inoperable locally advanced pancreatic masses on imaging. Details recorded were: age, body mass index (BMI), co-morbidity including cardiovascular, diabetes mellitus, chronic airway disease and anticoagulation. Also recorded were the World Health Organisation (WHO) performance status, position of the tumour and the requirement of a biliary stent. Patients who received chemotherapy were identified from the chemotherapy registry data. The diagnosis of PDAC was based on histological diagnosis or with clinical progression compatible with the diagnosis or death from malignancy.

Results In total 104 underwent EUS-FNA [55 men, mean age 68.5 years SD ± 9.1]. All patients had a performance status of <3 . Of these patients 50 (48.1%) went onto start palliative chemotherapy. None of the 8 patients ≥ 80 years old who underwent EUS-FNA received chemotherapy compared to 50 out of 96 (52.1%) patients <80 years old ($p=0.0014$). There were no other significant differences or predictors of chemotherapy uptake in patients when analysing presence of comorbidity, position of tumour, jaundice at presentation, WHO performance status and BMI <20 .

Conclusion In this study, no patients over 80 years old having undergone EUS-FNA went on to receive palliative chemotherapy for PDAC. We would advise an initial oncology consultation first in these patients to avoid unnecessary EUS procedures. In patients under 80 years old clinical assessment should be considered when referring patients for suspected inoperable PDAC for EUS-guided FNA as only half go on to receive treatment, however no factors apart from age seemed to predict the uptake of palliative chemotherapy. Further validation of these outcomes could form a decision tool to decide who should be triaged to oncology clinics before EUS-FNA performed.

PTU-024 PANCREATIC CYSTS – CAN INVESTIGATIONS BE SAFELY RATIONALISED?

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Introduction Pancreatic cysts are a frequent incidental finding on cross-sectional imaging of the abdomen. We examined the decision making and outcome of patients with a pancreatic cyst(s) discussed at the Royal Derby Hospital HPB cancer MDT and compared practice against the 2015 American Gastroenterology Association (AGA) and 2017 International Association of Pancreatology (IAP) guidelines on the management of pancreatic cysts.

Methods A search of HPB MDT meeting reports, from January 2016 to October 2017 ($n=1144$) identified 88 patient (51 female) reports relating to the first discussion of a pancreatic cyst. Electronic medical records were examined to collect data pertaining to subsequent investigations and outcome. Details of medical comorbidities were used to calculate a Charlson comorbidity index.

Results The median age was 72 years (range 32–87) and the median estimated 10 year survival based on the Charlson Comorbidity Index was 53% (range 0%–98%).

86% of pancreatic cysts were judged to be an incidental finding. The median cyst diameter was 19.5 mm (range 4–110 mm). 43/88 (49%) patients proceeded to endoscopic ultrasound (EUS), with 33 having a fine needle aspiration

(FNA). 4/88 (5%) patients had probably malignant (C4) or malignant (C5) cytology. All 4 patients had “high risk stigmata” on their initial CT/MRI. The final outcome for most patients was no further intervention (56%) or follow-up imaging (36%), with 5 (6%) patients offered surgery.

Applying the 2017 IAP management algorithm, 13 (15%) patients had “high-risk stigmata” on CT/MRI and except where their performance status or co-morbidity precluded further investigation/treatment (5), were recommended for surgery (1) or EUS (7). Of the remaining 75 patients, 45 (60%) had no worrisome features on CT/MRI and so would not have required EUS. 21/45 (47%) of these patients in our practice underwent EUS, but none demonstrated definite mural nodules, main duct involvement or suspicious/positive cytology.

The 2015 AGA management algorithm could only be applied to those patients who had undergone initial radiological assessment with MRI ($n=11$). None of these patients had two positive features on MRI, indicating a need for EUS. 6/11 (55%) patients did, however, have an EUS, with none identifying positive features or concerning cytology.

Conclusions These findings suggest that a significant proportion (24%) of patients with pancreatic cysts underwent unnecessary EUS. Application of international guidelines can reduce the number of patients who require an endoscopic ultrasound.

PTU-025 EUS FNA MICROCORE BIOPSY IS SUPERIOR TO ENDOBILIARY BIOPSY IN DIAGNOSING MALIGNANT PANCREATICOBILIARY LESIONS

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Introduction The ability to provide definitive and timely histological diagnosis of malignancy in suspected malignant pancreaticobiliary lesions depends on high quality tissue sampling. We conducted a study to evaluate the diagnostic utility of endobiliary biopsy versus endoscopic ultrasonography-guided fine needle aspiration (EUS FNA) microcore biopsy.

Methods We performed a retrospective search of our laboratory information management system for patients with clinically suspected malignant pancreaticobiliary lesions who had endobiliary and EUS FNA microcore biopsies. The haematoxylin and eosin-stained slides were retrieved and reviewed. All biopsies were categorised into whether a definitive diagnosis can be established (diagnostic) or not (non-diagnostic).

Results The search yielded 94 endobiliary biopsies and 78 EUS FNA microcore biopsies. 77 out of the 94 endobiliary biopsies were deemed adequate, and out of this 54 was diagnostic of malignancy (sensitivity 57%). In 11 cases where the endobiliary biopsy was not diagnostic, subsequent EUS FNA microcore biopsies provided a malignant diagnosis in 9. 96% of EUS FNA microcore biopsies were adequate and in 62 a malignant diagnosis could be established (sensitivity 83%). Cholangiocarcinoma was the pathological diagnosis in the majority of the endobiliary biopsies and there were two metastases from lung and two neuroendocrine tumours. The main malignant diagnosis in the EUS FNA microcore biopsies was adenocarcinoma of pancreaticobiliary-type, but also included neuroendocrine tumours, solid pseudopapillary neoplasm and adenosquamous carcinoma. There were also three metastases from the colorectum, kidney and breast.