PTH-188 SMALL BOWEL DIAPHRAGM DISEASE: DIAGNOSIS WITH CAPSULE ENDOSCOPY AND TREATMENT WITH BUDESONIDE

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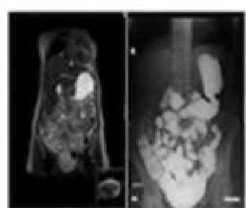
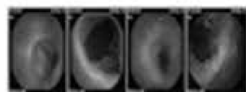
[1,*]R Pandey, [1]M Khan, [1]N Van Someren, [1]K Besherdas. [1]*Gastroenterology, Barnet & Chase Farm NHS Trust, London, UK*

Introduction Diaphragm disease is characterised by strictures that mainly occur in the small intestine, resulting from the use of non-steroidal anti-inflammatory drugs. It may present with vague gastrointestinal symptoms or as a surgical emergency requiring laparotomy. Most cases are diagnosed retrospectively at laparotomy. Laparoscopy and various radiological imaging modalities are often inconclusive. Capsule endoscopy effectively diagnoses diaphragm disease pre-operatively. Following withdrawal of the offending NSAID, surgical resection, strictureplasty and double balloon enteroscopy have all been used as potential treatments. Specific drug treatment of small bowel diaphragm disease has not been described. We present a case series of three patients who were diagnosed with Diaphragm disease at capsule endoscopy and responded to Budesonide therapy.

Methods Case notes of three patients with a confirmed diagnosis of Diaphragm Disease were analysed, with respect to presenting symptoms, duration of symptoms, investigations, treatment and follow-up.

Results Three female patients between the ages of 56 and 72 presented with gastrointestinal symptoms, including abdominal pain, nausea, vomiting, bloating and loose stool. Symptoms were present from a range of two months to four years before their presentation to secondary care. All patients had a history of regular NSAID use and were investigated with gastroscopy, colonoscopy and CT abdomen, all of which were normal. Small bowel MRI was also normal in two patients (Fig.1). Capsule endoscopy in all patients demonstrated characteristic features of diaphragm disease (Fig.2). All patients received a tapering dose of Budesonide, starting at a dose of 9mg. A symptomatic response was observed in all patients. One patient has now been started on Azathioprine to maintain long term remission. Two remain on reducing doses of steroid with a significant improvement in symptoms.





Abstract PTH-188 Figure 1

Conclusion Diaphragm disease is an under recognised clinical entity that can present in a variety of ways. It can be difficult to diagnose with routine endoscopy or conventional radiology. Capsule endoscopy appears to be the most sensitive test. Clinicians should have a high index of suspicion for this condition, particularly in the context of NSAID use and chronic gastrointestinal symptoms. Budesonide appears to be an effective therapy for Diaphragm Disease, and it seems likely that long-term therapy with azathioprine can maintain remission. However this is an observational study with a small number of patients. Further research is required to validate this as successful, viable, evidence based treatment option.

Disclosure of Interest None Declared.

PTH-189 DOUBLE BALLOON ENTEROSCOPY IN THE ELDERLY WITH OBSCURE GI BLEEDING- IS IT WORTH THE PUSH AND PULL?

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[1,*]R Sidhu, [1,2]S Hardcastle, [1]D S Sanders. [1]*Gastroenterology;* [2]*Royal Hallamshire Hospital, Sheffield, UK*

Introduction Double Balloon enteroscopy (DBE) is an increasingly important procedure particularly in the context of obscure GI bleeding (OGB) with a high reported diagnostic yield. There is however paucity of data on its use in the elderly. The aim of this study was to assess the utility of DBE in the elderly and risk of complications compared to a younger cohort.

Methods A prospective review of consecutive patients who underwent DBE over the last six years for the indication of OGB was conducted. The majority of patients underwent a capsule endoscopy prior to DBE, either locally or at our centre. Data was collected on demographics, procedure duration, dose of sedation/analgesia, diagnostic yield and subsequent change in management and complications encountered. Patients were divided into group 1: age≥ 70 years, group 2: age < 70 years.

Results One hundred and forty eight DBE procedures were carried out for the indications of OGB. The majority were for the indication of iron deficiency anaemia (IDA, n = 109.74%), 53% were males and the oral route was carried out in 69% of patients. Group 1 (age≥ 70 years) consisted of 27% (n = 40) of the cohort with a mean age of 77 years (range 70–83 years). There were 38% of patients with the presence of significant co-morbidity and four patients were on warfarin. The diagnostic yield in Group 1 was 53%. There was no significant difference in the yield between those with IDA and overt bleeding (p = 0.7). The commonest diagnosis in the elderly was angioectasia (45%, n = 18). The other findings included a small bowel tumour and mantle cell lymphoma (n = 2) and a Meckels diverticulum (n = 1). Therapeutics was performed in 45%. There was one respiratory arrest in a patient with known chronic airways disease (COPD). This patient was subsequently discharged home after a short stay on intensive care. The mean age in group 2 (n = 108) was 54 years, 44% females and the diagnostic yield was 35%. Comparison of the two groups demonstrated a trend towards a higher diagnostic yield in the elderly (p = 0.06). On logistic regression, previous transfusion requirement was associated with a higher yield with DBE in all patients (p = 0.04).Subsequent management was altered in a significant greater proportion of the elderly (28% versus 50%, p = 0.01, OR 2.6, 95% CI 1.2–5.5). There was no difference in the duration of the procedure between the two groups (p = 0.4), whilst the median dose of midazolam and fentanyl was significantly greater in group 2 (4.5 mg versus 6 mg, p < 0.001, 50mcg versus 75mcg, p < 0.001 respectively).There were no complications in group 2.

Conclusion DBE has a high diagnostic yield with a positive impact on patient management in the elderly. Albeit low rate of complications, careful selection of patients would help reduce risks in this age group.

Disclosure of Interest None Declared.

PTH-190 DOES THE AMOUNT OF SEDATION HAVE AN IMPACT ON THE DIAGNOSTIC YIELD OF DOUBLE BALLOON ENTEROSCOPY ? EXPERIENCE FROM A TERTIARY CENTRE

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[1,*]R Sidhu, [1]S Hardcastle, [1]D S Sanders. [1]*Gastroenterology, Royal Hallamshire Hospital, Sheffield, UK*

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