PTU-177 RETROSPECTIVE AUDIT OF MANAGEMENT OF PATIENTS ADMITTED TO INTENSIVE CARE UNIT (ITU) WITH SEVERE ACUTE PANCREATITIS(SAP)

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Introduction To compare management strategies and mortality of patients admitted to ITU with SAP against national standards and study the group who succumbed to their disease in detail to identify the most accurate prognostic indicators in this group of patients.

Methods Retrospective audit of management and outcome of consecutive patients admitted to ITU with SAP during 2007–2010. The development of necrosis and organ failure(OF)was recorded. Patients were classified into four groups: I (No necrosis or OF), II (sterile necrosis or transient OF), III (infected necrosis or persistent OF) and IV (infected necrosis and persistent OF).

Results Fifty one patients were admitted to ITU with SAP (APACHE II > 8, modified Glasgow score > 3). All cases fulfilled the Atlanta criteria of SAP. Median age: 66 ± 17.5. The overall mortality rate was 38% (n-19) above national standard of 30%. All 7 patients in group IV died, 5 of them underwent necrosectomy and 1 had CT guided drainage of infected acute fluid collection. The table shows the total number of patients and respective mortality in each group. Neither antibiotics nor nutritional support had significant impact on survival. Outcome (death) correlated with organ dysfunction criteria (Atlanta criteria and APACHE II score).

Abstract PTU-177 Table The mortaltiy of SAP in the different groups

Group	Total Number	Mortality	% of Mortality
I	12	0	0%
II	2	0	0%
III	30	12	40%
IV	7	7	100%

Conclusion While the presence of infected necrosis or persistent organ failure in SAP (group III) is associated with high mortality, the combination of "infected necrosis and persistent organ failure" (group IV) is uniformly fatal. Further research is necessary to confirm our findings and to explore ways of optimising patients in group III to improve survival.

Disclosure of Interest None Declared.

PTU-178 PITFALLS OF FAECAL ELASTASE ESTIMATION

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Introduction The faecal elastase test measures the concentration of the elastase-3B enzyme found in faecal matter with an enzyme-linked immunosorbent assay (ELISA). It is a good indicator of exocrine pancreatic status, and is less invasive and expensive than the secretin-cholecystokinin test, the current gold standard. Levels of faecal elastase lower than 200 μg/g of stool indicate an exocrine pancreatic insufficiency (EPI).

Methods Aim: Faecal elastase is a marker for EPI particularly in chronic pancreatitis and pancreatic malignancy. Our aim was to outline the value of faecal elastase in patients with obscure diarrhoea. Methods: We retrospectively collected data of patients who had a faecal elastase test from June 2010 to 2012. We correlated the abnormal results with symptoms, findings on imaging and response to treatment. We also stratified these findings in patients with ultra low faecal elastase to assess whether the diagnostic yield was different. Paediatric patients were excluded from the study.

Results There were a total of 72 abnormal results out of 523 in this 2 year study of which 33 (45%) patients had large volume diarrhoea. Of these, 26 (78%) patients had no therapeutic response to pancreatic enzyme supplements (PES) and had normal imaging, 4 had a response and in 3 we could not establish whether PES was trialled. Of the patients who responded to treatment, 2 had imaging suggestive of chronic pancreatitis. 9 of the patients who were investigated for steatorrhoea were on statins but had normal faecal elastase, normal cross sectional imaging and good response to treatment with PES 41 patients had ultra low faecal elastase levels (< 50μg/g), of these 32(78%) patients had significant pancreatic pathology whilst only 9(22%) had watery diarrhoea.

Conclusion 1- A normal faecal elastase does not exclude EPI – as the 9 patients who were on statins had normal faecal elastase and pancreatic imaging and a dramatic response to PES. Other drugs like azathioprine, steroids causing EPI needs further investigation.

2- An ultra-low faecal elastase level (<50 μg/g), is more likely to be related to significant pancreatic pathology with a response to treatment. Patients with watery diarrhoea are less likely to have a level this low. In these patients stool lyophilising or concentration should be performed before faecal elastase estimation. 3- In our patient group conditions like diabetes, coeliac disease, Addisons disease, gastrointestinal fistulas, short bowel syndrome, microscopic colitis, bile salt malabsorption and previous radiation all lead to falsely low levels without clinical correlation or response to treatment. Faecal elastase in this sub group should be interpreted with caution.

Disclosure of Interest None Declared.

REFERENCE

The role of faecal elastase-1 in detecting exocrine pancreatic diseaseJohn S. Leeds, Kofi Oppong & David S. Sanders

PTU-179 DIAGNOSTIC YIELD OF EUS-FNA IN PANCREATIC NEURO-ENDOCRINE TUMOURS (PNET) – SOLID VERSUS CYSTIC PNETS – 9 YEAR EXPERIENCE FROM A TERTIARY CENTRE

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Introduction The detection and diagnosis of pNETs remains challenging. EUS and EUS-FNA has a significant role in the detection, precise localisation and cytological confirmation of pNETs.

Methods A retrospective review of all pNET patients undergoing EUS-FNA between April 2003 and September 2011 was carried out to determine the efficacy of EUS-FNA in confirming pNETs and compare performance over two consecutive 4 year period.

Results 10 patients (3% of EUS procedures for cystic lesions) with cystic pNETs and 44 (4% of EUS procedures for solid lesions) with solid pNETs were identified. Table 1 compares the size, demographics and diagnostic performance of radiology, EUS & cytology in solid and cystic pNETs. 17 and 5 solid and cystic pNETs respectively were diagnosed between 2003 and 2007 while 27 and 5 solid and cystic pNETs were diagnosed between 2008 and 2011. EUS-FNA diagnosis of cystic and solid pNETs has improved from 20% and 59% respectively between 2003 and 2007 to 100% and 81% respectively between 2008 and 2011. Overall, sensitivity of EUS cytology has improved from 50% to 84.4% (p = 0.015) during this period. Malignant potential of solid pNETs was higher (54.5% vs 20%) compared to cystic pNETs. Curative resection was higher in patients with cystic pNETs (80% vs 68%) compared to solid pNETs.

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