17.1% of ultrasounds. Of patients with adequate imaging, 67 (46.9%) had pancreatic abnormalities detected; including 31 with chronic pancreatitis and 7 pancreaticobiliary cancers. 124 patients (68.1%) had nutritional blood tests sent. Of these, 65 (52.4%) had one or more abnormal result.

103 patients (56.6%) received PERT; median initial dose 50000 IU/meal. 77 patients (66.4%) were referred to dietetics. 67 patients (81.7%) responded clinically to PERT. Patients with severe PEI were no more likely to respond than those with mild PEI (OR 1.28, 95% CI 0.40–4.03; p=0.68). Initial PERT dose was not associated with clinical response (OR 1.00, 95% CI 1.00–1.00; p=0.51), nor was referral to dietetics (OR 0.61, 95% CI 0.12–3.04; p=0.54). However, patients with abnormal pancreatic imaging or nutritional blood tests had four times the odds of responding to PERT than those with normal results (OR 4.77, 95% CI 1.16–19.57; p=0.03, and OR 4.12, 95% CI 1.07–15.94; p=0.04).

Conclusions All patients diagnosed with PEI should be screened for malnutrition and undergo pancreatic imaging with CT or MRI. Abnormal results are common and may predict response to treatment.

Small bowel

P260 BILE ACID DIARRHOEA OUTSIDE TERTIARY CENTRES-HOW BAD IS BAD?

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Introduction Chronic diarrhoea causes significant morbidity and these patients are commonly referred to gastroenterology clinic. Bile acid diarrhoea (BAD) is considered causal in up to 1/3 of people investigated for IBS-D. BSG guidelines recommend investigation for BAD in secondary care using SeHCAT scanning/serum bile acid precursors.[1] Empirical trial of treatment is not recommended. Access to tests can be limited in district general hospital settings. We report our experience in a DGH where diagnostic testing is provided by a centre 39 miles away.

Methods A retrospective notes review was performed for all outpatients from East and North Herts NHS trust (catchment population 600,000) who had SeHCAT scans performed by a regional service (Mount Vernon Hospital) in 2019. Data were collected on demographics, symptoms, risk factors, other investigations, time between first clinic and scanning and prior empirical treatment. Comparison were made between positive and negative groups using multiple regression analysis.

Results 50 scans were requested of which 48 results were available. Median age was 49 (23 – 84 y), 33(69%) female. 21 scans (44%) were positive for BAD, 3 (14%) mild, 10 (48%) moderate 8 (38%) severe. Only patients with complete data (45) were included in subsequent analyses. Risk factors are presented in table 1. A statistically significant association between cholecystectomy and positive SeHCAT scan was found (P=0.026). There was considerable delay in diagnostic confirmation for some patients with a positive test taking 1 month to 10 years. Overall 41/45 patients had prior testing with faecal calprotectin (FC), 32 patients had colonoscopies of whom 24 had colonic biopsies, 43/50 had thyroid function checked and 39/50 were screened for coeliac disease. 10 patients had empirical treatment with bile acid sequestrants before scanning.

Abstract P260 Table 1 Risk factors for BAD in chronic diarrhoea

Risk factors	Negative SeHCAT scan (26)	Positive SeHCAT scan (19)
Cholecystectomy	5 (19%)	10 (53%)
Crohn's	1 (4%)	1 (5%)
Right hemicolectomy	1 (4%)	1 (5%)
Coeliac	2 (8%)	0 (0%)
Diabetes	2 (8%)	2 (10%)
Other surgery	1 (4%)	0 (0%)
No risk factors	16 (59%)	7 (37%)

Conclusions Our study has shown a burden of incident BAD in the outpatient DGH setting. This is underestimated due to use of empirical treatment without testing, lack of investigation of some patients with disease and referral for SeHCAT scanning in other centres not identified. Patients had appropriate initial investigations performed for chronic diarrhoea. In keeping with larger studies from tertiary centres prior cholecystectomy is the commonest predisposing factor (type III) and >1/3 of patients had no identified risk factor (type II). There are limited data regarding BAD investigation and management in DGH setting where patients have to travel considerable distance for testing. There are problems associated with empirical treatment including current drug availability in the UK. National management guidelines based on large studies and wider availability of economically viable testing are needed.

REFERENCE

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P261 THE MICROBIOTA IS A KEY FACTOR INFLUENCING GUT REHABILITATION IN EARLY ONSET SHORT BOWEL SYNDROME

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Introduction Short bowel syndrome (SBS) is the most common cause of paediatric intestinal failure (IF) and its prevalence is rising. Home parenteral nutrition (HPN) is life-saving but can be associated with serious complications such as intestinal failure-associated liver disease (IFALD) and catheter related blood stream infections (CRBSI), therefore the ultimate aim is intestinal autonomy. Current understanding of predictive factors for achieving intestinal autonomy is limited, but include remaining bowel length, type and quality of bowel, and earlier age of onset of SBS. Significant dysbiosis also occurs in SBS and may impact on the likelihood of successful intestinal rehabilitation (IR).

Our aim was to phenotype patients with SBS, comparing children who achieved intestinal autonomy to those who remained on HPN or required intestinal transplant, to identify possible factors that impact upon the likelihood of successful IR.