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

Abstract PTH-2 Table 1 Baseline demographic and clinical details

		Number(%)
Demographic Data	Male	26(28%)
	Female	67(72%)
	Age(range)	57(27-85)
Primary Cancers	Cervical	33(35%)
	Prostate	18(19%)
	Anorectal	16(17%)
	Endometrial	12(13%)
	Vaginal	3(3%)
	Vulval	3(3%)
	Sarcoma	1(1%)
	Bowel	1(1%)
	Lymphoma	1(1%)
	Ovarian and endometrial	1(1%)
Cancer Treatments	Chordoma	1(1%)
	EBRT*	67(72%)
	EBRT* followed by brachytherapy	26(28%)
	Brachytherapy without EBRT*	1(1%)
	Chemotherapy	53(57%)
	Surgery	17(18%)

*External beam radiotherapy

have high diagnostic yield². We report a large case series of patients referred to a tertiary pelvic radiation clinic with chronic diarrhoea.

Method Data were collected from electronic records of patients referred with chronic diarrhoea between July 2018 to December 2020, including demographic data, primary cancer, cancer treatments, symptoms and investigation results.

Results 93 patients were identified. Baseline demographic and clinical details are shown in Table 1.

44(47%) patients were treated for BAM. Of those, 13 (30%) had severe BAM (SeHCAT retention 0-5%), 5(11%) had moderate BAM (SeHCAT retention 5-10%), and 15(34%) had mild BAM (SeHCAT retention 10-15%), with 10(23%) having a borderline result (SeHCAT retention 15-20%), which can be associated with symptoms. SeHCAT result was not recorded for one (performed elsewhere).

17(18%) patients were diagnosed with SIBO. Of those diagnosed, 10(59%) had positive hydrogen breath tests and 7 (41%) patients were diagnosed clinically with SIBO. 8(9%) patients were diagnosed with both BAM and SIBO.

Conclusion This large case series confirms BAM is a common cause of chronic diarrhoea following pelvic radiotherapy, affecting over a third of patients. As per BSG

guidelines¹, SeHCAT scans and breath tests should be initial investigations in this patient group. SIBO remains a difficult condition to diagnose due to limitations of the investigations currently available, exacerbated by limited access during the Covid-19 pandemic. This may account for our lower diagnostic yield². Further work is needed to improve the detection of SIBO.

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PTH-3

WHAT IS THE ROLE OF MULTIPLE URINE GIPS IN ESTABLISHED COELIAC DISEASE?

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Introduction The mainstay of treatment for coeliac disease (CeD) is a gluten-free diet (GFD). Poor adherence can result in persistent villous atrophy (VA) and subsequent complications. Non-invasive methods to assess adherence may be preferred by patients, with recent interest in urine gluten immunogenic peptides (GIPs). In view of this, the efficacy of using urine GIPs to assess GFD adherence was assessed, in comparison to the gold standard of duodenal biopsies.

Methods Individuals with known CeD (n=22, female 54.5% [n=12], median age 41 years [range 19-79]) who attended outpatient endoscopy for on-going symptoms were reviewed. Four D2 and D1 biopsies were taken. Villous atrophy (VA) was defined as Marsh 3a or above. Individuals completed three urine GIP samples (one weekday, two weekend) around the time of endoscopy. Rapid immunochromatographic testing was used for analysis. The presence/absence of VA was used to determine the sensitivities, specificities and positive/negative predictive values (PPV/NPV) of urine GIPs.

Results Over half (59.1%, n=13) of individuals had at least one positive GIP, of which 38.5% (n=7) had VA. The sensitivity of urine GIPs was poor, although multiple positive GIPs led to a high specificity and PPV, as seen in Table 1.

Conclusions The presence of two or more positive urine GIPs was a good non-invasive predictor of VA in this small cohort. More data is required to confirm these findings.

Abstract PTH-3 Table 1 Table showing sensitivity, specificity, PPV and NPV of urine GIPs as a predictor of VA

	Sensitivity,% (95%CI)	Specificity,% (95%CI)	PPV,% (95%CI)	NPV,% (95%CI)
1 or more positive GIP (n= 13)	71.4 (29.0 - 96.3)	46.7 (21.3 - 73.4)	38.5 (24.3 - 54.9)	77.8 (49.1 - 92.7)
2 or more positive GIP (n=4)	57.1 (18.4 - 90.1)	100.0 (78.2 - 100.0)	100.0	83.3 (68.0 - 92.1)
3 positive GIP (n=3)	42.9 (9.9 - 81.6)	100.0 (78.2 - 100.0)	100.0	79.0 (66.4 - 87.7)