PTU-182 SPECIALIST CARE OF IN-PATIENTS WITH NON-VARICEAL UPPER GASTROINTESTINAL BLEEDING IS ASSOCIATED WITH A SIGNIFICANT SHORTER LENGTH OF STAY – A PROSPECTIVE ANALYSIS

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Introduction Acute upper gastrointestinal bleeding (UGIB) is a common medical emergency that has a 10% mortality rate,[1] requiring specialist input and management.[2] We conducted a retrospective review last year which showed that the mean length of stay (days) was shorter in the GI group: 5.5 ± 5.7 vs 15.7 ± 20.8 (p = 0.02).[3] We conducted a prospective analysis to assess if the above results held true.

Methods A prospective review of case-notes (Electronic patient record-EPR) was conducted for all patients admitted to Kings College hospital with suspected UGIB between January and September 2013. Patients were divided as to whether they came immediately under the care of Gastroenterologists (GI) or general physicians (non-GI) after initial evaluation in the Acute Admission Unit. Patients were assigned on the basis of bed availability in a ward-based system. Statistical comparisons were made as appropriate with two tailed t-test or chi-squared test.

Results 138 patient episodes were reviewed of which 63 and 75 were treated by GI and Non-GI physicians. The two groups were broadly similar in their baseline characteristics. Mean length of stay (days) was significantly shorter in the GI group: 6.6 ± 5.6Vs 10.66 ± 11.3 (p = 0.006). Other comparators are shown in the table.

Conclusion The length of stay of patients with UGIB is significantly shorter when receiving specialist care. In line with previous reports,[4] we found that the incidence of UGIB was higher in males. Patients managed by GI physicians received less blood transfusion compared to the Non-GI physicians. The time to endoscopy was significantly shorter when receiving specialist care. Mortality rates in both groups compared favourably to the national average.

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Disclosure of Interest None Declared.

Abstract PTU-182 Table 1

Clinical Factors	GI (n = 63)	Non-GI (n = 75)	P value
Age (years)	58.15 ± 18.69	64.6 ± 17.1	0.03
Male:Female	51:12	42:33	0.03
Rockall score	3.16 ± 2.05	3.05 ± 2.2	0.70
Haemoglobin	93.9 ± 37.10	93.2 ± 36.4	0.86
Blood Transfusion	1.57 ± 1.73	2.26 ± 2.52	0.04
Time to endoscopy (days)	1.11 ± 1.65	2.19 ± 1.9	0.0007
Mortality ascribed to UGIB	3 (4.7%)	4 (5.3%)	0.8

PTU-183 DYSPHAGIA WITH NORMAL ENDOSCOPIC APPEARANCES – COULD WE DO BETTER?

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Introduction Dysphagia is an 'alarm symptom' that merits prompt investigation by gastroscopy to exclude cancer. Cases in whom cancer is diagnosed at endoscopy in the UK are 'fast tracked' for multidisciplinary team discussion to plan future management. If endoscopy shows no cancer or intrinsic lesion (peptic stricture, oesophageal ring or web), the cause is usually secondary to oesophageal dysmotility. It is recommended that this group of patients should receive a trial of anti-reflux therapy to exclude reflux-related dysmotility. If no improvement in symptoms is seen patients should be referred for oesophageal physiology studies.

Methods To assess the number of patients who underwent a gastroscopy for dysphagia that had no intrinsic cause found and to evaluate if these patients were managed in line with recommendations.

A retrospective analysis of all patients who underwent a gastroscopy for an indication that included dysphagia at Chase Farm Hospital over a 3-month period (April–June 2012) was performed. Data was obtained from endoscopy reports via the Unisoft GI Reporting Tool (Middlesex) and clinic outcome letters. Intrinsic oesophageal causes for dysphagia were said to be cancer, benign oesophageal stricture and eosinophillic oesophagitis (EE).

Results 106 patients (37 male, 69 female), median age 66 years, were investigated. 28 (26.4%) had an intrinsic cause for dysphagia - benign oesophageal stricture 18 (17%), cancer 8 (7.5%) and EE 2 (1.9%). 78 (73.5%) patients had no intrinsic cause – reflux oesophagitis 26 (32.5%), Barrett's oesophagus 2 (2.5%), hiatus hernia 28 (35%), gastritis/duodenitis 39 (48.8%), normal 22 (27.5%) and other 13 (16.3%). 55 (70%) of these patients had no follow-up organised after endoscopy. The remaining had clinic review 20 (25.6%), repeat endoscopy 4 (5%) or referral for oesophageal physiology studies 1 (1.3%). 30 (38.5%) patients with no intrinsic cause were prescribed anti-reflux medication after endoscopy. 19 (63.3%) of these patients had no further follow-up. The remaining had clinic review 9 (30%) or a repeat endoscopy 2 (6.7%); none were sent for oesophageal physiology studies.

Conclusion In this study, 75% of patients with dysphagia had no intrinsic cause identified. The majority of patients are discharged from the service without an accurate diagnosis or management recommendation. Our study highlights important shortcomings in the management of patients with a benign cause of dysphagia. We recommend that patients presenting with dysphagia who at endoscopy have no intrinsic cause, be prescribed acid suppression therapy followed by clinical review, and if symptoms persist be considered for oesophageal physiological studies.

Disclosure of Interest None Declared.

PTU-184 RESTRICTIVE VERSUS LIBERAL BLOOD TRANSFUSION FOR ACUTE UPPER GASTROINTESTINAL BLEEDING: CLUSTER RANDOMISED FEASIBILITY TRIAL

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Introduction Transfusion thresholds for upper gastrointestinal bleeding (UGIB) are controversial. Observational studies suggest associations between liberal red blood cell (RBC) transfusion and adverse outcome, and a recent trial reported increased mortality following liberal transfusion.
Methods Pragmatic cluster randomised trial to evaluate the feasibility and safety of implementing a restrictive (transfusion when haemoglobin (Hb) <8g dL) versus liberal (transfusion when Hb <10 g/dL) RBC transfusion policy for UGIB. Hospitals were randomised to a policy which was implemented through a multi-faceted educational intervention targeting all staff caring for patients with UGIB. All adult patients were eligible to participate, regardless of co-morbidity; the only exclusion criterion was exsanguinating haemorrhage. Feasibility and exploratory clinical outcomes were recorded up to day 28.
Results 936 patients were enrolled in 6 hospitals. The consent rate for follow up was higher in the liberal arm (62% vs. 55%; P = 0.04). There were some baseline imbalances, however the Rockall and Blatchford scores were identical between arms as was the prevalence of ischaemic heart disease (IHD) (14% liberal arm vs. 15% restrictive arm). Protocol adherence was 96% in the restrictive arm vs. 83% in the liberal arm. In patients with a Hb <12 g/dL, the Hb at discharge was 10.7 g/dL (sd 1.2) in the liberal arm vs. 10.1 g/dL (sd 1.3) in the restrictive arm (P = 0.05). In the restrictive arm there was a 13% absolute reduction in the proportion of patients receiving RBCs (95% CI for difference in% -35 to 11, P = 0.23) with a mean of 0.8 fewer RBC units transfused (95% CI: -1.9 –to 0.3, P = 0.12). Clinical outcomes were better in the restrictive arm, although differences were not statistically significant (28-day mortality, 7% liberal vs. 5% restrictive, adjusted difference in% = -1.3, 95% CI: -8.0 to 5.5, P = 0.63; further bleeding, 9 vs. 5%, P = 0.29; serious adverse events, 22% vs. 18%, P = 0.48). In the subgroup with IHD, there was a large observed difference for mortality (12% restrictive arm (n = 6) vs. 3% liberal arm (n = 2); interaction P = 0.11).
Conclusion The protocol was feasible and generated clinically important differences in the level of anaemia and RBC exposure. There was a consistent trend towards fewer complications in the restrictive arm, apart from the increased mortality observed in patients with IHD, which could in part be explained by imbalances in baseline risk. A large trial is required to clarify the risk-benefit balance before advocating restrictive RBC transfusion for all patients with UGIB.
Disclosure of Interest None Declared.

PTU-185 UPDATE ON THE HALT-IT TRIAL PROGRESS: TRANEXAMIC ACID FOR THE TREATMENT OF GASTROINTESTINAL HAEMORRHAGE – AN INTERNATIONAL, RANDOMISED, DOUBLE BLIND PLACEBO CONTROLLED TRIAL

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Introduction Gastrointestinal (GI) bleeding is a common medical emergency and an important cause of morbidity and mortality in high, middle and low income countries. Despite advances in resuscitative, pharmacological and endoscopic therapy, re-bleeding occurs in 10% of patients with non-variceal bleeding and up to 25% of those with variceal bleeding and is an important predictor of death. Excessive fibrinolysis may play an important role both in the failure to control initial bleeding and in the precipitation of re-bleeding through premature breakdown of blood clots at sites of vascular injury. This raises the possibility that an antifibrinolytic drug administered following GI bleeding could limit severity of bleeding and transfusion requirements.
Methods HALT-IT has been designed as a large, pragmatic randomised controlled trial which aims to quantify the efficacy and safety of tranexamic acid (TXA) in adults with significant acute upper or lower gastrointestinal bleeding. The trial will determine the effect of early administration of TXA on mortality, morbidity, blood transfusion, surgical intervention and health status in patients with GI bleeding. The primary outcome is death in hospital within 28 days of randomisation. Secondary outcomes include re-bleeding, need for surgery or radiological intervention, blood product transfusion and thromboembolic events.
Results UK recruitment began in August 2013. By January 2014, a total of 507 patients were randomised across 26 actively recruiting sites, averaging a recruitment rate of 20 patients per week. Centralised and statistical data monitoring ensures trial participants meet inclusion criteria and allows real time monitoring of event rates for the primary and secondary outcomes. The results will be presented by intention to treat and a pre-specified subgroup analysis will also determine the treatment effect in patients with liver cirrhosis and variceal bleeding.
Conclusion HALT-IT aims to recruit 8000 participants in hospitals worldwide and recruitment is ahead of schedule based upon a strong performance in the UK. The success of the trial to date has been dependent upon multi-disciplinary and societal engagement as well as infrastructural support provided by NIHR research networks. The results will add to our expanding knowledge about the role of tranexamic acid as an agent for patients with significant bleeding. It is anticipated that the full trial results will be available in 2017.
Disclosure of Interest None Declared.

PTU-186 THE "SPEEDBOAT-RS2": A NEW MULTI-MODALITY ENDOSCOPIC DEVICE FOR GASTRIC AND OESOPHAGEAL SUBMUCOSAL DISSECTION AND TUNNELLING

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Introduction Gastric and oesophageal mucosal lesions are optimally removed en-bloc for accurate histology and complete resection. We describe, a simple to use, multi-modality endoscopic device ("Speedboat-RS2") for en-bloc gastric/oesophageal mucosal resection and for oesophageal submucosal tunnelling.
Methods The 'Speedboat-RS2' cuts in forward, lateral and oblique planes using bipolar radio frequency (RF) cutting, provides haemostasis with microwave coagulation and incorporates a retractable needle for submucosal injection and tissue irrigation. The instrument blade has an insulated 'hull' to prevent thermal injury to the muscularis propria and the device catheter is partially torque stable allowing rotation and orientation of the hull