37.6 g/L vs 38.4 g/L for the overall study group (p=0.81, NS).

Conclusions Upper GI mural thickening on CT cannot be dismissed. Despite oesophagitis, gastritis and hiatus hernia making up most endoscopic diagnoses (75%), it correlated with malignancy, dysplasia or metaplasia in 10/59 (17%) patients in this study. Patients with malignancy could not be accurately differentiated by indication for imaging or by biochemical markers. We conclude that there is good concordance in pathology detection at gastroscopy following findings of thickening on CT scan. We recommend gastroscopy is performed in every case when this abnormality is detected incidentally.

REFERENCES

PTU-072 A MULTI-CENTRE REVIEW OF ACUTE UPPER GI BLEEDING; CAN BLOOD UREA LEVELS AID DIAGNOSIS?

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Introduction Risk scoring for acute upper gastrointestinal bleeding (AUGIB) is key when assessing patients for requiring OGD. The Rockall score utilises age, comorbidities and shock. The Glasgow-Blatchford score (GBS), in addition, utilises haemoglobin, melena, and blood urea levels.

Raised blood urea levels can represent digestion of blood from the upper gastrointestinal tract giving rise to melena; the presence of both gives a high GBS. However, inexperienced health care professionals can misinterpret the absence/presence of melena, raised urea levels may be due to kidney injury. Nevertheless, Gastroenterologists may use urea to diagnose AUGIB if patients haven’t had overt/witnessed/reliably reported haematemesis or melena.

It has been shown that a raised urea:creatinine ratio (URCR) can be associated with AUGIB and may be superior to urea alone as it mitigates for kidney injury. However, URCR is not widely used in the UK in the assessment of AUGIB. We aim to assess the association of urea and URCR levels with AUGIB.

Methods A retrospective review at three UK centres (Kettering General Hospital, Queen Elizabeth Hospital Birmingham, and University Hospital Coventry & Warwickshire) was undertaken. Endoscopy reports and blood tests were reviewed of patients undergoing inpatient OGD for suspected AUGIB within 2017/8, data were recorded in an Excel spreadsheet. URCR was calculated by dividing Urea by creatinine, and multiplying by 1000 (abnormal = ≥100). Statistics were analysed using SPSS.

Results 357 patients’ records were reviewed (median age = 68), 179 had a plausible AUGIB (50.1%). Receiver operator characteristic (ROC) curves for Urea gave an area under the curve (AUC) = 0.733. For URCR, AUC = 0.789.

Binary logistic regression modelling was performed using age, urea, and URCR. $\chi^2$ (3, $n = 357$) = 102.92, $p<0.001$. 25–34% of the variance in AUGIB is explained by the model.

The model URCR value of 97.7 can be used to predict AUGIB, applying this to our data set correctly identifies 124/179 patients with AUGIB (69.3%), and is predicted to correctly identify 74.5%.

Conclusion This pilot study has limitations as bleeding lesions may have not been identified at OGD. Urea and URCR have AUCs of 0.733, & 0.789. Logistic regression modelling suggests a URCR level of 100 would correctly identify ~70% of AUGIB in patients with suggestive symptoms. Outside of firm