10 patients underwent a 3rd CE. In 7/10 patients with concordant initial CEs, the DY of repeat CE was 0/7. Where the 2 initial CEs disagreed, DY was 2/3.

Conclusion 1. In patients with a negative or inconclusive initial CE for IDA or OGI, repeating the procedure has an overall DY of 25% (7/28).

The DY is highest when fresh blood was seen in the initial procedure (71.4%) even if no lesions were found initially.

Patients with initially normal studies had lower DY (22.7%).

3rd CE is only warranted by a change in presentation or discordance in the previous results, especially when one examination has identified active bleeding.

PWE-104 IDA PATIENTS WITH NEGATIVE COELIAC SEROLOGY ON STRAIGHT TO TEST PATHWAY; IS D2 BIOPSY NECESSARY?

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Introduction Current BSG guidelines for Iron Deficiency Anaemia (IDA) recommend screening all adult patients for coeliac disease (CD). Duodenal biopsies are only required in patients with positive coeliac serology due to very low post-test probability for CD if serology is negative. BSG CD guidelines however recommend duodenal biopsies regardless of the serology result. We aimed to assess current practise and outcomes in the setting of a straight to test (STT) IDA pathway.

Methods We conducted a retrospective analysis of all adult patients referred on STT IDA pathway over a 3 months period. Patients who did not ultimately undergo endoscopy or had a prior diagnosis of CD were excluded from the study.

Results During the study period 239 patients were referred under the STT IDA pathway. Of these, 175 (male 76, female 99) underwent endoscopic investigations and were included in the study. Mean age of male and female participants was 66 and 68 years respectively. The average haemoglobin on referral was 102 g/L. Pre-endoscopy coeliac serology was only available in 44/175 patients (25.1%). Serology was positive in 1 of these patients (2.3%)-CD was confirmed on duodenal biopsy. Duodenal biopsies were still taken in 31/43 (72.1%) patients with negative serology, histology was normal in all cases. 110/131 (84%) of patients without pre-endoscopy serology had duodenal biopsies taken. 9/110 (8.2%) had abnormal duodenal biopsies. 4 cases intraepithelial lymphocytosis, 2 duodenitis and 1 Giardiasis. 2 patients had villous atrophy with suspected CD-serology came back positive in 1 patient. Second patient awaiting further investigations. There was no difference in duodenal biopsy rate based on CD serology availability (72% vs 84% p=0.11).

Conclusions Patients in STT IDA pathway with negative CD serology are unlikely to have CD. Duodenal histology is abnormal in a significant number of patients with negative serology however failure to check CD serology prior to endoscopy leads to diagnostic uncertainty and delays in diagnosis. A point of care test for CD performed in endoscopy could fill this gap. Incongruent anaemia and CD guidelines lead to uncertainty amongst clinicians and may explain variable practise.

PWE-105 IS THERE A CORRELATION BETWEEN SEVERITY OF BILE ACID MALABSORPTION (BAM) AND RESPONSE TO TREATMENT?

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Introduction NICE guidelines in 2012 have recommended SeHCAT to be used in research in order to collect more information in its usefulness in the diagnosis and treatment of BAM. A previous study has identified a lack of consistent cut-off threshold values for abnormal SeHCAT results. The aim of this study is to determine whether there is any relationship between the severity of BAM and treatment response.

Methods Medical records of 492 patients who had a SeHCAT scan at Aberdeen Royal Infirmary between 23/7/2013 to 9/6/2017 were retrospectively reviewed. Mild, moderate and severe BAM were defined as 10.1%–15%, 5.1%–10% and <5% retention of SeHCAT after one week respectively. Data including the severity and types of BAM were recorded. Treatment responses to bile acid binders were also recorded when patients were followed up in the clinic after the scans.

Results 492 scans were performed and 51% (252/492) of patients had abnormal SeHCAT results (<15%) over the study period. The mean age was 51.6 with a female predominance of 69% (174/252).

20% (50/252) of these patients had a prior diagnosis of IBS and 27% (67/252) patients had previous cholecystectomy.

17% (44/252) had type 1 BAM, 53% (134/252) had type 2 BAM and 29% (74/252) had type 3 BAM. The mean SeHCAT retention percentage was 2.59% for type 1 BAM, 7.45% for type 2 BAM and 5.63% for type 3 BAM. The difference was statistically significant (p<0.001).

52% (132/252) of patients had treatment response documented following their scans and 13% (17/132) of these patients stopped treatment due to side effects.

For the remaining 115 patients, 71% (12/17) of patients with mild BAM had good response to bile acid binder compared to 77% (23/30) with moderate BAM and 78% (55/68) with severe BAM. The difference was not statistically significant (p<0.635).

15 out of 90 patients who responded to colestyramine previously found cholestyramine ineffective or intolerance of it.

Conclusions In our study, the mean SeHCAT retention level was significantly lower for BAM type 1 compared to BAM types 2 and 3. There was an overall good therapeutic response to bile acid binders in patients with a positive SeHCAT scan. However, there was no statistically significant difference between severity of BAM and therapeutic response.

Further prospective study using larger sample size is required to assess the accuracy and cut-offs of the SeHCAT test in diagnosing BAM as determined by therapeutic response to BAS treatment.

PWE-106 CHANGES IN THE TESTING FOR AND INCIDENCE OF COELIAC DISEASE IN THE UK 2005–2015

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