the covering mucosa by repeated biopsies, enables access to tumours below the mucosa.

We investigated the utilisation, safety and diagnostic yield of an intensified tunnel biopsy protocol.

Methods The endoscopy reporting database was searched for patients with reported subepithelial lesions in the upper gastrointestinal tract from March 2013 to September 2017.

The tunnel biopsy protocol was defined as bite-on-bite technique from the identical spot creating a submucosal tunnel, taking at least 10 passes of double biopsies with a standard biopsy forceps, while targeting the subepithelial lesion. Patient records were reviewed for histology reports, imaging studies, adverse events and readmissions after endoscopy.

Results 152 patients (70 M, 82 F) were found to have at least one subepithelial lesion at upper endoscopy with a median lesion size of 12 mm (interquartile range 9–25 mm). Superficial conventional biopsies were taken in 79 patients and were diagnostic only for one lipoma (1.3%). Tunnel biopsies were taken in 71/152 patients (47.4%). Sites were oesophagus (9), stomach (58) and duodenum (4). Tunnel biopsies were diagnostic in 31/71 (43.6%), revealing 9 leiomyomas, 1 leiomyosarcoma, 7 lipomas, 2 pancreatic rests, 10 GISTs, 1 retention cysts and 1 fibrotic nodule.

For lesions ≥ 20 mm the diagnostic yield of tunnel biopsies further increased to 16/28 (57.0%). There was no major immediate adverse event or 30 day readmission related to delayed complications from the procedure.

Only two of the 36 endoscopists involved in this study routinely performed tunnel biopsies from subepithelial lesions. Attempting tissue acquisition via tunnel biopsy was significantly more likely to achieve diagnostic histology than by superficial biopsies ($p < 0.00001$).

Conclusions Tunnel biopsy is a simple, safe and reasonably efficient diagnostic modality for tissue acquisition in subepithelial lesions in the upper gastrointestinal tract. This technique is still underutilised and should be routinely attempted if a subepithelial lesion is detected at the index endoscopy.

PTH-017 LONG-TERM OUTCOMES FOR RFA IN EARLY BARRETT'S-ASSOCIATED NEOPLASIA – ARE WE SUCCEEDING?

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Introduction Minimally invasive, endoscopic therapies (radio-frequency ablation (RFA) with/without endoscopic resection (ER)) are widely performed for early Barrett's-associated neoplasia (dysplasia or intramucosal carcinoma) and appear to be effective in the short term. There is however, a paucity of longer term outcomes including overall survival, in a cohort of patients who are often significantly co-morbid or increasingly elderly. We aim to study and overall survival (OS) in a cohort of patients with early neoplasia in Barrett's oesophagus (BO-EN) treated since 2008.

Methods A retrospective audit of a cohort of patients receiving RFA for BO-EN, of any length, at the Ninewells Hospital and Medical School was analysed. Between December 2008 and January 2018; 39 patients were undergoing/completed treatment and engaged in active surveillance.

These patients were assessed for baseline demographics, duration of follow up and mortality, with a future directive

being the assessment of complete resolution of both BO-EN and Barrett's Oesophagus – Intestinal Metaplasia (BE-IM).

Results In total, we have a completed cohort of 39 patients with absolute dataset who have undergone treatment. Of our population; 27 (69%) are male with the remaining 12 (31%) being female with a median age of 67 (Range 44–82 years). Patients were followed up for a median of 42 months (Range 1–172).

A total of 39, 27 and 17 patients were included in the baseline (<1 year post therapy), 3 year and 5 year analyses, respectively. The presenting histology was Low-Grade Dysplasia (LGD) – 8 (21%), High-Grade Dysplasia (HGD)– 22 (56%) and Carcinoma *In-Situ* – 9 (23%).

Overall survival at 1, 3 and 5 years was 100%, with no progression to overt invasive malignancy demonstrated within this populace.

Conclusions RFA (with/without ER) appears to be effective at controlling BO-EN and preventing progression to invasive adenocarcinoma, with a sustained effect appreciable to at least 5 years and possibly beyond.

Not unsurprisingly men appear to develop higher grades of dysplasia; at younger ages, this is consistent with known risk bias within the published literature (Average age at diagnosis; M=65 years vs F=81).

Our data suggests that despite the considerable comorbidity of these individuals, the intervention is well tolerated, with minimal deleterious sequelae and good survival prospects, albeit in a small sample size.

We aim to continue to expand the dataset prospectively and actively record the capability for RFA treatment to completely reverse underlying intestinal metaplasia in this group.

PTH-018 IS DYSPHAGIA UNDER INVESTIGATED AT ENDOSCOPY?

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Introduction The 2015 NICE guidelines recommend endoscopy (OGD) to investigate dysphagia, to rule out oesophageal cancer. However when performing these endoscopies it is important to look for other causes of dysphagia like gastro oesophageal reflux disease (GORD) and rarer conditions such as eosinophilic oesophagitis (EOE).

The recently published BSG quality standards for endoscopy suggest that biopsies should be taken from two different sites in the oesophagus to rule out eosinophilic oesophagitis in those presenting with dysphagia/food bolus obstruction, where an alternative cause is not found.

This study aimed to investigate the proportion of patients who had biopsies at endoscopy performed for dysphagia, and look at other investigations performed and final diagnosis made.

Methods Using Scorpio all OGDs performed for dysphagia between Jan 2017 and March 2017 were identified. Primary outcome assessed was proportion of patient with dysphagia who had oesophageal biopsies performed, if no visible cause was found. Other outcomes assessed included biopsy findings, additional investigations performed and final diagnosis made.

Results 155 OGDs were performed for dysphagia, 76.7% were urgent referrals, mean ($\pm$ SD) age of patient was 62.3 ($\pm$ 17.3) years.

108 (69.67%) patients had no visible cause for dysphagia identified at endoscopy, but only 55 (50.9%) of these patients