Analysis of RFA naïve patients (table 1).

Abstract PTU-052 Table 1

	"true" LGD (n=34)	IND (n=13) (Downstaged cohort)	NDBO (n=21) (Downstaged cohort)
Mean age, years	66	71	69
Male sex	30/34 (88%)	12/13 (92%)	16/21 (76%)
Median progression time to HGD/ IMC (months)	10(IQR,4–16)	19(IQR,11–28)	42(IQR 28–72)
Median months of follow-up	17(IQR, 6–39)	31(IQR,15–46)	17(IQR,6–31)

Conclusion Our data shows the variability in the diagnosis of LGD from referring centres, with 32% of referrals with confirmed LGD. The cumulative incidence of progression to HGD/IMC and time to progression varied across subgroups. Confirmed LGD had a shorter progression time compared to the down-staged group (NDBO/IND). It is important to differentiate these subgroups so that decisions on surveillance/endo-therapy can be more personalised and resources utilised more wisely.

PTU-053 DYSPLASIA DIAGNOSIS AT BARRETT'S SURVEILLANCE – SEATTLE PROTOCOL DOMINANT STRATEGY IN REAL WORLD NON-EXPERT CENTRES

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Introduction Detection of dysplasia at Barrett's surveillance depends on a number of factors - the endoscopist's skill, use of advanced imaging, adherence to Seattle protocol, and high risk patient factors like male sex, smoking, length of Barrett's segment and family history of oesophageal adenocarcinoma. Whether the high rates of dysplasia diagnosis reported from expert tertiary centres can be replicated in the real world is debatable.

Aim The aim of this study was to analyse the routes to dysplasia diagnosis in a dedicated Barrett's surveillance programme in County Durham, specifically looking at the grade of the endoscopist, use of advanced imaging (NBI, Acetic Acid), diagnosis by targeted biopsy vs. Seattle Protocol, and the nature of dysplasia (Low grade vs. high grade).

Methods An electronic database search of over 600 Barrett's surveillance histology was carried out for the period 2015–2018, extracting all reported dysplasia. The endoscopy database was then interrogated for the following: patient demographics, grade of endoscopist (medical consultant gastroenterologist, non-medical endoscopist and surgical consultant), sedated vs. unsedated procedure, visible dysplasia, HD-white light vs. image enhancement, length of Barrett's segment and Prague classification, Paris classification of any visible lesions, targeted vs. Seattle Protocol biopsies, and grade of dysplasia. All endoscopies were carried out using high-resolution scopes and where a visible lesion was identified a targeted biopsy was taken.

Results 94 patients with dysplasia were analysed, M:F ratio 3.5:1, mean age 71 yrs. Barrett's length ranged from 1–14

cm, with 32% endoscopists reporting the Prague classification. Surveillance was done by: consultant gastroenterologists (48pts), nurse endoscopists (42pts) and consultant surgeons (4pts). Although only 3.2% endoscopists explicitly mentioned a Seattle biopsy protocol in their report, histology showed that protocol had been followed in 51% of endoscopies. 52% consultant gastroenterologists, 45% nurse endoscopists and 100% consultant surgeons adhered to Seattle biopsy protocol. The distribution of low grade dysplasia (LGD):high grade dysplasia (HGD):carcinoma-in-situ (situ) in the Seattle group 21:21:6 compared with a random biopsy protocol of 8:19:19. Image enhancing techniques were used in just 4% pts.

Conclusions In this real world NHS study, we found that after 4 years of the BSG guidelines, visible dysplasia is extremely difficult to detect. The Seattle biopsy protocol was followed in only 51% of endoscopies. There is a need for quality improvement & training for Barrett's surveillance amongst medical and non-medical endoscopists, including image enhanced surveillance and chromoendoscopy.

PTU-054 IN CHILDREN WITH EOSINOPHILIC OESOPHAGITIS, SYMPTOM RESOLUTION DOES NOT CORRESPOND WITH ENDOSCOPIC OR HISTOLOGICAL IMPROVEMENT

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Introduction Eosinophilic esophagitis (EoE) is a chronic, local immune-mediated condition characterised by symptoms relating to oesophageal dysfunction and histologically by eosinophil-predominant inflammation. In this study, we describe symptomatic, endoscopic and histological response to treatment in children attending a tertiary paediatric gastroenterology centre.

Methods Retrospective analysis of all children (age <18 yrs) diagnosed with EoE from 1/1/12 to 6/1/17 with ≥ 1 year follow-up. Diagnosis was based on the presence of ≥15 eosinophils/high powered field (eos/hpf) in endoscopic oesophageal biopsies. Children with mucosal eosinophilia elsewhere in the gut were excluded. Histological review was carried out by an independent pathologist. Data was analysed using SPSS 21 (Armonk, New York, NY, USA) and Prism 7 (San Diego, CA, USA). Significance was two-tailed and defined as p<0.05.

Results Of the 25 children who met the criteria, the mean age at diagnosis was 5.8 yrs with a mean symptom duration of 16.4 months, and a mean eos/hpf count of 26.3. The commonest presenting symptoms were vomiting and abdominal pain. All patients received a PPI; 22 were prescribed dietary therapy; and 16 topical steroids.

There was a high rate of symptomatic improvement, with 18 patients denying any gut symptoms at latest follow-up. However, even within this group a significant fall in eos/hpf count between diagnosis and follow up endoscopies was not observed (figure 1). This was seen regardless of the treatment modality used: dietary manipulation before and after mean [SD] 26.9 [15.1] vs 23.9 [20.0], p=0.4; topical steroids mean [SD] 31.4 [14.1] vs 28 [19.1], p=0.5; both concurrently mean [SD] 32.8 [14.4] vs 30.2 [19.7], p=0.7. Overall, 17/25 (68%) still had an eos/hpf count of >15. Only 20% had macroscopically and histologically normal mucosa at follow up endoscopy. None of the children had a stricture at diagnosis or developed one during follow up.