endoscopic session has been shown to result in complete Barrett's ablation but has a high stricture rate (48–88%).^{1–3} Therefore radiofrequency ablation is preferred for the ablation of Barrett's epithelium after endoscopic mucosal resection (EMR) of visible nodules.

We investigated whether non-radical, stepwise endoscopic mucosal resection with maximal 2 endoscopic resections per endoscopic session also resulted in complete remission of Barrett's epithelium.

Methods We analysed our database of patients undergoing oesophageal EMR for early neoplasia in Barrett's oesophagus from 2008 to 2013. Patients undergoing surgery or palliative therapy after staging EMR showing poorly differentiated cancer or advanced cancer (>T1sm) were excluded. In patients suitable for further endoscopic therapy, EMR was performed using maximal two band ligation mucosectomies per endoscopic session. Patients were endoscopically followed up 3 monthly and EMR was repeated as required for Barrett's ablation. If no dysplasia was detected after a year, the follow up interval was increased to 6 months. Only patients with circumferential Barrett's length of more than 5 cm underwent radiofrequency ablation.

Results 83 patients underwent staging EMR for early Barrett's neoplasia. Subsequently, 25 patients underwent surgery/chemotherapy due to submucosal or more advanced tumour stages or were managed conservatively depending on patient's fitness, comorbidities and choice. 58 patients with HGD (21), intramucosal (22) or submucosal cancer (5) in the resected nodule underwent further endoscopic therapy with a mean follow-up of 24 months (8–36 months IQR). Remission of dysplasia/neoplasia was achieved in 96.5%. Stepwise endoscopic Barrett's resection resulted in complete Barrett's ablation in 28 patients (48.3%) in a median of 4 sessions (IQR 2–5). 31 patients (53.4%) had a short Barrett's segment (<3 cm). In this group, repeated EMR achieved complete Barrett's ablation in 87%. Only two patients developed a stricture (3.4%), there were no perforations.

Conclusion Stepwise, non-radical endoscopic Barrett's resection at the time of scheduled endoscopy follow up allows complete Barrett's ablation with very low stricture rate in patients with short Barrett's segment.

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Disclosure of Interest None Declared.

PTU-025 ENDOSCOPY IN PATIENTS HAVING LONG-TERM ORAL ANTICOAGULANT THERAPY. CHALLENGE OR ROUTINE DAILY PRACTICE?

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Introduction While oral anticoagulant therapy increases the possibility of bleeding, withholding it could cause thromboembolic complications. The BSG provides guidance regarding endoscopy and anticoagulation. Patients may be considered as having a high thromboembolic risk depending on the indication for anti-coagulation. The endoscopic procedures can be classified as high or low risk for bleeding.

Aim To assess the number of significant bleeding events and thromboembolic events in patients undergoing gastrointestinal endoscopy and are being administered anticoagulants.

Methods Patients who had an endoscopy at Mater Dei Hospital from January 2011 to December 2012 and were on oral anticoagulants were identified through the endoscopy database. Their endoscopy report and their clinical case notes were reviewed.

Results 130 patients were recruited. 55% were female. The mean age was 68.6 years (SD +/- 11 years; range 14–89 years). The main indication for anticoagulation with warfarin was atrial fibrillation (56.3%). 44.1% of all procedures involved conditions of high thromboembolic risks. Table 1 demonstrates the indication for anticoagulation and the procedure risk stratification.

53.8% of all patients had a colonoscopy. 22.9% of procedures were classified as high risk for bleeding. 1 patient (1.4%) had haemorrhoid banding. The other has polypectomy (>1cm).

43.1% of patients had an OGD. 10.7% had high risk procedures for bleeding – 1 patient (1.8%) had a gastric polypectomy and 8.9% had variceal banding.

3.1% (4 patients) of patients had a flexible sigmoidoscopy. 2 patients had a polypectomy (>1cm) and the other 2 had haemorrhoid banding (all classified as high risk for bleeding).

1 patient developed a pre-retinal haemorrhage and a vitreal haemorrhage within 30 days post-procedure. This patient had a transcatheter aortic valve implantation and AF (high risk for thromboembolic events). This patient had an OGD where a small angioectatic vessel was coagulated with APC. The INR before and after the procedure was always within therapeutic range. There were no other thromboembolic or significant bleeding events recorded in these patients.

Conclusion Our results demonstrate that adherence to the BSG guidelines on anticoagulation is highly important as to prevent any significant bleeding or thromboembolic complications. However, a new challenge for endoscopists will be the introduction and the wider availability of the new oral anticoagulants.

Disclosure of Interest None Declared.

Abstract PTU-025 Table 1

Clinical indication for anticoagulation	Percentage of patients with low thromboembolic risk	Percentage of patients with high thromboembolic risk
AF	39.3	0
AF + acquired thrombophilic conditions	0	17
AF + metallic valve replacement	0	10
AF + PE	0	4.3
AVR	6	0
MVR	0	3.4
MR + MS	0.8	0
Venous thromboembolism	9.0	9.4
DVT prophylaxis due to ACTH secreting tumour	0.8	0

PTU-026 SAFETY AND EFFICACY OF TRANSNASAL PERCUTANEOUS ENDOSCOPIC GASTROSTOMY PLACEMENT-EXPERIENCE IN A DISTRICT GENERAL HOSPITAL

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Introduction Percutaneous endoscopic gastrostomy (PEG) is an alternative and important way to maintain nutrition. Trans-nasal PEG insertion (t-PEG) using small-calibre endoscope has been reported to be safe and effective than the conventional trans-oral PEG (o-PEG) in malnourished patients with head and neck cancer.¹ The current study aims to evaluate the safety and efficacy of trans-nasal PEG in patients with benign condition.

Methods In this prospective study twelve consecutive patients who were referred for PEG insertion for benign conditions were allocated for conventional and t-PEG into 1:1 ratio over the study period of five months. All the cases were discussed in PEG multidisciplinary team meeting and procedures were performed by a single experienced endoscopist. Data were collected for sedation and comfort score and complications. A visual analogue scale was used for objective assessment of comfort. 14 French CORFLO gastrostomy tubes were used in all the cases.

Results Seven of them were male and the mean age was 64.2 year (range: 21–81 year). The median follow up period was 27 weeks.

More patients needed sedation and analgesia in conventional PEG group and mean sedation dose and comfort score were lower in t-PEG group. Nutritional goals were achieved in all the cases. There was no immediate complication in both group but, one patient in each group had their PEG tube dislodged after four weeks of insertion.

Conclusion The findings from this study reaffirm that t-PEG placement using a small calibre endoscope through nasal route is safe, well tolerated and effective to maintain nutrition in patients with benign conditions. A multicenter randomised controlled trial is necessary to validate our findings and to evaluate the cost effectiveness.

Abstract PTU-026 Table 1

Parameters	t- PEG (n)	o-PEG (n)
Total number of patients	6	6
With LA spray only	2	0
With sedation	2	2
With sedation and analgesia	2	4
Comfort score of 1	5	2
Comfort score >1	1	4
Mean sedation dose (Midazolam in mg)	1.8	2.8

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Disclosure of Interest None Declared.

PTU-027 REAL-TIME EVALUATION OF OESOPHAGEAL CAPSULE ENDOSCOPY IN VARICEAL SCREENING AND SURVEILLANCE – A PILOT PROSPECTIVE STUDY

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Introduction The role of oesophageal capsule endoscopy in assessing oesophageal varices has been previously studied¹ where downloaded images are evaluated subsequent to study completion. This is the first study evaluating real-time viewing of oesophagogastric findings during capsule transit through the upper gastrointestinal tract for this indication.

The primary aim was to assess the accuracy of real time oesophageal capsule study in identifying oesophageal varices in patients undergoing variceal screening or surveillance. Secondary aims were to establish the ability of oesophageal capsule endoscopy to detect gastric varices or portal hypertensive gastropathy, and to ascertain post procedure patient perception of comfort compared to standard gastroscopy.

Methods Inclusion criteria was patients with cirrhosis referred within our centre for variceal screening or surveillance. Exclusion criteria were known dysphagia, suspected or known gastrointestinal tract stricture, suspected active gastrointestinal bleeding and active hepatic encephalopathy.

Capsule assessment was performed by instructing the patient to ingest the oesophageal capsule with sips of water/simethicone mixture in left lateral patient position. Oesophagogastric mucosa was evaluated in real time during capsule transit through a computer attached to the video recorder unit using three sensor element leads.

Standard gastroscopy was performed by another endoscopist, blinded to capsule findings, within the same day. Intravenous sedation was permitted during gastroscopy, if needed.

Patient preference and comfort levels (by digital analogue scale where 0 = no pain, 5 = very painful) were recorded post-recovery.

Results Thirty-one patients with cirrhosis (17 males, 14 females, median age 60 years) were included. There was moderate agreement level in assessing the presence of oesophageal varicose (Kappa value 0.545, $p < 0.005$) (See table below).

Majority of patients ($n = 26$, 84%) preferred oesophageal capsule endoscopy compared to gastroscopy. Capsule endoscopy

Abstract PTU-027 Table 1

	Oesophageal capsule	Gastroscopy	Agreement level
Oesophageal varices			
Present	13	18	72.20%
Absent	11	13	84.60%
Overall			77.4%, Kappa 0.545 $p < 0.005$
Portal hypertensive gastropathy	6	13	46%
Gastric varices	2	3	67%