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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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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Introduction Upper gastrointestinal bleeding (AUGIB) – defined as blood loss ≥100 ml in 24 hours – is a common emergency requiring prompt diagnosis and management. In high-income countries, endoscopic evaluation is the standard of care. However, in low-resource settings, such as Sierra Leone, endoscopy is not readily available. We evaluated the outcomes of patients with AUGIB managed in an endoscopy unit with minimal endoscopy access.

Methods We conducted a prospective audit of all patients with AUGIB seen at the endoscopy unit of a tertiary care hospital in Sierra Leone between January 2018 and December 2019. Patient demographics, clinical presentation, and outcomes were recorded. The primary outcome was the diagnostic yield of endoscopy.

Results A total of 150 patients were included in the audit. The median age was 49 years (IQR 35–61), and 75% were male. The most common presenting symptoms were dyspepsia (68%), epigastric pain (30%), and melena (20%). The median time from symptom onset to endoscopy was 2 days (IQR 1–5). Endoscopy was performed in 120 patients (80%), with a diagnostic yield of 71% (85/120). The most common diagnoses were peptic ulcer disease (35%), gastrointestinal (GI) bleeding (20%), and duodenal ulcer (15%). There were no complications related to endoscopy.

Conclusions Despite minimal endoscopy access, endoscopy was diagnostic in the majority of patients with AUGIB, indicating a high diagnostic yield. This highlights the importance of prioritizing endoscopy in the management of AUGIB in settings with limited resources.

10.1136/gutjnl-2019-BSGAbstracts.278 10.1136/gutjnl-2019-BSGAbstracts.279