Abstract PTU-061 Table 1

Patient	Age (years)	Gender	Immunotherapy C=combination P=pembrolizumab N=nivolumab	Number of cycles	Time to first symptom	Time from symptom to diagnosis	Treatment
1	21	F	C	4	342	91	Steroids
2	72	F	P	6	83	57	Steroids then IFX
3	72	M	C	4	486	67	PPI then steroids
4	69	M	P	18	398	5	PPI
5	64	F	C	2	48	32	Steroids
6	60	M	N	1	12	222	PPI and ranitidine
7	51	M	C	3	69	10	Steroids
8	43	F	P	14	342	7	Steroids
9	79	F	P	31	737	16	PPI
10	44	F	C	3	100	11	PPI
11	70	M	C	2	456	39	PPI

Conclusions While immunotherapy-related colitis usually occurs at week 7, our data suggest that symptomatic irG occurs much later. Given the constitutional symptoms of weight loss and anorexia observed in irG overlap with those commonly seen in cancer, it is probable that irG occurs more frequently than our data suggest. Moreover, such presenting features of gastritis almost certainly contributes to the observed delay in diagnosis. Some patients may respond to PPI alone if they have had other immunotherapy-related adverse events treated with steroids before. First line irG treatment is usually steroids, and infliximab may be useful if steroid-refractory. Early liaison with gastroenterology team to facilitate timely endoscopy and biopsy is paramount.

PTU-062 "THE ONLY GOOD H. PYLORI IS A DEAD H. PYLORI" – CHALLENGES IN ISOLATION AND ERADICATION

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10.1136/gutjnl-2019-BSGAbstracts.278

Introduction *Helicobacter pylori* (HP) resistance to antibiotics is frequent and resistance patterns are country and region-specific. There are multiple cases of repeatedly failed eradication, where bacterial isolation for culture and sensitivities is needed to inform re-treatment. HP culture, however, has a high rate of failure.

The aims of this study were:

- To assess the success rate for HP culture, investigate the causes of failure and improve the diagnostic yield.
- To identify the local resistance pattern after failed eradication and develop a local eradication protocol.

Methods HP culture data was collected by the microbiology laboratory and clinical information from our electronic records. We retrospectively evaluated HP cultures performed in 2017 and analysed the possible causes of false negative results. Then we developed a protocol for optimal sample processing and transportation and prospectively evaluated the

diagnostic yield of the new protocol. This was integrated with a local guidance for re-treatment after failed eradication based on local resistance patterns.

Results In 2017, 49 patients had endoscopic biopsy for HP culture due to failed eradication. HP was isolated in 10/49 (20%). There was no growth in 35 samples (71%) and 4 samples were contaminated. Nineteen culture negative samples were proven to be false negatives (HP positivity confirmed by other methods). Antibiotic sensitivities were: amoxicillin 100%, clarithromycin 33%, metronidazole 11%, levofloxacin 56%, and doxycycline 89%. The analysis of culture negativity indicated that the time from sampling to laboratory was the main predictor of unsuccessful isolation. The new sampling protocol involved endoscopies for HP culture being scheduled only on morning lists, Monday to Thursday, samples sent to reference lab on the same day, a minimum of 6 biopsies taken, control sampling for urease test or histology. After the implementation of the new protocol for sample processing, the rate of positive culture increased to 71% (24/34; Chi-square 21.9, $p < 0.00001$) with only 2 proven false negatives.

Conclusions The high failure rate of HP culture in our setting was mainly a consequence of inadequate sampling and delay in transportation to the laboratory. This issue can be effectively addressed by simple changes in local practice. The resistance rate to clarithromycin and metronidazole is high in patients who failed initial eradication and the use of these antibiotics as 2nd or 3rd line may not be justified unless sensitivity has been proven. Our findings highlight that sampling protocol is crucial to obtain positive HP cultures and assessing the local resistance pattern is important to optimise re-treatment.

PTU-063 UPPER GASTROINTESTINAL BLEEDING (AUGIB) IN SIERRA LEONE – AUDIT OF OUTCOMES WHEN MINIMAL ENDOSCOPY ACCESS

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10.1136/gutjnl-2019-BSGAbstracts.279