

Abstract PTU-183 Table 1

	Potential Type 1 BAM		Potential Type 2 BAM		Potential Type 3 BAM	
SeHCAT result	Abnormal	Normal	Abnormal	Normal	Abnormal	Normal
	n = 8	n = 9	n = 27	n = 39	n = 18	n = 7
Median age	45	52	53	57	54	71
Sex (% female)	75%	89%	78%	64%	100%	57%
Average stool frequency per day	6	6	6	6	8	5

may particularly benefit from earlier use of SeHCAT scan. Clinical response to colestyramine in BAM was high, although data on long-term compliance/response was not available.

Disclosure of Interest None Declared.

PTU-184 UNLOAD THE BURDEN OF UNNECESSARY INVESTIGATIONS AND REDUCE THE DELAY IN DIAGNOSING BILE ACID MALABSORPTION (BAM)

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Introduction BAM is an often forgotten cause for chronic diarrhoea and though it is easily diagnosed by means of the SeHCAT scan, the diagnosis is often made late in the day with SeHCAT used only as a third or fourth line investigation. In this observational study we aim to analyse the unnecessary investigations and chronological delay it took to diagnose BAM in our centre.

Methods All patients who underwent a SeHCAT scan between the period January 2009-June 2012 were identified. Patient notes were retrieved and blood results, radiological imaging and endoscopy procedures performed prior to SeHCAT scan were reviewed. An abnormal SeHCAT was defined by bile acid retention < 8%.

Results A total of 112 patients underwent a SeHCAT scan during this period. 4 patients were excluded due to unavailability of notes.

53 patients (49%) had abnormal SeHCAT results. All 53 patients had normal inflammatory markers (normal white cell count, C reactive protein < 5), 98% (52) had normal haemoglobin levels and 91% (48) had coeliac disease excluded by negative tissue transglutaminase antibodies. The median age at time of diagnosis was 52 years (range 26–80 years), 38 of the 53 patients being female. The average stool frequency was 7 times a day.

In these 53 patients, a total of 5 hydrogen breath tests were performed prior to SeHCAT, 4 of them normal. A total of 19 barium studies were performed prior to SeHCAT, 15 were normal. A total of 18 CT Abdomen/Pelvis were performed prior to SeHCAT, 13 were normal. A total of 21 flexible sigmoidoscopies were performed, all of them normal. A total of 24 colonoscopies were performed, 21 of them normal. All abnormal results from the above summary apart from 2 abnormal CT Abdomens (which were detected in patients who were post-cholecystectomy) were found in patients who were known to be at risk of Type I BAM (previous TI Crohn's disease/previous ileal resection/previous pelvic radiotherapy). This includes the 3 abnormal colonoscopies from patients with known Crohn's disease with histology confirming active Crohn's inflammation.

The average time from first clinic consultation to time of diagnosis was 4.8 months (range 2 – 34 months).

Conclusion There is a significant time delay in diagnosing BAM and the study confirmed our suspicions that patients with BAM often undergo a whole barrage of investigations which yield negative results. Patients with Type I BAM, however, seem to yield abnormalities in most other investigations which might throw physicians off course initially, resulting in further diagnostic delay. BAM certainly needs to be thought of earlier in all patients and it

merits a consideration even in patients who appear to have active inflammatory disease.

Disclosure of Interest None Declared.

PTU-185 WHAT IS THE COST OF DUODENAL BIOPSIES IN PATIENTS WITHOUT SEROLOGICAL EVIDENCE OF COELIAC DISEASE?

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Introduction The BSG guidelines recommend anti tissue transglutaminase antibody (TTG) testing as a first line test for coeliac disease. Duodenal biopsies (D2) should be performed only after a positive serological test or a negative test with a high clinical suspicion. We aimed to analyse whether the indications for duodenal biopsies and current practise are in keeping with guidelines.

Methods This was a retrospective review of the electronic records of 171 consecutive patients who had had duodenal biopsies.

Results The indications for endoscopy were iron deficiency anaemia (IDA) (51%), weight loss (16%), diarrhoea (3%) and non-specific gastrointestinal symptoms (30%). Seventy (41%) patients had a TTG done prior to endoscopy, 5 patients (2.9%) had a positive TTG prior to a positive D2 biopsy. Sixty-five (38%) patients had D2 biopsies despite a negative TTG. Hundred and one patients (69%) patients had D2 biopsies without any serological testing prior to endoscopy (1 positive biopsy). Nine (5.26%) patients had a TTG checked despite negative histology. The excess cost incurred: for processing biopsies after a negative TTG was £3139.50 and TTG after negative histology was £126.£3430 would have been saved by carrying a TTG test in subjects having a negative biopsy.

Conclusion A significant proportion of duodenal biopsies are done in patients with a negative TTG. The diagnostic yield for coeliac disease in those with a negative TTG was zero. If BSG guidelines were adhered to, £6695 would have been saved in this cohort.

Disclosure of Interest None Declared.

PTU-186 12 MONTH OUTCOME AND PATIENT SATISFACTION WITH STRUCTURED GASTROENTEROLOGICAL EVALUATION FOR CHRONIC GASTROINTESTINAL SYMPTOMS FOLLOWING PELVIC RADIOTHERAPY

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Introduction Seventeen thousand patients are treated with radical pelvic radiotherapy annually in the UK. 50% develop chronic GI symptoms. The structured approach to management used in this service evaluation has been shown to identify treatable diagnoses and improve symptoms in the short term. We report the first 12 month outcome data for the effect of structured gastroenterological evaluation on symptom burden and patient satisfaction.