

Methods Records of cases undergoing ERCP between November 2008 and November 2011 were retrospectively reviewed. Only patients who were in the intensive care unit requiring ventilatory and/or inotropic support and general anaesthesia for stabilisation at the time of ERCP were included. Data collected included indications, co-morbidities, technical success and 30-day mortality.

Results A total of 2237 ERCPs were performed during this period, out of which 36 (2%) emergency ERCPs were performed in 32 patients. There were 15 males and 17 females. 27/32 patients (84%) had not had previous ERCP. The median age of patients was 79 years (range 42–89). ASA grade prior to the presenting illness was 1 in 6 (17%); 2 in 15 (42%); 3 in 15 (42%). All cases were performed under general anaesthesia in emergency theatre. 27/36 cases (75%) required inotropic support. Indications included cholangitis 28/36 (78%); acute pancreatitis with cholangitis 5/36 (14%); post-operative bile leak 3/36 (8%). Biliary cannulation was achieved in all cases (100%). Endoscopic findings included: common bile duct (CBD) stones in 26/36 (72%); bile leak in 3/36 (8%); CBD stricture in 2/36 (6%); Mirizzi's in 1/36 (3%); blocked plastic stent in 1/36 (3%) and post-sphincterotomy bleed with clot obstruction in 1/36 (3%). Sphincterotomy was performed in 25/36 (69%) cases. 23/36 (64%) patients had stent insertion and in 11/36 (30%) patients balloon trawl was sufficient to clear the ducts. A rapid reduction in bilirubin was observed within 24–48 h following ERCP (Pre ERCP bilirubin: median 104, range 9–553 mmol/l; post ERCP bilirubin: median 29.5 range 12–217 mmol/l $p < 0.001$ (Wilcoxon Signed rank test). 30-day mortality was 25% (8/32 patients) and the majority of these patients (6/8, 75%) died within 24 h of ERCP due to overwhelming sepsis. There was a single case of post sphincterotomy bleed that required a repeat procedure due to clot obstruction. There were no other procedure related complications. The median length of hospital stay was 21 days (range 2–49).

Conclusion Although the 30-day mortality remains high due to multi-organ dysfunction, ERCP is successful in majority of these patients and translates to a good outcome for this cohort of critically ill patients, in whom the prognosis is inevitably poor without an emergency ERCP.

Competing interests None declared.

PWE-152 PALLIATIVE BILIARY STENTING; NOT SO PALLIATIVE IN MANY CASES!!

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V Vemala,* P Premchand. *Department of Gastroenterology, Queen's Hospital, London, UK*

Introduction Palliative biliary stenting has been practiced widely to treat symptomatic patients with non-resectable pancreatic carcinoma and other forms of cancers obstructing the biliary system. We have undertaken this study to assess the outcome of this practice in these patients especially who are on end of life care and to assess whether biliary interventions on occasions cause or hasten death.

Methods We retrospectively studied 160 consecutive patients who had ERCP (Endoscopic Retrograde Cholangiopancreatography) from October 2010 to October 2011 at Clinical Diagnostic Unit, Queen's Hospital, Romford, London. Data were collected using Scorpio data (GI reporting tool) on demographic variables, aetiology, type of cancer, Patients symptomatology pre and post procedure, Liver function tests (Cyberlab), complications secondary to ERCP, 30-day mortality post ERCP.

Results Of the 160 ERCP patients, 12 (7.5%) had 30-day mortality post ERCP. One patient could not be stented due to technical reasons. Of the 12 patients 11 had Metastatic Ca that is, Pancreas (5), Breast (2), Oesophagus (1), Cholangiocarcinoma (1), Lung (1), unknown primary (1). Of the cancer patients 6 (11) were male and 5

(11) were female with a mean age of 70.7 years. Seven of those patients had a presenting complaint of severe abdominal pain not fully controlled with opiates, all 11 (11) patients had varying degree of deranged liver function tests predominantly cholestatic picture, 3 (11) patients had SIRS (Systemic Inflammatory Response Syndrome). Technical failure to place the stent occurred in 1 patient. Post ERCP 6 (11) were symptomatically better on discharge, 4 (11) had worsening of their symptoms, Baseline bilirubin was 213 $\mu\text{mol/l}$ with 7 days post ERCP bloods showed improvement with mean bilirubin of 73 $\mu\text{mol/l}$ in four patients (11), ALP of 6 (11) and conversely rest of the patients showed worsening LFT's. 30 days mortality showed four patients died in hospital, two in hospice and five at home. All three patients with SIRS died within 1-week post ERCP.

Conclusion Malignant biliary obstruction has significant mortality. Identification of patients with SIRS is important as these patients have very high mortality and may not improve from ERCP and biliary interventions. Older age >65 years and more advanced disease were related with higher mortality despite interventions. This series suggest better selection of patients for biliary interventions in advanced metastatic cancers.

Competing interests None declared.

PWE-153 SINCALIDE CHOLESCINTIGRAPHY IN PATIENTS WITH SUSPECTED GALL-BLADDER DYSKINESIA: ASSESSMENT OF ALTERNATIVE FUNCTIONAL PARAMETERS AND POSSIBLE ROLE IN PATIENT SELECTION

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¹V Rao,* ²E Papadopoulos, ¹N Baqai, ¹A Kaleem, ²G Wright, ¹K Wedgwood. ¹Department of Surgery, Castle Hill Hospital, Cottingham, UK; ²Department of Nuclear Medicine, Castle Hill Hospital, Cottingham, UK

Introduction Gallbladder ejection fraction (GBEF) from sincalide cholescintigraphy is frequently used as an index for referring patients with gallbladder dyskinesia for cholecystectomy. Many studies have reported the cut-off point used (GBEF $\leq 35\%$) to be arbitrary and a significant number of patients who undergo cholecystectomy on this criteria remain symptomatic even after surgery. The aim of this study is to examine alternative parameters for quantification of hepatobiliary scintigraphy.

Methods 81 patients who were investigated with sincalide cholescintigraphy (including GBEF_{max} estimation) were reviewed at 6–18 months. GBEF at 10 min (GBEF₁₀), peak emptying rate, time to peak emptying rate and area under the curve (AUC) were calculated. These parameters were compared between the groups of patients remaining symptomatic and asymptomatic post-operatively and in those who did not undergo surgery. Student t test was used to compare group means.

Results 40/81 patients had abnormal GBEF_{max} ($\leq 35\%$). 31/40 patients underwent laparoscopic cholecystectomy along with 10/41 patients with a normal GBEF_{max}. 12/41 patients (29%) remained symptomatic post-operatively. There were significant differences between symptomatic and asymptomatic patients of the surgery group for GBEF₁₀ (13% vs 22%, $p=0.03$), peak emptying rate (-0.03 cpm^2 vs -0.05 cpm^2 , $p=0.01$) and AUC (0.88 counts vs 0.81 counts. $p=0.047$). These parameters were more "normal" in those patients who benefited from surgery. No significant differences were found between symptomatic and asymptomatic patients from the non-surgery group or patients with normal vs abnormal histology.

Conclusion Patients who remain symptomatic after laparoscopic cholecystectomy for gall bladder dyskinesia have more abnormal values in the above mentioned alternative parameters implying an inherent abnormality in biliary tract function. Hence we propose