

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

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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.

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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

risk, but did not account for the difference between the two groups (table 1).

Conclusions ESD remains a low risk therapeutic option for early oesophageal neoplasia, however the stricture risk is higher in squamous neoplasia, irrespective of circumferential lesion involvement. We would suggest counselling patients with squamous neoplasia for a higher risk of stricture and having a lower threshold for steroid injection or prophylactic dilatation in these patients.

P228 OUTCOMES OF RFA FOR BARRETT'S MUCOSA: 10 YEARS' DATA FROM A TERTIARY CENTRE

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Introduction Radiofrequency ablation (RFA) with or without endoscopic mucosal resection (EMR) is an established, effective and safe treatment for dysplastic Barrett's oesophagus, aiming to cause complete regression to squamous mucosa. In high volume centres, complete remission of dysplasia (CR-D) is seen in 91%, and complete remission of intestinal metaplasia (CR-IM) in 83.9%¹.

Method The audit assessed the outcomes of all patients treated at the Royal Liverpool Hospital for Barrett's mucosa with low grade dysplasia (LGD), high grade dysplasia (HGD) or intra-mucosal cancer (IMC) through RFA (HALO 360 or HALO 90) with or without EMR over a ten year period (2009–2019). The patients were treated by consultant gastroenterologists following referrals from throughout the Mersey region. Data was collated through the United Kingdom Radio Frequency Ablation Registry, which was regularly updated in this time period.

Results 227 patients completed treatment in the 10 year period; 185 male and 42 female, with a median age of 68 years at time of first therapy (range 38–88). 45 had initial histology of LGD, 135 HGD, and 47 IMC. The median Barrett's extension was C1 (range 0–15 cm) M4 (0–16 cm). 147 patients underwent EMR prior to RFA.

The median number of ablations performed was 3 (range 2–12). Patients were followed up for a median of 1020 days (range 188–3557). As highlighted in the graphic, 209/227 (92.07%) patients achieved CR-IM at their latest endoscopy. Of those patients who have not achieved or maintained squamous mucosa upon completion of treatment, initial histology was predominantly HGD (12/18), with both LGD and IMC accounting for the remainder (3/18 each).

Conclusion The data demonstrates a high proportion of patients receiving RFA for Barrett's with dysplasia achieve CR-IM, exceeding national standards. Those whose initial histology was HGD or IMC were at higher risk of failing to achieve this.

These outcomes, from a large dataset over an extended time period, highlight the level of expertise of the relevant endoscopists, and reinforce the benefit of therapy being undertaken in high volume centres.

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P229 A NOVEL APPROACH TO RADIOTHERAPY TARGETING FOR OESOPHAGEAL SQUAMOUS-CELL CANCER USING LUGOL'S-SOLUTION GUIDED ENDOCLIP MARKING

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Introduction Squamous cell carcinoma (SCC) of the oesophagus often presents at a late stage with dysphagia symptoms. Chemoradiation (definitive or neoadjuvant treatment) remains the standard strategy for the treatment of localised SCC. Accurate radiotherapy target delineation is however problematic for very early tumours that cannot be visualised on cross-sectional imaging. We describe a novel technique of endoscopic clip placement to mark the area for targeted radiotherapy, in conjunction with Lugol's iodine chromoendoscopy to delineate the dysplastic field.

Methods A prospective study of procedures performed using the technique between 2017 and 2020 was undertaken in a tertiary referral centre. Unstained lesions (USL) were described and photographed, The proximal and distal extent of USLs were marked with ResolutionTM endoclips (Boston Scientific) which were placed on normal appearing squamous tissue 0.5 cm away from the USL. Four operators carried out the procedures with expertise in Endoscopic Eradication therapy and lesion recognition. Endoscopy reports, clinic letters, and imaging modalities were all interrogated to evaluate patient outcomes.

Results Fifteen patients were enrolled, 4 male, 11 female. Thirteen (86.7%) were for a new diagnosis of SCC, and 2 (13.3%) were for SCC recurrence. All patients were staged as T2N0M0 on CT. Eight patients had prior EUS and 13 had PET-CT scans, but these imaging modalities could only detect the area of abnormality in 3 (20%), and 4 (26.7%) of cases respectively.

Lugol's Chromoendoscopy was able to clearly delineate the dysplasia in all cases (100%). The mean total length of oesophageal USL marked with clips was 7.3 cm \pm 3.8. The mean length of endoscopic procedure was 9.2 minutes \pm 2.4. All procedures were undertaken with conscious sedation with a median dose of 2.5 mg midazolam (2.5–3.0) and 50 mcg fentanyl (0–75 mcg). All 15 patients scored comfortable on a GRS scale. Mean time from clip deployment to CT radiotherapy planning scan was 7.8 days (\pm 5.1). No clips fell off prematurely requiring repeat endoscopy. Median dose of radiotherapy delivered was 50Gy. At 12-months, of those followed up 26.7% had evidence of relapse free survival.

Conclusions Here we describe a novel technique using Lugol's guided clip placement prior to radiotherapy, demonstrating it to be a quick and uncomplicated procedure which can be used in the management of patients with SCC.

P230 PREVALENCE OF CERVICAL INLET PATCH IN PATIENTS WITH AND WITHOUT GLOBUS

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Introduction The cervical inlet patch (CIP) is an island of heterotopic gastric mucosa, most commonly found in the