

Abstract PWE-197 Table 1

USS/CT	Total patients	Median Age (Years)	Range (Years)	Gender = Male	Further Pathology on MRCP	No further pathology on MRCP	MRCP diagnostic yield (%)
Dilated biliary tree*	75	65.3	21 – 89	22	25	50	33.3
Undilated biliary tree	44	53.3	21 – 87	18	2	42	4.5
p value		0.033		0.23			0.0002
* Intrahepatic or extrahepatic ducts							

PWE-198 OUTCOMES FOR PATIENTS UNDERGOING MESENTERIC ANGIOGRAPHY FOR ACUTE SEVERE GASTROINTESTINAL BLEEDS IN AN INTENSIVE CARE UNIT OF A TERTIARY HOSPITAL

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Introduction In acute severe gastrointestinal bleeding, endoscopy has a failure rate of 10–30% in detecting active bleeders and achieving haemostasis. Further aggressive treatment may be necessary and mesenteric angiography has the advantage of being both a therapeutic and diagnostic modality. Previous outcome data on patients undergoing angiography report a normal angiogram in 52% (due to the intermittent nature of bleeds), with lower rebleed rates than in those with positive extravasation, but a higher mortality. Where there was positive extravasation and subsequent embolization, a rebleed rate of 9–47% is reported, with a surgery rate of 0–35% and 30 day mortality of 3–27%. We would like to report our department's experience of the outcomes of acute severe gastrointestinal bleeds requiring mesenteric angiography.

Methods Over a 5 year study period between 2006–2011 in the general intensive care unit of St George's Hospital, patients were included if they had had a non-variceal acute severe gastrointestinal bleed that required mesenteric angiography after failed endoscopy. Retrospective data was collected on patient demographics, endoscopic findings, angiographic findings, embolization, rates of rebleeding, number of packed red blood cells (PRBC) transfused, hospital stay, and mortality at 30 days.

Results 26 patients were included, 18 male and 8 female. Overall, each patient needed an average of 22.2 units of PRBCs; rebleeding occurred in 28.9%; surgery was performed in 6 patients (including 4 colectomies); 30 day mortality was 35% (n = 9) and 90-day mortality was 50% (n = 13). Subgroup analysis showed that for the 18 patients with positive angiographic findings and subsequent embolization, 10 had positive endoscopic findings (4 gastric ulcers, 5 duodenal ulcers, 1 Dieulafoy lesion) whilst 8 had inconclusive findings at endoscopy. For this group, an average of 18 units PRBCs were transfused, the rebleed rate was 35%, subsequent surgery was performed in 24%, 30 day mortality was 44% (n = 8) and 90 day mortality 54% (n = 10). For the 8 patients (27%) with a negative angiography, all had a negative endoscopy. Only 13% required surgery (n = 1), an average of 11 units was transfused, the rebleed rate was 13% (n = 1), 30 day mortality 13% (n = 1) and 90 day mortality 38% (n = 3).

Conclusion Overall, this group of patients needing angiography have a very high risk of mortality. Only 31% of our patients had a normal angiogram, suggesting a more astute selection of cases. Interestingly, for those with a negative angiography, the rates of rebleeding and surgery were lower than in the positive extravasation group, but the mortality is also lower, a finding in contrast to previous studies.

Disclosure of Interest None Declared.

PWE-199 DIAGNOSTIC RADIATION EXPOSURE IN PATIENTS WITH CROHN'S DISEASE TREATED WITH INFLIXIMAB

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Introduction Exposure to radiation from diagnostic imaging is thought to be associated with an increase in cancer risk. Patients with Crohn's Disease (CD) frequently require x-ray exposure throughout the course of their illness. Studies have quantified cumulative radiation exposure in patients with CD¹. However, as far as we know, there has only been one study that has identified infliximab as an independent risk factor for increased radiation exposure². We aimed to quantify all imaging and associated radiation exposure for this subset of patients in our institution.

Methods Our unit is in a district hospital serving a population of 500,000 across 2 sites. All patients with CD who have received infliximab from January 1997 to January 2013 were identified from our hospital databases. Diagnostic imaging records were also retrieved from the databases. Using local protocols, a mean effective dose for each imaging modality was calculated. The cumulative effective dose (CED) per patient was calculated as the sum of the mean effective dose for all imaging modalities. The mean diagnostic radiation exposure per year = CED/years of follow-up.

Results 131 patients (52% female, mean age 46 years) were included in the study. Total number of imaging procedures was 624 (plain abdominal film = 351, CT abdomen/pelvis = 168, barium study = 105). Other imaging modalities included MRI abdomen/pelvis = 72 and abdominal ultrasound = 65. Average total number of imaging per patient was 5 (plain abdominal film = 3, CT abdomen/pelvis = 1, barium study = 1). The total CED for all imaging was 1828.1 mSv (85% attributed to CT imaging). The mean CED per patient was 14.0mSv (range 0–171.9mSv) with the mean diagnostic radiation exposure per year being 2.4mSv/year (range 0–28.7mSv/year).

Conclusion Imaging requests in patients with CD is high, particularly when they have received infliximab. In spite of concerns about radiation risk, 93% of our patients have CED less than 50mSv exposure, a level considered to be associated with a low cancer risk. However, most patients are young and are likely to accumulate more radiation exposure over time. The move towards more specialised care should lead to reduction in use of CT scans and increased use of MRI and ultrasound studies.

Disclosure of Interest None Declared.

REFERENCE

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