Abstract PTH-114 Table 1

Variable	US (n=85)		CT (n=38)		MRCP (n=68)	
	Sensitivity%		Sensitivity%		Sensitivity%	
	(95% CI)		(95% CI)		(95% CI)	
	All	CBDS	All	CBDS	All	CBDS
	CBDS	≥1 cm	CBDS	≥1 cm	CBDS	≥1 cm
Dilated CBD	63 (52–73)	67 (54–80)	87 (76–98)	96 (88–100)	77 (67–87)	93 (86–100)
Intra-ductal Contents	16 (8–24)	17 (6–28)	68 (53–83)	77 (60–95)	85 (77–93)	97 (91–100)

Overall US performed poorly for the detection of CBDS even when accounting for stone size. As the presence of overlying bowel gas may have contributed to these Results, a further analysis was performed after excluding the 22 cases (25%) in which the bile duct could not be visualised at US. In this sub-group analysis, the sensitivity of US for detecting CBDS remained similar (dilated CBD sensitivity 64% and intra-ductal content sensitivity 18%).

Conclusion Our study demonstrates that US performs poorly in the detection of CBDS in a real-world setting even when accounting for confounding factors such as overlying bowel gas or stone size. In our study, approximately one third of patients with CBDS did not have a dilated CBD on US (diameter ≤6 mm). Moreover, due to spectrum bias it is likely that the true sensitivity of US in the wider population is much lower. By contrast, the performance of both CT and MRCP was more comparable with published data. Whereas our findings may relate specifically to the performance of US in our unit, a larger study continues to determine if the sample size has contributed to our findings.

PTH-115 TREATMENT OF GASTRIC FUNDAL VARICES WITH EUS GUIDED EMBOLISATION COMBINING COIL PLACEMENT WITH THROMBIN INJECTION

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Introduction Gastric varices are present in 5%–33% of patients with portal hypertension with incidence of bleeding of around 25% in 2 years.¹ If gastric varices are identified as the source of bleeding, therapeutic options include endoscopic Methods, TIPSS, surgery and non-selective beta blockade.² There are reports of EUS guided coiling combined with cyanoacrylate glue³ but limited literature on safety and efficacy of EUS guided coil embolisation with human thrombin injection. We report our experience.

Methods We analysed data of all EUS guided interventions for the management of bleeding gastric varices between 2015–2017 at a liver transplant centre. Olympus EUS linear scope was used to inject human thrombin (Tisseel; 500IU/ML) in gastric varices with or without coils (Nester Embolization Coils).

Results A total of 10 EUS guided interventions in 6 patients (4 M and 2 F), aged 55 (41–59) yrs for secondary prophylaxis. 67% patients had cirrhosis with MELD score of 14(10–21) and 75% were Child-Pugh class C. The remainder had

non-cirrhotic portal hypertension. All patients had previous bleeding from gastric varices and 2/3rd were intolerant of beta-blockers. 67% had previous thrombin injection that had failed to obliterate the gastric varices. EUS guided coil embolisation was undertaken with thrombin injection in 6, and thrombin alone in 4 (2 had previous coils embolisation). The largest feeding vessel was 12(7–16) mm with a median 5 (2–10) coils placement followed by thrombin injection of 3500 (2500–5000) IU.

Most (8/10) stayed overnight after intervention and only 2 required longer stays, Median F/U was 9 (3–20) months with zero 30 day mortality. 1 patient had fever 2 days post procedure requiring IV antibiotics. No reported episodes of re-bleeding except in 1 patient at 23 months. 4 had follow up EUS (5–7 months) and showed no flow at the level of the coils. 1 patient died within 3 months of procedure secondary to hepatic decompensation.

Conclusions In our experience EUS guided coil embolisation and injection of thrombin, is a technically safe and well-tolerated procedure even in patients with advanced liver disease especially who have failed eradication of gastric varices from single modality therapy. Due to the lower incidence of gastric variceal bleeding in comparison to oesophageal varices bleeding, we recommend multi-centre prospective data collection evaluating the modalities being used and reporting of outcomes to help inform national guidelines.

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Oesophagus and Gastroduodenum

OTU-010 VITAMIN D RECEPTOR AS A MARKER OF PROGNOSIS IN OESOPHAGEAL ADENOCARCINOMA: A PROSPECTIVE COHORT STUDY

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Background Vitamin D receptor (VDR) expression has been associated with survival in several cancers. This study aims to evaluate the association between VDR expression and prognosis in oesophageal adenocarcinoma patients.

Methods The study included 130 oesophageal adenocarcinoma patients who underwent neo-adjuvant chemotherapy and surgery at the Northern Ireland Cancer Centre between 2004 and 2012. Formalin fixed paraffin embedded (FFPE) resection specimens and matched clinical data were retrieved via the Northern Ireland Biobank. Tissue microarrays (TMAs) were created and VDR immunohistochemical analysis performed on triplicate 1 mm tumour cores from each block. Immunohistochemical VDR expression was assessed by two independent observers, blinded to the clinical data, by multiplying the staining intensity with the percentage of tumour cells staining positive for VDR, to give an H-score between 1 and 300. Comparison between maximum VDR expression and prognosis was calculated using Cox proportional hazards regression models adjusted for age, gender, nodal status, circumferential

resection margin, lymphovascular invasion, smoking status and tumour location. Outcomes studied included overall survival, disease specific survival and recurrence free survival.

Results During a mean of 3 (range 0.5–9) years of follow-up, 75 patients died. In analysis adjusted for confounders, higher VDR expression was associated with an improved overall survival (HR 0.49 95% CI 0.26–0.94) and disease-specific survival (HR 0.50 95% CI 0.26–0.96), when comparing the highest with the lowest tertile of expression. These associations were strongest in sensitivity analysis restricted to junctional tumours.

Conclusions This study is the first to demonstrate that patients with higher VDR expression in oesophageal adenocarcinoma have a more favourable prognosis. This study identifies VDR expression as a potential prognostic indicator although further work is needed to validate VDR as a prognostic marker and define its role in the aetiology and progression of oesophageal adenocarcinoma.

OTU-011 TIME TO ENDOSCOPY FOR ACUTE UPPER GASTROINTESTINAL BLEEDING: RESULTS FROM A PROSPECTIVE PAN-MIDLANDS TRAINEE-LED AUDIT

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Introduction Prompt endoscopy for acute upper gastrointestinal bleeding (AUGIB) is associated with improved outcome. NICE recommends early endoscopy (<24 hour from admission) for all patients with AUGIB whereas the JAG Global Rating Scale stipulates early endoscopy in $\geq 75\%$ as a minimum standard for service accreditation. We aimed to audit these outcomes and identify predictors of delayed endoscopy (>24 hour from admission).

Methods A prospective, pan-Midlands, multi-centre study was jointly undertaken by GARNet and WMRIG trainee networks. Adults admitted with AUGIB and had inpatient endoscopy between Nov-Dec 2017 were enrolled over 30d. Admission, endoscopy referral and procedure times were collected, along with clinical, laboratory, endoscopic and post-endoscopic variables. Heterogeneity between sites was assessed using Mann-Whitney and χ^2 . Multivariate binary logistic regression analysis was used to study factors associated with delayed endoscopy.

Results 337 patients met inclusion criteria (median age 69.5, SD 18.8). The median time from admission to endoscopy (figure 1) was 20.9 hour (IQR 11.5–31.8). The time from admission to endoscopy referral were comparable between East and West Midlands (median 8.1 hour, IQR 3.6–18.1; $p=0.242$), as was the time from referral to endoscopy (median 6.6 hour, IQR 3.0–22; $p=0.219$). 61.1% of patients received endoscopy within 24 hour of admission ($p=0.025$ across sites) and 79.3% within 24 hour of referral ($p=0.012$). 4/20 sites (20%) met the minimum JAG standard. On multivariate analysis (table 1), 7 pm–7 am admission, rectal examination <1 hour, higher Glasgow-Blatchford score (GBS) were associated with early endoscopy. Each 1 hour increment in referral time led to a 4% added risk of delayed endoscopy. Weekend admission, region, melaena or suspected varices did not affect this outcome. Early endoscopy did not affect rates of endoscopic therapy ($p=0.536$), 30d readmission or death ($p=0.985$), but reduced length of stay (median difference 1d; $p=0.039$).

Abstract OTU-011 Figure 1

Abstract OTU-011 Table 1

Factor	OR for delayed endoscopy	p-value
Region (EM)	0.78	0.476
Weekend	2.35	0.070
7 pm–7 am	0.30	0.002
Age	1.02*	0.160
Per rectum<1 hour	0.34	0.005
Melaena	1.00	1.000
GBS	0.88*	0.008
Nil by mouth<1 hour	1.36	0.407
Time to referral (h)	1.04*	0.002
Suspected variceal	1.02	0.969
Endoscopic therapy	1.30	0.536

Conclusions Time to endoscopy for AUGIB generally fell below national standards during the period of Nov-Dec. Early endoscopy can reduce length of stay, but is dependent on prompt recognition, assessment and referral. As such, ongoing audit and strategic initiatives involving acute care services may be required to improve this outcome.

OTU-012 A MODEL FOR IDENTIFYING INDIVIDUALS AT RISK OF ESOPHAGEAL ADENOCARCINOMA WITHIN THE UK BIOBANK

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Introduction The prognosis for most patients with esophageal adenocarcinoma (EAC) is poor because they present with advanced disease. Models developed to identify patients at risk for EAC and increase early detection have been developed based on data from case-control studies. We analysed data from a prospective study to identify factors available to clinicians that identify individuals with a high absolute risk of EAC.

Methods We collected data from 3 55 034 individuals (all older than 50 years) without a prior history of cancer enrolled in the UK Biobank prospective cohort study from