Introduction Perforated gastric ulcers are potentially complicated surgical emergencies. Appropriate early management is essential to avoid subsequent problems including the detection of underlying malignancy. Our aim was to examine the management and outcome of patients with gastric perforations undergoing emergency laparotomy for peritonitis.

Methods Patients undergoing laparotomy in the department of General Surgery for perforated gastric ulcers were identified from the prospectively maintained Lothian Surgical Audit (LSA) database over the 5-year period 2007–2011. Additional data were obtained by review of electronic records and the endoscopy reporting system (UNISOFT), in addition to reference with the South East Scotland oesophagogastric Cancer Network (SCAN) database and the histopathology laboratory Database (APEX).

Results 45 patients were identified. The procedures performed were: 41 omental patch repairs (91%), two simple closures (4%) and two double positive cells into the duodenal mucosa of patients with postsurgical functional dyspepsia. Am J Gastroenterol 2010; 105: 1835–42.

REFERENCES

PWE-176 THE MANAGEMENT OF PERFORATED GASTRIC ULCERS

doi:10.1136/gutjnl-2012-302514d.176

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References

PWE-178 FEASIBILITY, SAFETY AND EFFICACY OF ENDOSCOPIC RESECTION OF UPPER GASTROINTESTINAL SUBMUCOSAL LESIONS IN A WESTERN SETTING

doi:10.1136/gutjnl-2012-302514d.178


Introduction Submucosal lesions are a relatively common finding at upper gastrointestinal endoscopy. Endoscopic resection (ER) may be warranted in larger lesions, those causing symptoms or those with malignant potential. However submucosal origin makes these lesions difficult to resect by an endoscopic approach. Advances in resection techniques have made this feasible.

Methods Portsmouth Hospitals is a tertiary referral centre for advanced ER. All ER procedures between 2005 and 2011 were recorded in a prospective database. We analysed our database to identify all submucosal lesions removed by ER in the past 7 years.

Acute bleeding from upper GI tract angiodysplasia can be managed successfully by endoscopic therapy in the majority of patients, but approximately a third of patients will experience recurrent bleeding requiring additional medical therapy.

Competing interests None declared.

PWE-177 ACUTE BLEEDING FROM UPPER GI TRACT ANGIODYSPLASIA

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Introduction Angiodysplasia is a relatively uncommon cause of acute upper GI bleeding (AUGIB). The aim of this study was to characterise the presentation, management, and outcome of this condition.

Methods Retrospective audit of upper GI endoscopies (UGIE) performed at our institution between 1 January 2007 and 30 June 2010. Data were extracted from the endoscopy reporting software (UNISOFT) database using search terms “angiodysplasia,” “angiomatous” and “telangiectasia” for oesophageal, gastric and duodenal diagnoses. These three terms were grouped together as “angiodysplasia” for analysis. The casenotes for all patients presenting with haematemesis and/or melena were reviewed.

Results During the 42-month period of the audit, a total of 1542 UGIEs were performed. A diagnosis of upper GI tract angiodysplasia was recorded in 199 procedures, representing 152 patients. Of these, 38 were excluded as they had presented with chronic anaemia and 35 patients had undergone UGIE for other indications. 59 patients had presented with haematemesis and/or melena. Of these six were excluded from further analysis as the diagnosis of angiodysplasia was not confirmed at subsequent endoscopy, a further seven patients had co-existing lesions which were thought to have accounted for the bleeding. Therefore, the results are presented for 26 patients; the mean age was 70 years (range 34–91) and 15 (59%) were males. Twelve (44%) were taking aspirin NSAIDs, and five (19%) were on anticoagulant therapy. Mean haemoglobin level at presentation was 9.4 g/dl (range 4.0–14.9). Three (11%) of patients had a past history of AUGIB of unknown source, two (7.4%) of patients had a history of previous bleeding from known angiodysplasia. Von Willebrand’s disease was noted in three (11%) of patients: four (14.8%) of patients had documented aortic stenosis, with a further two (7.4%) having had an aortic valve replacement. The 26 patients experienced 42 separate admissions (single admission—13 patients, eight patients >1 admission) with AUGIB during the study period. In 39 (93%) of these episodes the presentation was with melena, and three (7%) with haematemesis plus melena. Active bleeding was seen in 13 (30%) of these episodes, with luminal blood present in a further four (9%) cases. Endoscopic therapy with argon plasma coagulation or heater probe was undertaken in 35 (81%) of these episodes. Seven (26%) of the patients required additional therapy with either Octreotide, Thalidomide or Tranexamic Acid for uncontrolled or recurrent bleeding. There were no deaths observed due to GI bleeding.

Conclusion Acute bleeding from upper GI tract angiodysplasia can be managed successfully by endoscopic therapy in the majority of patients, but approximately a third of patients will experience recurrent bleeding requiring additional medical therapy.

Competing interests None declared.

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Methods Portsmouth Hospitals is a tertiary referral centre for advanced ER. All ER procedures between 2005 and 2011 were recorded in a prospective database. We analysed our database to identify all submucosal lesions removed by ER in the past 7 years.

All procedures were carried out by a single skilled endoscopist.

REFERENCE