Introduction
The traditional diagnosis of celiac disease (CD) requires a small bowel biopsy to identify at histology the characteristic mucosal changes. The current biopsy practise among endoscopists for CD is in most part unknown. The aims of this study were to compare the different diagnostic criteria in various centres in Italy, Iran, Lithuania, Romania and the UK, the methodological approach to the biopsy and to investigate the pitfalls of CD diagnosis.

To measure the number of specimens submitted during duodenal biopsy among patients in Italy, Iran, Lithuania, Romania and the UK, and to determine the incremental diagnostic yield of adherence to the recommended number of specimens.

Methods
A total of 931 patients who underwent duodenal biopsy for CD were recruited prospectively at nine centres in European and Middle East countries. Small-bowel biopsies were obtained from the duodenal bulb and the second part of the duodenum (and from the duodenal bulb when it had a micronodular appearance). The histopathological appearances were described according to the modified Marsh classification.

Results
The most frequent degree of villous atrophy amongst Iranian subjects was 3A and that of the rest of the study population was 3C. The most common number of biopsy specimens for Romans subjects was 1 (52%) followed by 2 for Iranian (56%), 3 for Lithuanian (66.7%) and British patients (65%) and 4 for Italian patients (48.3%). The main presenting symptom was anaemia (18.7%) followed by malabsorption (10.5%), diarrhoea (9.3%) and dyspepsia (8.2%).

Conclusion
Taking less biopsy samples than recommended will have a negative impact in detecting massive number of undiagnosed cases. As CD is more common with atypical presentation, taking 4 duodenal biopsies is mandatory for an accurate diagnosis or its exclusion.

Disclosure of Interest
None Declared

Abstract OC-023 Table

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>GI (n = 53)</th>
<th>Non-GI (n = 24)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male:Female</td>
<td>43:10 (4.3:1)</td>
<td>17:7 (2.4:1)</td>
<td>0.37</td>
</tr>
<tr>
<td>Time to endoscopy (days)</td>
<td>1.23 ± 1.57</td>
<td>1.79 ± 2.93</td>
<td>0.38</td>
</tr>
<tr>
<td>Laparotomy</td>
<td>0</td>
<td>2 (8.3%)*</td>
<td>0.09</td>
</tr>
<tr>
<td>Mortality ascribed to UGB</td>
<td>3 (5.7%)</td>
<td>2 (8.3%)*</td>
<td>0.64</td>
</tr>
</tbody>
</table>

*Different patients

Conclusion
The length of stay of patients with UGB is dramatically shorter when receiving specialist care. This was statistically significant even after adjusting for social issues. Further data regarding the specific management of each case will be forthcoming. In line with previous reports [3], we found that the incidence of UGB was higher in males. There was a trend toward better risk assessment, shorter time to endoscopy, reduced need for surgery and mortality in the GI group. Mortality rates in both groups compared favourably to the national average.

Disclosure of Interest
None Declared

REFERENCES
1. CG141
2. Scope for improvement: A toolkit for a safer Upper Gastrointestinal Bleeding (UGIB) service. www.bsg.org.uk

OC-024 PROLONGED PLATELET ACTIVATION IN PATIENTS WITH ACUTE UPPER GASTROINTESTINAL BLEEDING

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Introduction
Acute upper gastrointestinal bleeding (AUGIB) is a common reason for hospital admission and is associated with significant cardiovascular (CVS) morbidity and mortality. Patients who have aspirin withheld for 8 weeks following AUGIB have significantly higher rates of CVS events. We previously demonstrated that patients with AUGIB have significantly higher levels of platelet activation during the index hospital admission. This study aimed to assess the level of platelet activation and reactivity 12 weeks following admission for AUGIB.