Intriguingly CP patients who consume excess alcohol have more peripheral blood Th1 cells. Alcohol increases gut permeability causing high circulating levels of lipopolysaccharide which is known to generate Th1 cell responses. These combined features may contribute to the pathogenesis of CP.

Competing interests None declared.

REFERENCES

OC-112 UTILITY OF CYST FLUID AMYLASE IN THE DIFFERENTIATION OF SUSPECTED PANCREATIC NEOCYSTIC CYSTS
doi:10.1136/gutjnl-2012-302514a.112

1K Oppong, 2K Elamin, 3J Leeds, 1M Dawwas, 1M K Nayar.*

Introduction The Differentiation of mucinous (MCA, IPMN) from non-mucinous pancreatic cysts is important because of the malignant potential of the former. Cyst fluid amylase is known to be elevated in cysts with overt communication with the pancreatic duct (Pseudocysts and IPMN) recent data has also suggested it may be elevated in MCA and that malignant mucinous cysts have a significantly lower level than benign.1 We aimed to assess the diagnostic performance of cyst fluid amylase in a large cohort of histologically confirmed pancreatic cysts.

Methods The study population comprised all patients with suspected neoplastic pancreatic cysts who underwent EUS-FNA between June 2003 and October 2011. The study group consisted of cases with a definitive diagnosis (resection histology, biopsy histology or malignant cytology) in whom a cyst amylase value had been recorded. Test performance was compared using Mann-Whitney U test and an ROC curve was generated to characterise the diagnostic performance of cyst fluid amylase to differentiate pseudocyst from non pseudocyst.

Results During the study period 334 cyst EUS-FNA procedures were performed. A definitive diagnosis was available for 95 individuals, an amylase level was available for 59/93 (63.4%) of cases. 57 mucinous cyst (24 benign, 15 malignant), 22 non-mucinous (eight pseudocysts). Median values (IU/L) and IQR for differing categories of cyst amylase level was available for 59/93 (63.4%) of cases. 37 mucinous cyst (24 benign, 13 malignant), 22 non-mucinous (eight pseudocysts), 24 benign, 13 malignant), 22 non-mucinous (eight pseudocysts).

Conclusion Cyst fluid amylase while significantly elevated in pseudocysts cannot be solely relied upon to distinguish from mucinous cysts and cannot be used to differentiate between IPMN and MCA.

Competing interests None declared.

OC-113 PREVENTION OF POST-ERCP ACUTE PANCREATITIS: COMPLETE SYSTEMATIC REVIEW
doi:10.1136/gutjnl-2012-302514a.113

1K Altaf,* 1M A Javed, 2D Lythgoe, 2F Wright, 1R Sutton. 1Department of Molecular and Clinical cancer medicine, Liverpool NIHR Pancreas Biomedical Research Unit, Liverpool, UK; 2Department of Medical statistics, University of Liverpool, Liverpool, UK

Introduction Post-ERCP acute pancreatitis (post-ERCP AP) occurs in ~5% of patients undergoing ERCP; severe in ~1%. Despite multiple trials, optimal prophylaxis remains undetermined. We sought to clarify the effectiveness of prophylactic interventions for post-ERCP AP through multiple meta-analyses of randomised controlled trials (RCTs).

Methods MEDLINE, EMBASE and the Cochrane Library were searched by two independent reviewers to identify all RCTs that tested treatments to reduce post-ERCP AP. Data were extracted to permit Jadad scoring, grouping of RCTs by therapeutic mechanism and separate meta-analysis of each group. The main outcome measure was post-ERCP AP, defined as amylase elevated to >3 × upper limit of normal with >24 h abdominal pain.

Results 71 RCTs of the highest quality (Jadad score 5 for pharmacological and three for interventional trials) were identified. Pancreatic stents (trials (5)—; patients (P)=577; RR 0.90; CI 0.70 to 1.19) were most effective; significant reductions in post-ERCP AP resulted from secretion inhibitors (P=4; IRR 0.54; CI 0.36 to 0.82), protease inhibitors (P=1—; P=5752; RR 0.54; CI 0.38 to 0.78) and smooth muscle relaxants (P=1—; P=2110; RR 0.67; CI 0.52 to 0.87).

Non-steroidal anti-inflammatory drugs (NSAIDs; P=1—; P=7); RR 0.68; CI 0.46 to 1.00), interleukin-10 (IL-10; T=1—; P=642; RR 0.79; CI 0.55 to 1.14), anti-oxidants (T=1—; P=2110; RR 0.90; CI 0.54 to 1.50), anticoagulants (T=2; P=533; RR 0.85; CI 0.48 to 1.55), non-ionic (vs ionic) contrast agents (T=1—; P=5055; RR 1.32; CI 0.92 to 1.88), wire guided cannulation, (T=7; P=2110; RR 0.63; CI 0.54 to 1.17) pre cut papillotomy (T=4—; P=555; RR 0.57; CI 0.20 to 1.98) and steroids (T=1—; P=924; RR 1.09; CI 0.70 to 1.70) did not reduce post-ERCP AP.

Conclusion This is the most comprehensive systematic review on the subject to date which shows that pancreatic stents, secretion and protease inhibitors and smooth muscle relaxants reduce the risk of post-ERCP AP. Large well-designed RCTs of combination vs single agent prophylaxis are required.

Competing interests None declared.

Colorectal free papers

OC-114 EMR VS ESD FOR THE RESECTION OF LARGE RECTOSIGMOID LESIONS: DATA FROM A LARGE UK CENTRE
doi:10.1136/gutjnl-2012-302514a.114

G Longcroft-Wheaton,* P Bhandari. Department of Gastroenterology, Portsmouth Hospitals NHS Trust, Portsmouth, UK

Introduction Endoscopic resection of large benign rectal lesions is becoming established as an attractive alternative to surgery. However, the optimal technique is not clear. This series compares the experience of EMR and ESD in a tertiary referral centre.
Methods A prospective review of patients undergoing endoscopic resection of neoplastic polyps in the rectosigmoid colon. Patients were tertiary referrals from experienced consultants. The polyps were considered technically challenging due to size, difficult lesion access or recurrences on previous EMR scars. Referral was made prior to surgical referral. All lesions were assessed using indigocarmine chromoendoscopy and lesions suspicious for invasive malignancy were excluded. The choice of endoscopic technique was made based on the Endoscopist’s judgement of best approach for each lesion. Completeness of resection was recorded. Endoscopic follow-up was performed to assess for incomplete resection or recurrence.

Results 45 lesions were resected by ESD technique and 100 by EMR technique. For ESD procedures the median lesion size was 40 mm (range 20–150), 19/45 were salvage procedures post failed attempts at endoscopic resection. Endoscopic clearance was achieved at first attempt in 91% of the procedures. A further 7% were cleared in a subsequent procedure. One patient was referred for surgery for perforation and two patients went to surgery for unsuspected cancer found on histological examination of the resection specimen. At endoscopic follow-up 100% had complete clearance with no residual disease. There was one perforation requiring surgery, two microperforations (endoscopically managed), three delayed bleeds and two post polypectomy syndromes (conservatively managed) giving an overall complication rate of 13%. For the EMR cohort the median lesion size was 40 mm (range 20–100). All procedures were primary resections. Endoscopic clearance was achieved in 90% of cases. Two patients were referred for surgery for incomplete resection. In seven patients unsuspected cancer was found, all of whom were referred for surgery. At endoscopic follow-up 95% of cases had achieved complete clearance with no residual disease. There was seven delayed bleeds and one post polypectomy syndrome giving an overall complication rate of 8%.

Conclusion Both EMR and ESD results in an excellent complete clearance rate. While ESD appears to result in fewer recurrences at follow-up it is associated with an increased complication rate compared to EMR, predominately due to the risk of perforation. However, it is effective in patients with previous failed attempts at resection. It should be considered as an option for difficult or scarred lesions where complete clearance with EMR could be difficult.

Competing interests None declared.

OC-115 COMPARISON OF SCREEN DETECTED AND INTERVAL COLORECTAL CANCERS IN THE BOWEL CANCER SCREENING PROGRAMME: EXPERIENCE FROM THE NORTH EAST OF ENGLAND

doi:10.1136/gutjnl-2012-302514a.115

1,2,3 M Gill,* 2,3 M G Bramble, 2,3 C J Rees, 1,3 M Bradburn, 3,4 T J Lee, 1,3 S J Mills.
1 Northern Colorectal Cancer Audit Group, Northern England; 2 University of Durham, Durham, UK; 3 Northern Region Endoscopy Group, Northern England; 4 University of Newcastle, Newcastle, UK

Introduction The NHS Bowel Cancer Screening Programme (BCSP) commenced screening in North East England in February 2007. It offers biennial faecal occult blood testing (FOBT) followed by colonoscopy for those with a positive FOBT. All cases of colorectal cancer were considered technically challenging due to size, difficult lesion access or recurrences on previous EMR scars. Referral was made prior to surgical referral. All lesions were assessed using indigocarmine chromoendoscopy and lesions suspicious for invasive malignancy were excluded. The choice of endoscopic technique was made based on the Endoscopist’s judgement of best approach for each lesion. Completeness of resection was recorded. Endoscopic follow-up was performed to assess for incomplete resection or recurrence.

Results 45 lesions were resected by ESD technique and 100 by EMR technique. For ESD procedures the median lesion size was 40 mm (range 20–150), 19/45 were salvage procedures post failed attempts at endoscopic resection. Endoscopic clearance was achieved at first attempt in 91% of the procedures. A further 7% were cleared in a subsequent procedure. One patient was referred for surgery for perforation and two patients went to surgery for unsuspected cancer found on histological examination of the resection specimen. At endoscopic follow-up 100% had complete clearance with no residual disease. There was one perforation requiring surgery, two microperforations (endoscopically managed), three delayed bleeds and two post polypectomy syndromes (conservatively managed) giving an overall complication rate of 13%. For the EMR cohort the median lesion size was 40 mm (range 20–100). All procedures were primary resections. Endoscopic clearance was achieved in 90% of cases. Two patients were referred for surgery for incomplete resection. In seven patients unsuspected cancer was found, all of whom were referred for surgery. At endoscopic follow-up 95% of cases had achieved complete clearance with no residual disease. There was seven delayed bleeds and one post polypectomy syndrome giving an overall complication rate of 8%.

Conclusion Both EMR and ESD results in an excellent complete clearance rate. While ESD appears to result in fewer recurrences at follow-up it is associated with an increased complication rate compared to EMR, predominately due to the risk of perforation. However, it is effective in patients with previous failed attempts at resection. It should be considered as an option for difficult or scarred lesions where complete clearance with EMR could be difficult.

Competing interests None declared.