well as their re-bleed rates were compared. A Chi-squared test was performed using SPSS.

Results

Abstract PTU-016 Table 1

Method of PPI administration	No. of patients with re-bleed	No. of patients who did not re-bleed	Total
Infusion	9	55	64
Bolus	7	63	70

The re-bleed rate prior to the change in guidelines was 14% (9 of 64) and after the change this fell to 10% (7 of 70) though the difference was not statistically significant (p-value 0.53).

Conclusions Our real-world data mirror the current evidence from the meta-analyses; we found no deleterious effects from switching to IV bolus PPI as adjuvant treatment in high risk peptic ulcer disease that has been treated endoscopically. We recommend switching to from PPI infusions to IV boluses which has cost and nurse time advantages while maintaining efficacy.

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PTU-017 GIANT GASTRIC ULCERS: MALIGNANCY YIELD AND PREDICTORS FROM A 10-YEAR RETROSPECTIVE SINGLE CENTRE COHORT

Richard Lord*, Mohammed El-Feki, Lea Tomos, Noor Mohammed, Venkat Subramanian, Bjorn Rembacken. *Leeds Teaching Hospitals NHS Trust, Leeds, UK*

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Introduction Gastric cancer is known to reside in some gastric ulcers but what predicts this association is still unclear. Historically it was thought that increasing size of gastric ulcers maybe a predictor for harbouring malignancy. Little is known about this risk in giant gastric ulcers (>3 cms). We looked at malignancy yield in giant gastric ulcers and determined if any demographic, clinical or endoscopic predictors for malignancy exist. Secondary outcomes included the 30 day and 12 month mortality.

Methods This was a retrospective study including patients with giant gastric ulcers dating from September 2005 to December 2015. Predictors for malignancy were determined using binary logistic regression, after demographic, clinical and endoscopic variables were tested using univariate analysis and checking for collinearity.

Results A cohort of 111 patients was included for the final analysis. 42 giant gastric ulcers were malignant, equating to a yield of 37.8% (95% CI 28.8–46.8). Binary logistic regression analysis revealed predictors for malignancy were ulcer location (odds ratio (OR 4.417; 95% CI 1.10–17.76; p=0.036), younger age of patient (OR 0.202; 95% CI 0.06–0.71; p=0.013) and endoscopic 'non-suspicion' (OR 0.138; 95% CI 0.049–0.39; p<0.001). Patient's 12 month mortality for giant gastric ulcer was 61.9% (26/42) for malignant giant ulcers and 21.9% (11/73) for benign histology.

Conclusion Giant gastric ulcers have a high malignancy yield and associated with significant 12 month mortality. Predictors for malignancy include ulcer location, patient's age and endoscopist's 'non-suspicion' during endoscopy.

Abstract PTU-017 Table 1 Results of binary logistic regression, testing association of statistically significant variables in predicting malignant ulcer histology. Data presented as odds ratios with its associated p value.

	Odds Ratios (95% confidence Intervals)	P value
Age (20–59)	0.202 (0.06–0.71)	p=0.013
No. of ulcers (Single ulcer)	1.514 (0.85–2.70)	p=0.161
Location combined (Fundus/Cardia/Incisura)	4.417 (1.10–17.76)	p=0.036
Endoscopic 'non-suspicion'	0.138 (0.05–0.39)	p<0.001

PTU-018 A PATIENT WITH 16 MULTIPLE SPORADIC GISTS- AN EXTRAORDINARY DIAGNOSIS WITHIN A DISTRICT GENERAL HOSPITAL

Jay Patel*, Fathima Dambha, Rashmi Haria, Paul Richman, Anthony Leahy. *West Hertfordshire NHS Trust, Watford, UK*

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Introduction Gastrointestinal Stromal Tumours (GISTs) are usually regarded to be sporadic and solitary by nature. The estimated worldwide incidence of GISTs is 1:1 00 000.¹

Multiple GISTs are an extremely rare phenomena, restricted to paediatric setting or attributed to type 1 neurofibromatosis (NF1), familial GIST syndrome, Carney's Triad or sporadic by nature.

We present a 29 year-old female, unrelated to any known hereditary syndrome, who was found to have 16 sporadic multiple gastric GISTs.

Case report The patient, with no current co-morbidities, presented with a 5 day history of epigastric pain and melaena. An OGD was performed, showing a large GIST and an adherent clot. The surrounding antrum looked deformed, suggestive of further GIST tissue; multiple biopsies from the larger GIST heralded only reflux/reactive gastritis.

Following this, a staging CT found an exophytic, 42 mm gastric mass, with multiple submucosal heterogeneous lesions along the entire length of stomach, with no enlarged lymph nodes or metastases. An endoscopic ultrasound (EUS) demonstrated at least 6 submucosal lesions with typical features suggestive of GISTs. Fine needle aspiration with EUS confirmed epithelioid gastrointestinal tumours.

Following an upper-gastrointestinal (GI) multidisciplinary meeting, the patient underwent a laparoscopic subtotal gastrectomy with Roux-en-Y gastrojejunostomy. Histopathology highlighted 16 GISTs, with range percentage of progressive disease between 0%–16%; immunohistochemistry confirmed GISTs with DOG-1, CD117 and CD34 positivity.

The patient underwent a PET CT and referred to oncology services for consideration for Imatinib.

Abstract PTU-018 Figure 1 Stomach specimen showing multiple nodular GISTs, involving the mucosa and serosa

Discussion The presence of multiple sporadic GISTs is extremely rare, with only one case-report in the literature. The patient had a reported normal paediatric development. She had no physical signs of NF-1 and there were no family history of GISTs.

It is certainly unclear if her multiple lesions were the result of metastatic spreading of a single primary GIST. Certainly further research is required to explore this phenomenon.

Despite a 'tunnelled' approach to biopsying the GIST, an OGD was not an effective way of achieving histological diagnosis, and highlighted the continuing importance of EUS and fine needle biopsy in the diagnostic investigations of upper GI lesions.

Surgery remains the cornerstone to treatment, despite the availability of targeted chemotherapy. Understandably, a subtotal gastrectomy for this young patient may have psychological and nutritional long-term sequelae.

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PTU-019 OUTCOMES FROM MESENTERIC ANGIOGRAPHY AND EMBOLISATION IN NON-VARICEAL UPPER GI BLEEDING; A SINGLE CENTRE EXPERIENCE

Aaron McGowan*, Alexander Robertson, Ian Penman. *NHS Lothian, Edinburgh, UK*

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Introduction Upper GI bleeding remains an important cause of morbidity and mortality. Mortality rates in non-variceal upper GI bleeding have remained relatively static over recent decades despite an ever-increasing range of therapeutic options.

Interventional radiology (IR) has become an increasingly available tool for management of upper GI bleeding when endoscopic haemostasis has failed. However, literature is lacking surrounding the technical success and long term outcomes of mesenteric embolisation in patients with non-variceal upper GI haemorrhage.

We therefore wished to assess the overall technical efficacy and outcomes of interventional radiology in patients presenting with upper GI haemorrhage who had undergone initial endoscopy at the Royal Infirmary of Edinburgh.

Methods We retrospectively analysed the interventional radiology database for all patients who had undergone embolisation procedures. We then focussed on patients who had presented with non-variceal haemorrhage and assessed their outcomes using computer-based records. Patients were followed up for a minimum of 1 year.

Results Data were available from 2007 onward. We assessed patient's mortality outcomes at 30 days and 1 year. In total, 24 patients had undergone mesenteric embolisation for non-variceal upper GI haemorrhage (15 female, 9 males). Median age was 72 (range 52–96).

Over half of patients (14 of 24, 58.3%) had an ASA grade of III or IV (figure 1).

19 of 24 had information available to calculate Glasgow-Blatchford score, with a median score of 15 (figure 2).

Mean length of hospital stay in survivors was 31.75 days (5–148).

23 lesions were located in the duodenum, 1 in the oesophagus. There were 2 Dieulafoy lesions, 1 tumour vessel, 1 unclear bleeding point and 20 ulcers with varying stigmata.

5 patients had already undergone surgical management of their bleeding lesion prior to IR.

IR was technically successful in 22 of 24 patients. 4 out of 24 patients rebled following embolisation.

No patients developed an acute kidney injury following angiography.

6 out of 24 (25%) of patients died within 30 days of their IR procedure (figure 3).

8 out of 24 (33%) died within 1 year. 3 of these were due to bleeding, 3 due to sepsis and 2 due to malignancies (figure 4).

Conclusions Mesenteric embolisation in patients with significant non-variceal upper GI bleeding has high technical success rates with low rebleeding rates, in a patient population that often is elderly with significant comorbidity.

Approximately one third of patients who undergo interventional radiology procedures for non-variceal upper GI haemorrhage will be dead at 1 year; the majority from non-bleeding related causes.

Abstract PTU-019 Figure 1 ASA Grade

Abstract PTU-019 Figure 2 Glasgow-Blatchford Score

Abstract PTU-019 Figure 3 Mortality at 30 days

Abstract PTU-019 Figure 4 Mortality at 1 year

PTU-020 INTRODUCTION OF SEMS FOR MALIGNANT DISTAL BILIARY STRICTURES AT A LARGE LONDON DISTRICT GENERAL HOSPITAL

Emma Dean*, Farhina Sayyed*, Lesley Bain*, Sudeep Tanwar. *Whipps Cross Hospital, London, UK*

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Introduction Biliary stents are commonly used to treat malignant biliary obstruction. Compared to plastic stents, self-expanding metal stents (SEMS) have a wider diameter and therefore offer enhanced biliary decompression and a longer duration of patency. In addition, biliary decompression with SEMS insertion at ERCP commands a significantly higher level of reimbursement than if a plastic stent is employed. For these reasons, at our hospital since 2015, plastic stents have been abandoned in favour of uncovered or covered SEMS (60 mm ×10 mm) in patients with unresectable disease or potentially resectable disease respectively. Herein, we report the first 2 years of this change in endoscopic practice at a large DGH in East London.

Methods Patients diagnosed with either pancreatic or biliary tract cancer between April 2015 and April 2017 and who underwent endoscopic biliary stenting were prospectively audited. Retrospective Data collection was performed from electronic systems including Somerset, CRS, EPR and unisoft GI reporting from this prospective cohort.

Results Of 86 patients diagnosed with pancreatic or bile duct cancer, 45 patients (52%) underwent biliary stenting (37 distal biliary stricture, 9 with a perihilar stricture). Of the 37 with a distal stricture, CBD cannulation rate was 92%, the remainder required a rendezvous procedure to access the CBD. A SEMS was deployed across the stricture in all cases. A fully covered and uncovered SEMS was deployed in 27 and 12 patient respectively. A >50% reduction in bilirubin was identified in 94% of cases with this effect similar in both covered and uncovered SEMS. Following SEMS insertion 77% of patients achieved a bilirubin <50 μmol/L. In total, 24 patients required repeat ERCP due to tumour progression with an average of 2.2 interventions per patient. During re-intervention, a new SEMS was deployed within the previous SEMS. 30 mortality post ERCP was 9%. Mortality at 6 months was 19%. Distal stent migration was not identified in any patient. Four patients (3 covered and 1 uncovered) suffered cholecystitis due to gallbladder contrast retention after occlusion of the cystic duct orifice. Whereas this was treated with stent removal in patients with covered SEMS, cholecystostomy drainage was required in the patient with uncovered SEMS.