

London Cancer Network has devised and implemented a suspected cancer referral form for Primary Care Practitioners for patients to be seen within two weeks of referral to secondary care. One group referred on the suspected upper GI cancer referral form is patients unexplained iron deficiency anaemia (IDA) without other symptoms. Whilst IDA is a recognised finding in upper GI cancer we hypothesise that it is a rare presentation of upper GI cancer in the absence of other symptoms.

**Methods** The aim of this study is to assess the presenting symptoms in patients diagnosed with upper GI cancer when endoscopy is performed for anaemia as the primary indication.

A single centre, retrospective analysis of all patients undergoing endoscopy for IDA from August 2008 for 5 years at a District General Hospital in North London was performed. Data was collected using electronic patient records and unisoft endoscopy database. Those diagnosed with upper GI cancer were scrutinised for presence of symptoms in addition to anaemia at presentation.

**Results** Over the study period, 1529 patients were gastroscopied for IDA, and 1228 colonoscoped for IDA. 20 upper GI cancers (16 stomach, 4 oesophageal) were detected during the study. No patients with upper GI cancer had IDA alone with addition symptoms including weight loss (9 patients), malaena (3), dysphagia (3), abdominal pain (2), anorexia (2), abnormal CT scan (2), altered bowel habit (2). Other benign diagnosis at gastroscopy in anaemic patients included: Barrett's oesophagus (52), oesophagitis (159), oesophageal varices (11), gastric erosions (27), gastritis (438), pyloric stenosis (2), angiodysplasia (20), duodenal ulcer (35), duodenitis (139). In the group colonoscoped for anaemia findings included: Normal in 550, 66 had colorectal cancer, polyps in 173, angiodysplasia in 33, and IBD in 16.

**Conclusion** From this study we conclude that upper GI cancer is diagnosed on gastroscopy in only 1.3% of patients presenting with IDA. When Upper GI cancer is diagnosis in IDA it is always associated with an additional symptom such as weight loss, anorexia, dysphagia, malaena or an abnormal CT scan.

Patients should not be referred with IDA on a suspected upper GI cancer referral form unless accompanied by additional alarm features. If a patient has isolated IDA and cancer is suspected a diagnostic colonoscopy is more rewarding than a gastroscopy and it is more appropriate to refer these patients to the colorectal cancer pathway. If similar findings are replicated than National guidelines should be informed and altered accordingly.

**Disclosure of Interest** None Declared.

#### PTU-050 THE VALUE OF GASTROSCOPY IN THE INVESTIGATION OF NON CARDIAC CHEST PAIN

SK Butt\*, K Besherdas. *Gastroenterology, Chase Farm Hospital, London, UK*

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**Introduction** Non-cardiac chest pain (NCCP) is a common cause for referral to gastroenterology. Following the exclusion of a cardiac cause, NCCP is attributed to a variety of disorders, including gastroesophageal reflux disease (GORD), oesophageal dysmotility and oesophageal hypersensitivity, panic attack, musculoskeletal pain, and microvascular disease (cardiac syndrome X). GORD is the most prevalent cause of NCCP, accounting for up to 60% of cases. The prevalence of GORD in NCCP has been studied by pH monitoring and found to be 41% to 43%.

**Methods** The aim of this study was to assess the diagnostic yield of gastroscopy as a first line investigation in the management of patients with NCCP. A retrospective analysis from September 2000–March 2013 of the endoscopic findings (using the Endoscribe and unisoft endoscopy reporting system) along with patient case notes, of consecutive patients with NCCP undergoing gastroscopy, in a district general hospital in North London was undertaken.

**Results** A total of 146 patients (age range was 21 to 93 years with a male to female ratio of 68:78) were identified as having had an upper GI endoscopy for chest pain alone. 49/146 (34%) patients had a normal gastroscopy, 29/146 (20%) had evidence of GORD (oesophagitis, peptic stricture, Barrett's oesophagus or hiatus, hernia), 27 patients (18%) had gastritis, and 11 (7%) with oesophageal motility disorders. Other findings included: 9 patients with duodenitis, 1 with gastric ulcer, 1 with oesophageal ulcer, 2 with gastric polyp.

**Conclusion** In this study, the diagnostic yield of gastroscopy as to a oesophageal cause of NCCP is poor. 73% of patients with NCCP had a normal or incidental benign non-contributory findings at endoscopy. Only 27% of patients had evidence of GORD or oesophageal dysmotility. The majority of these could have been diagnosed by high dose acid suppression therapy trial. We conclude that endoscopy in patients presenting to gastroenterology with NCCP is not a cost effective diagnostic tool and would suggest other modalities such as high dose proton pump inhibitor trial, barium swallow or oesophageal manometry/pH testing be explored as first line investigations.

**Disclosure of Interest** None Declared.

#### PTU-051 OODYNOPHAGIA – A SYMPTOM WORTH ASKING ABOUT?

S Subramaniam\*, G Goodchild, K Besherdas. *Department of Gastroenterology, Barnet and Chase Farm NHS Trust, London, UK*

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**Introduction** Oodynophagia can be defined as a painful sensation in the oesophageal region that occurs in relation to swallowing. Unlike dysphagia, which has historically been an alarm symptom or warning sign of oesophageal cancer, oodynophagia is not classified as an alarm symptom and does not form part of the suspected upper gastrointestinal (GI) cancer referral form in the UK. Endoscopy is the gold standard imaging modality for the diagnosis of mucosal lesions in the oesophagus. However, there is no clear data regarding the findings at endoscopy in patients scoped for oodynophagia. Mucosal abnormalities even in the presence of typical symptoms of gastro-oesophageal reflux disease, namely heartburn and regurgitation are absent in up to 70%. We hypothesise that the presence of oodynophagia has a high predictive value of mucosal abnormality at endoscopy and aimed to assess the findings at endoscopy for patients scoped for oodynophagia.

**Methods** A retrospective analysis of all patients who underwent upper GI endoscopy for oodynophagia as a primary symptom over an 8-year period (2005–2013) within an NHS Trust in north London was performed. Data was obtained from the Unisoft Endoscopy reporting software. The findings at endoscopy in patients with oodynophagia were scrutinised.

**Results** 50 patients were endoscoped for oodynophagia during the study period. 34 of 50 patients (68%) had oesophageal mucosal lesions (4 Barrett's mucosa, 2 candida oesophagitis, 14 reflux oesophagitis, 6 malignant tumour, 5 oesophageal stricture,