months. No patient had complications of bleeding or perforation. Twelve of the lesions were sub-classified as SM1, 4 as SM2 and 2 as SM3. Further endoscopic and histological characteristics can be seen in table 1. Eleven patients underwent surgical resection following their initial EMR (table 2). Five are still alive, 2 died from metastatic oesophageal cancer (after 7 and 39 months respectively) and 4 died from causes unrelated to oesophageal cancer (34, 44, 58 and 67 months later). Three of the patients who underwent surgery had no residual cancer or lymph nodes found in the surgically resected specimen; one was found to have high grade dysplasia. In the remaining 7 patients not undergoing surgery, 2 were palliated and died 4 and 7 months later. The other 5 patients had either radiotherapy alone (3), chemo-radiotherapy (1) or oesophageal radiofrequency ablation (1) and are all alive to date after a median follow up of 32 (IQR 13–48) months.

Abstract PTH-124 Table 1 Patient characteristics

Oesophageal EMRs reviewed	170
T1b adenocarcinomas	18
Mean Age	68.6
Male sex	18(100%)
Median follow up (months)	37
Enblock resections	4
2 Piece EMR	4
3 Piece EMR	4
4 Piece EMR	4
5 Piece EMR	0
6 Piece EMR	1
7 Piece EMR	1
Clear Deep Margin on EMR sample	5
SM1	12
SM2	4
SM3	2
Well differentiated	3
Moderately differentiated	9
Poorly differentiated	6
Lymphovascular involvement on EMR sample	6
Surgical resections	11
Lymphovascular involvement on Surgical sample	2
Positive Lymphnodes on Surgical Sample	2

Abstract PTH-124 Table 2 Histological characteristics of EMR & subsequent surgical resection

	Number	Surgical resection (%)
SM1	12	8 (66.6%)
Well differentiated	3	1 (30%)
Moderately differentiated	5	3 (60%)
Poorly differentiated	4	4 (100%)
Clear Deep margin on EMR	4	4 (all had LVI +ve)
Lymphatic or vascular involvement	4	4 (100%)
SM2	4	1(25%)
Well differentiated	0	n/a
Moderately differentiated	3	1(33%)
Poorly differentiated	1	0
Clear Deep margin on EMR	1	0
Lymphatic or vascular involvement	2	1(50%)
SM3	2	2(100%)
Well differentiated	0	n/a
Moderately differentiated	1	1(100%)
Poorly differentiated	1	1(100%)
Clear Deep margin on EMR	0	n/a
Lymphatic or vascular involvement	0	n/a

Conclusion The management of patients who are found to have EOA with submucosal involvement needs to be

individualised. The majority of our patients underwent further treatment. Surgical resection revealed no residual tumour in some but metastatic disease occurred in others. Treatment decisions should be taken through a multi-disciplinary approach depending upon the histological characteristics and the comorbidities of the patient.

PTH-125 VARIATION IN THE INVESTIGATION AND DIAGNOSIS OF EOSINOPHILIC OESOPHAGITIS IN DAILY CLINICAL PRACTICE

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Introduction Eosinophilic oesophagitis (EO) is a recognised cause of dysphagia, with an estimated annual incidence of 6–13 cases/100,000 persons. Endoscopic features may be subtle or absent and as such societal guidelines advocate the acquisition of six non-targeted oesophageal biopsies, where a cause has not been identified. We aim to determine whether these recommendations are adhered to in clinical practice.

Methods We performed a database review of all diagnostic OGDs performed to investigate dysphagia or food bolus obstruction, during the 12 month period between 1 st July 2016–30th June 2017 within three large teaching hospitals (Cambridge University Hospital, Sheffield Teaching Hospitals and Nottingham University Hospital). Endoscopy reports were reviewed to determine endoscopic findings. Histology reports were examined to establish the number of biopsy samples received and whether a diagnosis of EO was made.

Results During this time period a total of 25,495 OGDs were performed, of which 4056 (16%) were carried out as part of the investigation of dysphagia. Failed and repeat procedures were excluded leaving a total study population of 3712. An endoscopic diagnosis potentially causing dysphagia was observed in 1286 patients (oesophagitis/ulceration 583 (15.7%), benign stricture 311 (8.4%), malignancy 188 (5.1%) or other causes 156 (4.2%). In the remaining 2468 patients (66.5%) an endoscopic cause of dysphagia was not identified. Biopsies to exclude EO were taken during 923 (37.4%) of these non-diagnostic procedures. A reason for not taking biopsies was documented in 19 cases. The recommended 6 biopsies were received by histopathology in 87 patients. A diagnosis of EO was considered in 42 patients based on endoscopic features, of which 68% went on to be confirmed with histology. During the 12 month period a total of 83 histologically confirmed cases of EO were diagnosed. Endoscopy had a sensitivity and specificity for the diagnosis of EO of 33.7% and 96.8% respectively. Physician endoscopists were more likely take biopsies, acquiring these in 46.4% of procedures where this would be appropriate, compared to surgical endoscopists who took these in 13.3%. Physicians consequently diagnosed 77 (93%) of confirmed cases.

Conclusions This study demonstrates variable adherence to recommendations for the investigation of EO. The hospitals included serve a combined population of approximately 3.2 million, giving rise to a below expected incidence of 2.6 cases per 1 00 000 per year