Aim To evaluate the changes in prevalence and aetiology of FBI of the oesophagus.

Methods Details relating to all patients who presented with FBI to the Department of Gastroenterology at the Royal Adelaide Hospital from 1996 to 2010 were reviewed from a prospective database. The periods were divided into 1996–2000, 2001–2005 and 2006–2010. Detailed endoscopic and histological findings were examined for patients who presented between these periods. Data from coding department were analysed to assess the pattern of presentation and specialties involved.

Results Over 15 years, 248 patients presented with FBI (74% male) to the Gastroenterology department. The prevalence of FBI increased overtime (1996–2000: n=30, 2001–2005: n=80; 2006–2010: n=137). While there was no change in gender, the age of presentation was significantly younger in 2006–2010 (56.2 ± 1.6 yrs) than that from 2001 to 2005 (61.6 ± 1.9 yrs, $p=0.03$) and 1996–2000 (62.8 ± 3.3 yrs, $p<0.01$). The predominant causes for FBI between 1996 and 2000 related to benign strictures and complications of reflux disease (64%), and no patient had EE. The diagnosis of EE was suspected during endoscopy in 10% of patients in 2001–2005 and 35% of patients in 2006–2010 ($p<0.01$). Oesophageal biopsies were taken significantly more frequently in patients who presented with FBI between 2006–2010 (75%) as compared to those in 2001–2005 (47%, $p<0.01$) and 1996–2000 (12%, $p<0.001$). Histologically proven EE was found in 6.2% of patients in 2001–2005 and 23% of patients in 2006–2010 ($p<0.01$). There were no significant changes in other aetiologies overtime (benign strictures, reflux disease, malignancy, or post-surgical strictures). Endoscopic findings of “normal” esophageal structure or mucosa reduced overtime occurred in 23% in 1996–2000, 17% in 2001–2005 and 14% in 2006–2010.

Conclusion The increased prevalence of FBI overtime is associated with an increased prevalence of eosinophilic oesophagitis. While this may be related, increasing awareness about eosinophilic oesophagitis and lower threshold for performing esophageal biopsy are also likely to contribute.

Competing interests None declared.

Neurogastroenterology and motility

PWE-044 GASTROINTESTINAL SYMPTOMS IN THE JOINT HYPERMOBILITY SYNDROME

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Introduction The Joint Hypermobility Syndrome (JHS) is a hereditary connective tissue disorder, characterised by hyperflexibility of the skin and joints and musculoskeletal symptoms. A high prevalence of JHS has been found in patients presenting to GI clinics with unexplained symptoms.¹ However, the range and prevalence of gastrointestinal (GI) symptoms in JHS patients coming from rheumatology clinics has never been adequately characterised or compared to other patient groups. This was our aim.

Methods Multicentre, cross sectional study in new referrals to GI clinics between April 2010 and December 2011. Patients between the ages of 16–70 with a rheumatological diagnosis of JHS were compared to those in whom JHS had been excluded, at their first GI clinic visit. The validated Bowel Disease Questionnaire was completed for GI symptom information. Clinical examination confirmed or excluded the diagnosis of JHS, using the 1998 Brighton criteria. Patients outside the age range or with limited English were excluded. GI symptoms were considered significant if they occurred at least once a week, and were compared between the two groups,

adjusting for sex and age. In view of the multiple comparisons, the significance level was set at 0.005.

Results 413 patients participated: 43 with a previous rheumatological diagnosis of JHS, and 370 in whom JHS had been excluded. There were significantly more females in the JHS group (95% vs 54%, $p=0.000$), and they were younger (mean age: 34.6 ± 10.97 vs 43.3 ± 14.2 , $p=0.000$). Abdominal pain was present in all JHS patients and was significantly more likely to be of more than 5 years duration (OR 4.38 CI 2.1 to 9.1). Other symptoms which were significantly different between the two groups are shown in Abstract PWE-044 table 1. There was no significant difference in the prevalence of constipation (OR 1.1), diarrhoea (OR 0.2), heartburn (OR 1.3), retrosternal chest pain (OR 2), vomiting (OR 1.2), or dyspepsia (OR 2).

Abstract PWE-044 Table 1 Comparison of GI symptoms

Symptom	% in JHS	% in non-JHS	OR (adj for age, sex)	CI
Alternating bowel habit***	63	26	4.6	2.3 to 9.2
Globus**	47	20	3.3	1.6 to 6.7
Dysphagia**	33	12	3.4	1.5 to 7.5
Regurgitation*	34	12	3.0	1.4 to 6.6
Nausea*	48	20	2.6	1.3 to 5.2
Postprandial fullness***	79	43	4.1	1.9 to 9.2
Early satiety**	60	29	2.9	1.5 to 5.8
Bloating***	88	47	6.3	2.3 to 16.9

* $p<0.05$, ** $p<0.005$, *** $p<0.001$.

Conclusion This is the first comparative study of GI symptoms in JHS patients. They have significantly more upper GI symptoms, bloating and alternating bowel habit even when adjusting for age and sex. In view of the association between JHS and unexplained GI symptoms, it is important to consider the diagnosis of JHS in patients with intractable functional GI symptoms, to enable multidisciplinary management. Further studies are needed to determine the mechanism of symptoms in these patients.

Competing interests None declared.

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PWE-045 GASTROPARESIS—CLASSIFYING SEVERITY AND PREDICTING RESPONSE

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Introduction Idiopathic gastroparesis is a chronic disorder of the stomach characterised by delayed gastric emptying in the absence of recognisable causative pathology such as mechanical obstruction or diabetes. Presenting symptoms include early satiety, vomiting and weight loss. Investigation usually includes gastric emptying studies, however significant overlap in gastric emptying times (GET) between normal and abnormal populations can make diagnosis difficult. Using a case series of patients managed at Gloucestershire Hospitals NHS Foundation Trust we explore the relationship between symptomatic presentation and GET, and attempt to correlate factors predicting successful response to treatment.

Methods Patients with clinical features of gastroparesis, and GET of over 100 min on nuclear medicine studies were identified from local radiology and clinic databases. Medical notes were scrutinised for