

REFERENCES

1. **Talley NJ**, Walker MM, Aro P, *et al.* Non-ulcer dyspepsia and duodenal eosinophilia: an adult endoscopic population-based case-control study. *Clin Gastroenterol Hepatol* 2007;**5**:1175–83.
2. **Walker MM**, Salehian SS, Murray CE, *et al.* Implications of eosinophilia in the normal duodenal biopsy - an association with allergy and functional dyspepsia. *Aliment Pharmacol Ther* 2010;**31**:1229–36.
3. **Friesen CA**, Sandridge L, Andre L, *et al.* Mucosal eosinophilia and response to H1/H2 antagonist and cromolyn therapy in pediatric dyspepsia. *Clin Pediatr (Phila)* 2006;**45**:143–7.
4. **Futagami S**, Shindo T, Kawagoe T, *et al.* Migration of eosinophils and CCR2-/CD68-double positive cells into the duodenal mucosa of patients with postinfectious functional dyspepsia. *Am J Gastroenterol* 2010;**105**:1835–42.

PWE-176 THE MANAGEMENT OF PERFORATED GASTRIC ULCERS

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

C Skouras,* M F Leeman, S Paterson-Brown. *Department of Surgery, Royal Infirmary of Edinburgh, Edinburgh, UK*

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 distal gastrectomies (4%—both for large perforations). There were four perforated gastric tumours (4%), of which two were suspected intra-operatively and confirmed histologically, one had unexpected positive histology and one had negative histology, but follow-up endoscopy confirmed carcinoma; all four were managed without resection at initial laparotomy. One of these patients underwent subsequent resection for cancer after full staging and optimisation but subsequently developed tumour recurrence and died. Median length of stay was 8 days (range 4–68). The overall inpatient mortality was 15% and there were 20 morbidities (44%; including nine respiratory complications, four wound infections and two myocardial infarctions). 33 patients had biopsies taken during surgery. Two of the remaining 12 patients had biopsies taken during postoperative endoscopy. None of the remaining 10 patients were subsequently referred with cancer. Seventeen patients in total underwent a follow-up postoperative endoscopy and 11 of them had biopsies taken.

Conclusion The majority of perforated gastric ulcers can be effectively managed by laparotomy and omental patch repair. Initial biopsy and follow-up endoscopy with repeat biopsy is essential to avoid missing an underlying malignancy.

Competing interests None declared.

PWE-177 ACUTE BLEEDING FROM UPPER GI TRACT ANGIODYSPLASIA

doi:10.1136/gutjnl-2012-302514d.177

¹P Phull, ²N Nagrath.* ¹*Gastrointestinal & Liver Service, Aberdeen Royal Infirmary, Aberdeen, UK;* ²*Medical School, University of Aberdeen, Aberdeen, UK*

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,” “angioma” 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 melaena were reviewed.

Results During the 42-month period of the audit, a total of 15 482 UGIEs were performed. A diagnosis of upper GI tract angiodysplasia was recorded in 199 procedures, representing 132 patients. Of these, 38 were excluded as they had presented with chronic anaemia and 55 patients had undergone UGIE for other indications. 39 patients had presented with haematemesis and/or melaena. 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 yrs (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—18 patients, eight patients >1 admission) with AUGIB during the study period. In 39 (93%) of these episodes the presentation was with melaena, and three (7%) with haematemesis plus melaena. 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.

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

P J Basford,* R J Mead, M D Duku, G R Longcroft-Wheaton, P Bhandari. *Department of Gastroenterology, Portsmouth Hospitals NHS Trust, Portsmouth, UK*

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. All procedures were carried out by a single skilled endoscopist.