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PWE-176 THE MANAGEMENT OF PERFORATED GASTRIC ULCERS

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Introduction Perforated gastric ulcers are potentially complicated surgical emergencies. Appropriate early management is essential to avoid subsequent problems including the detection of underlying malignancy. Our aim was to examine the management and outcome of patients with gastric perforations undergoing emergency laparotomy for peritonitis.

Methods Patients undergoing laparotomy in the department of General Surgery for perforated gastric ulcers were identified from the prospectively maintained Lothian Surgical Audit (LSA) database over the 5-year period 2007–2011. Additional data were obtained by review of electronic records and the endoscopy reporting system (UNISOFT), in addition to reference with the South East Scotland oesophagogastric Cancer Network (SCAN) database and the histopathology laboratory Database (APEX).

Results 45 patients were identified. The procedures performed were: 41 omental patch repairs (91%), two simple closures (4%) and two distal gastrectomies (4%—both for large perforations). There were four perforated gastric tumours (4%), of which two were suspected intra-operatively and confirmed histologically, one had unexpected positive histology and one had negative histology, but follow-up endoscopy confirmed carcinoma; all four were managed without resection at initial laparotomy. One of these patients underwent subsequent resection for cancer after full staging and optimisation but subsequently developed tumour recurrence and died. Median length of stay was 8 days (range 4–68). The overall inpatient mortality was 15% and there were 20 morbidities (44%; including nine respiratory complications, four wound infections and two myocardial infarctions). 33 patients had biopsies taken during surgery. Two of the remaining 12 patients had biopsies taken during postoperative endoscopy. None of the remaining 10 patients were subsequently referred with cancer. Seventeen patients in total underwent a follow-up postoperative endoscopy and 11 of them had biopsies taken.

Conclusion The majority of perforated gastric ulcers can be effectively managed by laparotomy and omental patch repair. Initial biopsy and follow-up endoscopy with repeat biopsy is essential to avoid missing an underlying malignancy.

Competing interests None declared.

PWE-177 ACUTE BLEEDING FROM UPPER GI TRACT ANGIODYSPLASIA

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Introduction Angiodysplasia is a relatively uncommon cause of acute upper GI bleeding (AUGIB). The aim of this study was to

characterise the presentation, management and outcome of this condition.

Methods Retrospective audit of upper GI endoscopies (UGIE) performed at our institution between 1 January 2007 and 30 June 2010. Data were extracted from the endoscopy reporting software (Unisoft) database using search terms “angiodysplasia,” “angioma” and “telangiectasia” for oesophageal, gastric and duodenal diagnoses. These three terms were grouped together as “angiodysplasia” for analysis. The casenotes for all patients presenting with haematemesis and/or melaena were reviewed.

Results During the 42-month period of the audit, a total of 15 482 UGIEs were performed. A diagnosis of upper GI tract angiodysplasia was recorded in 199 procedures, representing 132 patients. Of these, 38 were excluded as they had presented with chronic anaemia and 55 patients had undergone UGIE for other indications. 39 patients had presented with haematemesis and/or melaena. Of these six were excluded from further analysis as the diagnosis of angiodysplasia was not confirmed at subsequent endoscopy; a further seven patients had co-existing lesions which were thought to have accounted for the bleeding. Therefore, the results are presented for 26 patients; the mean age was 70 yrs (range 34–91) and 15 (59%) were males. Twelve (44%) were taking aspirin/NSAIDs, and five (19%) were on anticoagulant therapy. Mean haemoglobin level at presentation was 9.4 g/dl (range 4.0–14.9). Three (11%) of patients had a past history of AUGIB of unknown source; two (7.4%) of patients had a history of previous bleeding from known angiodysplasia. Von Willebrand’s disease was noted in three (11%) of patients; four (14.8%) of patients had documented aortic stenosis, with a further two (7.4%) having had an aortic valve replacement. The 26 patients experienced 42 separate admissions (single admission—18 patients, eight patients >1 admission) with AUGIB during the study period. In 39 (93%) of these episodes the presentation was with melaena, and three (7%) with haematemesis plus melaena. Active bleeding was seen in 13 (30%) of these episodes, with luminal blood present in a further four (9%) cases. Endoscopic therapy with argon plasma coagulation or heater probe was undertaken in 35 (81%) of these episodes. Seven (26%) of the patients required additional therapy with either Octreotide, Thalidomide or Tranexamic Acid for uncontrolled or recurrent bleeding. There were no deaths observed due to GI bleeding.

Conclusion Acute bleeding from upper GI tract angiodysplasia can be managed successfully by endoscopic therapy in the majority of patients, but approximately a third of patients will experience recurrent bleeding requiring additional medical therapy.

Competing interests None declared.

PWE-178 FEASIBILITY, SAFETY AND EFFICACY OF ENDOSCOPIC RESECTION OF UPPER GASTROINTESTINAL SUBMUCOSAL LESIONS IN A WESTERN SETTING

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Introduction Submucosal lesions are a relatively common finding at upper gastrointestinal endoscopy. Endoscopic resection (ER) may be warranted in larger lesions, those causing symptoms or those with malignant potential. However submucosal origin makes these lesions difficult to resect by an endoscopic approach. Advances in resection techniques have made this feasible.

Methods Portsmouth Hospitals is a tertiary referral centre for advanced ER. All ER procedures between 2005 and 2011 were recorded in a prospective database. We analysed our database to identify all submucosal lesions removed by ER in the past 7 years. All procedures were carried out by a single skilled endoscopist.

Demographic data, histology, procedure success, long-term outcome and complications were assessed.

Results A total of 161 lesions were treated by UGI ER between 2005 and 2011. 14 of 161 were submucosal lesions. Nine of the 14 patients were female and the mean age was 54.3 years (range 34–69 years). Five lesions were located in the oesophagus, seven in the stomach and two in the duodenum. Histology revealed granular cell tumour (3), neuroendocrine tumour (5), inflammatory fibroid polyp (2), lipoma (2), gastrointestinal stromal tumour (1), Leiomyoma (1). All cases were successfully treated in a single ER session of which 6 cases were treated by conventional EMR, 9 by ESD techniques. The single complication was a microperforation during ESD of an oesophageal GIST which was endoscopically clipped. The patient was managed conservatively with intravenous antibiotics and was discharged after 3 days. There were no cases of significant bleeding and no patient required surgery. After a mean follow-up of 19.5 months all patients remain well and have no signs of recurrence.

Conclusion The caseload of UGI ER for submucosal lesions in low with an average of two cases per year in a large UK specialist centre. The majority of cases required ESD skills and therefore these cases should be treated in specialist centres with expertise in this technique. Outcomes and complication rates were acceptable in this small series and major surgery was avoided in these patients reducing costs and bed occupancy.

Abstract PWE-178 Table 1

Oesophagus	Granular cell tumour	3
	GIST	1
	Leiomyoma	1
Gastric	Neuroendocrine tumour	4
	Lipoma	1
	Inflammatory fibroid polyp	2
Duodenum	Neuroendocrine tumour	1
	Lipoma	1

Competing interests None declared.

PWE-179 GASTRIC POLYPS: ARE WE FOLLOWING GUIDELINES?

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Introduction Gastric polyps are usually benign and >90% are found incidentally at endoscopy, most common type being fundic gland polyps (FGP).¹ Current guideline advocates biopsy for all types of gastric polyps.¹ Literature review failed to demonstrate a strong link between proton pump inhibitors (PPIs) and FGPs. BSG guidelines also suggest testing and eradicating *Helicobacter pylori* in patients with hyperplastic polyps. Our study is to analyse gastric polyp subtypes and management.

Methods Retrospective case note analysis of patients with gastric polyps between January 2009 and December 2010 at James Paget University Hospital. Data collected: Age, gender, endoscopic appearance, histology, association with PPI, management and follow-up.

Results Total number of patients was 79. Mean age was 67.1 (38–89 yrs). 60.8% were women (n=48). Reflux symptom was the most common indication for OGD (36.7%; n=29). 22.8% (n=18) had single polyp, 58.2% (n=46) had multiple polyps (>3). Majority had sessile appearance at OGD 62.0% (n=49). Most polyps were found in the gastric body 45.5% (n=36), followed by fundus 20.3% (n=16). 54.4% (n=43) polyps were estimated <5 mm, compared to 6.3%

(n=5) over 10 mm. Biopsy was performed in 94.9% (n=75) gastric polyps. 2.5% (n=2) polyps were not biopsied due to typical appearance of FGP. Fundic gland polyp (FGP) was the most common histopathological diagnosis (73.4%; n=58), followed by hyperplastic polyp (11.4%; n=9). Neither adenoma nor neoplastic lesions were detected. Information on PPIs use was obtained in only 60.8% patients (n=48): 33.3% (n=16) were not on PPIs; 35.4% (n=17) were on PPIs for an uncertain length of time; 8.3% (n=4) were on PPIs for <6 months; and 22.9% (n=11) were more than 6 months. The prevalences of FGPs in the above groups were 75%, 76.5%, 75% and 90.0% respectively. 3.8% polyps (n=3) were removed, all of which were greater than 10 mm. *H pylori* test was performed in 34.2% (n=27) of the patients. All nine patients (100%) with hyperplastic polyps underwent the test. 87.3% (n=69) patients had no follow-up. Only 2.5% (n=2) had repeat OGD.

Conclusion The local practice in management and follow-up seems to be concordant with the current guidelines. In this study, all gastric polyps were benign, with FGPs as the most frequent diagnosis (73.8%). It raises the question whether a routine biopsy is necessary for polyps with typical FGP appearance. There is no definitive link between PPIs and FGPs (75% FGPs in non-PPI users compared with 80.5% in PPI users). However, the percentage of FGPs presented in long-term PPI users is slightly higher (90%).

Competing interests None declared.

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PWE-180

CLINICAL AND LABORATORY CHARACTERISTICS AND THE USE OF BIODEGRADABLE STENTS IN EOSINOPHILIC OESOPHAGITIS: A SINGLE CENTRE UK EXPERIENCE

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Introduction Eosinophilic Oesophagitis (EoE) is an under recognised condition. There are clues in the history, biochemistry, immunology and gastroscopy to make the diagnosis. Strictures associated with this condition need careful endoscopic management.

Methods Retrospective review of histology proven eosinophilic oesophagitis cases between April 2009 and June 2011.

Results Total no of patients 16, Male: female=7:1. Age range: 18–89 years (IQR 24.25 (24.75–49). Mean age 41.5 years. All of them complained of intermittent dysphagia and 50% of them had a history of food bolus impaction on presentation. Only 25% had symptoms less than a year. 18.75% (3/16) had symptoms for more than 10 years. 10/16 (62.5%) had a history of atopy. 2/16 (12.5%) had food intolerance/oral allergy especially for fruits. 6/16 had oesophageal manometry; 5/6 of them had normal manometry findings and one showed dysmotility. 50% had barium swallow; two of them showed mild dysmotility. 7/16 had high peripheral eosinophil count (0.04–0.4). Mean 0.58. Only 56% (9/16) of patients had IgE levels checked, 8/9 had high IgE levels. All of them were treated with proton pump inhibitors, while 75% needed fluticasone inhaler. 25% needed montelukast maintenance therapy to achieve clinical benefit. 25% showed normal gastroscopy, remainder showed characteristic findings such as concentric rings, furrows with ulceration. 25% had symptomatic oesophageal strictures; two of them had balloon dilatation previously. The other 2 (50%) were successfully treated with biodegradable stent. One patient had sustained response with single stent even after 18 months, the other had two sequential stents (8 months apart) to improve the symptom of dysphagia.