positive biopsy cases. A proportion of patients will not have serological tests going straight to endoscopy as first line investigation for their anaemia. Serological testing remains useful in primary care and for physicians to diagnose coeliac disease; however it is important to be aware of the small number of cases (approximately 5%) that will be missed when relying on serology alone.

Competition interests None declared.

PWE-123 RESPONSE TO BILE ACID SEQUESTRANTS IS POOR IN PATIENTS WITH EQUIVOCAL SEHCAT RESULTS

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Introduction Bile acid malabsorption (BAM) is a common cause of chronic diarrhoea that can be diagnosed by the SeHCAT test and treated with bile acid sequestrants (BAS). The purpose of this study was to clarify the use and efficacy of BAS in the treatment of patients with diarrhoea and equivocal SeHCAT results.

Methods Case records were reviewed over a 6-year period for patients investigated by SeHCAT with a positive (>8%), equivocal (>5% and <16%) or negative (<16%) retention result. Patients were sub-characterised into the following groups. Group 1: terminal ileum Crohn’s disease, (pre or post resection) n=51. Group 2: diarrhoea predominant irritable bowel syndrome (D-IBS) n=159. Group 3: BAM associated with other gastrointestinal disease n=51; of which cholecystectomy (n=37), coeliac disease (n=1), chronic pancreatitis (n=1), bacterial overgrowth (n=2), diabetes (n=4) and other gastrointestinal surgeries (n=6). Group 4: terminal ileum disease plus cholecystectomy n=3. Patients’ sex and age were recorded. Use of BAS (colestyramine or colesevelam) and response were noted.

Results SeHCAT tests were performed in 264 patients and 39 (15%) patients were found to have equivocal results while 104 (39%) had positive results. Although 28/39 (72%) patients with equivocal results were offered treatment with BAS, information on response to treatment was only available in half of these patients (n=14). In comparison, there was a higher rate (75%) of follow-up in the patients with positive SeHCAT results with information on response to treatment being available in 73 of the 97 patients offered BAS treatment. There was a marked difference in response to BAS therapy between the two groups. A successful response was noted in only 36% (n=5) of patients with equivocal SeHCAT results while 66% (n=48) of patients with positive SeHCAT results had a successful response. The difference in treatment response was also most significant among the patients in group 2 with D-IBS. 75% (n=24/33) of the patients with positive SeHCAT results in group 2 responded to BAS therapy while only 33% (n=3/9) of those with equivocal SeHCAT results in this same group had a successful response.

Conclusion This retrospective study indicates that there is a poorer response to bile acid sequestrants among patients with equivocal SeHCAT results, however it is possible there was a disproportionate number of non-responders attending for follow-up in this group. More comprehensive follow-up is needed in patients with equivocal SeHCAT results in the future to help determine whether BAS treatment in this lower response group is cost-effective.

Competition interests None declared.

REFERENCE


PWE-125 DOES THE TNM STAGING CRITERIA PREDICT SURVIVAL IN PATIENTS WITH SMALL BOWEL NEUROENDOCRINE TUMOURS?

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Introduction Small bowel neuroendocrine tumours (SBNETs) are regarded as relatively indolent cancers. A TNM staging system designed by European NET Society (ENETS) was designed to help stage these tumours to enable ease in classification of these tumours. This study aims to demonstrate whether the TNM stage and grade of tumour predicts survival in this cohort of patients. The cause of death is also analysed.

Aim To retrospectively stage patients with known small bowel primary NETs and see whether survival is dependent on stage and grade of disease. The cause of death in patients with small bowel NETs was also analysed.

Methods A total of 135 patients with SBNETs were identified. Primary site: Duodenal 2.1% (3), Jejunal 2.9% (4), ileal 95% (131).
Patients with radiologically, endoscopically or surgically proven SBNETs were included in this study, patients with unknown primary were excluded. A total of 623 patient year’s follow-up, with a mean duration of follow-up of 5 years. The median age 61 years (range 24–84). Statistical analysis was performed using GraphPad Prism 5.1.

**Results**

TNM staging and follow-up data were available in 118 cases. Due to low numbers of Stage 2 and 3 tumours these were group together for comparison. There were four cases with stage 2, 23 cases with Stage 3 and 91 cases with stage 4 small bowel NETs. Kaplan–Meier plots were constructed these demonstrated a significant difference in survival between patients with different stage of disease (p=0.05). There was no significant difference in survival between stage 2 and stage 3 diseases. There was a significant survival difference between G1 (Ki67 ≤2) vs G2 (Ki67 3–20) p=0.049. The overall 5-year and 10-year survival was 79.5% and 48.5% respectively for all patients independent of stage of disease.

Of the patients that died the median time to death from diagnosis was 3 years (range 0–84 years). Only patients in whom current disease state was known were included in the study. Primary site: Duodenal 2.1% (3), Jejunal 2.9% (4), ileal 95% (131). Kaplan–Meier plots were constructed to determine survival. Staging was performed retrospectively using the TNM staging system proposed by ENETs.³

**Results**

100 patients had the primary resected, four patients had irresectable disease at laparotomy. The mean time to resection of primary from diagnosis was 5.8 months (range 0–78 months). There were no deaths within 50 days post surgery. Kaplan–Meier survival curves were constructed. There was a significant survival benefit in patients whom underwent resection of primary tumour compared to those who did not have the primary resected (120 vs 56 months, p<0.005). There were four patients with Stage 2, 23 patients with stage 3 disease and 91 with stage 4 disease. There were 10 patients in whom it was not possible to accurately stage of disease since the complete histology was not available, however, all of these patients had no evidence of recurrent disease in the initial post-operative period. No survival data were available for the remaining 10 patients. Of the patients who underwent attempted curative resection without distal metastatic disease at presentation, there were 36 patients suitable for analysis. Of these 15 of 36 (41.7%) patients have developed recurrent disease. Median period for development of recurrence was 59 months (range 11–606 months). There was no recurrence in the four patients with known stage 2 disease (4–168 months). Recurrence occurred in 8 of 23 patients (34.8%) with stage 3 disease.

**Conclusion**

This study demonstrated a marked improvement in survival in patients who underwent resection of the primary tumour. Disease recurrence is common in patients following curative resection of locally advanced small bowel NETs. Surveillance for a period of only 5 years will not identify a number of patients who will proceed to develop recurrence.

**Competing interests**

None declared.

**REFERENCE**


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**PWE-126**

Survival and Recurrent Disease in Patients with Resected Primary Small Bowel Neuroendocrine Tumours

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**Introduction**

Small bowel neuroendocrine tumours (SBNETs) are the most common of all GI NETs. The majority of patients present with metastatic disease. It is unclear whether resection of the primary tumour improves prognosis. Furthermore, the recurrence rate of disease in patients following “curative” resection is not previously been investigated.

**Aims**

To demonstrate if primary SBNET resection leads to improved survival and time to development of recurrent disease in patients following resection of primary tumour +/- mesenteric disease in an attempted curative resection.

**Methods**

158 patients with SBNETs seen in our institution; median duration of follow-up was 5 years. Median age 61 (range 24–84 years). Only patients in whom current disease state was known were included in the study. Primary site: Duodenal 2.1% (3), Jejunal 2.9% (4), ileal 95% (131). Kaplan–Meier plots were constructed to determine survival. Staging was performed retrospectively using the TNM staging system proposed by ENETs.³

**Results**

100 patients had the primary resected, four patients had irresectable disease at laparotomy. The mean time to resection of primary from diagnosis was 5.8 months (range 0–78 months). There were no deaths within 50 days post surgery. Kaplan–Meier survival curves were constructed. There was a significant survival benefit in patients whom underwent resection of primary tumour compared to those who did not have the primary resected (120 vs 56 months, p<0.005). There were four patients with Stage 2, 23 patients with stage 3 disease and 91 with stage 4 disease. There were 10 patients in whom it was not possible to accurately stage of disease since the complete histology was not available, however, all of these patients had no evidence of recurrent disease in the initial post-operative period. No survival data were available for the remaining 10 patients. Of the patients who underwent attempted curative resection without distal metastatic disease at presentation, there were 36 patients suitable for analysis. Of these 15 of 36 (41.7%) patients have developed recurrent disease. Median period for development of recurrence was 59 months (range 11–606 months). There was no recurrence in the four patients with known stage 2 disease (4–168 months). Recurrence occurred in 8 of 23 patients (34.8%) with stage 3 disease.

**Conclusion**

This study demonstrated a marked improvement in survival in patients who underwent resection of the primary tumour. Disease recurrence is common in patients following curative resection of locally advanced small bowel NETs. Surveillance for a period of only 5 years will not identify a number of patients who will proceed to develop recurrence.

**Competing interests**

None declared.

**REFERENCE**