Abstract PTU-70 Figure 1

($p=.0017$) and were more likely to receive chemotherapy (33 patients vs 12 patients, $p<.001$) compared to the no PERT group. The PERT group had longer survival times (median survival 151 days vs 46 days, $p<.001$, figure 1).

There was increased survival for patients treated with PERT when patients treated with chemotherapy were excluded (median survival of 98 days vs 37 days, $p=.004$). Additionally, there was increased survival for those treated with PERT and chemotherapy compared to those treated with chemotherapy without PERT (226 days vs 101 days, $p=.04$).

Sub-group analysis demonstrated statistically significant increased survival for patients treated with PERT with cancer of the pancreatic head (median survival of 165 days vs 44 days, $p=.001$) and of the pancreatic body (median survival of 174 days vs 37 days, $p=.001$).

Conclusions This retrospective, pragmatic study of patients diagnosed with unresectable pancreatic cancer showed that less than half of patients were treated with PERT. PERT was associated with a clinically significant (approximately 3-fold) increase in survival regardless of whether chemotherapy was given. However, these results are likely to be confounded by selection bias given the higher percentage of patients in the no PERT group with more advanced disease and poorer performance status. We recommend offering all patients diagnosed with unresectable pancreatic cancer PERT.

PTU-71 POST ERCP INDUCED PANCREATITIS: DOES PROPHYLACTIC PANCREATIC STENTING MAKE A DIFFERENCE?

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10.1136/gutjnl-2021-BSG.273

Introduction Post- ERCP Pancreatitis (PEP) is a significant complication of ERCP, especially in high risk cases or where there has been involvement of the pancreatic duct. Rectal NSAIDs and pancreatic duct stents are used to reduce the risk of PEP. It is not yet known if PD stents plus rectal NSAIDs reduce the risk of PEP more than rectal NSAIDs alone.

Methods We performed a retrospective analysis of 2028 ERCPs performed at a single large DGH centre in the UK to examine if PD stenting plus rectal NSAID significantly reduced the risk post procedure complications.

Abstract PTU-71 Table 1

	No PD wire or contrast	PD wire or contrast but no PD stent	PD wire or contrast and PD stent inserted
Total number	1469	348	211
Mean age in years	69	67	64
Range in years	16 - 101	17 - 101	19 - 94
Male: Female ratio	628:841	151:197	87:124
ASA Status	1.48	1.40	1.80
Pancreatitis rate	36/1469 (2.5%) ($p=0.01$)	15/348 (4.3%) ($p=0.03$)	10/211 (4.7%) ($p=0.03$)
Mean number of PD contrast injections	n/a	0.55	0.64
Mean number of PD wire passes	n/a	1.87	2.85
IV fluids administered post procedure	11%	0%	0%
Rectal NSAID given	36/36 (100%)	15/15 (100%)	10/10 (100%)
Severity of pancreatitis (Modified Marshall score)	0.97	0.4 ($p=0.13$)	0.6 ($p=0.53$)
Mean Length of stay (days)	7.7	6.9 ($p=0.70$)	5.5 ($p=0.11$)
ITU involvement	4/36 (11%)	2/15 (13%)	0/10 (0%)
Deaths	4/36 (11%)	1/15 (6.7%)	0/10 (0%)

Results We found pancreatitis occurred in 3% of ERCPs ($n=61$). All patients had rectal NSAIDs administered at time of ERCP. We found PD involvement significantly increased the rate of PEP. We found that PD stenting did not significantly provide reduction in the severity of pancreatitis, measured by Modified Marshall or Atlanta scores, compared to those that had PD involvement without PD stent insertion or those without PD duct involvement. There was no significant difference in length of admission amongst groups.

Conclusions Our study further demonstrates that PD involvement at ERCP increases the rate of PEP. However, our study suggests PD stenting does not significantly provide reduction in rates of pancreatitis when used in combination with rectal NSAID therapy. In addition, there is an additional cost associated with PD stent placement plus the need for further follow-up if the PD stent does not spontaneously pass. We do reflect the number of pancreatitis cases in our cohort was small and that this was the experience from a single, large centre. We suggest further randomised controlled trials are required to prove the benefit of PD stent placement in combination with rectal NSAIDs over rectal NSAIDs alone in prevention of post-ERCP pancreatitis.

PTU-72 OUTCOMES OF SURGERY FOR CHRONIC PANCREATITIS IN THE MANCHESTER SPECIALIST MULTI-DISCIPLINARY PANCREATITIS SERVICE

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10.1136/gutjnl-2021-BSG.274

Introduction The management of chronic pancreatitis is complex. In Manchester, a multi-disciplinary approach to care has

been in place since 1999. Patients are assessed by specialist pancreatologists, surgeons, and dietitians with a consensus approach toward endoscopic intervention as a first step. This study reports the outcome of surgery in patients managed by this approach.

Methods A retrospective database searches to identify all patients having pancreatic surgery for chronic pancreatitis (CP) in the Manchester Royal Infirmary) over a 20-year period from 1999-2019. Patients were excluded from the study if final histology revealed cancer.

Results 20 patients were identified; mean (range) age in years 49 (18-80). Sixteen (80%) were male. Alcohol was the cause in 10, 3 were idiopathic with the remainder including genetic, auto-immune, and pancreas divisum. Nineteen had undergone prior endoscopic intervention. Ten patients underwent Whipple pancreatoduodenectomy, nine underwent longitudinal pancreaticojejunostomy with partial head resection and there was one distal pancreatectomy. Hospital stay ranged from 6 to 32 days with a mean of 15 days. There was no operative mortality. Pancreatic exocrine insufficiency was documented in 60% before surgery and in 85% after. Diabetes was present in 55% before surgery and in 65% after.

Conclusion Multidisciplinary assessment is the key to the selection of patients to undergo surgery for chronic pancreatitis. In this selected population, surgery can be undertaken safely with low mortality.

PTU-73 PRE AND POST-OP PAIN ANALYSIS IN PANCREAS SURGERY FOR CHRONIC PANCREATITIS

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10.1136/gutjnl-2021-BSG.275

Introduction Chronic pancreatitis is defined as a spectrum of inflammatory disorders of the exocrine pancreas that typically result in loss of function and pain. The main indication for operating on patients with chronic pancreatitis is managing intractable pain or treating complications, however surgical intervention is usually the last resort after conservative measures have failed. Evidence from previous studies stated that early surgery has a more favorable outcome on the treatment of intractable pain compared to endoscopic management.

Aim To compare the analgesic requirements of patients who underwent surgical intervention for chronic pancreatitis pre- and post-operatively.

Methods A retrospective database search to identify all patients having pancreatic surgery indicated for CP in a tertiary center

Graph Showing Change in Analgesia Requirements Post-Operatively

Abstract PTU-73 Figure 1

(Manchester Royal Infirmary) over a 20-year period from 1999-2019. Patients were excluded from the study if histology showing pancreatic carcinoma was identified.

Results Analgesia was scored as a 1 for simple painkillers, 2 for PRN opiates, and 3 for regular opiates with pre- and post-op cumulative scores compared. The cumulative pain score pre-operatively was 46 (5 people scoring 1, 1 scoring 2, 13 scoring 3, and one patient not taking any painkillers).

Post-operatively pain score breakdown was 5 scoring 1, 3 scoring 2 and 12 scoring 3, however, 4 patients that remained on regular opiates were found to be on a reduced dose compared to pre-operatively. A reduction of 0.5 was used to denote patients that remained on regular opiates but had a reduction in their dosage. Therefore the cumulative pain score was 45.

The one patient whose analgesia requirements increased postoperatively developed a complication (pancreatic leak) post-operatively. This is believed to be the reason for the increased dependence. Excluding this patient gives a pre-operative cumulative pain score of 46 and a post-operative cumulative pain score of 42.

Conclusion From our patient cohort, we can demonstrate a reduction in total analgesic requirements postoperatively. Whilst this remains an uncommon indication for surgical intervention it appears to hold potential benefits and merits study on a larger scale.

PTU-74 WEIGHT REGRESSION ANALYSIS IN PATIENTS WHO HAVE UNDERGONE SURGERY FOR CHRONIC PANCREATITIS

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10.1136/gutjnl-2021-BSG.276

Introduction Chronic pancreatitis is defined as a spectrum of inflammatory disorders of the exocrine pancreas that typically result in loss of function and pain. It often results in weight loss due to the progressive loss of endocrine and exocrine function. Surgical interventions for chronic pancreatitis are the last resort option and normally saved for patients with intractable pain however the impact of surgery on weight gain has not been previously studied.

Aim To examine the impact of surgery on weight gain in patients with chronic pancreatitis.

Methods A retrospective database search to identify all patients having pancreatic surgery indicated for CP in a tertiary center (Manchester Royal Infirmary) over a 20-year period from 1999-2019. Patients were excluded from the study if histology showing pancreatic carcinoma was identified. Pre-op weights were taken from nutritional screening at the time of admission for surgery. Post-op weights were taken from follow-up clinic appointments on average six months postoperatively.

Results On studying patient weights pre-and post-op it was found that 40% of patients had a steady weight gain, 25% had a weight drop, 30% had no documented weights for comparison and 5% had stable weights.

Conclusion This study has shown that over half of the cohort of patients with recorded pre and post op weights had either gained weight or kept their weight steady after surgery. This supports the hypothesis that surgical intervention in patients with chronic pancreatitis does not compromise patient weights and merits further study.