**Abstract OC-019 Table 1**

| Station | Cardia (%) | Fundus (%) | Body (%) | Incisura (%) | Antrum (%) | Pylorus (%) |
|---|---|---|---|---|---|---|
| Fundal dependent + antral dependent | 87 | 99 | 99 | 100 | 100 | 45 |
| Fundal dependent + opposite antral dependent | 92 | 99 | 99 | 100 | 100 | 86 |
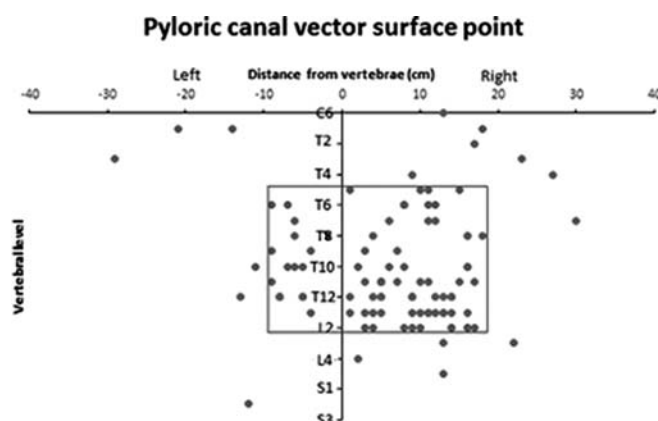


**Abstract OC-019 Figure 1**

ability of a capsule endoscope to visualise 6 anatomical landmarks (cardia, fundus, body, incisura, antrum and pylorus). Success of visualisation of an anatomical area was only accepted when >90% mucosal visualisation was achieved from a particular station. The pyloric canal angles were calculated to create a vector. We mapped the position of this vector on the patient's skin (pyloric canal vector surface point) to determine the optimal placement of the magnet that would allow traversing of the capsule endoscope through the pylorus.

**Results** There were 65 female and 35 male patients. Mean age of patients was 53 years (s.d+/-18 years). Best mucosal visualisation of the stomach landmarks was achieved from 3 stations; fundal dependant, antral dependent and opposite the antral dependent points. Maximal visualisation of the whole of the stomach, required combining 2 stations as shown in Table 1.

The box in the figure shows the placement of the magnet in the upper back towards the right loin would allow pyloric traversing of the capsule endoscope in 83% of cases. Increasing age (p = 0.03) and inability to view the pylorus (p = 0.04) were predictors of being outside the box.

**Conclusion** CT modelling has provided important data regarding the optimal stations in the stomach to position a magnetic capsule endoscope to allow maximal luminal mucosal visualisation and traversing the pylorus. Although there is some extreme variation in the upper GI anatomy, the majority of cases will allow the use of a single standard method in performing MACE which may be very useful for screening purposes.

**Disclosure of Interest** None Declared.

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OC-020 | **COMPARATIVE EFFECTIVENESS OF NOVEL TECHNIQUES FOR BARRETT'S OESOPHAGUS (BO) SCREENING IN THE COMMUNITY: A PROSPECTIVE RANDOMISED TRIAL**

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**Introduction** BO is the strongest precursor of oesophageal adenocarcinoma. Participation patterns and effectiveness of BO community screening using unsedated transnasal endoscopy (uTNE) is unknown. Feasibility of mobile van screening closer to home is also unknown. We aimed to assess the effectiveness of this technique compared to sedated endoscopy (SE).

**Methods** A population cohort ≥50 years of age, with no history of endoscopic evaluation, was identified from a group of subjects who previously completed a validated symptom questionnaire. Patients were randomised (stratified by age, sex and reflux symptoms) and invited to undergo either uTNE in a mobile research van (muTNE), uTNE in outpatient endoscopy suite (huTNE) or SE. uTNE was performed using a portable oesophagoscope with a disposable sheath. Procedure performance characteristics and validated tolerability scales (0 = none and 10 = severe) were recorded.

**Results** 459 subjects were contacted and 209 (46%) agreed to undergo study procedures (muTNE n = 76, huTNE n = 72, SE n = 61). Baseline characteristics were comparable among the three groups.

Participation rates were numerically higher in the unsedated arms (muTNE 47.5%, huTNE 45.7%) than in the SE arm (40.7%) (p = 0.27). Patients with acid reflux symptoms ≥1/week were more likely to participate (odds ratio 2.94, 95% confidence interval 1.47, 5.88).

Complete evaluation of the oesophagus was comparable using muTNE (99%), huTNE (96%) and SE (100%) techniques. Successful biopsy acquisition was lower in the muTNE (79%) and huTNE (83%) groups compared to SE (100%) (p = 0.001).

Mean duration (minutes) of examination was shorter in the SE arm (4.7) than in muTNE (8.0) and huTNE (8.5) groups (p < 0.001). However, recovery time was much longer for SE (67.3) compared to muTNE (15.5) and huTNE (18.5) techniques (p < 0.001).

While overall tolerability for SE was better than muTNE and huTNE (mean score 0.4 vs. 1.9 and 2.2 respectively, p < 0.001), the majority of patients who underwent muTNE and huTNE were willing to undergo the same procedure again in future (79% and 83%, respectively). No serious adverse events were reported. 16 subjects (7.6%) were diagnosed with BO.

**Conclusion** In this first large randomised trial evaluating novel approaches for community screening for BO, unsedated mobile van and clinic screening with TNE was feasible and effective. The patients' visit was significantly shorter with adequate tolerability, acceptability and safety profiles. Mobile and outpatient techniques may provide a cost-effective alternative to SE for BO screening.

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OC-021 | **GASTRIC ULCER FOLLOW-UP: THE IMPACT OF NICE GUIDELINES**

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**Introduction** While the National Institute for Health and Care Excellence (NICE) recommends a follow-up gastrocopy