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?
1Luke Sullivan*, 2Nekisa Zakeri, 3Rupert Nego, 4Damien Mack, 5Marsha Y Morgan. 1UCG Institute for Liver and Digestive Health, University College London, London, UK; 2Royal Free Hospital, London, UK

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/no culture cohorts. (A) Ethnicity (B) Deprivation

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
1,2Ali Taha*, 1Matthew Friar, 2Caroline McCloskey, 1Theresa Craigen, 2Wilson Angerson. 1University Hospital Crosshouse, Kilmarnock, Kilmarnock, UK; 2University of Glasgow Medical School, Glasgow, UK

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 gender, age, 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 UGIB 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 Adjusted for age, sex, smoking, alcohol P value
---
Admitted PHT 2.25 (1.73–2.89) <0.001 2.58 (1.90–3.52) <0.001
>7 days 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 1.83 (1.44–2.32) <0.001
NVL with PHT 0.58 (0.35–0.95) 0.031

Died PHT 5.17 (3.36–7.96) <0.001 6.09 (3.58–10.37) <0.001
≤30 days NVL 2.02 (1.29–3.15) 0.005

1University Hospital Crosshouse, Kilmarnock, Kilmarnock, UK; 2University of Glasgow Medical School, Glasgow, UK