(HR 1.83, 95% CI: 1.02–3.28). For gastric cardia cancer, there was also an elevated risk among women who had a bilateral ovariectomy but this did not quite attain statistical significance (HR 2.19, 95% CI: 0.98–4.86). The remaining reproductive factors analysed were not associated with risk of gastric cardia or non-cardia cancer.

Conclusion The results of this study suggest that reproductive factors in women may influence risk for gastric cancer, particularly non-cardia gastric cancer.

OTU-015 THE ACCURACY AND TOLERABILITY OF MAGNET ASSISTED CAPSULE ENDOSCOPY FOR THE INVESTIGATION OF OESOPHAGEAL PATHOLOGY

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Introduction Gastroscopy (OGD) is the established method for the investigation of oesophageal disease. Magnet Assisted Capsule Endoscopy (MACE) potentially offers a comfortable, patient friendly and community-based alternative to conventional endoscopy. This pilot study aims to explore whether this approach can be used to detect oesophageal pathology.

Methods MACE procedures were carried out using the Mirocam Navi capsule endoscope, which is steerable with the use of an external handheld magnet. A total of 50 participants were enrolled, of which 34 had known pathology, 17 Barrett's Oesophagus (BO), 17 Oesophageal Varices (OV), with 16 controls. Patients underwent the MACE procedure first by a single operator blinded to the indication. The subsequent OGD was performed by a different endoscopist blinded to the MACE findings. Sedation pre-OGD was given as per patient preference. Diagnostic yield, comfort and patient preference between the two modalities were compared.

Results 47 patients undertook both procedures (3 patients were unable to swallow the capsule), with a mean age of 61 years old (range 39–83), M:F of 2.1:1. Participants had a mean BMI of 29.5, with an average chest measurement of 105.3 cms. Three patients were unable to swallow the capsule. Sedation was requested by patients, in addition to throat spray, in 60% of OGDs (median 3 mg midazolam and 50 mcg fentanyl). With the use of the magnet, it was possible to hold the capsule in the oesophagus for a mean duration of 3 mins and 10 s and a maximum of 10 mins and 34 s. A correct real time MACE diagnosis was made in 11/15 patients with OV, 16/16 patients with BO and 15/16 controls. MACE was also able to correctly identify incidental findings, such as oesophagitis, hiatus hernia and as well as an inlet patch. Sensitivity and specificity of diagnosing OV was 73.3% (95%CI: 0.45–0.91) and 96.9% (95%CI: 0.82–1) respectively and in diagnosing BO 100% (95%CI: 0.76–1) and 100% (95%CI: 0.86–1).

MACE was considered more comfortable than conventional endoscopy ($p < 0.0001$) with a mean score of 9.2 with MACE compared to 6.7 with OGD, when assessed on a 10-point scale. 78% of patients would prefer to undergo MACE if a further examination was required compared to 0% OGD (22% had no preference). No MACE or OGD related complications occurred.

Conclusion This pilot study demonstrates that MACE is both safe and well tolerated by patients. Accuracy for the diagnosis

of BO was high and may therefore have a role in screening for this condition.

OTU-016 TIMELINE AND LOCATION OF RECURRENCE FOLLOWING SUCCESSFUL ABLATION IN BARRETT'S OESOPHAGUS: AN INTERNATIONAL MULTICENTRE STUDY

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Introduction Surveillance intervals and biopsy protocols after complete remission of intestinal metaplasia (CRIM) post radio-frequency ablation (RFA) in Barrett's oesophagus (BO) are intensive and not based on substantial evidence. We aimed to assess the timeline, location, and histology of recurrence following CRIM with the goal of assessing the appropriateness of current recommendations.

Methods Data on patients undergoing RFA for BO-related neoplasia were obtained from prospectively maintained databases of five (3 USA and 2 UK) tertiary referral centres with expertise in management of BO-related neoplasia. Patients underwent RFA following endoscopic mucosal resection (EMR) of visible lesions. RFA was performed every three months till CRIM was confirmed endoscopically and histologically on two consecutive endoscopies. Subsequent surveillance was performed at 3, 6, 9, and 12 months thereafter. Recurrence incidence was estimated using Kaplan-Meier method and Cox Proportional Hazards models were used to assess predictors of recurrence.

Results 594 patients achieved CRIM as of April 1 st 2017 and were included in the analysis. Mean (standard deviation (SD)) age was 67 (10) years and 86% were males. Median (interquartile range (IQR)) BO segment length was 4 (2–6) cm. 90% of patients were treated for dysplasia or carcinoma. 151 subjects developed recurrent BO over a median (IQR) follow up of 2.8 (1.4–4.4) years. BO recurred at the gastroesophageal junction (GOJ) in 67% of subjects and in the tubular oesophagus in 33%. 84% of BO recurrences in the tubular oesophagus occurred within 5 cm of the GOJ. Histology of recurrences included cancer (9%), high grade dysplasia (HGD) (8%), low grade dysplasia (LGD) (12%), indefinite for dysplasia (2%) and non-dysplastic BO (69%). Annual incidence of any recurrence was 9.6%, dysplastic (LGD/HGD/cancer) recurrence was 2.8% and HGD/Cancer recurrence was 1.6%. The recurrence hazard rate did not vary over the follow-up ($p = 0.74$) with 19% risk within 2 years and an additional 49% risk over the next 8.6 years. Recurrence hazard rate of any dysplasia and HGD/Cancer while lower, also did not vary over the duration of follow up ($p = 0.94$ and $p = 0.88$, respectively) (Figure 1). In a multivariable model, baseline HGD/cancer predicted recurrence (hazard ratio 1.9, 95% CI 1.2–3.1, $p = 0.004$).

Conclusions In this large multicentre and international cohort study, BO recurrence risk (at least in the first 5 years following CRIM) did not appear to vary over time suggesting that continued surveillance remains important. Most recurrences

Abstracts

appear to occur at the GOJ or distal 5 cm of the oesophagus. Sampling the GOJ and the distal 5 cm of the oesophagus in the absence of visible lesions may be adequate for surveillance.

Abstract OTU-016 Figure 1 The timeline of recurrent BO (overall; dysplastic; and HGD/cancer) following CRI

PTU-011 PREDICTORS OF MORTALITY AND REBLEEDING OUTCOMES AFTER PEPTIC ULCER BLEEDING

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Introduction Peptic ulcer disease (PUD) accounts for 25%–56% of acute upper gastrointestinal bleeding (AUGIB) cases and is associated with high rates of mortality and rebleeding. We aimed to assess the rates and factors associated with 1 year mortality and rebleeding in patients with bleeding PUD.

Methods This was a single-centre study of patients with AUGIB and endoscopic confirmation of PUD between November 2012–2014. All patients received at least 1 year of retrospective follow-up after endoscopy. Electronic records were scrutinised for outcomes of mortality and bleeding, with time-to-event analyses performed using a Kaplan-Meier plots and Cox-regression.

Results 91 patients (median age 78.4, 65.9% male) were included. 63.7% were admitted with AUGIB and 36.3% bled during their inpatient stay. Mortality at 30 days and 1 year were 12.1% and 34.1% respectively, with 1 year mortality comprising: cardiovascular (20.0%), bleeding (20.0%), other (33.3%), unknown (26.7%). On univariate analysis, predictors of 1 year mortality included inpatient bleeding (hazard ratio [HR] 2.38, 95% CI: 1.18–4.83, $p=0.016$) [Figure 1], age (HR 1.036 per increase, 95% CI 1.009–1.065, $p=0.009$), Forrest classification (HR 2.22 for class 1 and 2 vs. 3, $p=0.04$), Rockall Score (HR 1.64 per increase, 95% CI 1.28–2.10, $p<0.001$), Charlson index (HR 1.34 per increase, $p<0.001$), aspirin use (HR 3.05, $p=0.003$), rebleeding (HR 5.52, $p<0.001$). The effect of inpatient bleeding on mortality was not significant ($p=0.19$) after adjusting for Charlson index. *H. pylori* was positive in 35.7%; eradication was associated with reduced mortality even after adjusting for Forrest classification and age (HR 0.30, $p=0.007$). Multivariable analyses to

account for age are shown in table 1. The 1 year rebleeding rate was 7.8%. Higher haemoglobin on discharge (HR 0.940 per 10 g/dL increment, $p=0.04$), Forrest 3 ulcers (HR 0.18, $p=0.02$) and *H. pylori* eradication (HR 0.214, $p=0.02$) were significantly associated with reduced rates of rebleeding.

Abstract PTU-011 Figure 1 Survival Following Ulcer Bleeding

Abstract PTU-011 Table 1

Factor	Comparison	Hazard Ratio	95% CI	p-value
Inpatient AUGIB	Admitted with AUGIB	1.91	0.93–3.93	0.077
Forrest 1–2	Forrest 3	2.81	1.28–6.15	0.010*
Rockall Score	Per increase [§]	1.67	1.26–2.21	<0.001*
Charlson Index	Per increase [§]	1.30	1.07–1.58	0.008*
Aspirin on admission	No aspirin	2.07	0.92–4.67	0.081
<i>H. pylori</i> eradication	Not ascertained	0.26	0.11–0.61	0.002*

Conclusion Increasing age, higher Rockall and Charlson scores, Forrest 1 or 2 lesions, inpatient bleed, and rebleeding were factors associated with mortality in bleeding PUD. Higher rates of inpatient mortality may be explained by age and co-morbidities. Eradication of *H. pylori* was associated with improved outcomes and should be considered in all cases of bleeding PUD.

PTU-012 BIOPSY AVOIDANCE STRATEGY IN ADULT COELIAC DISEASE

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Introduction Paediatric ESPGHAN guidelines support a diagnosis of coeliac disease (CD) when immunoglobulin-A anti-tissue transglutaminase (IgA tTG) antibody titres are >10 times the upper limit of normal (ULN) and combined with supportive criteria. This study examines whether serological testing alone could be sufficient for diagnosis in adult patients, thus avoiding the need for duodenal biopsies.