oesophagus, 4 of 7 (57.1%) oesophageal squamous lesions and 6 of 39 (15.3%) gastric lesions. All patients were discussed at a multidisciplinary meeting and those patients who were fit were offered radical surgery or chemoradiotherapy. Six patients who were offered radical surgery opted for conservative management with endoscopic follow-up. 14 patients proceeded to radical surgery; six of these had no residual cancer in surgical specimen and eight had residual cancer present. 11 of the 14 are currently in disease free survival, two died of recurrence and one died of post-operative complications. Two patients received radical chemoradiotherapy; one is in disease free survival, the other died of advanced adenocarcinoma. One patient received radiotherapy and remains free of recurrence. Nine patients received conservative/endoscopic management; of these seven had disease free survival, two died of metastatic adenocarcinoma. Mean follow-up was 52 months.

Conclusion Our results show that submucosal invasion is found in a significant proportion of patients undergoing upper gastrointestinal ER. Management of SM invasive cancer following ER remains challenging and our series shows a wide variation in management outcomes. Further research to guide the optimum management of this group of patients is required.

Competing interests None declared.

PWE-025 POST-RADIO THERAPY PHARYNGEAL/PROXIMAL OESOPHAGEAL STRICTURES IN HEAD AND NECK MALIGNANCY: OUTCOME OF ENDOSCOPIC BOUGIE DILATION

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Introduction Chemo-radiotherapy is the standard of care for most patients with head and neck malignancy. Radiotherapy may lead to dysphagia due to pharyngeal/proximal oesophageal strictures. Endoscopic management of these strictures with antegrade dilation using Savary Gilliard bougie dilators is described in literature.1, 2 Our aim was to review the outcome in patients referred for bougie dilation for radiotherapy induced strictures.

Methods It is a retrospective case notes review.

Results 11 patients underwent bougie dilation of radiotherapy induced strictures in last 4 years. Nine male, two female patients with median age of 71 years. Five patients had laryngeal cancer and six had oropharyngeal cancer. All patients had radiotherapy where four had concurrent chemotherapy. Five patients required flouroscopy and seven patients required nase endoscope. Median size of initial bougie size was 11 mm and final bougie size was 17 mm. Mean number of procedures per patient was 4. No complications noted. While three patients had good response, six had borderline and two had none. Median interval from completion of radiotherapy to index procedure was 2.5 years with range from 2 months to 12 years.

Conclusion Savary Gilliard bougie dilation appears to be safe and well tolerated method for dilating pharyngeal/proximal oesophageal strictures secondary to radiotherapy treatment for head and neck cancer. While symptom improvement varied among patients probably early intervention might benefit the patient.

Competing interests None declared.

REFERENCES