

age was 46, aetiology of portal hypertension was, extrahepatic portal venous thrombosis (n=5), PSC (n=1), PBC (n=1) and obliterative portal venopathy (n=1). 2 patients previously had liver transplants. The indications for embolisation were splenomegaly associated abdominal pain (n=1), ascites (n=1) and recurrent VH (n=6). One patient had ascites (grade 3) pre-procedure. Post-embolisation median platelet and total white cell counts increased from 67 to $105 \times 10^9/L$ and 2.1 to $4.7 \times 10^9/L$ respectively and median bilirubin reduced from 26 $\mu\text{mol/L}$ to 16 $\mu\text{mol/L}$. After the procedure 0/6 patients embolised for VH had a recurrence. 7 out of 8 patients developed post-embolisation syndrome and 2 patients developed pleural effusions which did not require drainage. 1 patient had a puncture site haematoma treated conservatively. The patient embolised for ascites developed SBP and decompensated further, requiring transplantation 23 days after embolisation. 2 of 8 patients died following embolisation, one after 5 months from liver abscesses in a failing graft and the other 15 months later from an unrelated cause.

Conclusions In selected cases partial splenic embolisation can ameliorate portal hypertension (as evidenced by increasing white cell and platelet counts) and prevent recurrent VH. The majority of patients will develop post-embolisation syndrome and serious complications occurred in 3 of 8 patients. Further investigation into splenic embolisation as a treatment for portal hypertension in selected patients may be beneficial.

Oesophagus

P226

UNDERDIAGNOSIS OF EOSINOPHILIC OESOPHAGITIS IN PATIENTS WITH DYSPHAGIA IN A DISTRICT GENERAL HOSPITAL

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Introduction Eosinophilic Oesophagitis (EoE) has an annual incidence estimated at up to 20 new cases per 100,000 inhabitants.¹ It must be considered in the differential diagnosis of patients with dysphagia or a food bolus. Our previous audits have suggested it is underdiagnosed in our institution. The aim of this study is to evaluate the adherence to European guidelines in the detection of EoE.

Methods We retrospectively reviewed the electronic patient records of all patients presenting for an upper gastrointestinal endoscopic procedure with an indication of dysphagia or a finding of food bolus obstruction over 1 year. The study was undertaken in a district general hospital in the south of England. Data was then collected for sex, age, macroscopic findings, quality and location of biopsies as well as histology. This was measured against European guidelines in the diagnosis of EoE, including at least six oesophageal biopsies from different locations and a histological diagnosis documenting 15 eosinophils/hpf in the oesophageal mucosa.¹ We applied percentages, means and standard deviations to analyse the data.

Results 1 year of endoscopies were reviewed (n=249). 46% of patients were male, the mean age was 68 (range 17–97). At the time of endoscopy only 42.2% of patients had oesophageal biopsies. When we excluded patients with an endoscopic diagnosis of oesophageal malignancy this reduced further to 40.0%. In this group only 9.4% had the

recommended six biopsies. The average number of biopsies for each patient was 3.7 (standard deviation 2.5). There were 7 patients with a histological diagnosis of EoE, of whom 6 had a documented eosinophil count of 15 eosinophils/hpf on histology.

Conclusions Considering the incidence of EoE, our data suggests that it is very likely underdiagnosed in patients with dysphagia or a finding of food bolus. This may be attributed to lack of awareness of the condition leading to insufficient biopsies and/or the lack of awareness for the number of biopsies required. Our data suggests that histological analysis is largely adhering to guidelines. These practices could be commonplace among trusts nationwide and further work must be done to improve awareness and diagnosis of this treatable condition. This is particularly relevant with the recent addition of an orodispersible budesonide specifically for its management.

REFERENCE

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P227

A EUROPEAN COMPARISON OF BARRETT'S VERSUS SQUAMOUS OESOPHAGEAL RESECTIONS: IS STRICTURE RISK RELATED TO PATHOLOGY?

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Aims ESD is a minimally invasive therapeutic option for early oesophageal neoplasia, however is not without risk. In Europe, the complication profile is most established for Barrett's neoplasia, being the predominant pathology, and stricture risk has been shown to be related to lesion circumference. Our aim was to compare the safety of ESD between Barrett's and squamous neoplasia in a Western population.

Methods This was a retrospective analysis of all oesophageal ESDs performed within 3 tertiary referral centres in Europe. The primary outcome was post procedure stricture rate.

Results 226 oesophageal ESDs from 201 patients were included, consisting of 167 Barrett's and 59 squamous neoplasia. Average age was 70.7 in Barrett's and 68.5 in squamous neoplasia, with lesion size 34.6 mm and 34.2 mm and en bloc resection rate 96.6 and 94.6% respectively. The complication rate was 3/167 perforations or delayed bleeds and 7/167 strictures in Barrett's, with 1/58 perforations or delayed bleeds and 15/58 strictures in squamous (1 patient lost to follow up). Circumferential lesion involvement did increase stricture

Abstract P227 Table 1 Stricture Risk Stratified by Circumferential Lesion Involvement

Lesion circumference (%)	Strictures in Barrett's ESD (n,%)	Strictures in Squamous ESD (n,%)	p-value
≤1/3	0/98 (0.0%)	3/23 (13.0%)	<0.001
>1/3–2/3	1/56 (1.8%)	6/26 (23.1%)	0.001
>2/3	6/13 (46.2%)	6/9 (66.7%)	0.354