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PTU-054 TRANSNASAL GASTROSCOPY – ARE THE BIOPSIES SUITABLE FOR BARRETT'S SURVEILLANCE?

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Introduction Transnasal gastroscopy is a far more acceptable form of gastroscopy to the patient, with benefits including reduced gagging, ability to communicate during the procedure, greater flexibility of endoscope allowing easier visualisation of difficult areas and closer inspection of the laryn x.[1]

Due to the smaller working channel, 2.0mm as compared with 2.8 mm of a standard oral gastroscope, the biopsy forceps used in transnasal gastroscopy are smaller, leading to questions about the suitability of transnasal gastroscopy for Barrett's surveillance.

As an early adopter of transnasal gastroscopy, Braintree community hospital endoscopy service has performed many thousands of diagnostic transnasal gastroscopies including Barrett's surveillance. This study compares the dysplasia and malignancy rate of transnasal gastroscopy biopsies and oral gastroscopy biopsies.

Methods All patients attending for a follow up gastroscopy for Barrett's surveillance over the past three years were included in the study.

Patients attending for gastroscopy are sent information on the types of procedure when the appointment is booked. The patient is free to choose whichever form of gastroscopy they wish. On admission, the nurse will explain both procedures again and the patient will then choose. The vast majority choose to have transnasal gastroscopy.

For those that choose to have oral gastroscopy, a standard oral gastroscope is used rather than a transnasal gastroscope.

All endoscopists take quadrantic biopsies of the Barrett's segment in accordance with the BSG guidelines.

The study looked back at 3 years of Barrett's surveillance and compared the rates of dysplasia found in the transnasal series and the oral series. The overall dysplasia rate, including adenocarcinoma, was compared.

Results In the three year period there were a total of 1282 patients who underwent Barrett's surveillance.

Of these, 905 (70.6%) chose to have transnasal gastroscopy, the remainder, 377 (29.4%) chose to have oral gastroscopy.

Of the transnasal series, 12 (1.3%) had LGD, 5 (0.6%) had HGD, 3(0.3%) had ACA and 9 (1%) were indefinite for dysplasia.

Of the oral series, 7 (1.8%) had LGD, 0(0%) had HGD, 2 (0.5%) had ACA and 7 (1.8%) were indefinite for dysplasia.

The overall dysplasia and malignancy rate in the trans nasal group versus the oral group was 2.2% vs. 2.4% ($p = 0.4048$).

Conclusion Our series at Braintree community hospital shows that there is not a significant difference in the dysplasia and malignance rate found on transnasal biopsies as compared with oral gastroscopy biopsies.

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Disclosure of Interest None Declared.

PTU-055 A COMPARISON OF RADIOLOGICAL AND ENDOSCOPIC OESOPHAGEAL STENT PLACEMENT IN MALIGNANCY

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Introduction Self expanding metallic stent (SEMS) placement effectively palliates malignant dysphagia, most commonly due to oesophageal cancer. Typically stents are placed under fluoroscopic guidance, but some centres use direct vision endoscopy as an alternative.[1] There are however little data comparing the two techniques. At our 2-hospital institution, all patients presenting to Stoke Mandeville Hospital undergo radiologically guided stent placement, while patients at Wycombe Hospital undergo endoscopic placement without fluoroscopy. We describe our experience over a three year period.

Methods A retrospective observational study of all patients who underwent SEMS placement at our two hospitals over a three year period (2009–2012) was performed. 41 patients were included in the study, with placement of 48 SEMS. Improvement in dysphagia, survival and complication rates were the main outcome measures.

Results 21 patients underwent radiologically guided placement, 20 for oesophageal cancer, 14 male, median age 78 years. 20 patients underwent endoscopically guided placement, 17 for oesophageal cancer, 8 male, median age 80.5 years. Disease stage was similar in both groups, with metastases in 11/21 of the radiology group, and 10/20 of the endoscopy group. More patients in the radiology group had received prior radiotherapy (13 vs 8). Significant improvement in dysphagia was similar in both groups (14/21 radiology vs 14/20 endoscopy, $p = 0.82$). There was no significant difference in median survival after stenting (135 vs 116 days, $p = 0.98$), or major 30 day complications defined as perforation, recurrent dysphagia or death (5 in both groups).

Conclusion Direct vision endoscopic SEMS placement was as effective as radiological guidance for dysphagia palliation at our institution, with a similar mortality and complication rate. This provides further evidence for the role of direct vision endoscopic SEMS placement in palliation of malignant dysphagia.

REFERENCE

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Disclosure of Interest None Declared.

PTU-056 HIGHLY SUCCESSFUL, MINIMALLY INVASIVE ENTERAL ACCESS BY DOUBLE-BALLOON ENTEROSCOPY (DBE) AND LAPAROSCOPIC-ASSISTED DBE

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Introduction Patients with chronic gastroparesis frequently require prolonged enteral feeding via the jejunal route. This is often achieved through the placement of a percutaneous endoscopic gastrostomy with jejunal extension (PEG-J) or a surgically