PTU-052 LONG TERM OUTCOME OF PATIENTS WITH REFLUX SYMPTOMS AND SYMPTOMATIC ESOPHAGEAL DYSFUNCTION DURING AND AFTER A STANDARDIZED TEST MEAL:A HIGH-RESOLUTION MANOMETRY STUDY

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[1,*]R Sweis, [2]G Brady, [3]A Anggiansah, [1]A Lee, [1]A Valdes, [4]T Wong, [5]M Fox. *[1]Oesophageal lab; [2]St Thomas' Hospital, London, UK; [3]Oesophagael lab; [4]Gastroenterology Department, St Thomas' Hospital, London; [5]NIHR Biomedical Research Unit and Digestive Diseases Centre, Nottingham University Hospitals, Nottingham, UK*

Introduction Recently we presented novel methodology for the assessment of oesophageal function and symptoms during and after a standard test meal.[1] In the absence of a "gold standard", outcome data provides insight into the clinical impact of this test in patients with reflux symptoms

Methods 18 patients referred for investigation of reflux symptoms and 10 healthy volunteers underwent High Resolution Manometry (HRM) with 5ml water, 200ml water drink and test meal followed by 10min post-prandial observation. 24hr pH studies were performed in patients. The number of Symptoms Associated with oesophageal Dysfunction(SAD) was calculated. HRM findings and initial diagnosis were compared with the final diagnosis and outcome at 2 years

Results No symptoms occurred with 5ml water. 12/18(67%) patients had SAD (mean SAD 2(range 0–7)) during/after the meal. Compared to 5ml water, manometric diagnosis was altered in 12/18(67%). No healthy volunteers had SAD.

11/18 patients had GORD on pH studies. By 2 years, 5/11 had anti-reflux surgery with excellent outcome. All 5 exhibited dysmotility (e.g. hypotensive/failed peristalsis) during the meal with symptomatic postprandial reflux events (transient lower oesophageal sphincter relaxation + common cavity). Of the 6/11 with GORD who did not have surgery, 2 declined it despite pathological pH results and symptomatic reflux events after the meal; both remain symptomatic despite acid-reducing therapy. The remaining 4 of 6 patients also had symptomatic dysmotility but were not offered surgery. 2 with severe hypotensive dysmotility and symptomatic reflux responded to acid suppression. 1 with (peptic) outlet obstruction and 1 with diffuse spasm did not respond to medication.

Of the 7 with functional heartburn (negative pH results), 2 who had normal HRM responded to dietary/stress management. 2 with symptomatic reflux during HRM had good response to acid-suppression (i.e. false neg pH study). The final 3 with reflux-like symptoms had outflow obstruction identified only during the meal; 1 had good outcome after dilatation, 1 was too frail for therapy and remains symptomatic and the last was lost to follow-up.

Conclusion HRM studies which include a test meal and post-prandial observation provide an objective explanation for symptoms in the majority of patients referred for investigation of "reflux" symptoms. Long-term follow-up suggests this information can guide management especially in patientswithout definitive diagnosis following standard 5 ml water HRM and negative pH-studies

Disclosure of Interest None Declared

REFERENCE

1. Sweis R *et al. Gastro* 2011; **140**

Inflammatory bowel disease

PTU-053 USEFULNESS OF FECAL CALPROTECTIN IN CLINICAL PRACTICE IN A DISTRICT GENERAL HOSPITAL

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[1,*]A Malik, [2]D Bowen, [3]I Rees. *[1]Gastroenterology, Prine Philip Hospital, Llanelli; [2]Gastroenterology, West UK Hospital, Carmarthen; [3]Gastroenterology, Prince Philip Hospital, Llanelli, UK*

Introduction Calprotectin is a calcium and zinc binding protein, mainly contained in neutrophils. If present in stools it is a marker of bowel inflammation. We evaluated the diagnostic value of faecal calprotectin (FC) as a non-invasive marker of bowel inflammation in routine out-patient gastroenterology clinic.

Methods A retrospective study was conducted of patients who had faecal calprotectin evaluated for various indications in out-patient gastroenterology clinic over a 12 month period. Presenting symptoms, FC results and the endoscopic findings were recorded. FC level more than 50 μg/gm was considered positive.

Results FC was requested for 72 patients. 44 were female (mean age 44 years) and 28 were male (mean age 47 years). FC was requested for various symptoms including chronic diarrhoea, abdominal pain, abdominal distension and per rectal bleeding. Patients were divided into 3 groups based on clinical practise of gastroenterologist.

In the first group FC alone was requested initially as a screening test to assess bowel inflammation. 31 patients fell in this group, 21 of 31 had negative FC and no further investigations were done, while 10 of 31 had positive FC (mean 150.3 μg/gm). Out of these 5 had no further investigations as symptoms settled on subsequent clinic visit and 5 went on to have further investigations (Colonoscopy +/- Capsule endoscopy) which were all normal.

In the second group both FC and colonoscopy were requested on initial out-patient review. There were 23 patients in this group. 13 of 23 had normal FC and colonoscopy and no further investigations were done. 2 of 23 had abnormal FC (mean 271.5 μg/gm) and colonoscopy. Both were diagnosed with IBD. 8 of 23 had raised FC (mean 171.25 μg/gm) but a normal colonoscopy. 5 of 8 had no further investigations done while 3 had small bowel investigations which were normal. 1 patient of these 3 was treated for presumed small bowel Crohn's due to raised FC despite normal capsule endoscopy with good effect.

In the third group colonoscopy was the initial investigation of choice and was found to be normal but FC was done later in view of persistent symptoms to look for small bowel inflammation. 18 patients fell in this group. 12 of 18 had normal FC and had no further investigations. 6 of 18 had raised FC (mean 114.33 μg/gm). 3 patient's with raised FC had small bowel investigation done and all were normal.

Conclusion In conclusion FC was beneficial when negative. It provided reassurance to the clinicians and helped avoid invasive investigations. However when FC was positive clinical judgement and patient symptoms dictated the need for further investigations. None of the patients diagnosed with IBD had a negative FC.

Disclosure of Interest None Declared

PTU-054 OUTCOMES FOLLOWING INVESTIGATION AND ELECTIVE WITHDRAWAL OF ANTI-TNF THERAPY IN CROHN'S DISEASE: A UK MULTICENTRE STUDY

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[1,*]A J Brooks, [2]S Sebastian, [1]K Robinson, [3]L Warren, [1]A Wright, [1]A M Marsh, [2]H Tsai, [3]F Majeed, [1]M E McAlindon, [3]P J Hamlin, [1]A J Lobo. *[1]Sheffield Teaching Hospitals, Sheffield; [2]Hull & East Yorkshire NHS Trust, Hull; [3]Leeds Teaching Hospitals NHS Trust, Leeds, UK*

Introduction The impact of stopping anti-TNF for patients in clinical and/or endoscopic remission in routine clinical practise setting is uncertain. We aimed to evaluate clinical outcomes in patients who discontinued anti-TNF electively across 3 units in the Yorkshire & Humber IBD Network, UK.

Methods Crohn's disease (CD) patients in whom anti-TNF (62 infliximab (IFX), 9 adalimumab (ADA)) was stopped electively following a planned assessment were included. All had been treated for ≥ 12 months and followed-up for ≥ 3 months following cessation of anti-TNF. Investigations at assessment prior to cessation included ≥ 1 of; colonoscopy, colon capsule (CC), small bowel capsule (SBC),