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with a prevalence as high as 38%. Strictures also develop in the mid-pouch. Mid-pouch strictures are less well understood in terms of aetiology, incidence, management and outcomes. They are of particular interest from a surgical perspective as they are hard to access at EUA and therefore alternative management options need to be explored.

The management of pouch strictures include medical options, such as immunosuppressant and biological therapy, endoscopic management with balloon dilatation, or surgical management including, Hegar dilatation, stricturoplasty, pouch revision, diversion or pouch excision. There are limited data on the success of these techniques.

Methods Patients were identified between January 2008 to January 2017. Patients were identified from the endoscopy, biologics and pouch databases at our institution. Review of the clinical records was used to determine those who had pouch strictures. The primary outcome measure was avoidance of pouch failure. Pouch failure was defined as the need for defunctioning or pouch removal at last follow-up.

Results Forty-nine patients with pouch strictures were included in the study. Initial therapy for the treatment of pouch strictures was associated with pouch retention in a quarter of those treated with biological therapy, 87% for Hegar dilations and 80% for balloon dilatation with median follow-ups of 31 months, 16 months and 12 months respectively.

Conclusion Hegar dilatation should be considered the initial management approach for pouch-anal anastomotic strictures. Endoscopic balloon dilatation should be considered as first line therapy for both mid-pouch and inlet strictures. Limited evidence suggests that inflammatory inlet strictures are likely to be the most responsive to biological therapy.

Abstract PTU-060 Table 1 Pouch survival at each pouch stricture location

Location of stricture	Number of patients	Median follow-up	Pouch survival (%)
Pouch inlet	17	6 (range 2.5–113)	70
Mid pouch	7	12 (range 0–229)	71
Pouch-anal anastomotic	24	16 (range 1–59)	87

PTU-061 EFFICACY AND ACCEPTABILITY OF A RENEW ANAL INSERT IN PATIENTS WHO HAVE UNDERGONE RESTORATIVE PROCTOCOLECTOMY

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10.1136/gutjnl-2018-BSGAbstracts.402

Introduction Restorative proctocolectomy (RPC) has gained acceptance in the surgical management of medically refractive ulcerative colitis and cancer prevention in familial adenomatous polyposis (FAP).

Incontinence following RPC has not been widely researched. In one study at 10 year follow-up, continence to stool and flatus was present in 79.3% of patients, with 74.4% fully continent overnight. Incontinence following RPC can be multifactorial and be related to pouchitis, cuffitis, impaired pouch emptying and pelvic floor and sphincter weakness. Despite attempting to treat the underlying cause, incontinence

may still remain a problem and symptomatic control may be necessary.

Methods This was a single centre prospective study exploring the acceptability and efficacy of the Renew anal insert™ in controlling and improving incontinence in patients with a ileoanal pouch. Patients were included if they had undergone RPC for any reason that had self-reported passive incontinence for >2 weeks and were ≥18 years old at time of enrolment.

Patients with incontinence were asked to use the Renew™ insert for 14 days. The International Consultation on Incontinence Questionnaire-Bowels (ICIQ-B) was recorded before the trial of the Renew™ insert and at the end of the 14 days.

Results 15 patients were included in the study. There were 10 males and 5 females. The median age of the patients was 57 (range 24–74). All 15 patients had RPC for ulcerative colitis. One patient was lost to follow up.

A comparison of the pre and post-intervention scores were made, with the results summarised in table 1.

Abstract PTU-061 Table 1

Outcome	Pre Mean±SD	Post Mean±SD	Change (*) Mean (95% CI)	P-value
Bowel pattern	44.1±3.2	42.8±2.6	–1.3 (–6.0, 3.3)	0.55
Bowel control	58.3±15.6	53.8±20.2	–4.5 (–12.6, 3.5)	0.25
Quality of Life	36.3±16.4	36.7±14.8	0.5 (–5.7, 6.6)	0.88
Other symptoms	30.5±14.2	31.8±12.9	1.3 (–4.1, 6.8)	0.61
Day seepage	1.0±0.9	0.7±0.8	–0.3 (–0.7, 0.2)	0.22
Night seepage	1.8±71.2	0.9±0.9	–0.9 (–1.6, –0.1)	0.03

8/15 patients were satisfied with the device and 6/15 found the device efficacious. Five patients were totally dissatisfied with the device and 6 reported no efficacy.

Conclusions The Renew anal insert™ may be a treatment that can help patients who have undergone restorative proctocolectomy with faecal incontinence. The Renew anal insert™ in the correct selected patients is both acceptable and efficacious and is associated with significant reduction in night time seepage.

PTU-062 SYSTEMATIC REVIEW: THE MANAGEMENT OF EARLY POUCH-RELATED SEPTIC COMPLICATIONS IN ULCERATIVE COLITIS

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10.1136/gutjnl-2018-BSGAbstracts.403

Introduction It is well reported that ileoanal pouch-related septic complications (PRSC) increase the chance of pouch failure. There are a number of publications that describe the management of early PRSC in ulcerative colitis (UC) in small series. This article aims to systematically review and summarise the

relevant contemporary data on this subject and provide an algorithm for the management of early PRSC.

Method A systematic review was undertaken in accordance with PRISMA guidelines. Studies published between 2000 and 2017 describing the clinical management of PRSC in patients with UC within 30 days of primary ileoanal pouch surgery were included. A qualitative analysis was undertaken due to the heterogeneity and quality of studies included.

Results 1157 abstracts and 266 full text articles were screened. Twelve studies were included for analysis involving a total of 207 patients. The studies described a range of techniques including image-guided, endoscopic, surgical and endocavitational vacuum methods. Based on the evidence from these studies, an algorithm was created to guide the management of early PRSC.

Conclusion Although the rate of successful salvage following early PRSC has improved over time there is a paucity of research correlating the method used with functional outcome. Short course Endo-SPONGE® therapy with early surgical closure seems to offer increased chance of salvage. We present an algorithm for the management of early PRSC.

PTU-063 MISS RATES FOR COLORECTAL CANCER INVESTIGATED WITH COMPUTER TOMOGRAPHY SCANS

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10.1136/gutjnl-2018-BSGAbstracts.404

Introduction Computer tomography (CT) scans are often the initial investigation for patients suspected of colorectal cancer (CRC) because they are better tolerated than colonoscopy. This study aims to evaluate the CRC false negative results (or miss rates) for CT investigations of the colon.

Methods This is a retrospective review of 773 consecutive CRC cases encountered at Royal Berkshire Hospital between 2014 and 2016. Evidence of CT investigations in the previous 3 years was obtained from computerised health records. Only CT scans with the indication suggestive that it was done for suspected bowel malignancy were labelled as 'missed cancer'. CT scans done to investigate other abdominal organs were not considered. Statistical analysis was done with a confidence interval of 95%.

Results 5.4% of patients diagnosed with CRC had an unremarkable CT scan in the previous 3 years. The indications included mostly iron deficiency anaemia, change in bowel habit, weight loss, abdominal pain and rectal bleeding. Patients being missed were significantly older than the rest of CRC patients (78.2 years vs. 69.5 years, $p=0.000003$). A higher proportion of right sided cancers were missed as compared to left sided cancers (7.3% vs. 4.8%) but this was not statistically significant ($p=0.36$). Average time from scan to diagnosis was 512.9 days (1.4 years). Most CT studies (33 of 42, 79%) were after administration of oral contrast. Two were CT colonographies that missed one caecal cancer and one rectal cancer at 1.2 and 1.8 years before diagnosis.

Concerning the entire cohort of CRC cases, mean age was 70, male:female ratio was 1:1.16, left sided lesions accounted for 60% and right sided lesions 34%. All of these values are comparable to national statistics.

Conclusions Approximately 1 in 20 patients diagnosed with colorectal cancer had at least one CT scan with no evidence of bowel malignancy in the previous 3 years. Bowel cancer should not be easily excluded by an unremarkable CT scan if

there is a high clinical suspicion, especially in a patient older than 70, regardless of the type of scan.

PTU-064 IMMUNE CHECKPOINT INHIBITOR COLITIS- A REVIEW OF CURRENT MANAGEMENT TRENDS

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10.1136/gutjnl-2018-BSGAbstracts.405

Introduction Immune checkpoint inhibitors (CPIs) are novel agents that work by boosting the body's immune system to fight tumour cells and are transforming cancer therapy. They are generally well tolerated but can cause side effects that mimic various autoimmune diseases. With its rising use across many tumour types, the prevalence of immune related adverse events such as colitis is fast becoming an issue encountered by many gastroenterologists. This review aims to characterise the current trends in management of CPI-induced colitis.

Methods An electronic database search was conducted on Pubmed and Embase. A total of 48 papers were identified for final analysis. This included 29 case reports and 19 case series describing the management of patients with CPI-induced colitis.

Results 48 papers containing 294 patients were included in the review. Of these, 264 were treated with CTLA-4 inhibitors, 18 with PD-1 inhibitors, 1 with PDL-1 inhibitors and 10 with combination therapy. Majority of patients (196) received treatment for melanoma. Other malignancy types included non-small cell lung cancer, urothelial malignancy and prostate cancer. A total of 226 patients with CPI-induced colitis were treated with steroids (oral or intravenous). Of these 61% responded to steroids alone whilst 47% required further treatment with infliximab. 94% of patients treated with infliximab had resolution of colitis. 8 patients were treated with vedolizumab after steroid failure and all of these patients had resolution. 20 patients required surgery due to complications such as perforation or ischaemia, 3 had infliximab prior to surgery.

Patients required a median of 2 doses of infliximab to attain resolution of colitis and where follow up data was available, there was no symptom relapse post treatment with infliximab.

Conclusions This review highlights that a step wise approach similar to the management of inflammatory bowel disease should be used to manage patients with CPI-induced colitis. However there should be an early consideration for use of biologic therapy. Protocols including a multi-disciplinary approach should be developed to ensure that gastroenterologists are aware of treatment modalities should these patients present to them.

PTU-065 SERUM LIPID PROFILE AND KRAS MUTATION ACCORDING TO TUMOUR LOCATION IN METASTATIC COLORECTAL CANCER

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10.1136/gutjnl-2018-BSGAbstracts.406

Introduction In metastatic colorectal cancer mutated Kirstin rat sarcoma viral oncogene (KRAS) and tumour location are