscopic diagnostic yield (53%). In two patients repeat examination was diagnostic (an angioectasia and a gastrointestinal stromal tumour). Antegrade double balloon enteroscopy had the best enteroscopic yield (31%). In 2 cases it allowed argon plasma coagulation of small intestinal angioectasias, which were missed by prior enteroscopy. Surgery had a diagnostic and therapeutic yield of 60%.

**Conclusion** Prolonged overt OGIB is difficult to manage. There may be clues to the underlying diagnosis from the history and clinical features. Capsule endoscopy is a good first-line test, which can guide enteroscopy. Similarly CT angiography can guide angiographic embolisation. Surgery is best as a last resort but is not always productive. Management should be individualised with consideration given to repeating investigations.

**Disclosure of Interest** None Declared.

**PTU-039 SHOULD MR ENTEROGRAPHY BE THE PREFERRED SURVEILLANCE MODALITY COMPARED TO SMALL BOWEL CAPSULE ENDOSCOPY IN PEUTZ-JEGHER'S SYNDROME?**

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**Introduction** Peutz-Jeghers syndrome (PJS) causes multiple hamartomatous polyp formation throughout the gastrointestinal tract. Large polyps within the small bowel (SB) may cause complications and morbidity including obstruction, bleeding, an increased risk of cancer and post surgical adhesional disease. Regular surveillance and removal of large polyps are important to prevent complications from occurring.

**Methods** The aim of our study was to assess the utility of SB capsule endoscopy (SBCE) compared with MR enterography (MRE) for the detection of small bowel PJS polyps.

We performed a retrospective review of all adult PJS patients under the care of the St Mark's Polyposis Registry between 2006–2012. Participants' MRE and SBCE findings, enteroscopy reports and case notes were reviewed. Polyps >10 mm were regarded as clinically relevant. Large polyps (>15 mm) resected at push enteroscopy (PE), double balloon enteroscopy (DBE) or intraoperative enteroscopy (IOE) were correlated in terms of size, location, number and need for resection with both MRE and SBCE findings.

**Results** 95 patient episodes involving 83 patients (median age 38 yrs, 60% female) were included. SBCE was performed in 78 patient episodes, either alone (n = 29) or prior to MRE (n = 49). Reasons for MRE post SBCE were: previous study involvement (n = 19), post-polypectomy reassessment (n = 10), persistent symptoms (n = 9) and confirmation of significant polyp findings (n = 11). There was no significant difference between patients in whom >10 mm polyps were detected (77 vs. 106 for SBCE and MRE, respectively; p = 0.124). In 6 patients, large polyps (>15 mm) not detected at SBCE, were identified at MRE. Endoscopic removal of large polyps was performed during 63 patient episodes. 22 patients episodes did not require polypectomy. DBE's were incomplete due to failure of deep intubation in 7 patients (19%) but 4 of these patients subsequently underwent laparoscopic assisted DBE and successful polypectomy.

Concordance with DBE findings for polyp size for SBCE vs. MRE was 61% and 79%, respectively (p = 0.18). Concordance with DBE findings for polyp location for SBCE vs. MRE was 79% and 92%, respectively (p = 0.76).

**Conclusion** MRE appears at least as effective as the current iteration of SBCE for small-bowel polyp surveillance in adults with PJS. MRE may be less prone to missing large polyps and more accurate in polyp size assessment and localisation and in post-polypectomy reassessment of the SB.

**Disclosure of Interest** None Declared.

**PTU-040 FIVE YEAR OUTCOMES FOR PATIENTS UNDERGOING ENDOSCOPIC THERAPY FOR BARRETT'S RELATED NEOPLASIA FROM THE UNITED KINGDOM'S LARGEST SINGLE CENTRE EXPERIENCE**

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