Conclusion Approximately 50% of patients presenting with AUGIB with endoscopic features of PUD were not tested for *H. pylori*. Almost 40% of those who were tested were infected. Post-eradication investigation rates were particularly low. No clear explanation for this level of non-compliance with guidelines is apparent but enforcement is clearly warranted.

PTU-067 **HELICOBACTER PYLORI RESISTANCE: A COMPLEX SOCIOECONOMIC PROBLEM?**

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Introduction *Helicobacter pylori* (*H. pylori*) infection is the primary cause of peptic ulcer disease and is globally prevalent. Although eradication therapy is effective, emerging antibiotic resistance rates are of considerable concern. *H. pylori* infection is more prominent in deprived populations but the effects of ethnicity and social determinants of health on *H. pylori* resistance is unclear. The aim of this study was to establish the significance of socioeconomic and ethnic influences on *H. pylori* resistance.

Methods The study population comprised of patients with recurrent/previous *H. pylori* infection plus current dyspeptic symptoms referred to the Royal Free Hospital, London, from 1 January 2017 to 1 September 2018, for endoscopic investigations. Gastro/duodenal biopsy samples were sent for culture and sensitivity testing. Demographic and clinical data were collected. Self-reported ethnic origin was recorded. Deprivation was analysed on a postcode basis, using the 2015 English Indices of Deprivation, by means of average decile ranking (1–10). Ethnic and socioeconomic differences between patients exhibiting resistance and those fully sensitive/culture negative were explored.

Results A total of 107 patients, including 26 children, (61.7% female; median (range) age 37.5 (4–81) years; 43.9% Caucasian, 39.2% Asian), were sampled. Five were excluded (3 contaminated, 2 inappropriate samples). Forty of the remaining 102 samples yielded positive cultures; of these 6/40 were fully sensitive but 34 (33% of total sample) displayed antibiotic resistance, most commonly to metronidazole (91.2%), and/or clarithromycin (77.4%). Dual resistance was present in 52.9%. Resistance to amoxicillin (n=2) and levofloxacin (n=3) was also identified. The remaining 62 samples were culture negative. There were no differences in the age or sex distributions between the two cohorts. Likewise, there was no significant difference in the ethnic distribution between patients displaying antibiotic resistance and those sensitive/culture negative (Asian 47% vs. 35% Chi²P=0.25) (figure 1A). Deprivation analysis showed very similar average decile rankings in both patient groups although distribution was skewed to the deprived end of each domain in both (figure 1B).

Conclusion One-third of biopsy samples referred for sensitivity testing, during the study period, exhibited antibiotic resistance, most commonly to first and second line eradication therapies. No significant differences were observed in ethnicity or in deprivation between patients exhibiting resistance and those sensitive/culture negative. However, trends identified in this study need to be further explored.

Abstract PTU-067 Figure 1 Comparative analysis of resistant vs. sensitive/no culture cohorts. (A) Ethnicity (B) Deprivation

PTU-068 **UPPER GASTROINTESTINAL BLEEDING IN THE PRESENCE OR ABSENCE OF PORTAL HYPERTENSION AND/OR NON-VARICEAL LESIONS**

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Introduction Upper gastrointestinal bleeding (UGIB) is caused by variceal lesions related to portal hypertension (PHT), or non-variceal lesions (NVL). Some patients may present with both PHT and NVL. We aimed to study the outcomes and possible interaction between the two conditions with adjustment for age, sex, smoking and alcohol.

Methods Patients presenting with UGIB were classified according to the presence or absence of PHT or NVL, or both. PHT included varices in the oesophagus or stomach and gastropathy or duodenopathy. Other lesions were considered as non-variceal, such as erosive oesophagitis, peptic ulcers, erosive gastritis or duodenitis, etc.

Logistic regression was used to assess PHT and NVL as predictive factors for UGIB outcomes, adjusting for demographic variables and testing for an interaction between PHT and NVL.

Results Between 2008–2016, the following subgroups entered the analysis: No PHT/NVL (n=595, 56% males, median age 64 years); NVL only (n=1556, 63% males, age 67); PHT only (n=187, 63% males, age 56); and PHT+NVL (n=106, 65% males, age 58). The results of the logistic regression analysis are shown in table 1.

Abstract PTU-068 Table 1 Odds ratios (OR) with 95% confidence intervals (CI) for the outcomes of UGI bleeding in patients with portal hypertension (PHT) and/or non-variceal lesions (NVL). The reference group (OR=1.0) is those without PHT or NVL

Outcome	Endoscopic findings	OR (95% CI)	P value	OR (95% CI)	P value
		Unadjusted		Adjusted for age, sex, smoking, alcohol	
Admitted >7 days	PHT	2.25 (1.73–2.91)	<0.001	2.58 (1.90–3.52)	<0.001
	NVL	1.51 (1.24–1.84)	<0.001	1.37 (1.11–1.69)	0.003
Transfused	PHT	5.28 (3.71–7.51)	<0.001	6.56 (4.43–9.71)	<0.001
	NVL no PHT	7.51	<0.001	1.83 (1.44–2.32)	<0.001
	NVL with PHT	1.95 (1.56–2.45)	0.043	0.58 (0.35–0.95)	0.031
		0.61 (0.38–0.98)			
Died ≤30 days	PHT	5.17 (3.36–7.96)	<0.001	6.09 (3.58–10.37)	<0.001
	NVL	2.02 (1.29–3.15)	0.002	1.94 (1.23–3.07)	0.005