PTU-051 RISK FACTORS FOR PROGRESSION OF CONFIRMED LOW GRADE DYSPLASIA IN A BARRETT'S TERTIARY REFERRAL CENTRE

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Introduction Barrett's Oesophagus (BE) is associated with increased oesophageal cancer (EAC) risk. The management of patient's with low-grade dysplasia (LGD) arising in BE remains controversial. There is a shift toward endoscopic eradication therapy to avoid cancer progression. We performed a retrospective study from a tertiary referral centre for BE neoplasia to look at risk factors for progression of 'true' LGD dysplasia (confirmed by two expert BE pathologists).

Methods We carried out retrospective analysis of all confirmed LGD BE in a tertiary centre (July '06-Oct '18). Extent was defined as unifocal (One endoscopic level of LGD) or multifocal (>1 endoscopic level of LGD). All patients underwent high definition white light endoscopy with chromoendoscopy with targeted and Seattle protocol biopsies following referral. All biopsies were reviewed by at least two expert pathologists. The primary end point was progression time to high grade dysplasia (HGD)/EAC.

Results 54 patients had confirmed LGD following index endoscopy, 34 were ablation naïve and had at least one follow-up endoscopy. Patients had an average of 2 (IQR, 1-3) follow-up endoscopies with biopsies from index referral. Median follow-up time was 22 months (IQR, 8-39).

16/34(47%) had multifocal LGD. 8(50%) progressed to HGD/EAC over a median time of 14 months (IQR,6-19). 2/18(11%) patients with unifocal LGD progressed to HGD/EAC over a median time of 2 months (IQR, 2-3) (P<0.05).

6/34(18%) patients had nodularity in BE at baseline. 4/6(67%) progressed to HGD/EAC over a median time of 8 months (IQR, 3-14). 6/28(21%) with no nodularity progressed to HGD/EAC over a median time of 11 months (IQR,5-21).

5/34(15%) patients had a short BE segment (<3 cm). 1/5(20%) of these patients progressed to EAC. 9/29(31%) patients with a long BE segment (≥ 3 cm) progressed to HGD/EAC over a median time of 13 months (IQR, 4-17).

Risk factors for progression (table 1)

Abstract PTU-051 Table 1

	Number progressed to HGD/EAC (%)	
Unifocal LGD	2/18(11%)	P < 0.05
Multifocal LGD	8/16(50%)	
Short BE segment	1/5(20%)	P = 0.6
Long BE segment	9/29(31%)	
Nodularity	4/6(67%)	P < 0.05
No nodularity	6/28(21%)	
Male	9/30(30%)	P = 0.8
Female	1/4(25%)	

Conclusion LGD in BE can be difficult to accurately diagnose pathologically and therefore management can vary. Robust prognostic markers are needed to differentiate patients needing surveillance/endotherapy. Multifocal LGD and nodularity were associated with a significant risk of progression to HGD/EAC. A longer segment of BE was associated with a higher progression risk.

There is an argument that the treatment of LGD with endotherapy should be individualised given the possible risks. Identifying risk factors of progression will tailor treatment.

PTU-052 THE NATURAL HISTORY OF LOW-GRADE DYSPLASIA IN PATIENTS WITH BARRETT'S OESOPHAGUS: A TERTIARY CENTRE EXPERIENCE

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Introduction Barrett's Oesophagus (BE) is associated with increased risk of oesophageal cancer (EAC). The optimal management of low-grade dysplasia (LGD) arising in BE remains controversial. We performed a retrospective study from a tertiary referral centre for BE neoplasia, to estimate time to progression in patients with confirmed LGD compared to down-staged LGD.

Methods We carried out retrospective analysis of tertiary BE LGD referrals in a single tertiary centre (July '06-October '18). Patients underwent high definition white light endoscopy with chromoendoscopy with targeted and Seattle protocol biopsies following referral. All biopsies were reviewed by at least two expert pathologists. We carried out analysis in ablation naïve patients with at least one follow-up endoscopy post index procedure. The primary end point was time to progression to high grade dysplasia (HGD)/EAC.

Results 141 LGD patients were included. 13 were diagnosed during surveillance at our centre. 128 were tertiary referrals. 43/128(34%) were upstaged at index endoscopy after referral to HGD/intramucosal adenocarcinoma (IMC).

44/128(34%) were down-staged, 28/128(22%) to non-dysplastic Barrett's oesophagus (NDBO), 15/128(12%) to indefinite for dysplasia (IND), one had no BE on index endoscopy. In the NDBO/IND group, 34 had no ablations and at least one follow-up endoscopy, 5/34(15%) progressed to HGD/IMC over a median time of 36 months (IQR,13-42).

41/128(32%) of all referrals had confirmed LGD at index endoscopy. There was 54/141(38%) confirmed "true" LGD including patients diagnosed under our surveillance programme. In this cohort 34 had no ablations and at least one follow-up endoscopy. 10/34(29%) progressed to HGD/IMC over a median time of 10 months (IQR,4-16). The remainder of this cohort had a median follow up of 27 months (IQR,14-45), and average number of 2 follow-up endoscopies with biopsies.