Abstract PTU-174 Table 1

	Severe, No. (%)	Moderate, No. (%)	Mild, No. (%)
High clinical likelihood supported by imaging	12 (52.2)	3 (16.7)	3 (15.8)
Clinically pancreatic cause no imaging/no evidence on imaging	7 (30.4)	4 (22.2)	2 (10.5)
Other diagnosis	4 (17.4)	6 (61.1)	14 (73.7)

In 2 patients the FE-1 was repeated; in 1 when treatment failed and FE-1 was still <100 ug/l (due to bile salt malabsorption), the other following treatment for coeliac disease and microscopic colitis (FE-1 147ug/l then normal). There was no difference in symptoms (steatorrhoea, diarrhoea, weight loss, abdominal pain) between the groups.

Conclusion This study shows that clinicians need to be aware that even in patients with FE-1 less than 100ug/l, the cause may be non-pancreatic in origin. FE-1 becomes a less reliable diagnostic tool in moderate to mild PEI parameters. FE-1 should be repeated if symptoms do not improve with pancreatic enzyme replacement. Symptoms may not be helpful in distinguishing pancreatic from non-pancreatic causes of low FE-1.

Disclosure of Interest None Declared

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PTU-175 QUADRUPLE, CLINICAL, RADIOLOGICAL, CYTOLOGICAL AND BIOCHEMICAL ANALYSIS OF PANCREATIC CYSTIC LESIONS ARE NECESSARY PRIOR TO THERAPEUTIC PLANNING

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[1,*]M Uppara, [1]A Rasheed. [1]*Upper GI Surgery, Royal Gwent Hospital, Newport, UK*

Introduction Back ground Distinguishing benign from malignant or pre-malignant pancreatic cystic lesions is essential when formulating the surgical therapeutic strategy. Lack of a well-defined pre-operative predictability criteria makes therapeutic planning challenging.

Aims To study the correlation between pre-operative morphological and biochemical features of resected pancreatic cystic lesions and predictive power of these features in relation to biological behaviour and final histology.

Methods We systematically reviewed the literature to identify the relevant variables that are used to predict the nature of pancreatic cystic lesions and aid therapeutic planning; this was followed by designing a template encompassing all these variables to collate data of resected pancreatic cystic lesions from two centres. We collated clinico-pathological and biochemical data, pre-operative CT, MRI, EUS, PET CT, FNA analysis and final post-operative pathology reports.

Results 63 patients with pancreatic cystic lesions were identified; 3 were drained endoscopically out of which two were psuedocyst and 1 was abscess,12 underwent resection, 3 were serous, 1 mucinous, 1 IPMN, 4 ductal adenocarcinomas, 1 endocrine neoplasm, 1 psuedocyst with abscess, one patient's final histology results was missing. Three patients had neoplastic cells on FNAC, 2 patients had FNAC results suspicious for neoplasm, 26 were reported to have benign findings at EUS and FNAC and managed conservatively. 10 had elevated intra-cystic CEA levels, 3 patients had elevated CA 19–9 levels at FNAC. 1 patient was diagnosed having VHL, 1 patient had lymphatic cyst, 1 patient was diagnosed having Giardiasis, 1 patient was stented for palliation, 7 patients were undergoing further definitive treatment, and 1 patient with IPMN had therapeutic ERCP.

Conclusion Our interim results suggest that quadruple assessment including clinical, radiological

(CT/PET/MRI/EUS), FNAC and biochemical analysis is necessary prior to therapeutic planning.

Disclosure of Interest None Declared.

PTU-176 RETROSPECTIVE AUDIT OF ANTIBIOTIC USE IN PATIENTS ADMITTED TO INTENSIVE CARE UNIT (ICU) WITH SEVERE ACUTE PANCREATITIS

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[1,*]O Jalil, [1]L Hopkins, [1]A Rasheed. [1]*General Surgery, Royal Gwent Hospital, Newport South UK, Newport, UK*

Introduction The Atlanta classification divides patients with acute pancreatitis (AP) into two groups, mild and severe. The severe form (severe acute pancreatitis, SAP) is best managed in HDU or ICU setting and is associated with high morbidity and mortality despite best efforts at early diagnosis and timely intervention. The use of antibiotics in SAP is controversial. The aim of the audit is to compare antibiotic use and mortality of patients admitted to the ICU against national standards.

Methods Retrospective audit of management and outcome of consecutive patients admitted to ICU with SAP during the period of 2007–2010. The timing of antibiotic use, the agent(s) used and the site of infection were compared.

Results Of 51 patients, 42 received antibiotics. 63% (n = 32) of patients were started antibiotics within 48 hrs of hospital admission. The first choice antibiotics were cefuroxime and metronidazole in 45% of cases, co-amoxiclav and metronidazole in 12% of cases and tazocin ± metronidazole in 14% of cases. In 26% of cases a combination of imipenem ±fluconazole ± gentamicin ± vancomycin was used.

Three patients were confirmed to have pancreatic infections based on positive culture and 10 patients had extra-pancreatic infections. Four patients had bacteraemia, 4 had chest infections, 2 had UTI and one had Clostridium difficle. All extra-pancreatic infections had Gram negative bacilli as a causative organism.

Antibiotic use did not improve survival, nor was there any observed survival benefit when the different antibiotic agents were compared (p = 0.7 and 0.4 respectively). The timing of antibiotic use also does not appear to confer a survival benefit (p = 0.5). All patients with proven pancreatic infection died, there was not a significant difference in survival in those with extra-pancreatic infections (p = 0.2).

Conclusion Current guidelines recommend the use of antibiotics only in the presence of proven infection. Given that a majority of patients were commenced on antibiotics within 48hrs of admission and that only a minority were shown to have proven infection it would seem that adherence to this guideline has been poor. It has been suggested that early antibiotic use without proven infection may lead to increased antimicrobial resistance. This audit has demonstrated that early antibiotic use does not benefit survival in severe acute pancreatitis. The choice of agent is important as no single combination has been shown to be advantageous. The agent selected should be based upon clinical findings and laboratory evidence as to the organism(s) present and their susceptibilities. Further work could investigate whether antibiotic use might reduce morbidity in SAP. Other therapeutic strategies should be investigated in order to try to improve survival in this patient group.

Disclosure of Interest None Declared