indications for OGD in suspected AUGIB (shock, previous/suspected variceal bleed), a raised URCR appears to be a useful marker to predict AUGIB: a larger study would be able to test this robustly.

Abstract PTU-072 Figure 1

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Pancreas

Orals

OWE-29 CAN DIGITAL SKELETAL MUSCLE INDEX PREDICT PALLIATIVE CHEMOTHERAPY UPTAKE BEFORE PATIENTS UNDERGO ENDOSCOPIC PANCREATIC BIOPSY?

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10.1136/gutjnl-2019-BSGAbstracts.289

Introduction An endoscopic ultrasound guided biopsy (EUS-B) is required prior to treatment with palliative chemotherapy for patients with suspected pancreatic ductal adenocarcinoma (PDAC). Given the urgency of treatment, EUS-B is often done prior to oncological assessment after which a significant proportion of patients do not take up chemotherapy. Low skeletal muscle index (SMI), termed sarcopenia, is common in PDAC and has been associated with poor outcomes. We aimed to assess if novel digital software can calculate SMI using a computerised tomography (CT) image to predict palliative chemotherapy uptake in patients with suspected PDAC, and streamline EUS-B.

Methods Patients who underwent an EUS-B showing PDAC between Jan 2016 and Dec 2017 with a CT scan performed within a month prior to biopsy were included in the study.

SMI was calculated by a single slice CT image taken at the level of the third lumbar vertebra. Software was used to identify skeletal muscle (sliceOmatic, Tomovision). Sarcopenia was defined as SMI<41(female) and <53 cm²/m²(male). Body mass index (BMI), performance status, demographic data were also compared between patients that went on to receive chemotherapy and those who did not.

Results EUS-B confirmed PDAC in 85 eligible patients during the study (median age 70;41–84 years). A total of 61/85(71%) of patients received at least one dose of chemotherapy. Sarcopenia was present in 57/85 (57.6%). Despite a raised BMI of >25 in 41/85 (48.1%) of the patients, sarcopenia was present in 25 (61.0%) of them.

Patients who did not take up chemotherapy had a lower SMI (40.5 vs 45.2 cm²/m², $p=0.04$) and a poorer mean performance status (1.25 vs 0.7: t -test $p=0.002$). There was no difference in BMI (26.8 vs 24.6 $p=0.10$) in patients that did and did not take up chemotherapy. No patients with a performance status of 3 ($n=3$) or age >80 ($n=5$) proceeded to chemotherapy. In those having chemotherapy, survival was higher in non-sarcopenic patients compared to sarcopenic patients (11.8 vs 7.7 months, $p=0.04$). Survival was similar in sarcopenic patients having chemotherapy and non-sarcopenic patients who did not have chemotherapy (7.7 vs 7.4 months $p=0.5$). Patients with performance status ≥ 2 and sarcopenia were much less likely to receive chemotherapy compared to those with performance status 0–1 without sarcopenia (83.9% vs 37.5%, $p=0.02$).

Conclusion Patients with PDAC and a performance status of ≥ 2 and low SMI were significant less likely to take up chemotherapy and had poorer survival. SMI measurement could act as part of a decision tool to assess suitability of patients to triage patients for rapid EUS-B, or clinical assessment prior to considering chemotherapy.

OWE-30 THE PROGRESSION OF CHRONIC PANCREATITIS ASSOCIATED WITH HETEROZYGOUS CYSTIC FIBROSIS GENES MUTATIONS 19 YEARS COHORT ANALYSIS

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10.1136/gutjnl-2019-BSGAbstracts.290

Introduction Very few data are available about the clinical course of chronic pancreatitis caused by Cystic Fibrosis Transmembrane Conductance Regulator (CFTR-Panc) gene mutations, when compared with non-CFTR causes of chronic pancreatitis, alcohol being the commonest cause.

Methods To study the clinical presentation and course of pancreatitis in patients with Cystic Fibrosis gene carrier status, compared with larger cohort of other causes of pancreatitis.

A retrospective analysis of all the patients in Manchester Foundation Trust Specialist Pancreatology Unit with Chronic pancreatitis and CFTR gene carrier status between 1999 to 2018, compared with the published literature for other causes of chronic pancreatitis.

Results A total number of 41 patients were heterozygous for CFTR gene mutations 29 male, Average age at presentation was 34.6 (range 11–65). Presentation varied: recurrent attacks of pancreatitis: 30 (73%); solitary attack of pancreatitis: 10 (24.3%) 1 (2.4%) patient presented with unexplained weight loss. Complications of pancreatitis occurred in (68.2%)

Abstract OWE-30 Table 1

Results	Heterozygous Cystic Fibrosis gene carriers	Other causes of pancreatitis in the literature
Incidence of Diabetes	10 (24.3%)	32%-83% [3.4]
Average time to endocrine failure months	91.3	67.2 [2]
Incidence of exocrine insufficiency	19 (46.3%)	36% [3]
Average time to exocrine insufficiency (months)	66.5	66 [2]
Pancreatic Pseudocysts	13 (31.7%)	40% [3]
Pancreatic ductal stricture	12 (29.2%)	18.1% [2]
Necrotising pancreatitis	10 (24.3%)	49% [1]
Pancreatic stones	3 (7.3%)	83% [2]
Endoscopic intervention	10 (24.3%)	73% [2]
Hepatobiliary surgery	3 (7.3%)	9.7% [2]
Common bile duct stricture	11 (26.8%)	21% [3]

Conclusion We report a different course and complication rate of chronic pancreatitis in CFTR carrier patients when compared to other causes of pancreatitis in the literature.

In this retrospective cohort analysis, when compared with the published literature, patients with chronic pancreatitis caused by a mutation in one CFTR gene appear to have a lower incidence of diabetes, which took longer to develop. Other complications of pancreatitis - pseudocysts, pancreatic strictures and necrosis, were also less frequent in our cohort when compared to the literature, suggesting a less aggressive disease course. However, we noted no difference in the pattern of exocrine insufficiency between the two groups. Based on these findings, a larger prospective study is now required.

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OWE-31 MANAGEMENT OF PANCREATIC FLUID COLLECTIONS WITHIN THE NORTHERN REGION REMOTE CARE PANCREATITIS SERVICE

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10.1136/gutjnl-2019-BSGAbstracts.291

Introduction Severe acute pancreatitis is a condition with high mortality with 40% of patients requiring intervention. NICE-POD recommends that this is best managed in a multidisciplinary team with access to specialist regional services as and when required. We report our experience of the management of pancreatic fluid collections (PFC) within the region's first remote care pancreatitis network.

Methods Data on patients with severe pancreatitis who were transferred to the service between June 2015 - July 2017 were analysed. The network was formally established in 2015 and serves a population of 3.5 million & 17 referring hospitals in the Northern region. All patients were discussed in the multidisciplinary meeting and only patients requiring specialist input were transferred. Baseline characteristics, aetiology,

nutritional support, antibiotic treatment, intensive care unit (ITU) stay, interventions, complications, mortality and follow up of at least one year were reported.

Results 285 patients were referred during this period. 83/285 (29%; 46 male) were transferred with a mean age 56 years [range 18–85]. The commonest aetiology was gall stones(45%) & alcohol(31%). The main reason for transfer(91%) was drainage of peripancreatic collections. Patients were referred after a mean of 13.7 [1–188] days from admission locally; 26% were admitted directly to ITU. Patients were transferred 4.5 [0–16] days post-MDT discussion. Fifty-five (66%) received antibiotics; however only 17 (20%) had appropriate antibiotics based on positive blood cultures. Appropriate feeding was 98%; 70 (84%) patients were enterically fed and 12 received parenteral nutrition (PN). One patient had inappropriate PN.

21% patients had intervention prior to transfer. On transfer, 15/83(18%) did not require intervention as there was spontaneous resolution of the collections. In the remaining patients the interventions included: endoscopic drainage only = 48%, percutaneous only = 29%, endoscopic + percutaneous = 12% & others = 5%.

35%(29/83) had multiorgan failure. 31/83 (37%) had complications following intervention. These were: sepsis = 35%, bleeding = 39%, thromboembolic events = 16% & others = 10%. Twelve (14%) patients died, 10 had MOF and 2 had pulmonary embolism, 11/12 were in ITU. Mean follow up was 18.2 months (range = 14 – 35).

Conclusions Majority of patients (82%) required intervention for treatment of PFCs. Endoscopic drainage was the commonest route of drainage. Inappropriate antibiotic use remains a concern however nutritional support was adequate in majority of the patients. This is the first reported data from the U.K. regarding a remote care network & the results highlight the role of regional multidisciplinary network in the management of patients with acute severe pancreatitis.

OWE-32 CAN FINE NEEDLE BIOPSY FOR PANCREATIC SOLID LESIONS IMPROVE ACCURACY WITH METAL BILIARY STENTS PRESENT?

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10.1136/gutjnl-2019-BSGAbstracts.292

Introduction National standards recommend the accuracy of endoscopic ultrasound (EUS) guided fine needle aspiration (FNA) of pancreatic solid lesions should exceed 78%. Presence of self-expanding metal stents (SEMS) placed to relieve biliary obstruction can potentially lower this accuracy by causing acoustic shadowing and localised inflammation complicating imaging and histological interpretation. Fine needle biopsy (FNB) needles have been developed to obtain cores of tissue in an attempt to improve accuracy. We aimed to assess if the introduction of FNB could improve accuracy of pancreatic solid lesion sampling with or without the presence a SEMS.

Methods All patients who underwent EUS guided tissue sampling of solid pancreatic lesions in a tertiary pancreatic cancer centre between January and December 2018 were retrospectively identified. The presence or absence of SEMS at time of EUS was noted. Standard bevelled 22-gauge (G) FNA needles were used for procedures between January and June, with a