endotherapy (median 2.5 treatments; range 2–12); mean SS was 1.0 at latest follow-up.

Per-procedure, mean reduction in SS was 0.8 points (p<0.01) with overall positive response rate of 67%. By symptom, vomiting was most responsive to endotherapy (86% pre v 32% post). By treatment type, Botox alone (n=66) had the highest overall response (78%) compared to EBD (38%, p≥0.02) or combination therapy (66%, p≥0.3). Response to Botox was greater in patients under 40 (83% v 61%, p≥0.04) and females (81% v 33%, p≥0.002). By indication, diabetic GP (n≥17) were most likely to respond (76%).

Sub-group analysis showed procedures for gastroparesis (diabetic/idiopathic, n≥75) responded significantly more to Botox (mean SS reduction 1, p<0.01) than EBD (mean SS reduction 0.2, p>0.1) or combination therapy (mean SS reduction 0.44, p≥0.12). Procedures for gastric transposition (n≥42) showed significant SS reduction post combination therapy (2.1 v 1.2, p≥0.01) but not post EBD (1.9 v 1.6, p≥0.1) or Botox (1.7 v 1.1, p>0.08).

Conclusions Endotherapy is a safe and effective treatment for refractory gastroparesis. We found Botox monotherapy significantly improved symptoms in diabetic or idiopathic gastroparesis, especially younger females; conversely, combination therapy was preferable for delayed gastric emptying post gastric transposition. Careful patient selection may augment therapeutic response.

**PWE-134 MANAGEMENT OF GASTROPARESIS: CURRENT PRACTICE IN A TERTIARY CENTRE**
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Introduction Gastroparesis is a syndrome characterised by delayed gastric emptying in the absence of mechanical obstruction. The aim of this study was to assess consistency and adherence to guidelines of current practice and to evaluate the effectiveness of routinely implemented interventions in a large London tertiary centre.

Methods A retrospective study was conducted by examining records of all adult patients with delayed gastric emptying, objectively measured by NM scintigraphy, between 2010–2017. Effectiveness was defined as evidence of symptomatic improvement either semi-quantitatively by the Gastroparesis Cardinal Symptom Index (GCSI) or by documented qualitative evidence from clinical records, before and after intervention. Our practice was compared to recommendations published by the American College of Gastroenterology in 2013.

Results We identified 91 patients diagnosed with gastroparesis from 655 consecutive scans. Of these, 46 were excluded due to incomplete records. 55 patients were included: median age 48 (range 21–89), 67% female. Diabetes (40%) was the commonest cause; 40% of cases were idiopathic.

Conservative management 34/55 (62%) patients had dietetic input with 16% requiring enteral nutrition. 17/55 (31%) of patients were taking a drug known to delay gastric emptying but stopped in only 12% of patients.

Medical management 48/55 (87%) patients received prokinetics, including metoclopramide 28/55 (51%), domperidon 33/55 (60%) and erythromycin 19/55 (35%) with treatment duration specified in only 30%. No patients had documented GCs. From qualitative records, 7/48 (15%) of these reported some benefit, while 20/48 (42%) had no effect and in 21/48 (44%) the effect was unknown.

Intrapyloric Botox was administered in 25/55 (45%) of patients but results were not documented by GCs. Nevertheless, 11/25 (44%) of patients reported some benefit. Additionally, 2 patients had pyloric dilatation and 1 feeding jejunostomy and venting gastrostomy.

Conclusions The management of gastroparesis showed wide variations in practice in our institution. The lack of semi-quantitative assessment of the results of different interventions hindered evaluation of effectiveness. Conservative measures, including discontinuation of contributing drugs, were adopted