PWE-200 MR ENTEROGRAPHY IS A USEFUL TEST IN THE INVESTIGATION OF SMALL BOWEL DISEASE

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Introduction MR enterography (MRE) aids assessment of small bowel (SB) inflammatory bowel disease (IBD). We aimed to determine the frequency and clinical impact of incidental findings detected by MRE in patients with suspected or known Crohn's disease (CD).
Methods We conducted a retrospective review of 948 MRE studies performed between June 2009 and December 2012 at our institution. Clinical data (demographics, disease characteristics and therapy) were obtained from electronic patient records. Incidental findings were defined as unexpected lesions in or outside the small intestine, previously unknown or unsuspected at the time of referral and unrelated to IBD.
Results Of 948 MRE studies 445 patients had a diagnosis of IBD, 385 had CD, 54 had ulcerative colitis and 16 had IBD unclassified (IBDU).

Of 385 CD patients, 224 were female, mean age 36 (range 12–72) and median follow up of 4 years (range 0–39). Abnormalities were noted in 285 scans, 162 active non-stricturing, 109 active stricturing and 13-fibrostenosis. Within active groups were 29 fistulae and 12 abscesses in 33 patients. Incidental findings included colitis (10), gallstones (17), ovarian cyst (15), sacroileitis (1), renal cyst (10), hepatic cyst (10), splenic haemangioma (1), mesenteric abscess (1), adrenal nodule (2), uterine fibroid (4), chronic pancreatitis (1) and splenomegaly (2) associated with portal vein thrombosis in and varices.

70 studies were performed in UC or IBDU; mean age 34 (range 15–82) 39 were female. Small bowel thickening with signs of active inflammation were seen in 9/13. Other findings included a fluid filled collection in the right ischio-anal fossa, pancreatic divisum, gallstones and liver, ovarian and Nabothian cysts, colitis in 6 and colonic polyps in 1.

Indications for MRE in the non-IBD group (503 patients) included iron deficiency anaemia, abdominal pain, weight loss, diarrhoea, vomiting, abnormal colonoscopy or intra-abdominal abscess. Findings included small bowel thickening (4), sub-acute small bowel obstruction (2), small bowel malignancies (2), small bowel stricture (1) and small bowel intussusception (1). Incidental findings included ovarian, hepatic and renal cysts, adrenal adenoma, ascites, splenic and liver haemangioma, AAA, PUJ obstruction, liver metastases, gallstones, gallbladder polyp, pelvic abscess, uterine fibroids, large bowel stricture, diverticular disease, cirrhosis, lymphadenopathy, horseshoe kidney, atrophic pancreas and acute appendicitis.
Conclusion A small but significant proportion of patients have important incidental findings at MRE. MRE can add meaningfully to the investigation of SB pathology. A careful selection of patients can be achieved through a collaborative approach between radiologists and clinicians.
Disclosure of Interest None Declared.

Poster presentation III

Colorectal/Anorectal

PTH-001 A NATIONAL SURVEY OF LOCAL HEREDITARY COLORECTAL CANCER SERVICES IN THE UK; A HIGHLY VARIABLE APPROACH?

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Introduction The identification of inherited gastrointestinal disease provides an opportunity to prevent colorectal cancer. Heritable factors contribute about 35% of all colorectal cancer risk which has a significant impact on clinical activity in centres managing colorectal cancer. The British Society of Gastroenterology (BSG) and Association of Coloproctologists of Great Britain and Ireland (ACPGBI), released updated guidelines in 2010 for the management of patients with a family history of colorectal cancer. There is evidence that adherence to these guidelines is highly variable both for endoscopic screening and testing individuals for inherited conditions such as Lynch Syndrome and the Polyposis Syndromes. The aim of this survey was therefore to facilitate understanding of how services for patients with inherited colorectal cancer risk can be improved, and to raise awareness of this issue amongst clinicians.
Methods Following consultation within the BSG Cancer Group, UK Gastroenterologists, Colorectal Surgeons, Clinical and Medical Oncologists were invited to complete a short 10 point questionnaire. This was cascaded by email to 1,793 members of the Royal College of Radiologists (RCR), Association of Cancer Physicians (ACP), the BSG and ACPGBI. We sought their opinion and perception of local hereditary colorectal cancer services, also their adherence to and understanding of current national guidelines.
Results Three hundred and eighty-two members responded to the survey, an overall response rate of 21.3%. Although 69% of respondents felt there was an adequate service for these patients, 64% also believed that another clinician was undertaking this work. There was no apparent patient pathway in 52% of centres, and only 33% maintain a register of these patients. Patients rarely receive initial tumour block testing for Lynch Syndrome. When asked what they would like to augment the service they receive many respondents requested 'clear guidelines', 'pathways' and dedicated support networks. Many appeared to be unaware of the BSG/ACPGBI guidelines for the management of these patients.
Conclusion There was wide variability in practise and in pathways for hereditary colorectal cancer patients with a perception that they should be managed by another unspecified clinician. BSG/ACPGBI National Guidelines are not adhered to, therefore we recommend improved education, well defined pathways and audit in order to improve care of patients with hereditary colorectal cancer risk.
Disclosure of Interest None Declared.

PTH-002 A SINGLE CENTRE AUDIT COMPARING COLONOSCOPY COMPLETION AND COMPLICATION RATES IN OLDER AND YOUNGER PATIENTS

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Introduction Colonoscopy is the gold standard test for large bowel assessment. Radiological techniques are available and have a high sensitivity and specificity for diagnosing colorectal cancer.[1] As part of the Joint Advisory Committee (JAG) for endoscopy accreditation, units should achieve a caecal intubation rate of > 90%. We audited our unit's performance.
Methods We audited colonoscopies carried out in 2011 at a District General Hospital. Endoscopy reports of 75 patients aged 80 and over and 75 patients under 75 years old were analysed.
Results 1635 colonoscopies were carried out by the unit in 2011. The pick-up rate for cancer was at least 3.5% and for polyps was 23%. Completion of colonoscopy in under 75 year olds was 97%. Completion in over 80 year olds was 79%. The unit's overall completion rate in 2011 was 90% (24% terminal ileum, 65% caecum, 1% anastomosis). Colonoscopy was better tolerated in the younger group with discomfort suffered in 7% of patients compared to 11% of elderly patients (see table 1). The overall pick-up rate for cancer in both groups was 3%.

Abstract PTH-002 Table 1 Table 1: Complications

Complication	Aged under 75	Aged 80 and over
Discomfort	5 (7%)	8 (11%)
Hypertension		1 (1%)
Respiratory depression		1 (1%)
Vasovagal syncope/ hypotension		1 (1%)
Poor prep		2 (3%)
Looping/anatomy		4 (5%)

Conclusion The completion rate in the elderly (79%) was below the standard as set by JAG (> 90%). This was due to more discomfort experienced by the elderly group and more complications. There were six new colorectal cancer diagnoses in the elderly. These cancers could have been diagnosed by radiographic techniques such as CT colonography or CT with faecal tagging. The 2011 NICE guidance on the management of colorectal cancer2 states that CT colonography can be used as a safe and effective alternative to colonoscopy. This audit demonstrates that patient selection for colonoscopy is very important. CT colonography should be considered for the first line investigation in the elderly to reduce unnecessary complications and low overall colonoscopic completion rates.

Disclosure of Interest None Declared.

REFERENCES

1. Pickhardt PJ, Hassan C, Halligan S, Marmo R. Colorectal cancer: CT colonography and colonoscopy for detection--systematic review and meta-analysis. Radiology 2011; 259(2):393–405.
2. National Institute of Health and Clinical Excellence. Colonoscopic surveillance for prevention of colorectal cancer in people with ulcerative colitis, Crohn's disease or adenomas. London: NICE 2011. http://www.nice.org.uk/nicemedia/live/13415/53641/53641.pdf [Accessed 5/1/13]

PTH-003 AN AUDIT ON TWO WEEK WAIT REFERRALS FOR SUSPECTED LOWER GI CANCER FOR IRON DEFICIENCY ANAEMIA – TOO OFTEN AN INAPPROPRIATE REFERRAL

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Introduction NICE guidelines state that unexplained iron deficiency anaemia (IDA) in men and non-menstruating women requires an urgent two week wait (2ww) referral for suspected cancer. These patients require assessment with upper endoscopy and colonoscopy according to BSG guidelines. IDA is defined as a microcytic anaemia with the presence of any of the following serum markers: low ferritin, low transferrin saturation, low iron or raised TIBC. The aim of this audit was to assess how many lower GI 2ww referral patients for IDA actually had IDA.

Methods We analysed all consecutive 2ww referrals for suspected lower GI cancer for IDA in our Hospital from May until October 2012. Patients' demographics, medical history, medications and blood test results (FBC, haematinics, eGFR, CRP, Hb electrophoresis) were collected using the General Practitioner (GP) referral letter and the hospital computer system. IDA was identified as microcytic anaemia with low ferritin; if ferritin was normal but unreliable (concomitant high CRP), we identified IDA as low transferrin saturation with high TIBC.

Abstract PTH-003 Table 1

	Age	Sex	Hb	MCV	Ferritin	CRP	eGFR	Investigation	Result
1	82	F	9.6	89.1	15	< 5		colonoscopy	Diverticular disease
2	88	F	9	92	473	< 5	14	CT	normal
3	73	M	10.6	81.3	36	< 5	> 90	none	
4	86	F	9.5	75.2	22	7	39	CT	Diverticular disease
5	67	F	9.3	84.2	62	< 5	46	colonoscopy	normal
6	82	F	9.5	81.7	65	< 5	75	colonoscopy	Diminutive polyps

Results A total of 36 patients (mean age 71±11; M:F = 19:17) were referred as 2ww with asymptomatic IDA. IDA was confirmed in 20 patients (55%). 6 patients (17%) did not have iron deficiency (see table): 3 of them had colonoscopy and 2 had CT abdomen (unfit for colonoscopy), none had significant pathology; one was not investigated. 10 patients (28%) had insufficient blood tests to define the cause of the anaemia: ferritin not available (2), normal ferritin with high CRP and no other iron markers available (6), normal ferritin with no inflammatory markers available (2).

Conclusion One in six (6/36) patients referred urgently for IDA and suspected lower GI cancer did not have IDA, and the majority were over 80 with multiple co-morbidities. Approximately 1 patient in 4 (10/36) did not have appropriate blood tests performed to assess their anaemia. We recommend GPs perform a full set of haematinics prior to referring patients with IDA and the results should be included in the 2ww referral form. If haematinics are not available at the time of assessment, these should be checked before booking endoscopic investigations. We are amending our referral form accordingly, implementing teaching sessions for GPs and re-auditing in 1 year time. We anticipate a reduction in inappropriate 2ww referrals and subsequent endoscopic requests.

Disclosure of Interest None Declared.

PTH-004 PREVENTION OF RELAPSE FOLLOWING CLOSTRIDIUM DIFFICILE INFECTION USING PROBIOTICS: A RETROSPECTIVE CASE-CONTROL STUDY

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Introduction Clostridium difficile infection is an important hospital acquired infection causing significant healthcare burden. Once patients have had C diff diarrhoea, recurrence rates are high with 44.8% of patients having a relapse of their disease. Lactobacillus Casei is a probiotic that has been shown to reduce rates of antibiotic-associated diarrhoea in elderly patients. There have been no studies analysing the use of probiotics in patients who have had established C.diff infection.

Methods The study was a single site, retrospective, case-control study of patients who have had C.diff infection and treated with either antibiotics and probiotics or antibiotics alone. Potential study participants were identified from the microbiology database. Criteria for inclusion in the study were adult patients (aged > 18 at time of infection), presence of diarrhoea (defined as ≥ 3 non-formed stool in 24 hours), positive stool C. diff toxin A or B and positive C. Diff antigen.

Results 66 patients were included for analysis in this study, 31 who had probiotics and 35 who had no-probiotics. The median age of the patients was 78 and 33.3% were male. The number of patients who had a further hospital admission for diarrhoea in the probiotic cohort was 6 (19.4%), compared to 13 in the non-probiotic cohort (35.1%) (p = 0.09). Rates of recurrent C.diff infection were significantly lower, 31.4% vs 6.5% (p = 0.024).

Conclusion Patients who have had a c.diff infection often have early re-admissions to hospitals as a result of further episodes of diarrhoea or c.diff recurrence. These admissions are associated with significant morbidity and mortality and cost to the health service. This study suggests that the widely available probiotic strain lactobacillus casei appears able to reduce rates of c.diff recurrence rates though further prospective studies are required.

Disclosure of Interest None Declared.