The risk of non-anastomotic CRC is shown in figure A (figure 1A) and significantly decreased after 36 months or more from resection, compared with that before this time point (odds ratio for non-anastomotic CRCs at 36–48 months vs 6–12 months after surgery, 0.61; 95% CI, 0.37–0.98; $P=0.031$); 53.7% of all non-anastomotic CRCs were detected within 36 months from surgery.

One hundred fifty-eight anastomotic CRCs were detected over more than 16-years follow-up (cumulative incidence of 2.7%; 95% CI, 1.9%-3.9%). The risk of anastomotic CRCs is shown in figure B (figure 1B), and was significantly lower after 24 months or more from resection than before (odds ratio for CRCs at anastomoses at 25–36 months after surgery vs. 6–12 months, 0.56; 95% CI, 0.32–0.98; $P=0.036$); 90.8% of anastomotic CRCs were detected within 36 months from surgery.

Conclusions After surgery for CRC, the highest risk of anastomotic and non-anastomotic CRCs is highest during 36 months after surgery - risk decreases thereafter. Patients who have undergone CRC resection should be evaluated by colonoscopy more closely during this time period. Longer intervals may be considered thereafter.

IDDF2019-ABS-0112

PREDICTORS OF OUTCOME OF PERCUTANEOUS CATHETER DRAINAGE OF ACUTE PANCREATITIS WITH FLUID COLLECTION AND DEVELOPMENT OF A PREDICTIVE MODEL

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10.1136/gutjnl-2019-IDDFabstracts.152

Background Percutaneous catheter drainage (PCD) is an effective initial strategy of step-up approach for the management of acute pancreatitis (AP). The objective of this study was to identify factors associated with outcomes after PCD

Methods This prospective observational study was conducted from July 2016 - Nov 2017. A total of 101 consecutive AP patients were recruited. Step up approach was followed for the management of patients. We evaluated the association between success of PCD (survival without necrosectomy) and baseline parameters (aetiology, demography, severity scores(SIRS,APACHE II, organ failure),total leucocyte count, C-reactive protein(CRP), and intra-abdominal pressure (IAP), morphologic characteristics on computed tomography, percentage of necrosis, CT severity index (CTSI), characteristics of collection before PCD (timing, nature of collection, volume, site, solid component), PCD parameters (initial size, maximum size, number and duration of drainage) and factors after PCD insertion (fall in IAP, reduction in volume of collection).

Results Among 101 patients of AP, 51patients required PCD. The success of PCD 66.66% (34/51). Four patients required surgical necrosectomy after PCD. Mortality was 29.4% (15/51, including 2 deaths after necrosectomy). Multivariate analysis(6 factors included after univariate analysis) showed the percentage of volume reduction of fluid collection ($p=0.016$) and organ failure (OF) resolution($p=0.023$) after one week of PCD predicted success of PCD. A predictive model based two factors resulted in AUROC- 0.915.

Internal validation by bootstrapping of 5000 resamples showed AUROC 0.906 & is similar to the original model. Nomogram was developed with above factors to predict the probability of success of PCD((figure 1. Nomogram for predictor of PCD success in managing fluid collection in patients with necrotizing pancreatitis total points line indicates total points obtained from predictors and which is synchronized w) figure 1: Total points line indicates total points obtained from predictors and which is synchronized with probability of PCD success line which indicates probability of PCD success). (table 1).

Abstract IDDF2019-ABS-0112 Table 1 Final logistic regression model

	Beta co-efficient	P value	OR	95 % CI of OR
Intercept	-4.83	0.003	0.008	
Organ failure resolution after PCD (Yes)	3.339	0.001	28.20	3.90–203.87
Percentage of volume reduction of collection after PCD	0.053	0.005	1.055	1.06–1.095

Conclusions Organ failure resolution and reduction in volume of collection after one week of PCD are significant predictors of successful PCD in patients with pancreatic fluid collection.

IDDF2019-ABS-0114

ROLE OF LINEAR ENDOSONOGRAPHY IN DIAGNOSIS OF BIOPSY NEGATIVE MALIGNANT ESOPHAGEAL STRICTURES: EXPLORING THE UNEXPLORED

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10.1136/gutjnl-2019-IDDFabstracts.153

Background Endoscopic biopsy is standard for diagnosis of esophageal malignancy. However, few cases present with smooth stricture with repetitive negative biopsy results. We aimed to use linear endoscopic ultrasound (EUS) and fine needle aspiration (FNA) in diagnosis of biopsy negative suspected malignant esophageal strictures.

Methods We retrospectively analyzed the data from August 2017 to December 2018 of biopsy negative esophageal strictures. All adult patients with twice negative biopsies and having smooth overlying esophageal mucosa on endoscopy were included. Clinical, epidemiological, endoscopic, imaging and EUS findings were noted and analyzed.

Results Eighteen patients underwent EUS for suspicion of malignant esophageal stricture. Seven were excluded as they were submucosal tumors in which the role of EUS is already established. Eleven patients showed the presence of malignancy on EUS FNA samples. Nine were males. Computed tomography showed esophageal wall thickening in 8 (16–38 mm) and esophageal mass in 3 patients. EUS showed loss of normal five layered wall structure of esophagus in all patients. FNAC revealed squamous cell carcinoma (n=4), adenocarcinoma (n=4), poorly differentiated carcinoma (n=2) and neuroendocrine carcinoma (n=1). There were no complications.