pathology of 28 IMC (28%) and 69 HGD (71%). Finally the time from first RFA to developing malignancy was a mean of 182 (42 – 733) days.

Conclusion In this cohort, there is a 4.7% chance of developing EAC, 2.8% of patients could not complete planned endotherapy and an 8.5% chance of death from non-oesophageal diseases. These outcomes are independent of the demographic, pathologic and endoscopic variables studied.

Disclosure of Interest None Declared

PTU-145 INCIDENCE OF EOSINOPHILIC OESOPHAGITIS IN A NEW ZEALAND POPULATION: A RETROSPECTIVE ANALYSIS

doi:10.1136/gutjnl-2013-304907.235

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Introduction Eosinophilic oesophagitis (EO) is the diagnosis in 10–15% of dysphagic patients in European and N American studies, most frequent in men aged less than 50 years. It is precipitated by aero-allergens. Diagnosis requires > 20 eosinophils per hpf on oesophageal biopsies. We investigated its incidence in a New Zealand population where the genetic profile is similar (92% NZ European descent) but the environmental exposure to flora very different.

Methods A retrospective review of 871 patients investigated by gastroscopy for dysphagia from 2006–11 at Dunedin hospital. Age, sex, endoscopic findings and whether biopsied were recorded from the endoscopy database. Histology was determined from the hospital PAS system and equivocal cases reviewed by a consultant histopathologist. Sex and age differences were interrogated with chi-squared and $P < 0.05$ was considered significant.

Results Average age of all patients was 68.7 years, 57.1% male. Common diagnoses were normal (27.7%), oesophagitis (21.7%), cancer (11.2%), dysmotility (7.3%), peptic stricture (5.0%). 20 patients (12 male, mean age 45.5 years) had EO. 5 of these had endoscopic abnormalities (2 × ridges, 2 × Schatzki rings, 1 × furrows). 351 patients (40.9%) had oesophageal biopsies, but only 86 of 434 where the underlying cause was not evidence ie no cancer, oesophagitis or peptic stricture. EO incidence was 2.3% of all patients, 5.7% of those biopsied but 23.2% of those where an alternative diagnosis was not evident. Annual incidence varied from 1.1 to 4%. The frequency of biopsies was greater in 2011 (73.6%) than previous years (26.9–44.1%) but the number of cases identified did not differ significantly (3.4–9.0% of those biopsied).

Abstract PTU-145 Table 1 Variation of Frequency of Biopsy and EO with Age and Sex

	Total	Biopsied	Eosinophilic oesophagitis
Male	497	224 (45.1%)*	12 (2.4%: 5.4% of those biopsied)
Female	374	133 (35.6%)	8 (2.1%: 6.0% of those biopsied)
< 50 years old	96	42 (43.8%)	12** (12.5%: 28.6% of those biopsied)
≥50 years old	771	313 (40.6%)	8 (1.0%: 2.6% of those biopsied)

*$P < 0.05$
**$P < 0.0001$

Conclusion EO appears less frequent in a New Zealand dysphagic population than in previous Northern hemisphere studies although this might be due to few biopsies where no macroscopic abnormality was seen. Biopsies are more frequent in men than women but EO no more likely. Biopsies are not more frequent in younger patients (< 50 y.o) but EO is much more frequent. The exact incidence of EO and reasons for discrepancies with previous studies merit further investigation.

Disclosure of Interest None Declared

PTU-146 INCIDENCE AND PREDICTORS OF EOSINOPHILIC OESOPHAGITIS IN DYSPHAGIA: A PROSPECTIVE ANALYSIS

doi:10.1136/gutjnl-2013-304907.236

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Introduction Eosinophilic oesophagitis (EO) causes dysphagia: 10–15% in European and US studies. It is diagnosed by finding > 20 eosinophils per hpf in oesophageal biopsies. We prospectively examined the incidence and clinical indicators of EO in a New Zealand population.

Methods Interim analysis of demographics, symptoms and associated diseases by questionnaire prior to endoscopy in 75 consecutive patients with dysphagia. Endoscopic findings were recorded with histology.

An initial analysis was performed to investigate whether age and gender of patients and symptoms (duration of dysphagia, intermittent or progressive symptoms, level of dysphagia, weight loss, choking, reflux odynophagia or a history of allergy) were associated with a final diagnosis of EO using chi squared or Fisher's exact test as appropriate then logistic regression used to determine the final model.

The sensitivity and specificity of endoscopic changes (furrows, ridges and rings) was determined separately and significance determined by Fisher's exact test.

Statistical significance was taken as $P < 0.05$. Ethics approval was obtained.

Results 75 patients, mean age 56 (range 15–94 years), 31 male (41%), had gastroscopy because of dysphagia. 64 (85.3%) completed the questionnaire and 67 (89.3%) had endoscopic biopsies. 12 (16%) had EO, mean age 36.7 years (range 18–62), 8 male. Endoscopic abnormalities suggestive of EO were seen in 7 EO patients (sensitivity 38.9%, specificity 91.2%: $P < 0.01$).

Allergy/atopy (hayfever, asthma, eczema, coeliac) was no more common in EO (54.5%) than those without (49.0%). The level of dysphagia was not pharyngeal in 5 EO patients. Duration of dysphagia was at least 6 months in all bar one EO patient (range 26 – 1248 weeks). Weight loss of 7–10 kg was reported by 4 EO patients. No patient responding to PPI therapy had EO. The strongest predictor of EO was age under 50 (OR 20.0 95% CI 3.4–117.8) with male sex also being significant (OR 6.7 95% CI 1.4–32.3). No other factor was statistically significant.

Conclusion EO is present in a dysphagic New Zealand population with a relatively high incidence. It is more common in younger males but there was no obvious association with allergy. Although endoscopic changes associated with EO were highly specific they were not sufficiently sensitive to depend upon. We would recommend oesophageal biopsies in all patients presenting with dysphagia without obvious cause at endoscopy.

Disclosure of Interest None Declared

PTU-147 INCIDENCE AND PREDICTIVE FEATURES OF PHARYNGEAL POUCHES IN A DYSPHAGIC POPULATION

doi:10.1136/gutjnl-2013-304907.237

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Introduction Pharyngeal pouches (PPs) commonly present with dysphagia. Perforation of a pouch at gastroscopy is a feared complication. Predicting patients likely to have PPs can enable selection for barium swallow to reduce this risk. PP incidence in a dysphagic population has been reported as 0.3%[1]. We investigated PP incidence and predictive demographic and clinical features in patients referred to a dysphagia hotline service over a 7 year period.[2]