be particularly useful to control oozing. Larger prospective controlled studies are required to further determine its exact role in upper and lower GI bleeding.

REFERENCE

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Disclosure of Interest None Declared.

PTU-030 10 YEAR RETROSPECTIVE REVIEW OF ABDOMINAL TUBERCULOSIS FROM A LONDON TEACHING HOSPITAL: DIAGNOSTIC METHODS

[1]JS Nayagam*, [2]C Mullender, [1]A Poullis, [2]C Cosgrove. *[1]Gastroenterology and Hepatology, St George's Hospital, London, UK; [2]Clinical Infection Unit, St George's Hospital, London, UK*

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Introduction Abdominal tuberculosis (TB) is difficult to diagnose, due to non-specific symptoms and radiological, histological and endoscopic similarity to other conditions. It can mimic Crohn's disease and should always be considered as a differential diagnosis. There are significant risk of incorrectly diagnosing TB and committing patients to a prolonged course of toxic chemotherapy; or missing TB with public health implications and causing life-threathening disseminated TB when immunosuppressing patients. We sought to review the route to diagnosis of patients treated for abdominal TB, their sites of disease and the yield of various diagnostic modalities.

Methods A retrospective review of patients treated at St George's Hospital, London, for abdominal TB from June 2003 to August 2013 was conducted. Information was gained from electronic patient records and the hospital's tuberculosis database.

Results 65 cases of abdominal TB were identified. Average age was 42 years (range 18–97), with 49.2% females.

Pre-diagnosis: 49.2% underwent endoscopy, 64.6% ultrasound, 70.8% CT, 3.1% MRI and 10.8% small bowel series.

TB was cultured in 47.7% of patients, in the remaining 52.3% the diagnosis of abdominal TB was based on radiology, symptoms, suggestive histopathology, exclusion of other conditions or TB at another site.

The site was: peritonitis in 35.4%, enteritis in 27.7%, solid organ TB in 3.1%, combination of sites in 33.8%. 24.6% had co-existent pulmonary TB isolated on sputum culture.

The rate of culture positivity varied from modality of specimen acquisition as outlined in the table. 1 case was resistant to isoniazid and streptomycin.

Conclusion Confirming a diagnosis of abdominal TB is notoriously difficult, with the rate of positive culture below 50% in our series. Non-invasive imaging is commonly used and is useful to characterise the phenotype of abdominal TB and suggest sites for sampling, however it does not assist in obtaining a definitive diagnosis. Invasive testing is a cornerstone of diagnosis. Ascitic fluid and surgically acquired biopsies had a higher diagnostic rate than endoscopy. There was a low rate of endoscopic biopsies being sent for Microbiology. If TB is part of the differential diagnosis endoscopists must ensure microbiological samples are taken into normal saline solution and sent for mycobacterial culture.

Disclosure of Interest None Declared.

PTU-031 DUODENAL BIOPSY SPECIMEN COLLECTION AND DIAGNOSIS OF COELIAC DISEASE

[1]J Morrow*, [2]G Rafferty, [3]M Loughrey. *[1]General Medicine/Gastroenterology, Royal Victoria Hospital, BHSCT, UK; [2]Gastroenterology, Royal Victoria Hospital Belfast, UK; [3]Pathology, Royal Victoria Hospital, Belfast, UK*

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Introduction Coeliac disease is an immune-medicated, gluten sensitive enteropathy affecting 1% of the UK population.[1] Early diagnosis is important due to the potential long-term complications. Histological analysis along with serum biomarkers are used in diagnosis.[1] British Society of Gastroenterology (BSG) guidelines recommend a minimum of 4 duodenal biopsies in order to maximise detection rates.[2,3]

Objectives To determine the current practice relating to the number of duodenal biopsy specimens taken at endoscopy in Belfast HSCT compared to national guidelines, and to assess the correlation between serology results and subsequent diagnosis of coeliac disease.

Methods Retrospective review of the first 500 duodenal biopsy histology reports processed by Belfast Trust pathology laboratory in 2012. Positive/equivocal histological features based on criteria in BSG guidelines.[2]Serology results were checked via the Link Labs© system on all patients with pathology submitted.

Results 481 duodenal histology records were included in the study with 19 excluded. 225 specimens (46.7%) had **less** than the 4 recommended individual biopsy fragments. 26 patients were diagnosed with Coeliac disease based on histological findings, and a further 30 had 'equivocal' results. Patients with positive or equivocal coeliac histology had a higher percentage of 4 or more biopsies as compared to the whole group (80.7% and 77.3% respectively vs 53.3%). Overall **96%** with histological evidence of coeliac disease also had positive serology (n = 23). For those with 'equivocal' histology, serology was positive in 55% and negative in 45%. 2% of patients with negative histology had strongly positive serology.

Conclusion The number of duodenal biopsy specimens taken at endoscopy is below recommended guidelines in 46.7% of cases. There is a higher number of biopsy specimens taken in those with subsequently positive or equivocal histological features. 96% of cases where histology was diagnostic also demonstrated positive serology. 2% of patients with subsequently negative histology had strongly positive serology prior to endoscopy, and in these cases almost all had 4 or more individual pathology specimens.

This suggests that where strong clinical suspicion and positive biochemistry indicate a higher probability of coeliac disease, the endoscopist is inclined to take more biopsy specimens.

Abstract PTU-030 Table 1

	Number	Histology sent (%)	Histology suggestive of TB (%)	Microbiology sent (%)	Culture +ve (%)
Paracentesis	20	20 (100%)	7 of 9 (77.8%) without TB had lymphocytic effusion	19 (95%)	11 (57.9%)
Endoscopy	32	28 (87.5%)	14 (50%)	10 (31.3%)	3 (30%)
Surgery	16	15 (93.8%)	14 (93.3%)	13 (81.3%)	9 (69.2%)

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