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 enterosocpic approach via the Roux-en-Y anastamosis. 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