PTH-136 A MYRIAD OF CAUSES FOR DIARRHOEA IN PATIENTS PRESENTING AT A GIANT (GI AND NUTRITION TEAM) CLINIC IN A CANCER CENTRE

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Introduction Better cancer treatments have led to enormous improvements in the outcomes for these patients with the result that the overall number of survivors of cancer therapy continues to grow. However, after cancer treatment, up to 50% patients are left with diarrhoea - the most prevalent symptom. Causes are likely to encompass several contributing GI diagnoses.
Methods A service evaluation was conducted of new patients attending our clinic, reporting diarrhoea after treatment for cancer. All patients attending the clinic completed a patient recorded outcome measure describing their symptoms and a Bristol Stool Chart describing stool type. They were investigated using a peer reviewed investigational and management algorithm. Patient characteristics, symptom incidence and severity were recorded prospectively.
Results Over a 6 month period (July - Dec 2012), 207 patients were newly referred to the GIANTs. Of those, 104 (50%) reported diarrhoea (type 6 or 7 Bristol Stool Chart). In this group there were slightly more men (52%) than women (48%). Their median age was 62 years (range: 22–89). Primary tumour sites included urological cancer (34% - 82% of these prostate), gynaecological (22%), colorectal (20%), upper GI (10%), haematological (8%), and other (6%). 69% had undergone pelvic radiotherapy, 48% had been treated with surgery or received chemotherapy. 12% received pelvic radiotherapy alone, 6% surgery and 3% chemotherapy alone. Over a quarter (29%) received all 3 treatment modalities.

Small intestinal bacterial overgrowth was found in 49%. Bile acid malabsorption was newly diagnosed in 33% of patients. Weak pelvic floor musculature was a contributing factor in 20%. 13% were diagnosed with new pancreatic insufficiency. Excess fibre intake (>20g/day) was a contributory factor in 11% and Lansoprazole in up to 9% of patients. Other factors included: thyroid problems (9%), anal fissure (5%), rectal ulceration (5%), faecal loading (5%) and new onset Inflammatory Bowel Disease (3%). A colorectal polyp was found in 16% of patients, 1 patient had a new colorectal cancer and 2 had a GI stricture.

80% of patients had multiple causes for their diarrhoea. Most patients were discharged with a significant improvement in their symptoms with a median of 4 consultations (range 1–7) after systematic assessment and targeted management of the causes for their symptoms.
Conclusion Diarrhoea after cancer treatment is frequent in the patient cohort seen in our clinic. Several GI causes contribute to diarrhoea simultaneously in most patients but the majority can be discharged after a small number of consultations with a significant improvement or full resolution of their symptom if a systematic investigational and treatment approach is adopted.
Disclosure of Interest None Declared.

PTH-137 THE GI AND NUTRITION TEAM SERVICE (GIANTS): MANAGING GI CONSEQUENCES OF CANCER TREATMENT – WHO? WHAT? AND HOW?

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Introduction Our clinic specialising in gastrointestinal problems after cancer treatment, seems to be attracting patients with GI consequences resulting from a wider variety of cancer therapies. We present an analysis of new patients referred to our GI and Nutrition Team service.
Methods A service evaluation of new patients attending the clinic is ongoing after gaining appropriate approvals. All patients attending clinic complete a patient recorded outcome measure describing their symptoms, a Bristol Stool Chart describing stool type and a quality of life scale. Patients are investigated systematically depending on their symptoms, using a peer-reviewed algorithm. Patient characteristics, symptom incidence and severity are recorded prospectively.
Results Data for July-December 2012 were analysed. 207 patients were newly referred to the GIANTs. Their median age was 61.6 years (range: 22–89). 55% were male. The largest group were patients treated for a urological malignancy (37%), followed by those with a gynaecological (18%), colorectal (16%), upper GI cancer (12%), other cancers (8%), haematological malignancy (6%) and no previous cancer diagnosis (3%). 71% of patients had received pelvic radiotherapy, 3% chemotherapy, 11% GI surgery and 11% were treated with both chemotherapy and surgery. 4% had not yet received any cancer treatment and were usually referred to exclude the presence of IBD, a relative contra-indication to radiotherapy.

Comparing symptom profiles of patients who received pelvic radiotherapy (n = 140) and those treated with other treatment modalities (n = 61), reveals that most patients were troubled by multiple symptoms: urgency (62 vs. 52%), diarrhoea (57 vs. 51%), tenesmus (47 vs. 43%), flatulence (56 vs. 52%), borborygmi (36% vs 52%) abdominal pain (39% both groups), bloating (29 vs. 38%), faecal leakage (16 vs. 31%) and nocturnal defaecation (31% both groups). Rectal bleeding was reported by 34% of patients who received pelvic radiation, compared to 13% in the other group. Fatigue affected both groups (46 vs. 54%).

The types of diagnosis to account for the symptoms made in both groups were similar: small intestinal bacterial overgrowth (24% pelvic radiotherapy vs. 28% other cancer treatments). Bile acid malabsorption was diagnosed in 16% (both groups) and pancreatic insufficiency in 6 and 5%.
Conclusion Gastrointestinal problems after any cancer treatment are frequent and the symptom burden is high. The prevalence of symptoms patients describe after pelvic radiotherapy differs from those treated with other modalities but the causes identified for those symptoms are the same. A systematic management algorithm and multidisciplinary approach is required to manage those complex symptoms optimally.
Disclosure of Interest None Declared.

PTH-138 TNF-A DEPENDENT ANGIOPOEITIN MEDIATED ANGIOGENESIS IN SPORADIC SMALL BOWEL ANGIODYSPLASIA; NOVEL PATHOPHYSIOLOGY AND POTENTIAL CLINICAL MARKER

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Introduction Angiodysplasias account for over 50% of small bowel causes of obscure gastrointestinal bleeding. Angiodysplasias are thought to develop as a result of an imbalance in the