



coefficient 0.102; $P=0.04$). No significant correlations were found between AVVQ and the number of trunks affected (Spearman coefficient 0.085; $P=0.290$), or age (Spearman coefficient 0.082; $P=0.092$).

Conclusion: In a large cohort of CVD patients undergoing duplex ultrasound, no correlation between AVVQ and anatomical reflux was found, suggesting the presence of reflux alone is a poor surrogate marker for varicose vein patients' quality of life. Maximal vein diameter has limited utility. It is important to employ disease-specific quality of life tools in addition to imaging results.

1. Lattimer, C., Kalodiki, E., Azzam, M. and Geroulakos, G. (2013). The Aberdeen Varicose Vein Questionnaire May be the Preferred Method of Rationing Patients for Varicose Vein Surgery. *Angiology*, 65(3), pp.205-209.

P094 Adaptive technique - congenital cardiac MRI challenges

Jenny Corden-Jolly; Anne Davis

InHealth

Background: Over the past 20 years MRI has become increasingly important in the on-going management of congenital heart disease within the UK. The ability to image anomalies and disease for surgical planning or ongoing surveillance in greater detail, alongside Echocardiography, has reduced the incidence of open heart surgery and thereby improved outcomes and quality of life for patients. MRI is more widely accessible within the UK than ever before with mobile services providing a crucial role in increasing capacity and outreach services.

Purpose: This poster aims to demonstrate in detail the adaptive techniques used by Cardiac MRI Radiographers at InHealth to obtain high quality diagnostic images in patients with rare congenital disease and post-surgical intervention. These cases include patients who have undergone Senning and Mustard procedures for transposition of the great arteries, Tetralogy of Fallot repair, Fontan procedures and coarctation of the aorta repair. Anatomy can vary widely in patients with congenital heart disease, therefore the case reviews will be used to illustrate some of the common variants seen and how these may be approached technically to achieve desired image appearances for diagnosis and assessment to be made.

Summary: Not only must radiographers navigate the differing anatomical structures, they must also be conversant with related pathologies, adapting technique accordingly to ensure diagnostic efficacy. Although this can be technically challenging, it also proves to be incredibly rewarding.

GI & HEPATOBILIARY

P095 The evaluation of compliance with iRefer guidelines for abdominal imaging and the impact of the normal abdominal radiograph on the clinical confidence and decision making of emergency clinicians

Philip Mowlem¹; Agnes Gouveia¹; Jennifer Plinn¹; Maryann Hardy²

¹Poole Hospital NHS Foundation Trust; ²University of Bradford

Introduction: Attendance of adult patients to the Emergency Department (ED) with acute abdominal pain is a frequent event. Abdominal radiography (AXR) is commonly the first line of investigation but previous studies have suggested that the AXR has no place in assessing acute abdominal pain because of its low diagnostic yield and limited contribution to direct clinical decision making. However, no evaluation of the impact of a negative AXR on the clinical confidence and decision making of emergency clinicians has been undertaken. This study fills this gap.

Method: A self-designed paper questionnaire was distributed to medical clinicians on ED placement at a single NHS trust in Dorset. The survey sought to explore the impact of the negative AXR on clinical confidence and decision making and compliance with iRefer guidelines for referring to alternative imaging modalities (ultrasound and computed tomography) should the option to refer for AXR be removed.

Results: A total of 28 ($n=28/41;68.3\%$) completed questionnaires were returned. Most clinicians ($n=18/28; 64.3\%$) indicated that the negative AXR had little impact on their clinical decision making although a small majority ($n=10/18; 55.6\%$) acknowledged it provided greater clinical confidence in their decision making. Variable compliance with iRefer guidelines for referral to ultrasound and computed tomography was noted.

Conclusion: Whilst the negative AXR did not impact on the clinical decision making of most ED clinicians it did increase clinical confidence. Consequently, the AXR should remain a referral option in the workup for adult patients presenting with acute abdominal pain to the emergency department.

1. Blackmore C. Mecklenburg R. and Kaplan G. (2011). Effectiveness of Clinical Decision Support in Controlling Inappropriate Imaging. *J Am Coll Radiol*. 8(1) 19-25.
2. Dauer L. Thornton R. Hay J. Balter R. Williamson M. and St. Germain J. (2011). Fears Feelings and Facts: Interactively Communicating Benefits and Risks of Medical Radiation with Patients. *AJR Am J Roentgenol*. 196(4) 756-761.
3. Flood R. Strugnell M. and Moritz G. (2016). iRefer; are abdominal X-ray guidelines being followed? *Clin Radiol*. 71 S11-S25.
4. Gangadhar K. Kielar A. Dighe M. O'Malley R. Wang C. Gross J. Itani M. and Lalwani N. (2015). Multimodality approach for imaging of non-traumatic acute abdominal emergencies. *Abdom Radiol*. 41(1) 136-148.
5. Gans S. Pols M. Stoker J. and Boermeester M. (2015). Guideline for the Diagnostic Pathway in Patients with Acute Abdominal Pain. *Dig Surg*. 32 23-31.
6. Gans S. Pols M. Stoker J. and Boermeester M. (2012). Plain abdominal radiography in acute abdominal pain; past present and future. *Int J Gen Med*. 5 525-533.
7. Hughes C. Kramer E. Colamonic J. and Duszak Jr R. (2015). Perspectives on the Value of Advanced Medical Imaging: A National Survey of Primary Care



Physicians. *J Am Coll Radiol.* **12** 458-462

8. Laméris W. van Randen A. Wouter van Es H. van Heesewijk J. van Ramshorst B. Bouma W. ten Hove W. van Leeuwen M. van Keulen E. Dijkgraaf M. Bossuyt P. Boermeester M. and Stoker J. on behalf of the OPTIMA study group. (2009). Imaging strategies for detection of urgent conditions in patients with acute abdominal pain: diagnostic accuracy study. *BMJ.* **339**b2431.

9. Meyer A. Payne V. Meeks D. Rao R. and Singh H. (2013). Physicians' Diagnostic Accuracy Confidence and Resource Requests. *JAMA Intern Med.* **173**(21) 1952-1959.

10. Microsoft Excel (2016) Redmond: Microsoft.

11. Morris-Stiff G. Stiff R. and Morris-Stiff H. (2006). Abdominal radiograph requesting in the setting of acute abdominal pain: temporal trends and appropriateness of requesting. *Ann R Coll Surg Engl.* **88** 270-274.

12. Smith J. and Hall E. (2009). The use of plain abdominal x rays in the emergency department. *Emerg Med J.* **26** 160-163.

13. Snaith B. and Hardy M. (2013). The perceived impact of an emergency department immediate reporting service: An exploratory survey. *Radiography.* **19**(2) 92-96.

14. Sreedharan S. Fiorentino M. and Sinha S. (2014). Plain abdominal radiography in acute abdominal pain—is it really necessary? *Emerg Radiol.* **21** 597–603.

15. The Royal College of Radiologists (2017). RCR iRefer Guidelines: Making the best use of clinical radiology 8th Ed. London: The Royal College of Radiologists.

16. The Royal College of Radiologists (2012). RCR iRefer Guidelines: Making the best use of clinical radiology 7th Ed. London: The Royal College of Radiologists.

17. van Randen A. Laméris W. Luitse J. Gorzeman M. Hesselink E. Dennis E. Dolmans G. Peringa J. van Geloven A. Bossuyt P. Stoker J. and Boermeester M. on behalf of the OPTIMA study group. (2011). The role of plain radiographs in patients with acute abdominal pain at the ED. *Am J Emerg Med.* **29** 582–589.e2.

18. Zeina A. Shapira-Rootman M. Mahamid A. Ashkar J. Abu-Mouch S. and Nachtigal A. (2015). Role of Plain Abdominal Radiographs in the Evaluation of Patients with Non-Traumatic Abdominal Pain. *IMAJ.* **17** 678-681.

P096 CT Colonography: Should we use it for polyp surveillance?

Meghavi Mashar; *Horace D'Costa*

Oxford University Hospitals NHS Foundation Trust

Background: Colorectal cancer is the third most common cancer and polyps are known to be precursors up to 10 years prior. CT colonography (CTC) has high sensitivity for colorectal carcinoma (83-100%), but size dependent specificity for polyps (59-100%). It claims to be as accurate as colonoscopy for polyps >8mm and highlight extra-colonic findings. We aimed to characterise the sensitivity of CTC.

Method: A retrospective analysis of 97 patients who had CTCs, analysed by a single operator over 2016-2017. Colonoscopy findings were the comparative gold standard. 79 patients had both CTC and colonoscopy.

Results: Referrals for CTC were most commonly due to change in bowel habit (44%) and anaemia (24%).

10% of colonoscopy referrals were due to an abnormal CTC. CTC had 100% sensitivity for malignancy (2/2). Where documented (36/79), polyps were >5mm (17/34), 6-9mm (10/34) and >10mm (7/34). CTC showed 76% (13/17) sensitivity and 90% specificity (56/62). All 4 false negatives on CTC had polyps 4-7mm. 50% of CTCs showed extra-colonic findings: herniae (21%), gallstones (15%), and 1 possible lymphoma.

Conclusion: Patients were appropriately referred for CTC as per RCR guidelines and we had a 100% malignancy detection rate. 50% of our cohort had at least 1 extra-colonic finding. Our sensitivities and specificities are within documented ranges for polyps 2-25mm. All false negatives were for polyps 4-7mm. Polyps <5mm are diminutive and CTC sensitivity is as low as 65%. Given the accuracy of CTC demonstrated, it confirms the use of CTC for malignancy detection and possible detection of large polyps.

P097 Patient anxiety prior to initial CT examination to investigate malignancy: The influence of patient demographics

Craig Roe¹; *Maryann Hardy*²

¹Leeds Teaching Hospitals NHS Trust; ²University of Bradford

Background: It is believed that patients experience anxiety prior to first time CT examination. However, as no published literature regarding patient anxiety prior to radiological examination in the UK has been identified, statements about patient anxiety are based on supposition rather than research evidence. This study aimed to address this evidence gap.

Methods: This study was undertaken at a large teaching hospital Trust in the North of England. Any adult patient who had not previously experienced a CT examination and who had been referred for CT Colonography or an Abdomen/Pelvis scan (single, dual or triple phase) was eligible to participate. A sample size of 60 (30 in each group) was calculated. A study pack was sent to all eligible patients and participating patients completed the validated State-Trait Anxiety Inventory (STAI) questionnaire immediately prior to CT examination. HRA ethical approval was received (16.LO.2211).

Results: Patients were recruited between March and October 2017. Systematic differences in the age and gender were noted between groups with patients in CT Colonography group more likely to be older and female. Acknowledging these differences, STAI analysis indicated that anxiety measures across both groups were greatest in females, elderly (over 65 years) and in those attending for CT Colonography.

Discussion: This is the first study to explore patient anxiety prior to CT examination using a validated anxiety measurement tool. The findings confirm that patients do experience anxiety prior to CT examination but that this anxiety is not consistent across patient examination, gender or age groups.

Mikocka-Walus, A. A., Moulds, L. G., Rollbusch, N. and Andrews, J. M. (2012) "'It's a tube up your bottom; it makes people nervous": the experience of anxiety in initial colonoscopy patients', *Gastroenterology Nursing: The Official Journal of The Society of Gastroenterology Nurses and Associates.* Vol 35(6), pp. 392-40.

Spielberger, C. D., Gorsuch, R. L., Lushene, R., Vagg, P. R., & Jacobs, G. A. (1983). *Manual for the State-Trait Anxiety Inventory.* Palo Alto, CA: Consulting Psychologists Press.



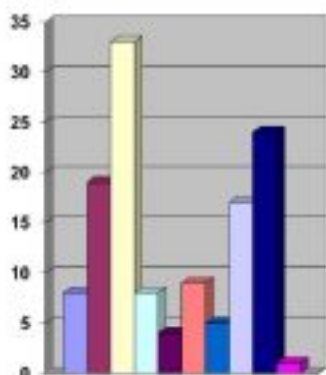
P098 Local accuracy of CT colonography for colon cancer staging: Comparison with the histopathology report

Michael Smith; Christopher Marsh; Ingrid Britton

University Hospital of North Midlands

CT Colonography (CTC) is the imaging examination of choice for patients with a broad range of colorectal symptoms, with a high sensitivity and specificity. When colorectal cancer (CRC) is suspected on CTC, TNM (tumour, node, metastasis) staging is now routinely reported in order to assess patient suitability for prospective treatment planning, including surgery and trial participation. The aim of this study was to assess radiology reported tumour and nodal (TN) staging on CTC and compare this with histopathology reports. We already know that CT is very accurate when assessing metastatic distant spread. Previous studies suggest that on CT, tumour staging is variable and nodal staging is inaccurate (Andersen et al, 2011, da Fonte et al, 2012, Fillipone et al, 2004, Leufkens et al, 2011). No national standards are available.

A search was conducted on the local radiology information system (CRIS), from 2014-2016, for all patients undergoing CTC examination and having a subsequent or known diagnosis of CRC. Each report was then reviewed for TN staging, and the accuracy evaluated against the final histopathology report. All assessments of TNM staging were performed without any prior knowledge of histopathological staging. TNM 7th, 6th and 5th editions were used for histology staging therefore any sub-stages were removed from the final evaluation. Main recommendation is that all T & N-staging on CTC is undertaken using MPR. Poster will consist of images and tables to demonstrate methods and results.



Andersen, E.M., Betts, M. & Slater, A. (2011). The value of true axial imaging for CT staging of colonic cancer. *European Radiology*, 21(6), pp 1286-1292. da Fonte, A.C., Chojniak, R., de Oliveira Ferreira, F., Pinto, P.N, dos Santos Neto, P.j. & Bitencourt, A.G. (2012). Inclusion of computed tomographic colonography on pre-operative CT for patients with colorectal cancer 2012. *European Journal of Radiology*, 81(3), pp 298-303. Fillipone, A., Ambrosini, R., Fuschì, M., Marinelli, T., Genovesi, D. & Bonomo, L. (2004). Preoperative T and N Staging of Colorectal Cancer: Accuracy of contrast-enhanced multi-detector row CT colonography—initial experience. *Radiology*, 231(1)pp 83-90. Epub Leufkens A.M., van den Bosch M.A., van Leeuwen M.S. & Siersema P.D. (2011). Diagnostic accuracy of computed tomography for colon cancer staging: a systematic review, *Scandinavian Journal of Gastroenterology*, 46(7-8), pp 887-94.

P099 The who's who of groin hernias

Maged Mestrah; Jane Belfield

Royal Liverpool University Hospital

Background: CT has historically played a minor role in differentiating between groin hernias, but the introduction of higher-resolution multidetector computed tomography has allowed radiologists to more accurately delineate the minute anatomical relations of these hernias that was previously not possible through imaging techniques alone. Correctly identifying the type of presenting groin hernia plays a major role in the patients' risk stratification, management plan and, if required, surgical approach; hence a methodical approach to an accurate diagnosis is vital.

Purpose: To be able to correctly identify different types of groin hernias using the relevant pelvic anatomy on cross sectional imaging.

Summary:

- Introduction including a brief overview of the different management plans for each hernia
- Radiological anatomy of the inguinal region, femoral canal and relevant surrounding structures with illustrations and cross sectional imaging examples
- Direct inguinal, indirect inguinal and femoral hernia characteristics on cross sectional imaging with cross-sectional imaging examples containing overlays for clarification.

P100 Hepatic haemangioma and 18FDG PETCT: Case study

Peter Strouhal; Arash Bakhtyari

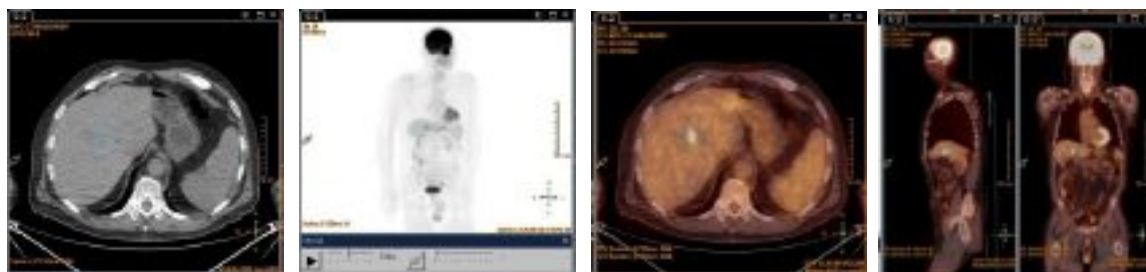
Royal Wolverhampton NHS Trust

Background: PETCT imaging has become commonplace, not least as problem solving tool for liver lesions identified on conventional imaging. Whilst malignant lesions usually show increased 18FDG avidity, some benign entities can also. Correlation



with prior imaging and clinical background are vital in correct interpretation of focal hepatic uptake. Case reports have previously described increased 18FDG uptake in FNH and hepatic adenoma, and even circumferentially around cavernous haemangioma, but there have been no recent publications highlighting hepatic haemangioma doing the same. Indeed, older papers typically described hepatic haemangioma as showing poor FDG uptake (SUVmax of less than 2). This patient with lymphoma recurrence in paranasal sinuses and spleen (with splenomegaly) was referred for restaging baseline PETCT; disease recurrence confirmed on PETCT along with focal hepatic uptake - corresponding to known haemangioma that had been previously well characterised on serial CT (over 10 years) and also on more recent MR; but not apparent on low dose CT as part of PETCT. This lesion was unchanged on follow-up PETCT while lymphoma showed complete response.

Purpose/summary: Highlights that haemangioma is a possible albeit rarer cause of focal hepatic uptake but which should still be part of the differential, as well as commoner causes such as malignant lesions (primary, metastasis, focal lymphoma) and other benign entities like FNH and adenoma.



1. Luk WH et al (2013). Imaging pattern of liver uptakes on PET scan: pearls and pitfalls. Nucl Med Review 16; 2; 75-81
2. Shimada K et al (2010). FDG PET for giant cavernous haemangioma: important clue to differentiate from malignant vascular tumor in the liver. Clin Nucl Med 35; 12; 924-6.
3. Sollaku S et al (2017). The rare case of positive FDG-PET for giant cavernous haemangioma of the liver. Brit J Res 4; 3; 19 4.
4. Shen Tan GJ et al (2014). FDG PET/CT in the liver: lesions mimicking malignancies. Abdominal Imaging 39; 1; 198-195.

P101 Anorectal melanoma - a rare cause of rectal bleeding

Priya Agarwal; *Grazvydas Gaikstas*

Pennine Acute Trust

Background: Primary malignant anorectal melanoma is an extremely rare malignancy constituting to 1% of all malignant melanomas and less than 0.5% of all colorectal malignancies. Due to its rarity and non-specific presentation it is often misdiagnosed as a haemorrhoid or polyp.

Purpose: We present an 81-year-old man with a solitary symptom of rectal bleeding post defecation. Colonoscopy revealed a 40mm malignant looking polypoid lesion in the distal rectum close to the anal verge. Biopsies were taken with histopathology results showing an ulcerated poorly differentiated tumour, with partial covering of anal squamous epithelium and focal brown pigment. The tumour was positive for HMB45, S100 and Melan- A and negative for CEA, CDX2, p63, CK5/6, Cam5.2, AE1/3, confirming malignant melanoma. Computed Tomography (CT) scan showed a rectal lesion with no signs of distant tumour spread. Magnetic Resonance Imaging (MRI) showed T2 intermediate signal intensity lesion with restricted diffusion on diffusion weighted (DW) images, radiological staging T2 N0 M0. The patient was listed for abdomino-perineal resection and consideration for adjuvant chemotherapy.

Summary: Malignant anorectal melanoma provides diagnostic confusion due to its rarity, non-specific symptoms and amelanotic histological appearance as seen in 80% of cases. Therefore, 60% of cases will present with metastatic disease. This highlights the need for accurate imaging to assess disease extent for management and prognostic purposes. Studies have proven 18F-FDG-PET/CT's superiority in diagnostic accuracy in assessing for metastatic disease, and the importance of MRI scans in assessing tumour size and invasion into local tissue, with comparison to CT.

1. Bello, D.M. and Smyth, E. Anal versus rectal melanoma: does site of origin predict outcome? Diseases of the colon and rectum (2013) 56(2): 150-157
2. Falch, C. and Mueller, S et al. Anorectal malignant melanoma: curative abdominoperineal resection: patient selection with 18F-FDG-PET-CT. World Journal of Surgical Oncology (2016) 14 (185)
3. Ferguson, H.J.M. Nandi, S. Hejmadi, R.K. and Ismail, H.T. A pilot study of extralevator abdominoperineal excision for primary melanoma of the anorectum. Techniques in coloproctology (2014) 18(11): 1113-1116
4. Horvat, C.M. and Rady, P.M. et al Prospective comparison of the impact of treatment decisions of whole-body magnetic resonance imaging and computed tomography in patients with metastatic malignant melanoma. European Journal of Cancer (2006) 42(3): 342-350
5. Kohli, S. and Narang, S. et al. Malignant melanoma of the rectum. Journal of Clinical Imaging Science (2014) 4(4)
6. Pfannenberg, C. and Aschoff, P et al. Prospective comparison of 18F- fluorodeoxyglucose positron emission tomography/ computed tomography and whole-body magnetic resonance imaging in staging of advanced malignant melanoma. European Journal of Cancer (2007) 43(3): 557-564
7. Puryoko, A.S. and Coppa, C.F. et al Benign and malignant tumours of the rectum and perirectal region. Abdominal imaging (2014) 39(4): 824-852
8. Sahoo, M.R. Gowda, M.S. Kaladagi, R.M. Primary amelanotic melanoma of the rectum mimicking adenocarcinoma. The American journal of case reports. (2013) 14: 280-283.
9. Schüle, S.C. Eigentler, T.K. et al. Influence of 18F-FDG PET/CT on therapy management in patients with stage III/IV malignant melanoma. European journal of nuclear medicine and molecular imaging. (2016) 43(3): 482-488
10. Tomioka, K. and Ojima, H. et al. Primary malignant melanoma of the rectum: report of two cases. Case reports in surgery (2012) 2012 Article ID 247348
11. Yeh, JJ. and Shia, J et al. The role of abdominoperineal resection as surgery therapy for anorectal melanoma. Annals of Surgery (2006) 244(6): 1012-1017



P102 Early low rectal tumour staging - a multi-modal pictorial review

Carl Bradbury; Ingrid Britton

Univeristy Hospitals of North Midlands

Early low rectal cancers prove difficult to provide accurate Radiological staging. The prognosis of low rectal tumours is different to that for higher tumours (Taylor et al, 2008). Surgical improvements have generally been made for both mid and upper rectal cancers; whereas low rectal lesions have been treated by abdominoperineal excision; which leads to high morbidity and permanent stoma (Christensen et al, 2011). There is a surgical challenge of ensuring a clear resection margin whilst attempting to maintain the anal sphincters (Weiser et al, 2009 & Rullier et al, 2013). Considering this, the provision of accurate information about the location and extent of the rectal tumour is essential for optimising the resection and retaining the anal sphincter function; low rectal cancer management proves an exceptional challenge due to the poor oncological outcomes and permanent stoma rates (Battersby et al, 2016); hence accurate radiological staging is of utmost importance to guide the appropriate management.

The poster will present high quality MRI, endo-rectal ultrasound images, histology slides and endoscopic appearances of a variety T0, T1, T2 rectal tumours staged using the MINSTREL proforma (MINSTREL, 2016). The images will be presented in rows for each of the tumour stages detailed above and each slice of the multi-modal imaging/investigations will correspond to demonstrate the stage of the tumour. Each rectal cancer T stage example will be gold standard verified through the histology report. The poster will be presented as a cross-modality and cross-speciality teaching atlas; of verified low rectal cancer cases.

Battersby, N.J., How, P., Moran, B., Stelzner, S., West, N.P., Branagan, G., Strassburg, J., Quirke, P., Tekkis, P., Pedersen, B.G. and Gudgeon, M., 2016. Prospective validation of a low rectal cancer magnetic resonance imaging staging system and development of a local recurrence risk stratification model: the MERCURY II study. *Annals of surgery*, 263(4), pp.751-760. Christensen, H.K., Nerstrøm, P., Tei, T. and Laurberg, S., 2011. Perineal repair after extralevator abdominoperineal excision for low rectal cancer. *Diseases of the Colon & Rectum*, 54(6), pp.711-717. MINSTREL (2016). MINSTREL CRF. Retrieved: <http://minstrelstudy.co.uk/downloads/study-crf-v2.pdf> accessed at 08.30am on 19/10/2017. Rullier, E., Denost, Q., Vendrely, V., Rullier, A. and Laurent, C., 2013. Low rectal cancer: classification and standardization of surgery. *Diseases of the Colon & Rectum*, 56(5), pp.560-567. Taylor, F. G., Swift, R. I., Blomqvist, L., & Brown, G. (2008). A systematic approach to the interpretation of preoperative staging MRI for rectal cancer. *American Journal of Roentgenology*, 191(6), 1827-1835. Weiser, M. R., Quah, H. M., Shia, J., Guillem, J. G., Paty, P. B., Temple, L. K., ... & Wong, W. D. (2009). Sphincter preservation in low rectal cancer is facilitated by preoperative chemoradiation and intersphincteric dissection. *Annals of surgery*, 249(2), 236-242.

P103 The cascade stomach revisited in the 21st century - what has changed?

Carl Bradbury; Nagammapudur Balaji

University Hospitals North Midlands

Background: Routine audit highlights discordance between the endoscopic appearances and the barium meal appearances of the presence or absence of a hiatal hernia. One area of disagreement is defining the appearance of a cup and spill stomach versus the presence of a hiatal hernia. Literature identifies a cup and spill stomach as the variant of the shape and topography of the stomach; cited often as a Radiological feature (Burdan et al, 2012). A cascade stomach is thought to be associated with symptoms of dyspepsia; with the shape of the stomach a risk factor (Miwa et al, 2015) and association of cascade stomach with Oesophageal reflux has been identified in previous studies (Kusano et al, 2012; Kusano et al, 2016); thus there is a close correlation of the symptomology of hiatal hernia and a variance in the topography of the stomach.

Purpose: To highlight the variances in topography of the stomach, a cross-modality pictorial review will demonstrate barium meal, CT and endoscopic features which may account for the false positive presence of a hiatal hernia during endoscopic evaluation.

Content: A small audit of Barium meal examinations which suggest the presence of a cup and spill stomach will be co-presented with the pictorial review. Summative findings explain that varying configurations of the cascade configuration (Classic, Reverse, Antral) may warrant a revised radiological classification of this uncommon but interesting anatomical variant of the stomach configuration. Endoscopic diagnosis of large hiatus hernia should be correlated with fluoroscopy to exclude a variance in topography.

1. Burdan, F., Rozylo-Kalinowska, I., Szumilo, J., Zinkiewicz, K., Dworzanski, W., Krupski, W. and Dabrowski, A., 2012. Anatomical classification of the shape and topography of the stomach. *Surgical and radiologic anatomy*, 34(2), pp.171-178. 2. Kusano, M., Hosaka, H., Moki, H., Shimoyama, Y., Kawamura, O., Kuribayashi, S., Mori, M. and Akuzawa, M., 2012. Cascade stomach is associated with upper gastrointestinal symptoms: a population-based study. *Neurogastroenterology & Motility*, 24(5), pp.451-455. 3. Kusano, M., Hosaka, H., Yasuoka, H., Kawamura, O., Kawada, A., Kuribayashi, S., Shimoyama, Y., Mizuide, M., Tomizawa, T., Ishihara, S. and Sagawa, T., 2016. New endoscopic classification of cascade stomach, a risk factor for reflux esophagitis. *Journal of gastroenterology*, pp.1-7.

URORADIOLOGY/GYNAECOLOGY/OBSTETRICS

P104 A review of genitourinary fluoroscopic studies

Michelle Ooi; Alistair Cowie; Syahminan Suut

Salford Royal Foundation Trust

Introduction: Fluoroscopy has evolved from the early days of poor quality images on fluoroscopic screen requiring dark radiography room and red goggles for eye adaptation. It has improved substantially in our modern world both in quality and speed of image processing. It seems to be superseded in many respects especially by computed tomography (CT) scan, eg: CT