Abstract PTU-77 Table 1

Patient	Location	Size (mm)	Pre-TTNB MDT diagnosis	Post-TTNB histological diagnosis	Outcome	Adverse event
1	HOP	35	IPMN vs. SCN	IPMN	Start surveillance	No
2	TOP	33	Indeterminate	Indeterminate	Continue surveillance	No
3*	Retroperitoneal	250	GIST	GIST	Chemotherapy	Yes
4	BOP	35	MCN	Lymphoepithelial cyst	Avoided surgery	No
5	HOP	40	SB-IPMN vs. MCN	SCN	Avoided surveillance	No
6	BOP	50	SB-IPMN	SCN	Avoided surveillance	No
7	BOP	40	IPMN vs. MCN	MCN	Surgery	No

cytological modalities in the diagnostic algorithm of patients with pancreatic cystic lesions (PCL). We aimed to describe the utility of EUS-TTNB in influencing management outcomes at a tertiary hepatopancreatobiliary unit.

Methods A prospective database of consecutive patients who underwent EUS-TTNB from March 2020 to October 2020 was retrospectively analysed. Recorded variables included patient demographics, technical success, histological results, adverse events and management outcomes.

Results Seven patients (4 male; 3 female) were identified. All patients were discussed in dedicated multidisciplinary team (MDT) meetings and a consensus on the nature of the lesion was not possible. Seven patients had PCLs and one patient had a retroperitoneal cystic lesion. Technical success was achieved in 100% of patients. Specimen adequacy for definitive histological diagnosis was achieved in 85.7% of patients (n=6), leading to a change in management. An adverse event was encountered in one patient* who developed an infection of the cystic lesion post EUS-TTNB. After extensive MDT discussion, EUS guided drainage was performed resulting in good clinical response. The table summarises the key characteristics and outcomes of the patients.

Conclusions Our case series has demonstrated EUS-TTNB to be a valuable and safe tool in the diagnostic pathway of patients with cystic lesions and led to a change in management in the majority of patients. Further larger prospective studies are required.

Small bowel

PTH-1 SMALL-BOWEL NEUROENDOCRINE TUMOURS: THE ROLE OF DOUBLE-BALLOON-ENTEROSCOPY. A CASE SERIES FROM A TERTIARY REFERRAL CENTRE

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Introduction The incidence of small bowel neuroendocrine tumours (SBNETs) is rising. In this context, double-balloon

enteroscopy (DBE) appears to be critical for identification of the primary tumour, definitive histopathological diagnosis and lesion marking for subsequent surgical resection. Additionally enteroscopy provides a further assessment of the disease potential multifocality.

Methods Our aim was to evaluate the role of DBE in the management of SBNETs. Cohort-analysis was performed of consecutive patients with SBNETs who underwent DBE in our tertiary centre, from November 2012 to November 2019. Demographic, clinical, endoscopic findings and surgical data were analysed.

Results Eleven patients were included, 4 women; overall mean age of 56.2 years. Eight patients were referred for further investigation of mid gastrointestinal bleeding; 4 presented with overt bleeding and 4 presented with iron deficiency anaemia. Two cases were referred for further investigation of a lesion incidentally found on cross-sectional imaging. The final case was referred electively for localization of a primary tumour lesion, following previous resection of NET mesenteric metastasis. Twelve DBE procedures were performed (retrograde, n=9; anterograde, n=3). All DBEs successfully identified the primary lesion as per indication and submucosal tattoo was placed for surgical reference. All lesions were located within the ileum. Multifocal SBNETs identified with DBE were confirmed at surgical resection (n=3). Histopathology samples taken through DBE were pathognomonic in all cases. The tattoo placed during DBE was identified in all surgical procedures thus facilitating 4 minimally-invasive tattoo-guided laparoscopic SB resections (mean resection length: 33.7cm (SD ±14.4cm) clearing 16 SBNETs.

Conclusions DBE has an important role to play within the diagnostic and management algorithm of SBNETs. Consequently enteroscopy could facilitate identification of multiple lesions and guide minimally invasive bowel-preserving surgical resection.

PTH-2 BILE ACID MALABSORPTION AND SMALL INTESTINAL BACTERIAL OVERGROWTH IN PATIENTS WITH DIARRHOEA FOLLOWING PELVIC RADIOTHERAPY

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Introduction Bile acid malabsorption (BAM) and small intestinal bacterial overgrowth (SIBO) are common causes of diarrhoea following pelvic radiotherapy¹. BSG guidelines recommend 23-seleno-25-homotaurocholic acid (SeHCAT) and hydrogen breath testing for BAM and SIBO respectively as initial investigations in this patient group¹. These tests seem to