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Neurogastroenterology

PWE-53 THE RELATIONSHIP BETWEEN HOSPITAL ADMISSIONS FOR CONSTIPATION AND OPIOID PRESCRIBING: A 20 YEAR CORRELATION STUDY

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Background Constipation is a common problem with numerous causes, including several drugs among which opiates are prominent. Considering the reported increase in opioid prescriptions worldwide, we hypothesised that if this is mirrored in England then hospital admissions for constipation would rise in proportion to the rise in opiate prescriptions.

Methods Publicly available data on admissions was obtained using NHS Hospital Admissions Statistics and data on opioid prescribing using NHS Prescription Cost Analysis. Admissions and opioid prescriptions were summarised annually, and the changing age structure of the population measured as the proportion over 75 between 1998 and 2020. Annual opioid prescriptions were plotted against annual admissions for constipation and the data modelled using Poisson regression to correct for the effect of changing population structure.

Results Between 1998 and 2018, opioid prescribing increased by a factor of 5 and constipation admissions have increased across age groups except (0-14). Patients are spending less days in hospital (declining from a mean of 5 to 3 days) per admission with the overall number of bed days remaining relatively consistent over the past 20 years. The English population has become more elderly with the proportion over 75 years of age increasing. A plot of opioid prescriptions against admissions for constipation confirms that they rise together (Figure 1). Poisson regression shows that admissions rise with an incidence rate ratio of 1.025 (95% CI 1.024-1.026) for

Abstract PWE-53 Figure 1 Plot of constipation admissions against opioid prescriptions between the years 1998-1999 (referred to as above as 1999) and 2017-2018 (2018)

every million extra prescriptions after correcting for the aging population.

Discussion The findings demonstrate a clear association between opioid prescribing and constipation in England over the last 2 decades. We are unable to correct for the effect of most potential confounders, although we have attempted to address the possible effect of an aging population. The ecological nature of the study in addition precludes us attributing causality to the association. However, the strength of the relationship, the biological plausibility of the mechanism and the importance of the problem, mean this needs to be investigated further.

PWE-54 TRANSDUODENAL SPHINCTEROPLASTY IN THE MANAGEMENT OF REFRACTORY PAIN IN TYPE II SPHINCTER OF ODDI DYSFUNCTION

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Introduction The management of Type II sphincter of Oddi dysfunction (SOD) or functional biliary sphincter disorder (FBSD) is complex. Endoscopic biliary sphincterotomy is ineffective in a proportion of patients and many patients continue to experience debilitating attacks pancreaticobiliary pain necessitating multiple hospital admissions. Intermittent intra-sphincteric Botulinum toxin (Botox) injection, in conjunction with neuromodulatory therapy is useful in alleviating pain in many patients with ongoing functional biliary pain¹, but some patients develop pain refractory to Botox therapy. Surgical biliary sphincteroplasty has been previously demonstrated to be effective in the management of SOD.² We present our experience in managing refractory pancreaticobiliary pain in FBSD by surgical sphincteroplasty.

Methods A retrospective review of case notes over a 7-year period (2013-2020) was performed. The diagnosis of Type II SOD or FBSD was made in post cholecystectomy patients with abdominal pain identical to their pre-cholecystectomy pain. All patients underwent extensive investigations including blood tests, gastroscopy, trans-abdominal ultrasonography, cross-sectional imaging with MRCP or CT and endoscopic ultrasound and Morphine TBIDA scans. Patients with typical pre-cholecystectomy pain and either a dilated bile or abnormal liver function tests (ALT or ALP x 1.5 times upper limit of normal) in line with the modified Milwaukee criteria and/or a positive Morphine TBIDA scan were identified as Type II SOD or FBSD. All patients underwent endoscopic biliary sphincterotomy and due to ongoing pancreaticobiliary pain, underwent intermittent Botox injections, under deep sedation or anaesthesia, in a quadrantic fashion around the sphincterotomised ampullary area. Transduodenal surgical sphincteroplasty was performed in these patients once their pain became refractory to further Botox therapy. The efficacy of surgical sphincteroplasty was recorded at post-procedure outpatient review using a nominal pain scale. The need for opioid analgesia and adjustments to neuromodulatory medication were recorded on follow up.