

accounting for confounding factors such as overlying bowel gas or stone size. In our study, approximately one third of patients with CBDS did not have a dilated CBD on US (diameter ≤ 6 mm). Moreover, due to spectrum bias it is likely that the true sensitivity of US in the wider population is much lower. By contrast, the performance of both CT and MRCP was more comparable with published data. Whereas our findings may relate specifically to the performance of US in our unit, a larger study continues to determine if the sample size has contributed to our findings.

PTH-115 TREATMENT OF GASTRIC FUNDAL VARICES WITH EUS GUIDED EMBOLISATION COMBINING COIL PLACEMENT WITH THROMBIN INJECTION

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Introduction Gastric varices are present in 5%–33% of patients with portal hypertension with incidence of bleeding of around 25% in 2 years.¹ If gastric varices are identified as the source of bleeding, therapeutic options include endoscopic Methods, TIPSS, surgery and non-selective beta blockade.² There are reports of EUS guided coiling combined with cyanoacrylate glue³ but limited literature on safety and efficacy of EUS guided coil embolisation with human thrombin injection. We report our experience.

Methods We analysed data of all EUS guided interventions for the management of bleeding gastric varices between 2015–2017 at a liver transplant centre. Olympus EUS linear scope was used to inject human thrombin (Tisseel; 500IU/ML) in gastric varices with or without coils (Nester Embolization Coils).

Results A total of 10 EUS guided interventions in 6 patients (4 M and 2 F), aged 55 (41–59) yrs for secondary prophylaxis. 67% patients had cirrhosis with MELD score of 14(10–21) and 75% were Child-Pugh class C. The remainder had non-cirrhotic portal hypertension. All patients had previous bleeding from gastric varices and 2/3rd were intolerant of beta-blockers. 67% had previous thrombin injection that had failed to obliterate the gastric varices. EUS guided coil embolisation was undertaken with thrombin injection in 6, and thrombin alone in 4 (2 had previous coils embolisation). The largest feeding vessel was 12(7–16) mm with a median 5 (2–10) coils placement followed by thrombin injection of 3500 (2500–5000) IU.

Most (8/10) stayed overnight after intervention and only 2 required longer stays, Median F/U was 9 (3–20) months with zero 30 day mortality. 1 patient had fever 2 days post procedure requiring IV antibiotics. No reported episodes of re-bleeding except in 1 patient at 23 months. 4 had follow up EUS (5–7 months) and showed no flow at the level of the coils. 1 patient died within 3 months of procedure secondary to hepatic decompensation.

Conclusions In our experience EUS guided coil embolisation and injection of thrombin, is a technically safe and well-tolerated procedure even in patients with advanced liver disease especially who have failed eradication of gastric varices from

single modality therapy. Due to the lower incidence of gastric variceal bleeding in comparison to oesophageal varices bleeding, we recommend multi-centre prospective data collection evaluating the modalities being used and reporting of outcomes to help inform national guidelines.

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Oesophagus and Gastroduodenal

OTU-010 VITAMIN D RECEPTOR AS A MARKER OF PROGNOSIS IN OESOPHAGEAL ADENOCARCINOMA: A PROSPECTIVE COHORT STUDY

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Background Vitamin D receptor (VDR) expression has been associated with survival in several cancers. This study aims to evaluate the association between VDR expression and prognosis in oesophageal adenocarcinoma patients.

Methods The study included 130 oesophageal adenocarcinoma patients who underwent neo-adjuvant chemotherapy and surgery at the Northern Ireland Cancer Centre between 2004 and 2012. Formalin fixed paraffin embedded (FFPE) resection specimens and matched clinical data were retrieved via the Northern Ireland Biobank. Tissue microarrays (TMAs) were created and VDR immunohistochemical analysis performed on triplicate 1 mm tumour cores from each block. Immunohistochemical VDR expression was assessed by two independent observers, blinded to the clinical data, by multiplying the staining intensity with the percentage of tumour cells staining positive for VDR, to give an H-score between 1 and 300. Comparison between maximum VDR expression and prognosis was calculated using Cox proportional hazards regression models adjusted for age, gender, nodal status, circumferential resection margin, lymphovascular invasion, smoking status and tumour location. Outcomes studied included overall survival, disease specific survival and recurrence free survival.

Results During a mean of 3 (range 0.5–9) years of follow-up, 75 patients died. In analysis adjusted for confounders, higher VDR expression was associated with an improved overall survival (HR 0.49 95% CI 0.26–0.94) and disease-specific survival (HR 0.50 95% CI 0.26–0.96), when comparing the highest with the lowest tertile of expression. These associations were strongest in sensitivity analysis restricted to junctional tumours.

Conclusions This study is the first to demonstrate that patients with higher VDR expression in oesophageal adenocarcinoma have a more favourable prognosis. This study identifies VDR expression as a potential prognostic indicator although further work is needed to validate VDR as a prognostic marker and define its role in the aetiology and progression of oesophageal adenocarcinoma.

OTU-012 A MODEL FOR IDENTIFYING INDIVIDUALS AT RISK OF ESOPHAGEAL ADENOCARCINOMA WITHIN THE UK BIOBANK

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Introduction The prognosis for most patients with esophageal adenocarcinoma (EAC) is poor because they present with advanced disease. Models developed to identify patients at risk for EAC and increase early detection have been developed based on data from case-control studies. We analysed data from a prospective study to identify factors available to clinicians that identify individuals with a high absolute risk of EAC.

Methods We collected data from 3 55 034 individuals (all older than 50 years) without a prior history of cancer enrolled in the UK Biobank prospective cohort study from 2006 through 2010; clinical data were collected through September 2014. We identified demographic, lifestyle, and medical factors, measured at baseline, that associated with development of EAC within 5 years using logistic regression analysis. We used these data to create a model to identify individuals at risk for EAC. Model performance was assessed using area under the receiver operating characteristics curve (AUROC), sensitivity, and specificity analyses.

Results Within up to 5 years of follow up, 220 individuals developed EAC. Age, sex, smoking, body mass index, and history of esophageal conditions or treatments identified individuals who developed EAC (AUROC, 0.80; 95% CI, 0.77–0.82). We used these factors to develop a scoring system and identified a point cut off that 1 04 723 individuals (29.5%), including 170 of the 220 cases with EAC, were above. The scoring system identified individuals who developed EAC with 77.4% sensitivity and 70.5% specificity. The 5 year risk of EAC was 0.16% for individuals with scores above the threshold and 0.02% for individuals with scores below the threshold.

Conclusions We combined data on several well-established risk factors that are available to clinicians to develop a system to identify individuals with a higher absolute risk of EAC within 5 years. Studies are needed to evaluate the utility of these factors in a multi-stage, triaged, screening program.

OTU-013 OUTCOMES OF 360 HALO EXPRESS RADIO-FREQUENCY ABLATION FOR BARRETT'S OESOPHAGUS RELATED NEOPLASIA

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Introduction Radio-frequency ablation (RFA) for the treatment of Barrett's oesophagus (BE) related neoplasia ablative intervention after endoscopic resection (ER)For circumferential BE, the 3 cm HALO 360

balloon used to treat large areas. A new device, the HALO 360 Express self-sizing catheter was recently launched and can potentially allow quicker ablation times and better coverage of the mucosa due to the improved tissue/catheter contact and 4 cm balloon length. We have previously presented initial data of 3 month follow up in these patients but now present more extensive data including end of treatment biopsies.

Method Specialist centres in the UK and Ireland submitted cases where Halo 360 express had been used. Patients returned for follow up at 3 months after index RFA express treatment. surface area regression of BE regression of intestinal metaplasia (EoT (End of Treatment) CR-IM) and dysplasia (EoT CR-D) were analysed.[MDP1]

Results 11 centres submitted 123 patients treated with the HALO 360 Express catheter. 112 of these cases had 3 month follow up. The mean age was 67 years±10. 83% were male. 43 patients (35%) had low grade dysplasia (LGD) as initial histology; 62 had high grade dysplasia (HGD) 50%, 19 had intramucosal carcinoma (15%), 1 had invasive adenocarcinoma. 54 (44%) had had previous endoscopic mucosal resection (EMR).The mean pre-treatment circumferential Barrett's segment was 5.5 cm ±4.3 cm and the mean mucosal length (M) was 7.8 cm ±3.6 cm mean% reduction in C of 78% ±36% and mean reduction in M of 55%±36% at this first 3 month follow up.

17 patients developed strictures which required dilation at this 3 month follow up. The median number of dilations was 2 (IQR2–4). 4/17 (24%) were treated with 12J/no clean, 10/17 were treated with 10J/no clean (59%), 3/17 (17%) had been treated with 10J/clean protocol. 8/17 (47%) had had previous EMR.

47 patients had 12 month EoT biopsies, 40 (85%) had CR-D and 34 (76%) had CR-IM. 4/112 patients (<4%) had progressed to invasive cancer at the time of writing. The median number of treatments (focal RFA, EMR, APC (argon plasma coagulation)) to EoT was 2(IQR1–4)

Conclusions The HALO 360 Express catheter shows good reduction in C and M length at 3 months, and effective eradication of IM and Dysplasia in those at 12 months. However, as previously reported by us the stricture rate is high

OTU-015 THE ACCURACY AND TOLERABILITY OF MAGNET ASSISTED CAPSULE ENDOSCOPY FOR THE INVESTIGATION OF OESOPHAGEAL PATHOLOGY

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Introduction Gastroscopy (OGD) is the established method for the investigation of oesophageal disease. Magnet Assisted Capsule Endoscopy (MACE) potentially offers a comfortable, patient friendly and community-based alternative to conventional endoscopy. This pilot study aims to explore whether this approach can be used to detect oesophageal pathology.

Methods MACE procedures were carried out using the Mirocam Navi capsule endoscope, which is steerable with the use of an external handheld magnet. A total of 50 participants

were enrolled, of which 34 had known pathology, 17 Barrett's Oesophagus (BO), 17 Oesophageal Varices (OV), with 16 controls. Patients underwent the MACE procedure first by a single operator blinded to the indication. The subsequent OGD was performed by a different endoscopist blinded to the MACE findings. Sedation pre-OGD was given as per patient preference. Diagnostic yield, comfort and patient preference between the two modalities were compared.

Results 47 patients undertook both procedures (3 patients were unable to swallow the capsule), with a mean age of 61 years old (range 39–83), M:F of 2.1:1. Participants had a mean BMI of 29.5, with an average chest measurement of 105.3 cms. Three patients were unable to swallow the capsule. Sedation was requested by patients, in addition to throat spray, in 60% of OGDs (median 3 mg midazolam and 50 mcg fentanyl). With the use of the magnet, it was possible to hold the capsule in the oesophagus for a mean duration of 3 mins and 10 s and a maximum of 10 mins and 34 s. A correct real time MACE diagnosis was made in 11/15 patients with OV, 16/16 patients with BO and 15/16 controls. MACE was also able to correctly identify incidental findings, such as oesophagitis, hiatus hernia and as well as an inlet patch. Sensitivity and specificity of diagnosing OV was 73.3% (95%CI: 0.45–0.91) and 96.9% (95%CI: 0.82–1) respectively and in diagnosing BO 100% (95%CI: 0.76–1) and 100% (95%CI: 0.86–1).

MACE was considered more comfortable than conventional endoscopy ($p < 0.0001$) with a mean score of 9.2 with MACE compared to 6.7 with OGD, when assessed on a 10-point scale. 78% of patients would prefer to undergo MACE if a further examination was required compared to 0% OGD (22% had no preference). No MACE or OGD related complications occurred.

Conclusion This pilot study demonstrates that MACE is both safe and well tolerated by patients. Accuracy for the diagnosis of BO was high and may therefore have a role in screening for this condition.

OTU-016 TIMELINE AND LOCATION OF RECURRENCE FOLLOWING SUCCESSFUL ABLATION IN BARRETT'S OESOPHAGUS: AN INTERNATIONAL MULTICENTRE STUDY

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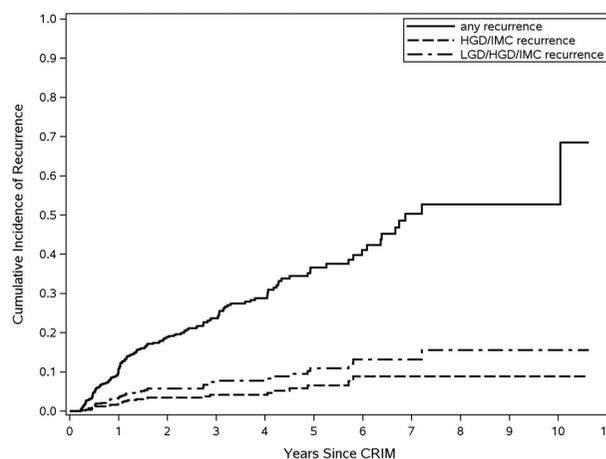
Introduction Surveillance intervals and biopsy protocols after complete remission of intestinal metaplasia (CRIM) post radio-frequency ablation (RFA) in Barrett's oesophagus (BO) are intensive and not based on substantial evidence. We aimed to assess the timeline, location, and histology of recurrence following CRIM with the goal of assessing the appropriateness of current recommendations.

Methods Data on patients undergoing RFA for BO-related neoplasia were obtained from prospectively maintained databases of five (3 USA and 2 UK) tertiary referral centres with

expertise in management of BO-related neoplasia. Patients underwent RFA following endoscopic mucosal resection (EMR) of visible lesions. RFA was performed every three months till CRIM was confirmed endoscopically and histologically on two consecutive endoscopies. Subsequent surveillance was performed at 3, 6, 9, and 12 months thereafter. Recurrence incidence was estimated using Kaplan-Meier method and Cox Proportional Hazards models were used to assess predictors of recurrence.

Results 594 patients achieved CRIM as of April 1st 2017 and were included in the analysis. Mean (standard deviation (SD)) age was 67 (10) years and 86% were males. Median (interquartile range (IQR)) BO segment length was 4 (2–6) cm. 90% of patients were treated for dysplasia or carcinoma. 151 subjects developed recurrent BO over a median (IQR) follow up of 2.8 (1.4–4.4) years. BO recurred at the gastroesophageal junction (GOJ) in 67% of subjects and in the tubular oesophagus in 33%. 84% of BO recurrences in the tubular oesophagus occurred within 5 cm of the GOJ. Histology of recurrences included cancer (9%), high grade dysplasia (HGD) (8%), low grade dysplasia (LGD) (12%), indefinite for dysplasia (2%) and non-dysplastic BO (69%). Annual incidence of any recurrence was 9.6%, dysplastic (LGD/HGD/cancer) recurrence was 2.8% and HGD/Cancer recurrence was 1.6%. The recurrence hazard rate did not vary over the follow-up ($p = 0.74$) with 19% risk within 2 years and an additional 49% risk over the next 8.6 years. Recurrence hazard rate of any dysplasia and HGD/Cancer while lower, also did not vary over the duration of follow up ($p = 0.94$ and $p = 0.88$, respectively) (Figure 1). In a multivariable model, baseline HGD/cancer predicted recurrence (hazard ratio 1.9, 95% CI 1.2–3.1, $p = 0.004$).

Conclusions In this large multicentre and international cohort study, BO recurrence risk (at least in the first 5 years following CRIM) did not appear to vary over time suggesting that continued surveillance remains important. Most recurrences appear to occur at the GOJ or distal 5 cm of the oesophagus. Sampling the GOJ and the distal 5 cm of the oesophagus in the absence of visible lesions may be adequate for surveillance.



Abstract OTU-016 Figure 1 The timeline of recurrent BO (overall; dysplastic; and HGD/cancer) following CRI

OTU-011 TIME TO ENDOSCOPY FOR ACUTE UPPER GASTROINTESTINAL BLEEDING: RESULTS FROM A PROSPECTIVE PAN-MIDLANDS TRAINEE-LED AUDIT

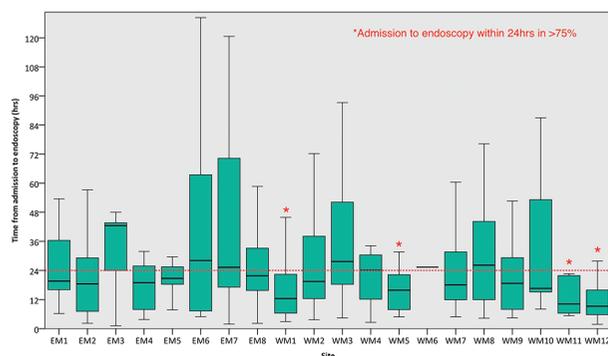
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Introduction Prompt endoscopy for acute upper gastrointestinal bleeding (AUGIB) is associated with improved outcome. NICE recommends early endoscopy (<24 hour from admission) for all patients with AUGIB whereas the JAG Global Rating Scale stipulates early endoscopy in **No entry** 75% as a minimum standard for service accreditation. We aimed to audit these outcomes and identify predictors of delayed endoscopy (>24 hour from admission).

Methods A prospective, pan-Midlands, multi-centre study was jointly undertaken by GARNet and WMRIG trainee networks. Adults admitted with AUGIB and had inpatient endoscopy between Nov-Dec 2017 were enrolled over 30d. Admission, endoscopy referral and procedure times were collected, along with clinical, laboratory, endoscopic and post-endoscopic variables. Heterogeneity between sites was assessed using Mann-Whitney and chi². Multivariate binary logistic regression analysis was used to study factors associated with delayed endoscopy.

Results 337 patients met inclusion criteria (median age 69.5, SD 18.8). The median time from admission to endoscopy (Abstract OTU011 Figure 1) was 20.9 hour (IQR 11.5–31.8). The time from admission to endoscopy referral were comparable between East and West Midlands (median 8.1 hour, IQR 3.6–18.1; p=0.242], as was the time from referral to endoscopy (median 6.6 hour, IQR 3.0–22; p=0.219). 61.1% of patients received endoscopy within 24 hour of admission (p=0.025 across sites) and 79.3% within 24 hour of referral (p=0.012). 4/20 sites (20%) met the minimum JAG standard. On multivariate analysis (table 1), 7 pm-7 am admission, rectal examination <1 hour, higher Glasgow-Blatchford score (GBS) were associated with early endoscopy. Each 1 hour increment in referral time led to a 4% added risk of delayed endoscopy. Weekend admission, region, melaena or suspected varices did not affect this outcome. Early endoscopy did not affect rates of endoscopic therapy (p=0.536), 30d readmission or death (p=0.985), but reduced length of stay (median difference 1d; p=0.039).



Abstract OTU-011 Figure 1

Abstract OTU-011 Table 1

Factor	OR for delayed endoscopy	p-value
Region (EM)	0.78	0.476
Weekend	2.35	0.070
7 pm-7 am	0.30	0.002
Age	1.02*	0.160
Per rectum<1 hour	0.34	0.005
Melaena	1.00	1.000
GBS	0.88*	0.008
Nil by mouth<1 hour	1.36	0.407
Time to referral (h)	1.04*	0.002
Suspected variceal	1.02	0.969
Endoscopic therapy	1.30	0.536

Conclusions Time to endoscopy for AUGIB generally fell below national standards during the period of Nov-Dec. Early endoscopy can reduce length of stay, but is dependent on prompt recognition, assessment and referral. As such, ongoing audit and strategic initiatives involving acute care services may be required to improve this outcome.

OTU-014 REPRODUCTIVE FACTORS AND RISK OF GASTRIC CANCER BY ANATOMICAL SUBSITE: THE EPIC STUDY

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Introduction Gastric cancer is more common in men than in women, indicating a potential role for sex hormones in its development. The aetiology of gastric cancer differs by anatomical subsite; however, few studies have compared hormonal and reproductive risk factors by subsite in prospective analyses. We investigated the association between reproductive factors and the risk of gastric cancer by subsite in the European Prospective Investigation into Cancer and Nutrition (EPIC) cohort.

Methods EPIC is an on-going multicentre prospective cohort study, which comprises of 5 21 448 men and women, aged 25–70 years, recruited between 1992–2000 from ten European countries. Questionnaires administered at baseline assessed reproductive factors, including age at menarche, menopause, first pregnancy, and first child birth, as well as parity, breast feeding, menopausal hormonal therapy, and oral contraceptive use. The association between reproductive factors and gastric cancer were examined in Cox proportional hazard models to estimate hazard ratios (HRs) and 95% confidence intervals (CIs), adjusting for potential confounders.

Results During an average of 14 years of follow up, 83 gastric cardia cancers and 191 gastric non-cardia cancers were diagnosed among 3 43 985 women. Compared to women who had their first pregnancy at an earlier age (<22 years), women who had their pregnancy at a later age (>26 years) had a decreased risk of gastric non-cardia cancer (HR 0.55, 95% CI: 0.32–0.92). In addition, compared with women who had not undergone ovariectomy, women who had a bilateral ovariectomy had an increased risk of gastric non-cardia cancer (HR 1.83, 95% CI: 1.02–3.28). For gastric cardia cancer, there was also an elevated risk among women who had a

bilateral ovariectomy but this did not quite attain statistical significance (HR 2.19, 95% CI: 0.98–4.86). The remaining reproductive factors analysed were not associated with risk of gastric cardia or non-cardia cancer.

Conclusion The results of this study suggest that reproductive factors in women may influence risk for gastric cancer, particularly non-cardia gastric cancer.

PTU-011 PREDICTORS OF MORTALITY AND REBLEEDING OUTCOMES AFTER PEPTIC ULCER BLEEDING

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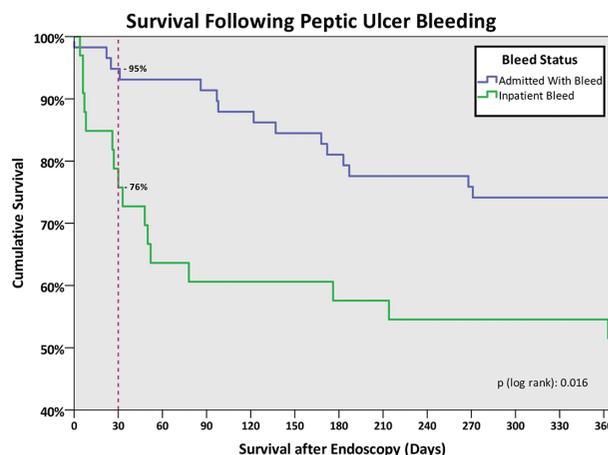
10.1136/gutjnl-2018-BSGAbstracts.274

Introduction Peptic ulcer disease (PUD) accounts for 25%–56% of acute upper gastrointestinal bleeding (AUGIB) cases and is associated with high rates of mortality and rebleeding. We aimed to assess the rates and factors associated with 1 year mortality and rebleeding in patients with bleeding PUD.

Methods This was a single-centre study of patients with AUGIB and endoscopic confirmation of PUD between November 2012–2014. All patients received at least 1 year of retrospective follow-up after endoscopy. Electronic records were scrutinised for outcomes of mortality and bleeding, with time-to-event analyses performed using a Kaplan-Meier plots and Cox-regression.

Results 91 patients (median age 78.4, 65.9% male) were included. 63.7% were admitted with AUGIB and 36.3% bled during their inpatient stay. Mortality at 30 days and 1 year were 12.1% and 34.1% respectively, with 1 year mortality comprising: cardiovascular (20.0%), bleeding (20.0%), other (33.3%), unknown (26.7%). On univariate analysis, predictors of 1 year mortality included inpatient bleeding (hazard ratio [HR] 2.38, 95% CI: 1.18–4.83, p=0.016) [Figure 1], age (HR 1.036 per increase, 95% CI 1.009–1.065, p=0.009), Forrest classification (HR 2.22 for class 1 and 2 vs. 3, p=0.04), Rockall Score (HR 1.64 per increase, 95% CI 1.28–2.10, p<0.001), Charlson index (HR 1.34 per increase, p<0.001), aspirin use (HR 3.05, p=0.003), rebleeding (HR 5.52, p<0.001). The effect of inpatient bleeding on mortality was not significant (p=0.19) after adjusting for Charlson index. *H. pylori* was positive in 35.7%; eradication was associated with reduced mortality even after adjusting for Forrest classification and age (HR 0.30, p=0.007). Multivariable analyses to account for age are shown in table 1. The 1 year rebleeding rate was 7.8%. Higher haemoglobin on discharge (HR 0.940 per 10 g/dL increment, p=0.04), Forrest 3 ulcers (HR 0.18, p=0.02) and *H. pylori* eradication (HR 0.214, p=0.02) were significantly associated with reduced rates of rebleeding.

Conclusion Increasing age, higher Rockall and Charlson scores, Forrest 1 or 2 lesions, inpatient bleed, and rebleeding were factors associated with mortality in bleeding PUD. Higher rates of inpatient mortality may be explained by age and comorbidities. Eradication of *H. pylori* was associated with improved outcomes and should be considered in all cases of bleeding PUD.



Abstract PTU-011 Figure 1 Survival Following Ulcer Bleeding

Abstract

PTU-011 Table 1

Factor	Comparison	Hazard Ratio	95% CI	p-value
Inpatient AUGIB	Admitted with AUGIB	1.91	0.93–3.93	0.077
Forrest 1–2	Forrest 3	2.81	1.28–6.15	0.010*
Rockall Score	Per increase [§]	1.67	1.26–2.21	<0.001*
Charlson Index	Per increase [§]	1.30	1.07–1.58	0.008*
Aspirin on admission	No aspirin	2.07	0.92–4.67	0.081
<i>H. pylori</i> eradication	Not ascertained	0.26	0.11–0.61	0.002*

PTU-012 BIOPSY AVOIDANCE STRATEGY IN ADULT COELIAC DISEASE

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Introduction Paediatric ESPGHAN guidelines support a diagnosis of coeliac disease (CD) when immunoglobulin-A anti-tissue transglutaminase (IgA tTG) antibody titres are >10 times the upper limit of normal (ULN) and combined with supportive criteria. This study examines whether serological testing alone could be sufficient for diagnosis in adult patients, thus avoiding the need for duodenal biopsies.

Methods We performed a prospective analysis of CD patients diagnosed in a University hospital. Symptoms of CD, villous atrophy (VA) on biopsy, IgA-endomysial (IgA-EMA) antibodies, tTG and Human Leukocyte Antigen (HLA) genotype were used for analysis. We then compared the TTG antibody level against small bowel histology.

Results 443 CD patients (66.8% female, median age 41 years, range 15–84 years) were diagnosed between 2008 and 2016.