

Abstract PTU-179 Table 1

	Combined solid & cystic pNETs (n = 54)	Solid pNETs (n = 44)	Cystic pNETs (n = 10)
Mean Age (yrs)	61.3	61.5	60.2
Sex (Male %)	AB59	AB64	40
Mean size of lesion in cm (range)	2.73 (0.7 – 9.5)	2.95 (0.7 – 9.5)	1.96 (0.8 – 5)
Sensitivity of CT/MRI in detecting pNET (%)	33.3 <sup>1</sup> @	38.5 <sup>1</sup> @	10 <sup>1</sup>
Sensitivity of EUS imaging in detecting pNET (%)	51.8 *	57 *	AB30
Sensitivity of EUS cytology in detecting pNET (%)	70.4 @	73 @	AB60
Sensitivity of combined EUS imaging and cytology in detecting pNET(%)	81.5 * <sup>1</sup>	84.1* <sup>1</sup>	70 <sup>1</sup>

Note: \* p < 0.05, <sup>1</sup> p < 0.05, @ p < 0.05 comparison within columns

**Conclusion** EUS & EUS-FNA is a useful test in diagnosing pNETs. Overall, the sensitivity of combined EUS imaging and cytology was significantly better compared to CT/MRI (p < 0.05) in detecting pNETs across all groups. Sensitivity of combined EUS imaging and cytology was significantly better compared to EUS imaging alone (p < 0.05) in the solid and combined pNET cohort of patients. Sensitivity of EUS cytology was significantly better compared to EUS imaging (p < 0.05) in the solid and combined pNET cohort of patients. Comparing the first 4 years to the second, there has been an increase in the number of cases of pNETs and statistically significant improvement in the diagnostic performance of cytology.

**Disclosure of Interest** None Declared.

## Small bowel

### PTU-180 BILE ACID DIARRHOEA – THE GOOD, THE BAD AND EQUIVOCAL RESPONDERS: A TWO CENTRE COMPARISON

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**Introduction** Bile acid diarrhoea (BAD) is a common cause of chronic diarrhoea, currently diagnosed using Se<sup>75</sup>-homo-chloro-tauric-acid (Se<sup>75</sup>HCAAT) testing, the “gold standard” in the UK and available to centres which support a gamma camera. Although the test has been available for over two decades, uptake has been slow despite its diagnostic value and evidence that treatment with sequestrants can be effective. This stems from a lack of formal clinical trials, which encourages a belief the good results reported may reflect patient selection, resulting in therapeutic nihilism. Thus the aim of this study was to compare treatment results between two centres: experienced ( $\alpha$ ), using data reported earlier, and novice ( $\beta$ ), with current data.

**Methods** The patients recruited comprised those with structural disease (e.g. ileal resection, cholecystectomy), and non-structural, the majority with diarrhoea-predominant irritable bowel syndrome (D-IBS). Abnormal Se<sup>75</sup>HCAAT results were defined as < 10% retention on Day-7. Response to treatment: 1<sup>st</sup> line (cholestyramine, colestid, colesitol) or 2<sup>nd</sup> line (colesevelam) was recorded in three categories: good, partial or poor.

#### Results

Centre  $\alpha$ : 2001–2006; recruited n = 162; treatment assessed n = 129. Centre  $\beta$ : 2008–2012; recruited n = 126; treatment assessed n = 99. Response to treatment

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Response	Centre $\alpha$	Centre $\beta$
Good	60 (47%)	40 (40%)
Partial	30 (23%)	23 (23%)
Poor	15 (12%)	10 (10%)

D-IBS – Abnormal Se<sup>75</sup>HCAAT: centre  $\alpha$  33%, Centre  $\beta$  31%.

**Disclosure of Interest** None Declared.

#### Conclusion

- Both centres had similar proportions with abnormal Se<sup>75</sup>HCAAT values, suggesting gastroenterologists are able to select appropriate patients who are likely to benefit from the test.
- Treatment response in both centres was similar, ~70% responding. This suggests treatment is genuinely effective and not limited only to centres with a special interest.

### PTU-181 THE LOW DIAGNOSTIC YIELD OF NON-TARGETED DUODENAL BIOPSIES

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**Introduction** Duodenal mucosa of normal endoscopic appearance is often biopsied (non-targeted biopsy) to exclude coeliac disease (CD) as the cause of iron deficiency anaemia or other symptoms. Our aim was to investigate the incidence of diagnosis of CD in non-targeted biopsies, in conjunction with tissue transglutaminase antibody (tTG) test results, in 3 adult age groups.

**Methods** Review of records of 297 consecutive patients having duodenal biopsy from July to October 2011. Age, indication for endoscopy, endoscopic appearance, tTG status and microscopy findings were recorded.

**Results** See table. Of 297 total patients, age range was 16–93 years. 60 biopsies (20%) were from endoscopically *abnormal* duodenum and 237 (80%) were from endoscopically *normal* duodenum, the latter including 12 from patients with follow-up of known CD and 7 with other clinical indication to biopsy normal duodenum. Therefore 218 (73%) were non-targeted biopsies with no indication to biopsy normal duodenum other than to rule out CD. 210 (96%) of the non-targeted biopsies were histologically normal or near normal with no features of CD & the remaining 8 (4%) had histological features consistent with CD. All 8 such patients had positive tTG results, 4 before & 4 after endoscopy, confirming the diagnosis of CD. 60 further patients from the 218 non-targeted group had tTG testing and all were negative. 65 (30%) non-targeted biopsies were from patients aged  $\geq 75$  years but CD was not newly diagnosed in this age group. 3 of the 60 patients with endoscopically *abnormal* duodenum had histological features consistent with a new diagnosis of CD and positive tTG ( $\leq 54$  years = 1, 55–74 years = 2,  $\geq 75$  years = 0).

**Conclusion** The majority of duodenal biopsies were non-targeted. CD was identified in 4% of non-targeted biopsies, in tTG positive patients. Non-targeted biopsies did not show significant findings in tTG negative patients. Reduction in biopsy workload could be achieved if non-targeted biopsies were to be taken only in the setting of positive tTG or other relevant clinical indication; no