with overall accuracy of 97% (CI: 92%-97%) for detection of pancreatic cancer using neighboring pancreatic tissue as the reference area. Future comparative studies using both reference areas on the same patients should allow us to decide which of these is optimal choice. References: 1. Mei M. et al. Gastrointest Endosc 2013;77:578-89. 2. Iglesias-Garcia J et al. Gastroenterology 2010;139:1172-80. 3. Dawas MF et al. Gastrointest Endosc 2012;76:953-61.

	Pancreatic cancer			
Strain Ratio	Indicative =/> 7.59	True pos 58/58	False pos 5/91	PPV 92% (87%-92%)
	Non indic. < 7.59	False neg 0/58	True neg 86/91	NPV 100% (96%-100%)
		Sens100% (94%-100%)	Spec 95% (91%-95%)	

Mo1169

Description of Findings of Endoscopic Ultrasound in Patients With Idiopathic Acute Pancreatitis, at Fourth Level University Hospital At Bogota Between 2011-2013

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Around 30% of idiopathic acute pancreatitis is reported in literature. However, with the advent of endoscopic ultrasound this percentage can be reduced to one-third. At our hospital we had acquired this technology, but we do not know the performance and the findings in our population.OBJECTIVES Describe the findings of endoscopic ultrasound (EUS) in patient with diagnosis of idiopathic acute pancreatitis, between 2011-2013. Describe the demographic and clinical characteristics in those patients in a cohort of patients and the findings in EUS. Assess if it clarified or changed de diagnosis allowing specific treatment options.POPULATION Patients who underwent EUS and who meet the inclusion criteria defined for this study, over 18 years, with all these tests normal: liver function tests, calcium levels, triglycerides, abdominal ultrasound, abdominal computerized tomography (CT).No history of chronic or recent alcohol consumption, not consumption of toxic substances or medicines, not family history of pancreatitis or cystic fibrosis.RESULTS A total of 21 cases were found to have idiopathic acute pancreatitis. The 57% were women, the median age was 56 (15-77 years). The EUS was performed in the first two weeks of the disease in the 57% and after 6 weeks in the 23.8%. Previous episode of pancreatitis were found in 23.8% of patients. They were classified as more than 3 points in the Ranson criteria in the 19% and an Atlanta score of 1 or more points in the 28.6%.It was performed a CT of abdomen to the 66.6% of the patients. The severity index was less than 3 in 64.2%, between 4 and 6 in 21% and more than 7 in 14.2% of those who had CT.There were no cases of mortality among these patients, and 33% where handle at intensive care unit.It was performed a magnetic resonance cholangiopancreatography (MRCP) in 23.8% of cases, the most common finding was a normal study, two cases of dilated bile duct and a case of dilated Wirsung without one specific cause. We detected no cases of tumors in MRCP.In EUS the 43% of the studies were normal, unspecific changes consistent with acute pancreatitis in 28.5% of the patients and in 28.5% of the studies there was a new diagnosis that could explain the cause of the pancreatitis Table 1. In nearly a third of the patients in this cohort presenting as acute idiopathic pancreatitis, endoscopic ultrasound gave a new diagnosis that helped to direct treatment options, as in other series biliary pathology represent the most frequent EUS finding followed by chronic pancreatitis and Oddi sphincter dysfunction. EUS is an useful, low-risk diagnostic tool for the evaluation of unexplained pancreatitis and should be considered in the diagnostic workup of this patients.
Table #1

New diagnosis found in the endoscopic ultrasound	Percentage
Gallstones	14.2%
Microlithiasis	5%
Chronic pancreatitis	5%
Oddi sphincter dysfunction	5%

Mo1170

Endoscopic Ultrasound-Guided Fine Needle Aspiration (EUS-FNA): Experience of a Regional Centre in Australia

Ming-yu Chuang, Omid Zarghom, Sara E. Mgaieth, Brent Mitchell, Scott B. Fanning

Introduction: Endoscopic ultrasound-guided fine needle aspiration (EUS-FNA) has become widely accepted as an effective, minimally invasive diagnostic tool for the evaluation of solid and cystic lesions of the gastrointestinal (GI) and respiratory tract. Although an increasing number of major tertiary centres have adopted EUS-FNA as a standard diagnostic tool, the availability of EUS-FNA in regional areas is still limited. To our knowledge, there are currently no reports on its performance in this setting in the literature. EUS was first introduced in our regional 300-bed hospital servicing Northern Tasmania in 2013. Here we report our single-operator experience with EUS-FNA with regard to clinical utility, diagnostic accuracy, and safety. **Methods**: Data was prospectively collected on consecutive EUS procedures performed at the Launceston General Hospital between January and October 2013. Patient demographics and the operating characteristics of EUS-FNA were recorded. Final diagnosis was based on a composite standard: histologic evidence at surgery, or non-equivocal cytology on FNA and follow-up. **Results**:A total of 100 EUS examinations with 64 EUS-FNA were performed during the study period (34 men, mean age 69.1 years, range 39-89). These included 28 solid pancreatic lesions, 8 cystic pancreatic lesions, 14 lymph nodes, 7 subepithelial GI lesions, and 7 intra-abdominal or mediastinal lesions (see figure 1). 25-gauge needle was used in 57 cases, and 22-gauge needle in 7 cases. Mean solid lesion size was 29.5 mm (range 5-45mm) with a median of 2 needle passes per lesion (range 1-4) to obtain a diagnosis. Adequate material, as assessed by in-room cytopathologist, was obtained from all solid pancreatic lesions, lymph nodes, and 6 of 7 subepithelial GI lesions. Malignant pathology was diagnosed in 85.7, 78.6, and 85.7% of cases respectively. EUS-FNA was highly sensitive and accurate for solid pancreatic lesions (91.7 and 92.86% respectively). Cyst fluid was assessed by well-establish criteria with 3 of 8 lesions (37.5%) being highly suspicious for malignancy (see table 1). No minor or major complications occurred during the study period. **Conclusions**: Our experience confirms that EUS-FNA can be safely and effectively performed while maintaining high diagnostic accuracy in a regional centre. Technical success approaches 100%, with yield from solid lesions in excess of 90%. We propose that EUS be utilised more frequently in regional centres, and be considered the preferred test when a cytological diagnosis is required.
Table 1. Endoscopic ultrasound fine needle aspiration (EUS-FNA) cytological findings and final diagnoses of targeted lesions

Type of Lesion	Sensitivity (%)	Specificity (%)	PPV (%)	NPV (%)	Accuracy (%)
Solid pancreatic lesions (n=28)	91.7 (22/24)	100 (4/4)	100 (22/22)	66.67 (4/6)	92.9 (26/28)
Cystic pancreatic lesions (n=8)	100 (3/3)	100 (5/5)	100 (3/3)	100 (5/5)	100 (8/8)
Lymph node aspirations (n=14)	81.8 (9/11)	100 (3/3)	100 (9/9)	60 (3/5)	78.6 (11/14)
GI subepithelial lesions (n=7)	66.7 (4/6)	100 (1/1)	100 (4/4)	33 (1/3)	71.4 (5/7)
Intra-abdominal and mediastinal lesions (n=7)	100 (5/5)	100 (2/2)	100 (5/5)	100 (2/2)	100 (7/7)

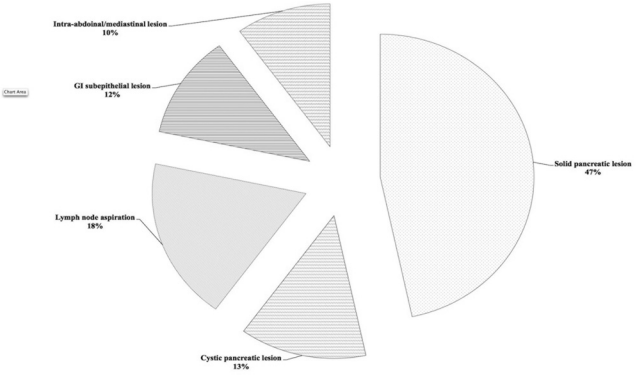

Figure 1. Types of lesion evaluated by EUS-FNA during the study period

Mo1171

Pancreatic Lesions Are More Common in Patients With Hepatitis C

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Introduction: Pancreatic cystic lesions are found in over 2% of patients undergoing abdominal imaging with computed tomography (CT) or magnetic resonance imaging (MRI). Up to 30% of the lesions may have malignant potential. About 3.2 million Americans are living with hepatitis C virus (HCV). HCV patients are frequently imaged and incidental lesions are often observed. HCV may increase the risk of non-hepatic malignancies. There are no studies to date that have investigated the incidence of pancreatic lesions in HCV patients compared to the general population. Methods: The EMR of our tertiary-care, academic center was queried for patients with HCV between January 2011 and October 2013 and a chart review was performed. Patients between 18 and 85 years old were included if they had an enhanced CT or MRI of the abdomen performed. Patients were excluded if they did not have an enhanced CT or MRI or had known pancreatic lesions. An age-matched control population was generated with the same inclusion and exclusion criteria. Information regarding age, sex, race, body mass index (BMI), alcohol use, tobacco use, history of diabetes, pancreatitis, imaging modality, chronic liver disease, cirrhosis, number and size of pancreatic cysts/masses, endoscopic ultrasound (EUS), fine needle aspiration (FNA), pancreatic surgery and final clinical diagnosis was collected. Adenocarcinomas were considered malignant lesions, mucinous neoplasms as pre-malignant, and pseudocysts/abscesses as inflammatory lesions. Results: In total, 1560 subjects were included (780 controls and 780 HCV subjects). The average ages of the HCV and control subjects were 56.4 and 55.3 years respectively (p= 0.065). There were more males in the HCV group compared to controls (67% vs. 44%, p= 0.0001). Of the 780 subjects with HCV, 39 (5%) had pancreatic lesions compared to 21 (2.7%) controls (p=0.025). There was a trend towards more pre-malignant/malignant lesions in the HCV group (1% vs. 0.5%, p=0.58). Diabetes was more common among HCV subjects with lesions than controls with lesions (44% vs. 10%, p=0.008). There were no differences between the two lesion groups in regards to age, sex, BMI, alcohol use, tobacco use, pancreatitis, imaging modality, type of pancreatic lesion, number and size of pancreatic cysts/masses, whether EUS, FNA or surgery was performed, the proportion of pre-malignant/ malignant lesions, and clinical diagnosis (Table 1). Conclusion: Our results demonstrate a statistically significant increased incidence of pancreatic lesions in HCV patients, with a relative risk nearly 2-times that of the control population (RR= 1.85). The increased risk could be related to the HCV itself, a combination of related factors or the fact that these patients undergo periodic cross-sectional imaging. Attention should be paid to the pancreas when imaging HCV patients.
Table 1