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.