

<1–64 years (median 17). 45% had smoking history. CD distribution and concomitant immunomodulation was heterogeneous. 58 (82%) patients had previous surgery. 46 (65%) were ileo-colonic anastomotic strictures while rest had it de novo (nine colon only, six terminal ileum, six jejunum, three duodenum, one oesophagus and one small and colon). The disease activity at anastomosis was i0–14 (30%), i1, i2–25 (55%) and i3, i4–5 (11%) while two had no record. Disease in de novo stricture was mild—5 (20%), moderate—10 (40%) and severe—7 (28%) while three had no record. The stricture length were 0.5–7 cms (median 2). CRP at first EBD was between 2 and 188 (median 5). Procedure: Maximum diameters of first and subsequent EBD were similar, 10–20 mm (median 15). 60 were performed at colonoscopy and 11 were performed at enteroscopy. 177 (range 1–11, median 2) EBD over median 8.5 months (1–84) were carried out total 84 (range 1–5, median 1) strictures. Outcomes: There were no serious complications. Success at index EBD was 31% with another 37% achieving long-term symptomatic relief from further EBDs. 18 (25%) patients needed surgery and five were lost to follow-up. Time to surgery following first EBD was 1–59 months (median 16.5).

**Conclusion** EBD was safe and seemed fairly effective (68% cases) in achieving long-term symptom improvement and avoided the need for surgery in 75% of cases. Further large prospective trials with control groups (those going straight to surgery) are needed to evaluate effects of CD phenotypes, endoscopic techniques and patient factors to help identify those that would best achieve palliation of symptoms with EBD compared to surgery.

**Competing interests** None declared.

## Radiology free papers

### OC-148 INVESTIGATION AND OUTCOME OF PATIENTS WITH CT FINDINGS SUGGESTIVE OF COLITIS

doi:10.1136/gutjnl-2012-302514a.148

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**Introduction** Multiple features of an abdominal CT scan may suggest underlying colitis, many of which are non-specific and may be mimicked by other pathologies. Such incidental findings often lead to difficulty in determining whether colonoscopic investigation is warranted. Studies that have looked at this area do not agree as to the best diagnostic approach for such patients and only included patients who had endoscopic investigations following the abnormal scan. This study aims to establish the clinical significance of an abdominal CT finding of colitis, ascertain how such findings are being investigated and determine whether these patients should undergo colonoscopy.

**Methods** All patients with CT findings of colitis in a district general hospital from March 2007 to March 2008 were included. Notes of all patients were reviewed over the 2 years following the abnormal CT scan, obtaining details of investigations, diagnosis and outcome.

**Results** 34 patients were included in our study. 62% were female and the median age was 72. 47% of patients with CT findings of colitis had the diagnosis confirmed with further investigation. 21% of patients had infective colitis, 12% ischaemic colitis and 15% inflammatory bowel disease (IBD). 6% of the total number of patients had a new diagnosis of IBD. 24% of colonoscopies undertaken were normal. 50% of patients did not undergo endoscopic examination because 12% had no GI symptoms, 24% were too unwell, 35% of diagnoses were reached by alternative investigation, 12% were unsuitable for endoscopic examination and 6% declined further investigation. Infective colitis was often poorly investigated with 32% of patients with acute diarrhoea not having a stool culture

or clostridium difficile screen. Our results showed a similar incidence of colitis as previous studies but low levels of neoplasia and new diagnoses of IBD. This could be due to the inclusion of patients that did not undergo endoscopic investigation in our analysis. In those patients where endoscopic tests were not carried out based on clinical judgement, no cases of missed serious bowel pathology were found in 2 years follow-up.

**Conclusion** In conclusion a CT scan suggestive of colitis can reflect serious underlying pathology; however endoscopic investigation is not always indicated. Each case needs to be considered individually, based on clinical presentation, ensuring that the appropriate non-invasive tests are considered first.

### Abstract OC-148 Table 1 Final diagnosis in patients with a CT finding of colitis

Diagnosis	Patients	Percentage
Inflammatory bowel disease	5	15%
Infective colitis	7	21%
Ischaemic colitis	4	12%
Diverticulitis	6	18%
Rectal cancer	1	3%
Colonic polyp	1	3%
Pancreatic cancer	2	6%
Other/non GI	7	21%
Declined investigation	1	3%

**Competing interests** None declared.

### OC-149 SECRETIN-ENHANCED MAGNETIC RESONANCE CHOLANGIO-PANCREATOGRAPHY (SECRETIN-MRCP): A CASE SERIES AND REVIEW OF CLINICAL UTILITY

doi:10.1136/gutjnl-2012-302514a.149

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**Introduction** MRCP is a standard investigation in pancreato-biliary disease. Secretin-MRCP has been shown to have value in the investigation of suspected Sphincter of Oddi dysfunction (SOD). We have used this modality since 2005 and review here the clinical utility of secretin-MRCP in our institution, with reference to indications, findings, and clinical outcomes.

**Methods** Patients undergoing secretin MRCP had a conventional MRCP, with determination of the best imaging plane for pancreatic and biliary ductal assessment. Secretin was then injected (1 U/Kg) and imaging was repeated every minute for 15 min, with documentation of ductal and exocrine responses. For this review, persistent ductal dilatation at 15 min was considered probable SOD and onset of pain after secretin possible SOD. All patients undergoing secretin-MRCP were identified from a radiology database. A casenote review was done, with documentation of indications and outcome measures as outlined above.

**Results** Seventy patients underwent secretin-MRCP between 2005 and 2011 (mean age 44, range 17–84, M:F ratio 3:1). Indications were; biliary pain with abnormal LFTs or ultrasound (suspected type 2 SOD, N=9), pain with normal investigations (suspected type 3 SOD, N=42), unexplained pancreatitis (N=13) or assessment of complicated pancreatitis (N=6). Forty-four scans were normal, 12 showed anatomical abnormalities and 14 probable/possible SOD (persistent ductal dilatation six, secretin-induced pain six, both two). Most (13/14) MRCP diagnoses of SOD were in patients where the clinical indication was biliary pain. In patients with SOD, 4/13