early phase (0–30s) than G2 (figure 2A,2B) showed homogeneously iso-enhancement in the early phase) and G3 (figure 3A,3B) showed inhomogeneously iso-enhancement in the early phase) tumors ($p=0.006$, $p<0.001$). Besides, the incidence rate of hyper-enhancement in the early phase was higher in G2 tumors than G3 tumors ($p=0.009$). While in the late phase (31–120s), the incidence rate of iso-enhancement in G1 tumor (figure 1C) showed iso-enhancement in the late phase) was higher than G2 (figure 2C) showed hypo-enhancement in the late phase) and G3 (figure 3C) showed hypo-enhancement in the late phase) tumors ($p=0.001$, $p<0.001$). Heterogeneous enhancement and non-enhanced area appeared more often in G2 tumor than G1 tumor ($p=0.007$, $p=0.002$).

Conclusions Sonographic features, such as tumor size, pancreatic duct dilatation or hepatic metastasis as well as enhancement pattern in each phase may help to predict different pathologic grade of pNETs.

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HYPERTROPHIC CECAL TUBERCULOSIS: A CASE REPORT

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Background Gastrointestinal tuberculosis (GITB) remains to be a major health problem in developing countries and results in significant morbidity and mortality. It can present with diagnostic challenges, and a high index of suspicion should be considered specifically in endemic regions. Clinical, radiographic, endoscopic, and histopathologic findings complement one another in establishing the diagnosis. It may involve any part of the gastrointestinal tract. Isolated colonic tuberculosis is less common. The hypertrophic type resembles an inflammatory mass that mimics malignant neoplasm, which can cause intestinal obstruction. It is important to recognize GITB early to prevent complications and the possible need for surgery. We report a hypertrophic type of isolated cecal tuberculosis mimicking colonic malignancy.

Methods A 56y/o male with chronic renal insufficiency presented with intermittent, colicky abdominal pain associated

Abstract IDDF2020-ABS-0042 Figure 1 Cecal mass almost completely obstructing the lumen

with changes in bowel movement and weight loss. He presented with fever, a slightly distended abdomen with hyperactive bowel sounds.

Results Complete blood count revealed anemia (Hgb 9.9 g/dL), leukocytosis ($17.3 \times 10^9/L$) and elevated serum creatinine (1166 $\mu\text{mol/L}$). Abdominal CT scan showed ascending colon wall thickening with associated pericecal fat stranding and luminal narrowing. Colonoscopy showed a large mass at the cecum near the ileocecal valve.

Histopathology showed chronic granulomatous inflammation with Langhans giant cells and necrosis consistent with cecal tuberculosis.

Anti-TB treatment for category 1 extra-pulmonary TB consists of two (2) months of isoniazid, rifampicin, pyrazinamide, and ethambutol (2HRZE) as intensive phase followed by four (4) months of isoniazid and rifampicin (4HR) as continuation phase.

Conclusions Differential diagnosis of gastrointestinal TB should always be considered in colonic masses producing obstruction among patients in TB-endemic countries. (Figure 1).

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INTERVAL TIME BETWEEN GASTRIC PREPARATION AND MAGNETIC-CONTROLLED CAPSULE ENDOSCOPY: A RANDOMIZED CONTROLLED TRIAL

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Background To investigate the best interval time between gastric preparation and magnetic-controlled capsule endoscopy by comparing the effect of various interval time on image quality of stomach, safety, tolerance and positive lesions through a randomized controlled trial.

Methods 80 patients referred for MCE from Jan. 2018 to Dec. 2018 were randomly assigned to three groups, interval time with 30 minute and less (A), 30 to 60 minutes (B) or 60 minutes and more (C). All patients fasted for at least 8 hours before MCE and administrated with dimethicone, pronase and sodium bicarbonate. Cleanliness and visualization scores, safety, tolerability, additional water required and diagnostic sensitivity were compared. A multi-factor analysis of cleanliness and visualization scores was conducted.

Results The total cleanliness scores were (mean $\pm$ SD) 20.44 ± 2.61 (A), 20.96 ± 1.68 (B), and 20.56 ± 2.90 (C). The total visualization scores (mean $\pm$ SD) were 16.33 ± 2.01 (A), 16.41 ± 1.50 (B), and 16.07 ± 1.96 (C). There was no statistical difference among groups A, B and C ($P>0.05$). MCE detected positive findings in 16 (59.3%), 18 (66.7%) and 15 (55.6%) patients in group A, B and C respectively, with no significant difference between groups ($P>0.05$). Additional water required during MCE were (mean $\pm$ SD) 107.41 ± 70.31 mL(A), 46.30 ± 39.04 mL(B), 79.63 ± 65.43 mL(C), and it was much less in group B than the other two groups ($P=0.003$). There was a negative correlation between cleanliness and visualization scores and the infection of *H. pylori* ($r_s = -0.326$, $P=0.003$ and $r_s = -0.235$, $P=0.035$).

Conclusions Patients administrated with dimethicone, pronase and sodium bicarbonate 30 minute and less, 30 to 60 minutes, 60 minutes and more were not statistically different