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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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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Sierra Leone is a developing country in W. Africa. Medical facilities are rudimentary. There was no gastroscopy service till 2016, when supported by a grant from the British Society of Gastroenterology (BSG), 4 gastroenterologists from northeast UK travelled to the capital, Freetown. We trained 3 doctors to perform gastroscopy (OGD). Since then we have supported the doctors remotely and by annual visits. They have done procedures in private hospital that owns endoscopy stack.

Aims No endoscopy equipment exists in Government sector. We felt that we should demonstrate the need for a service by concentrating on the management of a distinct clinical entity, AUGIB, in which the benefit of OGD is clear. We undertook an audit of UGIB presenting to the main government hospital in Freetown (Connaught Hospital) to look at clinical presentation and outcomes.

Method 2 house officers (HO's) allocated to collect data. The audit was publicised at weekly medical meetings and also, details were put in the hospital medical WhatsApp group. HO's visited outpatient department regularly to identify patients. Then, as record keeping is paper based and poor, they visited regularly to keep a record of clinical details results and outcomes. A proforma developed by the UK team and head of medicine was used to record demographic clinical and outcome details. Details from the proforma were transcribed on to an excel spreadsheet.

Results 24 patients identified in the period. 63.6% male. Median age- 45 (26–67); Symptom duration at presentation - 3 days (0.5–28). 10 patients had haematemesis, 2 melaena and 12 with both. None taking anticoagulant/antiplatelet drugs. 2 patients on non NSAID. Significant comorbidities as follows; Hep B +ve - 2 (one clinically cirrhotic); HIV +ve - 1. One patient had previous AUGIB.

Clinical parameters on admission as follows: Median haemoglobin - 5 g/dl (2–13.5); Median systolic BP - 98.5 mmHg (60–224); Median pulse - 115/min (80–146).

21 patients had at least one dose of IV Omeprazole. 15 patients had at least 1 unit of blood ((median Hb = 5 (2–7.3)). A single patient (Female aged 56) with admission Hb of 5 g/dL underwent OGD day 7 of admission: Diagnosis - erosive oesophagitis.

15 patients discharged after mean 11.3 days (5–27). 8 patients died giving crude mortality -3.4%. Mean time to death 3. Days (0–12).

Conclusion This 1st audit of outcomes of AUGIB in Sierra Leone shows a comparatively high mortality in relatively young patients. Reasons for this probably multifactorial. However, lack of access to endoscopy probably a contributory factor. We have developed a AUGIB bundle which we hope to administer whilst waiting for the government to invest in endoscopy equipment.

PTU-064 **ENDOSCOPIC RESECTION OF NON-AMPULLARY DUODENAL LESIONS: FEASIBILITY, SAFETY AND EFFICACY**

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Introduction Non-ampullary duodenal adenomas (sporadic and duodenal lesions associated with familial adenomatous polyposis or FAP) are rare, with most lesions found incidentally on gastroscopy.

Endoscopic resection of duodenal lesions is increasingly being used in place of invasive surgery. However, endoscopic resection in the duodenum can be challenging due to its anatomy and may be associated with a higher risk of complications. This study aims to evaluate the safety and efficacy of endoscopic resection of duodenal polyps.

Methods All patients with large (>10 mm) non-ampullary duodenal polyps who underwent endoscopic resection between February 2008 and January 2019 in a single tertiary referral centre were included in the study. A retrospective analysis on data including demographics, size, histology, location, method of resection and complications was performed.

Results There were a total of 85 patients with polyps >10 mm referred for endoscopic therapy (median age 64 years, [IQR] 27–87 years, 52% male). 58 (68%) underwent endoscopic mucosal resection (EMR) and 27 (32%) had knife assisted resection (KAR). Histology revealed 67 (79%) LGD and 11 (13%) HGD. Majority of the lesions (70) were found in D2 (82%). 8 patients (9.4%) had a diagnosis of FAP.

The mean polyp size was 25.3 mm [IQR 10–80]. 80 polyps (94.1%) were removed in a single session with an en-bloc resection rate of 40%. The overall recurrence, bleeding and perforation rate was 7%, 8% and 2% respectively.

Table 1 shows the complication and recurrence rates stratified by lesion size (<30 mm vs >30 mm).

Abstract PTU-064 Table 1

Lesion size	<30 mm	>30 mm	P value
Number	53	32	
Bleeding	2 (4%)	5 (15%)	p = <0.001*
Recurrence	1 (2%)	5 (16%)	p = <0.015*
Perforation	1 (2%)	1 (3%)	p = 0.62

*p<0.05.

All complications were managed endoscopically. The median follow up period was 38 months [IQR 4–120] and a higher rate of recurrence (16%) was noted in lesions >30 mm. The majority (4/6) of the recurrences were treated successfully with subsequent endoscopic resection. The complication and recurrence rate was similar in patients undergoing EMR and KAR. No procedure related mortality was noted in this cohort.

Conclusions Endoscopic resection of duodenal lesions is a safe and effective technique for complete removal of these polyps. Lesion assessment is crucial in patient selection for endoscopic removal as noted by the absence of cancers in this cohort. The risk of complications, particularly bleeding is higher in lesions greater than 3 cm. Similarly, recurrence rates are also higher in this group. Nevertheless, we demonstrated that all complications and most recurrences were successfully managed endoscopically.