

PTU-047 BIODEGRADABLE OESOPHAGEAL STENTS IN BENIGN AND MALIGNANT DISEASE – A SINGLE CENTRE EXPERIENCE

¹SS Siddhi*, ²J Plevris, ¹S Bow. ¹Gastroenterology, Royal Infirmary Edinburgh, UK; ²Gastroenterology, Royal Infirmary Edinburgh, University of Edinburgh, Edinburgh, UK

10.1136/gutjnl-2014-307263.121

Introduction Biodegradable oesophageal stents have been developed recently and the experience in their use and available literature is limited. Their usefulness has been demonstrated in refractory benign strictures in a handful of studies and their role in malignant strictures is relatively untested. We looked at our practice and the clinical outcomes in the use of these stents.

Methods This is a retrospective observational study looking at electronic case record and endoscopy reports. All patients who had biodegradable stents inserted between March 2011 and September 2013 were included for analysis.

Twenty-three stents were inserted in 16 patients. 5 of these patients had 2 stents and one patient had 3 stents over the period of time. Thirteen stents were inserted for benign disease and eight for malignant strictures. There were 9 males and 7 females with age range being between 47 yrs and 101 yrs. 2 stents were inserted in 1 patient with postoperative tracheo-oesophageal fistula.

Results In the benign group, an average of 10.5 endoscopies (0.95/month/patient) and 7.2 dilatations (0.65/month/patient) were necessary prior to stent insertion per patient. Post insertion there was a reduction to 3.5 endoscopies (0.03/month/patient) and 2 dilatations (0.016/month/patient). When the average number of dilatations was analysed pre and post stent insertions per patient per month, there was a significant reduction with a P value of 0.009 on the paired T test. In the benign group, on an average 7 endoscopies and 5 dilatations were avoided/patient. Interval between dilatations increased from 5.2 to 25 weeks.

In the malignant group, all patients were successfully bridged to chemo/radiotherapy. 2 out of 6 patients went on to metal stents after 3 and 5 months due to disease progression.

The stent insertion was technically successful in all cases following a dilatation of the stricture to 12mm at the time of insertion. Four patients complained of some pain post stent insertion (3 in the malignant group and 1 in the benign group). One patient developed sepsis post procedure but recovered well with a course of antibiotics. No other complications were noted. In all cases where a check up endoscopy was done, the stent had disintegrated within 8–12 weeks.

Conclusion BD stents are of value in recurrent benign oesophageal strictures as they reduced the number and frequency of dilatations. The BD stents successfully bridge patients with malignant strictures to oncological therapies.

Insertion of a BD stent does not preclude a later insertion of a permanent metal stent. Stent insertion was technically successful and safe.

Disclosure of Interest None Declared.

PTU-048 INITIAL EXPERIENCE WITH RADIOFREQUENCY ABLATION IN GASTRIC ANTRAL VASCULAR ECTASIA AND RADIATION PROCTITIS

SS Siddhi*, H Dalziel, EB Henry. Gastroenterology, Ninewells Hospital and Medical School, NHS Tayside, Dundee, UK

10.1136/gutjnl-2014-307263.122

Introduction Gastric Antral Vascular Ectasia (GAVE) and radiation proctitis can cause chronic GI bleeding and may be severe enough to cause transfusion dependent anaemia.

Current standard therapy for both these conditions is endoscopy with argon plasma coagulation. This usually requires multiple endoscopies over time and in many patients may be ineffective.

With the development of Radiofrequency Ablation (RFA) in Barrett's Oesophagus, we extended its use in these two settings. The available literature is small and our study adds to this body of evidence.

Methods Retrospective case record study. We collected data from all patients who received RFA between December 2012 and November 2013. Data was collected from endoscopy reports and electronic case records.

RFA was performed using the Halo 60,90 or through the scope probes at 12j energy (Barxx/Covidien).

Results Three patients received RFA for GAVE and six patients for Radiation proctitis.

GAVE: All patients presented with transfusion dependent anaemia. They needed 0.85 OGD/pt/month, 0.41 APC/pt/month and 6 units of packed cells /pt/month prior to RFA. Between 2–4 sessions of RFA was required. Post RFA, there was a reduction in endoscopies to 0.34/pt/month (P 0.239). In two out of three patients no further transfusions were required. Hence there was a significant reduction in transfusion requirement. (P 0.033).

Radiation Proctitis: All patients presented with PR bleeding. One was transfusion dependent. A mean of 0.58 APC sessions were done per patient/month. There was a significant reduction in the number of sigmoidoscopies from 0.87/pt/month to 0.2/pt/month (P 0.007). One patient who was requiring 9 units of packed cells per month stopped transfusions after RFA. Number of RFA sessions was between 1–3 (mean: 1.66).

In the NHS, therapeutic sigmoidoscopy with APC costs £704 and therapeutic OGD is £667. A single unit of blood transfusion costs £635. An RFA probe costs £920 and hence an RFA procedure proves cost effective above 2x APC or 2x blood transfusions.

Our only complication was one clinically insignificant stricturing but this was after 8xAPC and 3X RFA. Healing is optimum after 3 months. It is better tolerated than APC in terms of comfort.

Conclusion RFA for GAVE and RP is technically feasible, well tolerated and cost effective. We have demonstrated that there was a significant reduction in blood transfusions in GAVE and requirement for Sigmoidoscopy in RP.

We have shown no significant complications and RFA should be considered as a first line treatment in refractory GAVE and in RP where bleeding is significant.

We recognise this is a small, retrospective study but future work will include larger numbers, QoL data and establish if this should be considered the first line therapy.

Disclosure of Interest None Declared.

PTU-049 HOW REWARDING IS GASTROSCOPY IN DIAGNOSIS OF CANCER IN ISOLATED IRON DEFICIENCY ANAEMIA?

SK Butt*, K Besherdas. Gastroenterology, Chase Farm Hospital, London, UK

10.1136/gutjnl-2014-307263.123

Introduction The ultimate goal of the UK Cancer plan is to 'offer patients a maximum one month wait from an urgent referral for suspected cancer to the beginning of treatment'. The North