

had a colonoscopy, 20.0% had CT or MRI and 9.3% had a flexible sigmoidoscopy. Of the 75 patients with suspected functional bowel disorder with normal FC values, 2 patients were diagnosed with Crohn's disease affecting the terminal ileum on colonoscopy. For patients with suspected IBS the test had a specificity of 80.2% and a negative predictive value of 97.3%.

**Conclusion** Despite normal FC result, a significant proportion of young adults with suspected functional bowel disorder undergo colonoscopy with normal test results. As other studies have shown, consideration of the FC result before further investigations are ordered can reduce the number of patients requiring endoscopy or imaging and thus reduce cost<sup>1</sup>. However, FC is less sensitive for small bowel Crohn's disease and therefore careful history taking is required to ensure this is not missed due to a negative FC result.

#### REFERENCES

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**Disclosure of Interest** None Declared.

## Endoscopy III

### PTH-001 USE OF PANCREATIC STENTS IN ENDOSCOPIC RETROGRADE CHOLANGIO-PANCREATOGRAPHY

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**Introduction** The indications for placing pancreatic stents (PS) during endoscopic retrograde cholangio-pancreatography (ERCP) include pancreatic duct stones and strictures, prevention of post-ERCP pancreatitis and as an aid to biliary cannulation, where there is persistent preferential pancreatic cannulation. The flange at the proximal end of the stent used in our practice (Cook UK) is designed to prevent spontaneous migration. As a minimum, abdominal x-ray (AXR) should be performed at 4 weeks to confirm spontaneous stent passage. The aims of this study were to assess a) indications for PS b) compliance with AXR recommendation c) whether flange removal aids spontaneous stent passage.

**Methods** Retrospective review of ERCP reports and case notes in 1250 ERCPs performed at our institution between August 2011 and December 2013.

**Results** In 82 of 1250 ERCPs, PS were placed (6.5%). 31 male, 51 female, mean age 63 years (range 20–92).

The indication for PS placement in all 82 was to aid biliary cannulation, and in all 82, the PS was left *in situ* to reduce the pancreatitis risk. In 72/82, biliary cannulation was successful (pre-cut in 55).

42/82 had AXR, and in 36/42 the stent had passed.

21/82 had repeat ERCP and in 15/21 the stent had passed.

19/82 (23%) had no record of AXR or repeat ERCP.

Based on operator preference, the flange was removed in 38 and left *in situ* in 44. Of the 12 PS that failed to pass spontaneously the flange was removed in 4 and left *in situ* in 8.

**Conclusion** Pancreatic stents are a useful aid to biliary cannulation, and pass spontaneously in the majority of patients,

although flange removal may facilitate this. Compliance with the minimum recommendation of post-ERCP AXR to confirm stent passage in only 77% is poor, and requires further investigation.

**Disclosure of Interest** None Declared.

### PTH-002 ERCP: BALANCING DEMAND, TRAINING AND MANPOWER IN SOUTH EAST REGION

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**Introduction** The purpose of this survey is to assess trainees attitudes and exposure to ERCP training in the south east region of England and also to explore the demand for ERCP endoscopists in future.

**Methods** Two separate short survey questionnaires were sent using an online survey tool between July 2012 to October 2012. One was sent to the trainees and the second questionnaire was sent to the Consultant Gastroenterologists in this region. In some instances survey was conducted through telephone, e-mail or in person.

**Results** Out of 43 trainees, nearly 10/43 (23%) were getting trained in ERCP, 14/43 (33%) mentioned that their training needs had been assessed, 32/43 (75%) were not aware of the current need for consultant ERCPs in this region. Among the trainees who do not want to get trained in ERCP, 5/33 (16%) of them had interest in other sub-specialty, 4/33 (14%) considered it a difficult procedure to get trained and 3/33 (9%) did not have any appropriate guidance. The other reasons include high risks and complication 3/33 (9%), longer duration of training 1/33 (3%) and lack of training facilities 2/33 (6%). Among the trainees who performed ERCPs only 2/10 (20%) had done more than 100 procedures. None of them got more than 75% selective duct cannulation rate. Majority of trainees, about 30/43 (70%) of them pointed out that ERCP should not be an essential skill for gaining a consultant job.

Out of 55 consultants gastroenterologists 27/55 (50%) of them perform ERCP. Of these 27 consultants, 18/27 (67%) trained at least one trainee. Only 3/27 (11%) consultants mentioned that they would stop doing ERCP procedures in the next 5 years and 6/27 (22%) within next 10 years. 7/27 (25%) of the consultants thought that their colleague/colleagues would take over the ERCP service when they retire and 12/27 (45%) thought that new ERCP consultants will be recruited.

**Conclusion** This survey suggests that there is currently only a need for 2–3 trainees to be learning ERCP if the current demand is stable. The number of trainees training in ERCP need to be very small unless we accept that the trained ERCP endoscopists might give up on transition to consultant. There is a disparity in that consultants claim they are delivering ERCP training but this is not reflected in the results of the trainee's responses. Most of the trainees are in their early stage of in the ERCP training. None of the trainees got over 75% selective cannulation rate.

**Disclosure of Interest** None Declared.

### PTH-003 FULLY COVERED SELF EXPANDING METALS STENTS ARE EFFECTIVE IN REMODELLING BENIGN BILIARY STRICTURES IN PATIENTS WITH CHRONIC PANCREATITIS

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**Introduction** Symptomatic benign biliary strictures (BBS) in chronic pancreatitis (CP) have historically been treated with surgical biliary bypass or multiple plastic stents. We report our experience of fully covered self-expanding metal stents (fcSEMS) for this indication in a cohort of patients with CP.

**Methods** A prospectively recorded ERCP database including all CP patients undergoing fcSEMS for BBS, between Oct 2008 and Aug 2013, was analysed. Demographics, pathology results, stent data and patient outcomes were collated.

**Results** A total of 256 ERCPs involving biliary SEMS insertion were performed of which 115 (45%) were fcSEMS. 48/115 (42%) fcSEMS were performed in 24 patients (75% Male, median age 55 years) with BBS related to CP. Aetiological factors included alcohol (63%), autoimmune (13%) and idiopathic (8%). Surgical bypass was precluded in 23/24 (96%) patients due to extensive choledochal varices (58%), advanced cirrhosis (13%), medical comorbidities (13%), hostile surgical abdomen (13%) and autoimmune CP (13%). 17/24 (71%) patients had previous plastic biliary stent (s).

10mm diameter fcSEMS (Boston Wallflex or Cook Evolution) of 6 or 8 cm in length were used. They remained *in situ* for median 9.5 months (range 1–32). 13/24 (54%) patients achieved stricture remodelling, allowing trial of fcSEMS removal and follow up without stenting for median 7 months (range 0–22). These patients required median 3 fcSEMS (range 1–6) over median 24 months (range 2–51) to achieve stricture resolution. 42% (10/24) patients who had not yet achieved stricture resolution had fewer fcSEMS to date (median 1) and a shorter duration of stenting.

Complications included proximal (4%) and distal stent migration (16.5%), cholecystitis (6%) and acute pancreatitis (2%). Biliary obstruction +/- cholangitis occurred in 23% at some point. 96% (46/48) fcSEMS were easily removed without needing additional procedures. One fcSEMS was *in situ* for 18 months (patient lost to follow up) and it was not possible to then remove it (due to tissue in-growth). Another fcSEMS *in situ* for 32 months (due to tissue in-growth) was removed following a “stent-in-stent” fcSEMS procedure. 2 patients died before planned removal of their first metal stent due to pre-existing comorbidity.

**Conclusion** As suggested by smaller published series (Kaffes, GI Endoscopy 2013), FcSEMS are a safe and effective approach to managing BBS due to CP and may promote stricture remodelling. Endoscopic removal is straightforward if the fcSEMS is *in situ* for <12 months.

**Disclosure of Interest** None Declared.

#### PTH-004 SUBJECTIVE DESCRIPTION OF PAIN DOES NOT PREDICT BILIARY MANOMETRY OR RESPONSE TO ENDOTHERAPY IN SPHINCTER OF ODDI DYSFUNCTION: ARE THE ROME CRITERIA FIT FOR PURPOSE?

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**Introduction** In the absence of biochemical or radiological evidence of biliary obstruction, Sphincter of Oddi dysfunction (SOD) is a difficult condition to diagnose and to treat. The Rome III diagnostic criteria clearly state that, to meet a diagnosis of SOD, a patient should have “episodic pain at different time intervals (not daily)”. We observe heterogeneity in symptoms

amongst patients referred with suspected SOD with many patients reporting constant daily pain requiring potent analgesia. We aim to determine whether subjective reporting of pain (according to the Rome criteria) correlates with Sphincter of Oddi Manometry (SOM: the gold standard for diagnosis of SOD) and/or response to endoscopic sphincterotomy/plasty (ES).

**Methods** An ERCP database and electronic clinic lists (from September 2011 to 2013) were analysed to identify all cases of suspected SOD. Patients underwent a telephone questionnaire based on subjective recall of pre-ERCP pain according to the Rome criteria and post-ERCP response. Patients were asked to categorise pain as either intermittent with no pattern/not daily (Rome +ve) or daily/constant pain (Rome -ve).

**Results** 163 new patients with suspected biliary SOD were identified of whom 89 underwent ERCP. They were mostly Female (87%), White British (86%) with median age 37 years (range 18–69). 48 patients with SOD2/3, who underwent SOM, agreed to answer the questionnaire. Patients with SOD1 do not routinely undergo SOM. Biliary and/or pancreatic basal pressures were abnormally elevated (>40 mmHg) in 33/37 (89%) SOD2 and 8/10 (80%) SOD3, all of whom underwent ES. There were no significant correlations between Rome +ve pain and either biliary manometry ( $p = 0.3$ ) or improvement in pain following ES ( $p = 0.2$ ) in patients with either SOD 2 or 3 (see tables). However, there was a high relapse rate after initial improvement across both groups (SOD2 17/26=65%, SOD3 2/7=29%) irrespective of whether patients had Rome +ve or -ve pain initially.

**Conclusion** Despite the clear recommendations of the Rome criteria requiring intermittent/episodic pain for a diagnosis of SOD, our data suggest that correlation between description of pain and biliary manometry is poor. 30–35% of patients who meet the current gold standards for diagnosis of SOD have constant or daily (Rome -ve) pain. Additionally, description of pain does not predict response to endotherapy suggesting that the Rome criteria and/or SOM for suspected SOD are not clinically useful and may need to be redefined. We note that high rates of positive SOM and recurrence of pain post-ES was seen in our cohort.

**Disclosure of Interest** None Declared.

#### PTH-005 LAPAROSCOPY-ASSISTED ERCP FOLLOWING BARIATRIC GASTRIC BYPASS SURGERY: INITIAL EXPERIENCE AT A UK TERTIARY REFERRAL CENTRE

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**Introduction** Bariatric gastric bypass surgery is being increasingly performed, but ERCP in these patients poses a unique challenge because of lack of per-oral access to the stomach. Small series suggest a higher technical success rate, using Laparoscopy assisted ERCP (LA-ERCP), than with an enteroscopic approach via the Roux-en-Y anastomosis. We present the experience thus far of LA-ERCP at our UK tertiary referral Pancreaticobiliary unit.

**Methods** Retrospective case series of consecutive patients undergoing LA-ERCP in our unit between September 2011 and June 2013. Data was retrieved from electronic, clinical and endoscopy records.

**Results** All LA-ERCP procedures were undertaken in the operating theatre with a mobile endoscopy stack and Olympus TJF