HELICOBACTER PYLORI BREXIT: NICE VS MAASTRICHT A COMPARISON OF ERADICATION GUIDELINES AND RESISTANCE IN LONDON

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Introduction The Public Health England (PHE) advises HP testing and treatment if positive, in patients without alarm symptoms who have uncomplicated dyspepsia unresponsive to lifestyle change and antacids. However, the suggested antibiotic therapy is incongruent with latest Maastricht V/Florence guidelines which suggest bismuth containing quadruple therapy first line in regions with high metronidazole and clarithromycin resistance and second line routinely. In London, a study showed overall resistance to metronidazole at 59% and clarithromycin at 11% with non-UK birth being main risk factor.

Results A list of all gastroscopies with CLO testing over a 2-year period from January 2016 to December 2018 was generated. Between 2016 and 2018, 36 isolates of HP were cultured – 1 to levofloxacin, 1 to tetracycline and none to amoxicillin.

Conclusion Given that these patients are likely to have previously failed at least one treatment regime; the results are inevitable skewed towards resistant isolates. While NICE and PHE guidelines are appropriate for some populations, areas of London which are at risk of higher resistance rates should use Maastricht guidelines. Therefore, we recommend a 10-day course of bismuth-containing quadruple therapy as second line.

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, melaena, and blood urea levels.

Raised blood urea levels can represent digestion of blood from the upper gastrointestinal tract giving rise to melaena; the presence of both gives a high GBS. However, inexperienced healthcare professionals can misinterpret the absence/presence of melaena, 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 melaena.

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, UCR is not widely used in the UK in the assessment of AUGIB. We aim to assess the association of urea and UCR levels with AUGIB.

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 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 UCR. \( \chi^2 (3, n = 357) = 102.92, p<0.001 \). 25–34% of the variance in AUGIB is explained by the model.

The model UCR 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 UCR have AUCs of 0.733, & 0.789. Logistic regression modelling suggests a UCR level of 100 would correctly identify ~70% of AUGIB in patients with suggestive symptoms. Outside of firm