main presenting complaints were: dysphagia in 250 patients (79%), food bolus obstruction in 127 (40%) and heartburn in 59 (19%). Endoscopy appeared normal in 47 (15%) or consistent with reflux oesophagitis in 25 (8%). In the remaining 243 (77%) there were specific signs suggestive of EoE: strictures in 43, Schatzki ring in 10, white exudates in 16 and rings, trachealisation or furrows in the remainder.

Conclusion This is one of the world's largest registers of EoE. Dysphagia or food bolus obstruction are the most common symptoms. Endoscopic abnormalities suggestive of EoE are common but 23% do not have endoscopic signs to suggest EoE and therefore biopsy of all patients with dysphagia should be performed regardless of endoscopic appearance. There is variable reporting of EoE in the UK. Several centres had sufficient patients to facilitate research on diagnosis and treatment. However it is uncertain, for those hospitals that did not enter any patients, whether no patients with EoE were diagnosed or whether patients were diagnosed but not entered into the register.

Competing interests None declared.

PTU-200 HOME JEJUNOSTOMY FEEDING POST-OESOPHAGECTOMY: A CHANGE IN PRACTICE

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Introduction Early enteral nutrition support via a needle catheter jejunostomy (NCJ) is a safe and effective method of providing nutrition support post-oesophagectomy. In our specialist unit all patients have a NCJ placed at the time of surgery for post-operative nutrition support. Maintaining nutritional status in the months following oesophageal resection is very challenging and up to 82% of patients lose weight by their first outpatient (OPD) visit.¹ To address this, patients are now routinely discharged on supplementary feeding until their first OPD visit (after 4 weeks) and receive a dietetic telephone review 1 week post discharge. The aim of this retrospective review was to assess the impact of home jejunostomy feeding on nutritional status, length of hospital stay and timing of the first OPD visit.

Methods All patients who had an oesophageal resection in the 12-month period before and after the change in practice were

considered for this study. Patients who underwent emergency or palliative resections, were participating in a clinical trial or had incomplete data were excluded. Dietetic records and the cancer database were reviewed and analysed using SPSS®. The medians were compared using Mann–Whitney U test.

Results Weight loss was observed in 69% of all patients from discharge to first OPD visit. Patients who were discharged on home feeding experienced less weight loss (See Abstract PTU-200 table 1). Length of stay was not significantly increased in the home feeding group, but the length of time to first OPD visit increased significantly by 8 days (See Abstract PTU-200 table 1). The majority (82%) of patients were discharged on 500 ml volume of a 1.2–1.5 kcal/ml enteral feed, providing an average 40% of calculated energy and 46% of protein requirements. Of the home feeding group 52% continued to require jejunostomy feeding after the first OPD visit.

Conclusion Home jejunostomy feeding can be successful in reducing weight loss following oesophagectomy and is frequently required for longer than 1-month post discharge. The increase in telephone contact may have contributed to a delay in the timing of first OPD visit. Organisation of home feeding in hospital did not delay discharge.

Competing interests None declared.

REFERENCE

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Endoscopy II

PTU-201 THE ENDOSCOPIC COST OF BARIATRIC SURGERY

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Introduction Complication rates of Roux-en-Y gastric bypass (REYGB) vary from centre to centre, but anastomotic stricture is the commonest and is managed in the majority by endoscopic pneumatic dilatation. This study aimed to assess the endoscopic costs of REYGB surgery.

Methods All patients undergoing REYGB surgery over a 29-month period were included (553) and were followed up retrospectively and prospectively for a minimum of 180 days to monitor for endoscopic procedures performed in relation to the REYGB.

Results 113 patients had 147 endoscopic procedures, including 65 pneumatic dilatations, at a cost to the endoscopy department of £58 077 over a 29 month study period, with an average cost of £2003 a month or £105 per REYGB operation performed. One patient required three dilatations, two required six dilatations and the rest were dilated once, using a range of 11 mm to 16 mm balloons at the endoscopists discretion. Five patients had completely occluded anastomoses. The anastomotic stricture rate for the group was 11.39%. Three patients had acute ulceration at the anastomosis, giving a symptomatic ulcer rate of 0.7%. The delay in time from surgery to dilatation ranged from 4–5–6 days, with a mean of 94 days. 60% of anastomotic strictures occurred within 3 months, 78% within 4 months, 92% within 5 months and 95% within 6 months.

Conclusion If bariatric surgery is performed locally then endoscopy departments must expect to factor in, not only the costs of dealing with actual complications, but also the cost of investigating for potential complications. The average cost to the endoscopy department per REYGB procedure performed is £105.

Competing interests None declared.

Abstract PTU-200 Table 1 Comparison of outcomes from discharge to first OPD visit

	Non home feeding group (n = 21)	Home feeding group (n = 28)	p Value
Weight change (kg)			
Mean	−2.7 ± 0.75	−1.9 ± 0.60	0.416
Median	−2.8 (−2.3–1.8)	−1.1 (−8.3–3.5)	0.058
Weight change (%)			
Mean	−3.1 ± 0.9	−2.5 ± 0.9	0.622
Median	−3.4 (−12.5–3.0)	−1.7 (−13.8–4.3)	0.665
Length of hospital stay (days)			
Mean	20 ± 2.05	25 ± 3.15	0.416
Median	16 (10–56)	20 (10–74)	0.283
Discharge to first OPD visit (days)			
Mean	22 ± 2.8	25 ± 1.69	0.375
Median	16 (10–56)	24 (10–47)	0.036

Mean ± SEM, median (range).