

Methods Retrospective analysis of a prospectively maintained database of all patients presenting with ABAP in whom a S-MRCP was requested from June 2008 to May 2013. The findings of S-MRCP were compared with those of MRCP and EUS (performed prior to S MRCP) and the diagnostic yield of S-MRCP in the work up of a patient presenting with ABAP was estimated.

Results Of the 117 patients with ABAP [28 males and 89 female; mean age 48 yrs] were referred for S-MRCP, 114 (97.4%) patients successfully completed the scan. Of these 37 patients who had a normal MRCP, S-MRCP identified significant findings in 8 (22%) patients (Table 1). In the present study 78 (67%) patients had EUS. Out of the 41 patients who had a normal EUS, S-MRCP was able to identify significant pathology in 21 (54%) patients (Table 1).

Conclusion This study suggests that S-MRCP has a 22 and 54% additional diagnostic yield in ABAP patients who have a normal MRCP and a normal EUS respectively. The commonest abnormality identified in these patients on S-MRCP was obstruction at ampulla or proximal PD. S-MRCP should be considered in the diagnostic algorithm of patients with ABAP.

REFERENCES

- Mariani A, Arcidiacono PG, Curioni S, *et al.* Diagnostic yield of ERCP and secretin-enhanced MRCP and EUS in patients with acute recurrent pancreatitis of unknown aetiology. *Dig Liver Dis* 2009 Oct;41(10):753-8
- Matos C, Metens T, Devière J, *et al.* Pancreas divisum: evaluation with secretin-enhanced magnetic resonance cholangiopancreatography. *Gastrointest Endosc* 2001 Jun;53(7):728-33

Disclosure of Interest None Declared.

PTH-105 HOW OMINOUS IS THE "DOUBLE-DUCT" SIGN ? : A SINGLE CENTRE EXPERIENCE

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Introduction "Double-duct" sign on ERCP (Endoscopic retrograde cholangio-pancreatogram) is considered suggestive of pancreatic or biliary malignancy. This sign is frequently encountered in radiological imaging. We wish to investigate the prognostic value of the "double-duct" sign in patients who undergo Magnetic resonance cholangio-pancreatography (MRCP), attempting to define the associated features which would predict underlying malignant disease.^{1,2}

Methods A retrospective analysis of all the patients who underwent MRCP over a two year period; January 2011 to December 2012 was undertaken. All the radiological reports showing both a dilated common bile duct (CBD) and pancreatic duct (PD) or the "double-duct" sign were included. These were all interpreted and reported by specialist gastrointestinal radiologists. The demographics, liver biochemistry, final diagnosis and outcome for all patients with the "double-duct" sign were accessed using the radiology PACS® system, biochemical results WebICE®, hospital letters and case notes. Follow up information was available for a mean of 24months (range 12–36 months).

Results 1,367 patients underwent MRCP examination over two year period. 46 patients (3.5% incidence) had "double-duct" sign (Table 1.) with a mean age of 69.5 years. The ratio of male to female patients was (M:F) 12:11. The commonest cause of "double-duct" sign was choledocholithiasis (29.4%) followed by

Abstract PTH-105 Table 1 Patients with double-duct signs

Table 1 Patients with double-duct signs		
	(n)	%
Malignancy	12	26
Ca-HOP (Carcinoma head-of-pancreas)	9	75.0
Cholangio-carcinoma	1	8.3
Metastatic external compression	1	8.3
IPMN (Intra-ductal papillary mucinous neoplasm)	1	8.3
Benign	34	74
Distal/peri or ampullary choledo-cholelithiasis	10	29.4
Chronic pancreatitis ± PD stricture and/or calculi	7	20.5
Pancreatic cyst ± PD stricture	5	14.7
Common channel fibrotic stricture	3	8.8
Benign biliary stricture with pancreas divisum	3	8.8
Benign ampullary lesion	2	5.9
Idiopathic (NO cause identified)	2	5.9
IPMN	2	5.9

malignancy (26%). Patients with jaundice in the context of "double-duct" sign had a higher incidence of malignancy (48%). Nearly half of the patients, (21/46; 46%) with "double-duct" sign were anicteric. None of the anicteric patients were found to have malignancy. Of the anicteric patients, 29% (6/21) had completely normal liver test and the remaining 71% (15/21) had some abnormality of the liver enzymes (raised GGT and/or Alkaline phosphatase). Three patients in the anicteric group had benign tumours (2 cases of benign IPMN and 1 case of benign ampullary tumour). The benign nature was confirmed on clinical and radiological follow-up. No surgical intervention was deemed appropriate for any of these patients. All three remained anicteric over the period of follow-up (13 months; unrelated death, 18 and 36 months respectively). Our results show that "double duct" sign in the absence of jaundice makes a malignant aetiology unlikely.

Conclusion In patients with cross-sectional imaging evidence of "double-duct" sign, the absence of jaundice makes a malignant aetiology unlikely. Conversely, in jaundiced patients a malignant cause is much more likely. Figures from larger series are needed to support this conclusion.

REFERENCES

- Baillie J, *et al.* Biliary imaging: a review. *Gastroenterology* 2003; 125 (5):1565
- Ahualli J. The double duct sign. *Radiology*2007;244 (1):314–5

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Small bowel and nutrition

PTH-106 BILE ACID DIARRHOEA MASQUERADES AS DIARRHOEA-PREDOMINANT IRRITABLE BOWEL SYNDROME: RESULTS FROM A DUAL CENTRE PROSPECTIVE STUDY

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Introduction Several studies have suggested that bile acid diarrhoea (BAD) can present with symptoms that are compatible with diarrhoea-predominant irritable bowel syndrome (IBS-D). However, uncertainty exists as these have often been