Introduction Squamous Cell Cancer (SCC) of the oesophagus has a poor prognosis with 5-year survival at 10%. Squamous high grade dysplasia (HGD) is the precursor lesion to SCC. Risk of progression to SCC with Squamous HGD can be 65% at 5 years. Radiofrequency ablation (RFA) is a minimally invasive ablative technique with proven efficacy for early neoplasia in Barrett’s Oesophagus.

Methods Prospective multicenter registry of patients undergoing RFA for Squamous HGD and early carcinoma in situ (CIS) from eight UK centers. Nodular lesions were removed by endoscopic mucosal resection before RFA. Treatment consisted of a single ablation at 12 L/cm². Patients were followed-up monthly and repeat biopsies taken. Those with residual dysplasia underwent RFA 3 months after until 12 months where they were assessed for treatment success or failure.

Results 25 patients have undergone ablation for squamous HGD/CIS. We report on 17 patients to have completed protocol. Mean length of dysplastic epithelium ablated was 5 cm (1–14). Mean time to protocol completion was 8.7 months. CR-HGD was seen in 59% of patients and CR-D in 76% at end of protocol biopsy with mean of 1.4 RFA treatments (1–5). All those with successful outcomes remain free of dysplasia at most recent biopsy, median follow-up 10.6 months (2–36) from first treatment. At protocol completion, six of 17 patients (35%) had progressed to invasive cancer and referred for surgery or chemo-radiotherapy. Three patients (18%) required dilatations for oesophageal structuring after first treatment. Two of these patients have required serial dilatations thereafter with an average of four dilatations per patient.

Conclusion Squamous HGD and CIS are very aggressive pathologies as evidenced by the fact a third of patients progressed to invasive disease despite RFA. The role of RFA in these patients remains unclear. In our series 47% of patients responded to RFA & have reassuringly remained free of dysplasia at last follow-up. These figures are lower than limited published data to date but in our series an emphasis was placed on restaging carefully after each treatment to assess for progression. As our experience grows with confidence in identifying these lesions more accurately and increasing the frequency and number of ablations administered over the protocol period, dysplasia reversal rates will be expected to increase.

Competing interests None declared.

PWE-029 OBJECTIVE ASSESSMENT OF PHYSICAL ACTIVITY AS A MEASURE OF FUNCTIONAL RECOVERY AND QUALITY OF LIFE FOLLOWING OESOPHAGO-GASTRIC CANCER RESECTION

doi:10.1136/gutjnl-2012-302514d.29


Introduction Functional recovery following surgery is determined by the interaction between pre-operative performance, post-operative catabolism, nutritional status, and mood. Physical activity (PA) is an important domain of health-related quality-of-life (HRQL), and may be a useful objective index of recovery. We aimed to use an accelerometer-based activity metre (ActivPAL) to monitor post-operative PA in oesophago-gastric (OG) cancer patients undergoing surgery with curative intent.

Methods PA measures, including step count, time spent in various body positions, and energy expenditure of activity, were assessed over 7-day periods in patients undergoing oesophagectomy or gastrectomy (n=16). Nutritional status, HRQL (FAACT, FACIT-F and EORTC-QLQ-C30 questionnaires), and mood (HADS questionnaire) were also assessed. Time-points were pre-operatively and 1–2 weeks, 5–6 weeks, 3 months and 6 months post-operatively.

Results Compared with pre-operative results, PA measures were decreased by 23–89% (p<0.05) 1–2 weeks post-operatively, and were still decreased by 15–57% (p<0.05) 5–6 weeks post-operatively.

Competing interests None declared.

1 R J Haidry, * J Dunn, * M Banks, A Gupta, M A Butt, H Smart, P Bhanderi, LA Smith, P Willert, F Fullarton, M Di Pietro, P Penman, H Barr, C Gordon, P Patel, B Roger, N Kappor, B Mahon, M Burnell, M Novelli, L B Lovat. 1Department of Surgery, National Medical Laser Centre, London, UK; 2Department of Gastroenterology, University College Hospital, London, UK; 3Department of Gastroenterology, Royal Liver University Hospital, Liverpool, UK; 4Department of Gastroenterology, Princess Alexandra Hospital, Portsmouth, UK; 5Department of Gastroenterology, Bradford Teaching Hospital, Bradford, UK; 6Department of Gastroenterology, Central Manchester University Hospital NHS Foundation Trust, Manchester, UK; 7Department of Surgery, Royal Infirmary, Glasgow, Glasgow, UK; 8Department of Gastroenterology, Aintree University Hospital, Liverpool, UK; 9Department of Gastroenterology, Aberdeen’s Hospital, Cambridge, Cambridge, UK; 10Department of Gastroenterology, Royal Infirmary, Edinburgh, UK; 11Department of Surgery, Gloucestershire Hospitals NHS Trust, Gloucester, UK; 12Department of Gastroenterology, Royal Bournemouth Hospital, Bournemouth, UK; 13Department of Gastroenterology, Southampton University Hospital, Southampton, UK; 14Department of Gastroenterology, Aintree University Hospital, Liverpool, UK; 15Department of Gastroenterology, Queen Elizabeth hospital, Birmingham, UK; 16Department of Biostatistics, University College London, London, UK; 17Department of Histopathology, University College Hospital, London, UK