50 patients of investigational group (IG) additionally were treated by Sibutramin, daily dosage contained 15 mg and PUPC (daily dosage contained 1368 mg Phosphatidylcholine). 30 patients of control group (CG) were treated by Sibutramin, daily dosage contained 15 mg.

**Results** All 50 patients of IG and 30 patients of CG were available for follow-up reliable decrease (12.8%) of BMI and leptin level. In IG patients BMI and leptin level (24.7±2.1%—16.2±1.2%) was registered compared to CG patients (BMI decrease—9.3%, leptin level 24.5±1.5% to 19.9±1.1%). Moreover after 6 months of treatment the mean value of disease activity evaluated by Metavir scale was A1 in IG and A3 in CG. The results of liver biopsy (histological examination) and Fibromax test showed, that in patients with AILD additionally treated by PUPC, the progress of hepatic fibrosis was significantly slowly, then in CG (Fibromax test result: F1 vs F3) (p<0.06). In addition after 6 months of treatment we found significant increase of steatosis in IG, and its reduction in IG (p<0.06). Ultrasound studies were performed on the basis of liver attenuation value assessment and revealed the hepatic echo-structure had become significantly improved after Sibutramin treatment in 46/50 (92%) of patients, while there was no change in 7/30 (23.3%) individuals. Also in patients additionally treated by polyunsaturated phosphatidylcholine and Sibutramin we found significant reduction of glucose, insulin levels and of insulin resistance index HOMA. The usage of Sibutramin itself did not reveal significant changes.

**Conclusion** Study results suggest that Sibutramin combined with PUPC improves liver function and insulin-sensitivity, reduces steatosis and fibrosis in patients with obesity and effect of combined therapy is higher than of Sibutramin itself.

**Competing interests** None declared.

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**TREATMENT AND SURVEILLANCE OF POLYPOID LESIONS OF THE GALLBLADDER IN THE UK: RESULT OF A SURVEY**

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**Introduction** The management of gallbladder polyps (GBP) is still controversial. The increased use of routine abdominal imaging has led to a parallel surge of identified polyoid lesions in the gallbladder. The vast majority of these lesions are benign. True polyps, which are less frequent, have a malignant potential and surgery can prevent/treat early gallbladder cancer. In an era of constraint on health care resources it is important to offer cholecystectomy only to patients who have appropriate indications.

**Methods** The aim of this study was to assess the treatment and surveillance policies of GBP among hepatobiliary and upper GI surgeons in UK in the light of the current published literature. A questionnaire on GBP was devised and sent to the Consultant Surgeon members of the Association of Upper GI Surgeons (AUGIS) of Great Britain and Ireland after approval from the AUGIS Committee. There were eight questions regarding indications for laparoscopic cholecystectomy (LC) and surveillance based on GBP characteristics (size, number and growth rate), and patient characteristics (age, comorbidities and ethnicity).

**Results** There were 79 completed questionnaires. Three-quarters of surgeons consider 1cm as the size threshold for recommending surgery but 9% would consider LC irrespective of GBP size. 25% would recommend LC for multiple polyps irrespective of the size of the largest GBP. 28% of surgeons emphasise a growth rate of 5 mm or more as an indication for LC; more than 50% would not offer LC unless the polyp size matches their criteria for single polyp LC. 25% would recommend surgery for any number increase of GBP between surveillance scans. Surveillance protocols were heterogeneous but about 40% would agree to surveillance up to 5 years. About 30% would not offer LC for octogenarians and 10% would reconsider their surgery threshold according to ethnicity.

**Conclusion** GBP are a relatively common finding on abdominal ultrasound scans. About 50,000 LC are performed each year in UK and 800–4000 are for GBP. The survey has shown considerable heterogeneity among surgeons regarding treatment and surveillance protocols. Although no randomised controlled trials exist, international guidelines would help standardisation, formulation of an appropriate algorithm and appropriate use of resources.

**Competing interests** None declared.