Results With reference to our cases, we review the management protocols for ingested FB in paediatrics patients.

Conclusions Urgent Endoscopic removal (within 2 hours) is indicated in-

- All symptomatic patients • Sharp foreign body • Esophageal foreign body • Foreign body in the stomach if-
Age <5 years- >2 cm in diameter and >5 cm in length
Age >5 years- >2.5 cm in diameter and >6 cm in length
Non urgent endoscopic removal should be followed in-
• Magnetic foreign bodies within 24 hours • Ingested button batteries in stomach impacted for >48 hours • Blunt small nontoxic foreign body in the oesophagus for more than 24 hours.

IDDF2018-ABS-0002

ESOPHAGEAL DUPLICATION CYST: DIAGNOSTIC DIFFICULTY IN PAEDIATRIC PATIENTS PRESENTING WITH RECURRENT CHEST INFECTION AND WHEEZE

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10.1136/gutjnl-2018-IDDFabstracts.58

Background Esophageal Duplication Cyst (EDC) is a very rare congenital anomaly. It may present with respiratory and feeding difficulty depending upon the location in the oesophagus. We are reviewing this rare congenital malformation affecting the children who presented to us with the main symptom of recurrent chest infection and stridor.

Methods Our first patient is a 2 years 6 months old female child who had complaints of recurrent chest infections and stridor onset at 6 months of age. The child develops a cough, fever, fast breathing, retractions and stridor during each episode, these symptoms respond to the treatment for few weeks and then reoccurs. At 13 months of age, the child developed pneumonia, which was persisting, for which CECT chest was done. A cystic lesion adjacent to oesophagus was found suggestive of EDC. Our second case is an 11 months old female child who was well until 5 months of age had a history of recurrent chest infection and stridor on and off. The child develops a cough, fast breathing, retractions, noisy breathing (stridor) which response to medical treatment and then reappears after few weeks. On introduction of weaning food to the child, parents noted that child develops vomiting, regurgitates given a meal, and had choking like symptoms. These symptoms were more when given meal was semisolid (impacting) inconsistency and were increasing gradually. With these symptoms child brought to us. Chest X-ray done had shown tracheal deviation, CECT done revealed cystic lesion suggestive of EDC. In both cases, the diagnosis was confirmed by histopathological analysis of specimen removed surgically. On follow-up, patients were found healthy and asymptomatic.

Results Diagnosis of EDC is difficult but should be thought of after excluding common causes of persistent or recurrent wheeze, distress, stridor, vomiting and dysphagia. If missed, serious complications like rupture of the cyst, secondary infection, mediastinitis and malignant transformation can occur.

Conclusions EDC is a rare finding but should be included in patients presenting with recurrent wheeze and stridor, CECT is the diagnostic modality.

Abstract IDDF2018-ABS-0002 Figure 1

IDDF2018-ABS-0003

COMPARISON OF PERFORMANCE OF IMMUNOASSAY BASED 'CELIAC CARD' AND HUMAN ANTI-TISSUE TRANSGLUTAMINASE ANTIBODY ELISA KIT FOR CELIAC DISEASE

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10.1136/gutjnl-2018-IDDFabstracts.59

Background Serum levels of immunoglobulin A-tissue transglutaminase antibodies (IgA-tTG) by commercially available enzyme-linked immunosorbent technique (ELISA) are accepted as the best serology screening tool for celiac disease. ELISA based IgA-tTG tests are available only in centralised laboratories, and testing requires expert personnel in ideal conditions and therefore a long testing time. 'Celiac card' is recently developed rapid and sensitive one step immunoassay test based on detection of IgA. The objective of the study was to validate the diagnostic performance of immunoassay based 'celiac card' and compare it with human anti-tissue.

Methods This diagnostic accuracy study was carried out in Indian tertiary care hospital. Children aged between 1 to 12 years and considered to be high risk for celiac disease (recurrent diarrhoea/chronic diarrhoea/or recurrent abdominal pain along with poor weight gain or abdominal distension/or moderate to severe iron deficiency anaemia/or short stature) were recruited. Those with chronic gastrointestinal diseases like inflammatory bowel disease or already diagnosed celiac disease were excluded. Eligible participants were screened for IgA anti tTG antibodies by 'celiac card' and ELISA based 'Euroimmun kit'. Patients screened positive by either of the two diagnostic methods underwent upper gastrointestinal endoscopy and biopsy and diagnosis of celiac disease made as per Marsh grading.

Results Sensitivity and specificity of 'Celiac card' were calculated in 250 enrolled children and found out to be 92.31% and 98.28% respectively, which was similar to the ELISA based 'Euroimmun' kit.

Conclusions The diagnostic accuracy of the rapid 'Celiac card' test is high and similar to the sensitivity and specificity of the existing ELISA based 'Euroimmun' kit, which makes it an excellent screening test for celiac disease.

IDDF2018-ABS-0009 BREAKING THE WEB: A CASE OF PLUMMER VINSON SYNDROME IN THE PHILIPPINES

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10.1136/gutjnl-2018-IDDFabstracts.60

Background Plummer Vinson syndrome (PVS) is an extremely rare disease characterised by the triad of iron deficiency anaemia, dysphagia and cervical esophageal web. The most accepted possible aetiology of this syndrome is iron deficiency anaemia. The prevalence of anaemia in third world countries is high and yet there is no published case to date of PVS in the Philippines.

Methods We report a case of a 44 years old female, Filipino with two decades of iron deficiency anaemia, a decade of dysphagia with a cervical esophageal web on esophagogastro-duodenoscopy (EGD).

Results After EGD with mechanical dilatation, dysphagia was resolved, and patient now is able to eat a full regular meal. She was given iron supplementation and advised annual esophagogastroduodenoscopy.

Abstract IDDF2018-ABS-0009 Figure 1

Conclusions The triad of iron deficiency anaemia, dysphagia and cervical esophageal web is Plummer Vinson syndrome which can be readily managed by iron supplementation and esophageal dilatation. Patients need to be on annual surveillance EGD due to risk for esophageal or pharyngeal malignancy.

IDDF2018-ABS-0012 GALLSTONE ILEUS: A CASE REPORT ON A 30-YEAR-OLD YOUNG PATIENT AND LITERATURE REVIEW

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10.1136/gutjnl-2018-IDDFabstracts.61

Background Gallstone ileus is a rare cause of intestinal obstruction (1%–4% of all cases of bowel obstruction). It affects mainly the older population with a female preponderance. A 30-year-old woman presented to the emergency room with clinical signs of intermittent intestinal obstruction. Diagnostic imaging revealed obstruction of the terminal ileum caused by a 25 mm calculus. The patient completely recovered after urgent surgery. This condition is very rare and more so in a young patient.

Methods A 30-year-old female presented with intermittent vomiting and abdominal pain for 7 days. She had a history of episodic epigastric pain for the last one year and a half.

Physical examination showed a moderately distended abdomen, tympanitic and hypoactive sounds. Rectal examination was normal. Pertinent ancillary tests were done with the following results:

1. Leukocytosis (10.5×10^9 cells/L)
2. Plain abdominal radiograph: dilated small bowels, and air fluid levels.

Whole abdominal CT scan showed pneumobilia and adhesions in the gallbladder wall and duodenal wall, dilated small bowels and an ovoid calcific density with internal hypodensity in the small intestine lumen. The result of which is consistent with the RIGLER TRIAD seen in gallstone ileus.

Results The patient underwent immediate exploratory laparotomy. Intraoperative findings revealed an impacted gallstone measuring 10 cm in widest diameter located at the terminal ileum (40 cm from the ileocecal valve) causing complete bowel obstruction on the proximal part of the ileum and jejunum. The gallbladder was inspected, and a stable cholecysto-enteric fistula was noted. An enterotomy was made on the proximal non-dilated part of the ileum and revealed a large gallstone ($10 \times 4.5 \times 3$ cm). There was difficulty in extracting the stone, so a segmental resection of the involved ileum was done. A 2-layer end-to-end anastomosis was done using silk 3.0.

The postoperative course was uneventful and was discharged improved on postoperative day 4 (hospital day 10).

Conclusions In conclusion, the choice of the surgical procedure is largely determined by the clinical condition of the patient. The single-stage procedure is performed in haemodynamically-stable patients, while enterolithotomy alone is considered sufficient for unstable patients with metabolic derangements.

IDDF2018-ABS-0013 THE COMBINATION OF PEMBROLIZUMAB AND BEVACIZUMAB IN THE TREATMENT OF CHOLANGIOCARCINOMA BRAIN METASTASES: CASE REPORT

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10.1136/gutjnl-2018-IDDFabstracts.62

Background Cholangiocarcinoma originates from primary malignant tumours of bile duct epithelial cells. Epidemiology