Abstract PTU-151 Table

	Preoperative median (IQR*)	Postoperative median (IQR*)
Hiatal hernia by HRM and intraoperative diagnosis (n)	11	0
Mean Basal EGJ pressure (mmHg)	8.3 (2.6, 11.2)	15.8 (9.9,22.8)
Minimal Basal EGJ pressure (mmHg)	0.5 (–2.8, 4.1)	6.5 (4.6, 14.8)†
IRP (mmHg)	1.5 (–0.7, 3.7)	5.2 (2.1, 11.8)††
IBP (mmHg)	14.1 (9.6, 18.7)	13.9 (7.1, 24.6)
DCI (mmHgxsxcm)	1324 (711.6, 2207.7)	1381.7 (648, 2699.7)

* interquartile range; † $p < 0.01$; †† $p < 0.001$

Conclusion HRM is not reliable tool to diagnose HH. Due to poor sensitivity of HRM in detecting HH, manometric profile of patients with HH versus those without should be evaluated with caution. Surgical correction of HH contributes to higher EGJ relaxation pressure and improvement of antireflux barrier however neither bolus pressurisation nor DCI is affected by fundoplication.

Disclosure of Interest None Declared

PTU-152 HIGH RESOLUTION MANOMETRY PATTERN OF ESOPHAGOGASTRIC JUNCTION AND ESOPHAGEAL MOTILITY IN PATIENTS BEFORE AND AFTER FUNDOPLICATION

doi:10.1136/gutjnl-2013-304907.242

[1,*]K Bilnik, [1]E Klimacka-Nawrot, [2]J Kurek, [1]B Blonska-Fajfrowska, [1,2]A Stadnicki. *[1]Basic Biomedical Sciences, Medical University of Silesia, Sosnowiec; [2]Department of Surgery, District Hospital, Jaworzno, Poland*

Introduction Until now it has been limited knowledge related to the application of high resolution manometry(HRM) for the evaluation of fundoplication results. The aim of this study is to assess prospectively esophagogastric junction(EGJ) relaxation and resting pressures and esophageal motility by HRM in patients with gastroesophageal reflux disease(GERD) before and after laparoscopic Nissen fundoplication.

Methods 25 patients with GERD(15 females; mean age 46.8) underwent HRM before(preoperative group) and at least 3 months after surgery(postoperative group). Manometric protocol included 10 consecutive swallows of 10 ml of water. Variables from pre and postoperative group were compared using Wilcoxon test for paired samples and also McNemar's test was done to evaluate if surgery had influenced values normalisation.

Results In postoperative group mean basal EGJ pressure as well as minimal basal EGJ pressure were significantly higher than in preoperative group. Integrated relaxation pressure(IRP) was also significantly higher in postoperative group as compared with preoperative group. IRP values were within the normal range in both examined groups(<15 mmHg) except one patient in postoperative group. Before fundoplication 11 patients had hiatal hernia, but none after surgery. Significant increase of intrabolus pressure(IBP) and decrease of contractile front velocity(CFV) were found in postoperative group as compared with preoperative group. Distal contractile integral(DCI) was significantly higher in postoperative group, however based on DCI threshold(450mmHgxsxcm) only trend from ineffective to effective esophageal motility was observed($p = 0.07$). Also double-peaked waves were more frequent in postoperative than in preoperative group. Early dysphagia was observed in 8 of 25 patients after fundoplication. Data is shown in table.

Conclusion HRM is valuable tool for EGJ characteristics in GERD patients before and after fundoplication. Fundoplication establishes antireflux barrier by increasing EGJ resting pressures and correcting hiatal hernia. Even moderate increased of IRP may contribute to motility disorders and bolus pressurisation in some patients after fundoplication.

Disclosure of Interest None Declared

PTU-153 A FORMAL SURVEILLANCE PROGRAM WITH DEDICATED ENDOSCOPY LISTS IS REQUIRED TO IMPROVE COMPLIANCE WITH THE BRITISH SOCIETY OF GASTROENTEROLOGY (BSG) GUIDELINES FOR DIAGNOSIS AND MANAGEMENT OF BARRETT'S COLUMNAR-LINED OESOPHAGUS

doi:10.1136/gutjnl-2013-304907.243

[1,*]K Nemeth, [2]V Shah, [1]A Rasheed. *[1]Gwent Centre for Oesophageal Diseases; [2]Department of Pathology, Royal Gwent Hospital, Newport, UK*

Introduction Endoscopic surveillance of Barrett's oesophagus is recommended by many national societies to detect progression to adenocarcinoma at an earlier stage.

Our aim was to audit Aneurin Bevan Health Board (ABHB) compliance with the 2005 British Society of Gastroenterology (BSG) guidelines for the diagnosis and management of Barrett's columnar-lined oesophagus.

Methods Aneurin Bevan Health Board electronic prospective histopathological database was searched to identify all cases coded as Barrett's oesophagus (BO) during the period from 2005 to 2011. Endoscopy reports of all patients were matched with histology reports. A retrospective registry was then constructed including demographics, clinico-pathological features, modes and rates of follow-up, pathological progression and incident cancer rate during the study period.

Results A total of 773 cases were coded as BO during the period 2005 to 2011. Interrogation of all records confirmed 620 cases to be worthy of inclusion excluding 153 cases due to inadequate data or incorrect coding. The 620 cohort of patients consisted of 406 males and 214 females with a median age of 65 years (range 20 to 97years). BO histological confirmation was attained in 592/620 cases at index endoscopy and during a follow-up endoscopy in 28/620 cases. Intestinal metaplasia was reported in 459/620 cases. Dysplasia was diagnosed in 58/620 cases at index endoscopy; 16/620 of these index

Abstract PTU-152 Table

	Preoperative median (IQR*)	Postoperative median (IQR*)	p value
Mean Basal EGJ pressure (mmHg)	10.0 (5.7 – 15.6)	15.8 (15.2 – 23.7)	$p < 0.05$
Minimal Basal EGJ pressure (mmHg)	1.8 (–1.1 – 6.5)	7.3 (4.6 – 13.9)	$p < 0.001$
IRP (mmHg)	2.0 (0 – 3.3)	6.0 (2.9 –11.4)	$p < 0.001$
Hiatal hernia (n, %)	11 (45%)	0	
IBP (mmHg)	10.2 (6.2 – 14.1)	13.9 (11.7 – 20. 8)	$p < 0.05$
DCI (mmHgxsxcm)	859 (430 – 1574)	1008 (725 – 1968)	$p < 0.05$
CFV (cm/s)	4.3 (3.1 – 5.4)	2.9 (2.0 – 4.0)	$p < 0.01$
Double-peaked waves (%)	(0 – 22)	(0 – 78)	$p < 0.01$

* interquartile range