

**Introduction** The National Institute of Clinical Excellence (NICE) in the United Kingdom (UK) approved the use of Radiofrequency ablation (RFA) as minimally invasive endoscopic therapy for the treatment of Barrett's Oesophagus related neoplasia as an alternative to surgery in 2010. These high risk patients carry a 40–60% risk of progressing to Oesophageal Adenocarcinoma (OAC), survival from which is poor. Over the past 5 years combined endoscopic mucosal resection (EMR) and RFA have become the preferred intervention for the curative treatment of patients with BE related neoplasia.

**Methods** We report prospective data from one of the UK's largest academic tertiary centres for patients undergoing RFA for early neoplasia arising in BE between 2008–2013 at University College Hospital, London. Before RFA, visible lesions were removed by EMR. Patients then underwent RFA every 3 months until all visible BE was ablated or cancer developed (endpoints). Biopsies were taken at 12 months or when endpoints reached. Primary outcomes were clearance for dysplasia (CR-D) and BE and intestinal metaplasia (CR-IM) at 12 months. Long term durability for CR-D for those with favourable outcomes at 12 months was assessed.

**Results** Two hundred patients have undergone RFA since 2007 at our centre. Of these 145 have completed treatment. Most are male (83%), mean age 69 years (range 44–91). Baseline histology HGD in 86% and IMC in 14%. Mean length BE segment prior to RFA 6cm (range 1–20). Ten per cent patients in our cohort underwent RFA for residual neoplasia after unsuccessful Photodynamic therapy (PDT). Prior to RFA treatment, 50% of patients had EMR for visible lesions. After 2–3 RFA treatments (range 1–6) over 12 months, 80% (116/45) patients had achieved CR-D and 65% CR-IM (94/145). Pre-treatment PDT, EMR or histology did not influence outcomes. Three patients (2.5%) progressed to invasive OAC at 12 months and in total 8 (7%) progressed at most recent follow up. At 5 years 95% of patients who had dysplasia clearance at 12 months remain disease free (median follow up 20 months, IQR 9–32). Kaplan Meir survival statistics demonstrate at 5 years after successful treatment 75% and 77% of patients are likely to remain free of dysplasia and IM respectively.

**Conclusion** We report on the UK's single largest prospective series to date of patients undergoing endoscopic therapy for BE related neoplasia. Our outcomes compare favourably with those published around the world and from within the UK patient registry. These patients are high risk and require vigilant follow up even after successful treatment as predicted recurrence can occur in up to 25% of cases.

**Disclosure of Interest** None Declared.

**PTU-041 SUB-SQUAMOUS COLUMNAR NEOPLASIA AFTER SUCCESSFUL RADIOFREQUENCY ABLATION FOR BARRETT'S RELATED NEOPLASIA IS RARE BUT HIGHLIGHTS REQUIREMENT FOR LONG TERM FOLLOW UP IN THESE PATIENTS**

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**Introduction** Radiofrequency ablation (RFA) combined with endoscopic mucosal resection (EMR) has become the preferred treatment for BE related neoplasia. Success rates of 90% after treatment with a durability of up to 95% at 5 years are reported. The development of sub-squamous intestinal metaplasia (IM)

after successful RFA is recognised and has been reported to range from 0–30%. It's clinical significance remains unclear. However the development of sub-squamous neoplasia after successful treatment is limited to only a few cases world wide in the literature.

**Methods** We prospectively examine the incidence of sub-squamous neoplasia after successful RFA from one of the UKs largest academic tertiary centres for patients undergoing RFA for BE neoplasia between 2008–2013 at University College Hospital, London. Before RFA, visible lesions and nodularity were entirely removed by EMR. Thereafter patients underwent RFA every 3 months until all visible BE was ablated. Biopsies were taken at 12 months. After successful treatment patients were followed up 3 monthly for the first year, at 6 month intervals for the second year and annually thereafter. Biopsies were taken from 1cm below the neo z-line and from the previously treated BE segment using the Seattle protocol. Enhanced imaging endoscopic imaging was used in all cases.

**Results** At our institution 197 patients have undergone RFA since 2007 of which 145 have completed treatment. Eighty percent of patients (116/145) achieved CR-D at 12 months. At 5 years 90% of patients remain disease free (median follow up 20 months, IQR 9–32). There have been a total of 11 recurrences after successful RFA (median time to recurrence – 380 days, IQR 150–884). Four of these patients had sub-squamous high grade glandular dysplasia (HGD). All had had confirmed eradication of dysplasia and IM after the 12 month end of protocol biopsy. These sub-squamous recurrences occurred at 3, 7, 13 and 36 months respectively after eradication was confirmed. One of the four patients was found to have buried HGD on biopsy at the neo z-line and the area was subsequently treated with EMR. The other 3 cases developed visible lesions in neo-squamous mucosa proximal to the neo z-line. All were removed successfully with EMR and demonstrated buried HGD. All 4 cases remain in follow up with no neoplasia at most recent biopsy.

**Conclusion** Although rare, buried neoplasia after successful eradication with RFA can occur. Identification of these cases indicates the need for continued and vigilant surveillance following RFA, even after complete eradication of IM. Early recognition of recurrence can lead to treatment at an early stage.

**Disclosure of Interest** None Declared.

**PTU-042 APPROPRIATELY TRAINED REGISTRARS ARE AS GOOD AS CONSULTANTS IN ENDOSCOPIC MANAGEMENT OF MODERATE-SEVERE UPPER GASTROINTESTINAL HAEMORRHAGE**

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**Introduction** The South West Thames region operates a unique regional gastrointestinal service covering 4 hospitals. Registrar endoscopists are assessed and signed off as competent in providing endoscopic haemostatic therapy before taking their place on the GI bleed rota, and are supported by an on-call consultant. We aimed to evaluate if there were any operator-dependent differences in outcomes of endoscopic procedures performed in cases of moderate-severe upper gastrointestinal haemorrhage between consultants and registrars

**Methods** Data were recorded for all emergency OGDs performed at St. George's Hospital, between 01/01/13 and 30/06/