

the second year, 14% in the third year and only 9% after 4 years.

Conclusion The majority of recurrences after successful RFA occur within the first 2 years (16/21–76%). These data support the practice of vigilant long term follow of patients who are fit for endoscopy after treatment with RFA. More intensive and frequent follow up should take place in the first 2 years when the majority of recurrences occur. Thereafter annual follow up appears adequate. *All collaborators of the UK RFA registry are acknowledged for their contributions to this work.*

Disclosure of Interest None Declared.

PTU-174 COST SAVING IMPLICATIONS OF NEW SURVEILLANCE GUIDELINES FOR BARRETT'S OESOPHAGUS

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Introduction The BSG have recently risk stratified Barrett's Oesophagus (BO) according to length of the BO segment and the presence of intestinal metaplasia (IM). Previously the recommendation was for a surveillance gastroscopy every two years. The surveillance interval recommended by the new guidelines¹ now reflects the risk of developing adenocarcinoma. We aimed to quantify the potential cost saving of the implementation of the new BO surveillance guidelines.

Methods Patients with an endoscopic diagnosis BO were identified from endoscopy database records at our unit between 2009 and 2012. BO segment length was available and the presence of IM in the biopsy samples was retrievable from histology records. We allocated our patients into three groups: The 1st was those with a BO segment <3 cm and no IM (not needing further surveillance), the 2nd was those with a BO segment <3 cm with IM (now needing surveillance every 5 years) and the 3rd were those with a BO segment of 3cm or greater (needing surveillance every 3 years). The cost of a surveillance gastroscopy is estimated to be £520² and our histopathology department advised that the cost of four quadrant biopsies was £65 (surveillance cost therefore being greater for those with longer BO segments). We first calculated the projected cost of surveillance over the next 10 years under the old guidelines. From this we subtracted the projected cost of surveillance for this period under the new guidelines.

Results 463 patients were identified who had an endoscopic diagnosis of BO. Sixty patients were excluded due to lack of data on BO length/IM.

The ten year projected cost saving for our trust by implementing the new BO surveillance guidelines was £754,260 (£75,426 per annum). There are over 150 hospital trusts in the UK that have endoscopy units, therefore even a conservative estimate is that the new BO guidelines will save the NHS in excess of £100 million in the next 10 years.

Conclusion New guidelines on BO surveillance will mean fewer surveillance gastroscopies need to be performed in the future. As well as giving the patients a better experience, these guidelines will result in a significant cost saving to our hospital and the NHS in general.

REFERENCES

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PTU-175 DIFFERENCES IN INTESTINAL METAPLASIA IN BARRETT'S OESOPHAGUS PATIENTS FROM AN ETHNICALLY DIVERSE SOUTH LONDON POPULATION

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Introduction Barrett's oesophagus (BO) is where any portion of the normal distal squamous epithelial lining has been replaced by metaplastic columnar epithelium and is a risk factor for oesophageal adenocarcinoma. The recent BSG guidelines for the endoscopic surveillance of BO have stratified the risk according to the length of the BO segment and the presence or absence of intestinal metaplasia (IM). We aimed to identify risk factors and ethnic differences for the presence of IM.

Methods We performed a retrospective database analysis in our unit which serves a large ethnically diverse southwest London population. Gastroscopy records between 2009 and 2012 were retrieved and patients with an endoscopic diagnosis of BO were identified. Multiple procedure reports for individual patients were removed from the analysis. Demographic information included age, sex and length of the BO segment. Patients from the Indian sub-continent were also identified, as previously described¹ The presence of IM was retrieved from the hospital pathology database and was the primary outcome measured. We performed a multivariate logistic regression analysis to determine the odds of having IM by ethnic origin and other demographics. **Results** 463 patients with an endoscopic diagnosis of Barrett's oesophagus were identified. Median age of diagnosis was 67.2 years (IQR: 56.7–76.6 years). Men were more likely to have an endoscopic diagnosis of BO than females (71.3% vs. 29.7%, $p = 0.01$). 9.7% of the cohort were from the Indian sub-continent.

There was an increased odds of IM amongst men although this was not statistically significant (OR 1.44, 95% CI: 0.94–2.21, $p = 0.09$). Lesion length greater than 3cm compared with less than 3cm was associated with a greater odds of IM (2.37, 95% CI: 1.61–3.51, $p = <0.001$). Patients from the Indian sub-continent were 70% less likely to have IM compared to other ethnicities (OR 0.32, 95% CI: 0.16–0.61, $p = 0.001$).

Abstract PTU-174 Table 1

| | Patients | Old cost of surveillance (10 y) | New cost of surveillance (10 y) | Cost saving over 10 y | Mean cost saving per annum |
|----------------|----------|---------------------------------|---------------------------------|-----------------------|----------------------------|
| <3 cm, no IM | 97 | £283,735 | £0 | £283,735 | £28,373 |
| <3 cm, with IM | 103 | £301,275 | £120,510 | £180,765 | £18,076 |
| >3 cm | 203 | £725,425 | £434,655 | £290,770 | £29,077 |
| All patients | 403 | £1,309,425 | £555,165 | £754,260 | £75,426 |