Background Ferric Carboxymaltose (Ferinject) is a commonly used intravenous iron preparation. Varying degrees of hypophosphataemia have been reported with Ferinject. This is thought to be due to FGF23 mediated renal phosphate wasting, which has been associated with osteomalacia. With only 2 case reports of symptomatic osteomalacia and insufficiency fractures, clinical significance of Ferinject related hypophosphatemia in the overall population receiving it is unclear. Alternative intravenous iron preparation Iron III Isomaltoside (Monofer), has been reported to have a lower incidence of hypophosphatemia compared to Ferinject (Detlie, et. al., 2019) but some case series have reported a higher rate of hypersensitivity reactions (Mulder, et. al., 2018)

Aim To investigate the incidence of clinically significant hypophosphataemia in patients receiving Ferinject therapy based at daycase unit at Nottingham University Hospitals.

Methods Electronic and paper medical records, including prescription charts, of patients receiving parenteral Ferinject between January 2017 and September 2019 were reviewed. Patients were identified from the local admission database. Data was collected including age, sex, and race, number of Ferinject infusions, Ferinject dose, eGFR, Vitamin D, parathyroid hormone (PTH) and phosphate levels before and after Ferinject infusion. Hospital admissions, symptoms related to hypophosphataemia and need for phosphate replacement was recorded. Normal lab phosphate levels were 0.80–1.50 mmol/L. Hypophosphatemia was defined as mild (0.65–0.79 mmol/L), moderate (0.32 to 0.64 mmol/L), and severe (<0.32 mmol/L).

Results We identified 400 (251 female and 149 male), patients who had received Ferinject during the study period. 56 (14%) and 51 (13%) patients had phosphate levels tested within 1 year before and after receiving Ferinject respectively. Of these patients, 4 (7%) had hypophosphataemia prior to and, 17 (33%) {3 mild, 13 moderate and 1 severe} after Ferinject therapy. None of the 17 patients had symptoms related to hypophosphataemia. 2 patients with moderate hypophosphataemia incidentally found on routine bloods were admitted for phosphate replacement. 3 patients were admitted for a cause unrelated to hypophosphataemia.

Conclusions Our audit demonstrates that in our practice no acute serious adverse events were recorded due to Ferinject related hypophosphatemia. The long term impact of Ferinject-related hypophosphataemia requires larger prospective studies. This is of particular relevance to patients with pre-existing risk factors for bone metabolism disorders. It is our practice to correct Vitamin D deficiency where possible prior to administration of Ferinject. It has not been our practice to routinely measure serum phosphate level post infusion.

P242 RETROSPECTIVE REVIEW OF SIGNET RING CANCERS OF GI TRACT

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10.1136/gutjnl-2020-bsgcampus.316

Introduction Signet ring cell cancer (SRCC) is a rare and aggressive adenocarcinoma. The incidence of SRCC is rising worldwide. It is often missed during endoscopic examination due to its subtle appearance. SRCC is often widespread at the time of diagnosis making treatment challenging. The aim of this review is to assess the significance of early diagnosis of SRCC and its response to treatment.

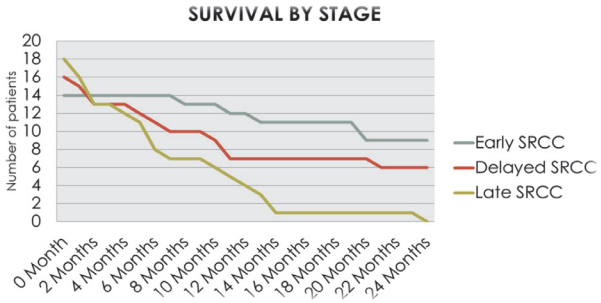
Methods We collected data from University Hospitals of Leicester for all patients who had histology confirmed diagnosis of SRCC between June 2005 and April 2018. We compared patients who had early SRCC (localized to the primary site), patient who had delayed SRCC (nodal spread) and patients who had late SRCC (distant spread) at the time of diagnosis. We excluded all patients whose staging could not be confirmed.

Results 51 patients were diagnosed with SRCC. 3 patients died before staging, hence excluded. 32/48 (66%) were males. Peak incidence age was seen between 70 and 79 years. SRCC was of gastric origin in 19/48 patients (40%), oesophageal in 14/48 patients (29%), colonic in 11/48 patients (23%) and pancreatic in 4/48 patients (8%).

14/48 patients (29%) had early SRCC, 16/48 patients (33%) had delayed SRCC, and 18/48 patients (38%) had late disease at the time of diagnosis.

11/14 (79%) of early SRCC patients and 10/16 (63%) of delayed presentations had surgical resection and neoadjuvant chemotherapy with or without radiotherapy. The rest of the patients were offered palliative therapy.

The 2 years survival among early SRCC group was 9/14 (64%), compared to 6/16 (38%) for the delayed SRCC group, and 0/18 (0%) survived in late group. The 2 years survival was 100% in patients treated by surgical resection, neoadjuvant chemotherapy and radiotherapy. Patients with colonic SRCC had the highest mean survival (26.5 months) compared to patients with pancreatic SRCC who had the lowest mean survival (7 months).



Abstract P242 Figure 1

Conclusions Early diagnosis and effective treatment of SRCC is likely to significantly improve the patient survival. SRCC of colonic origin appears to have the best prognosis. Our data suggest that combined surgical resection and chemo-radiotherapy has the best outcome. However, larger prospective study is likely to help in better understanding of this challenging cancer.

P243 NON-AMPULLARY SPORADIC DUODENAL ADENOMAS – TIME FOR A CONSENSUS ON ENDOSCOPIC RESECTION?

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10.1136/gutjnl-2020-bsgcampus.317

Introduction Sporadic duodenal adenomas (SDAs) are a rare but important finding at gastroscopy due to their malignant potential. Although endoscopic resection (ER) is generally advocated this carries significant risk related to the relatively thin, vascular and fixed duodenal wall. The lack of guidelines related to SDAs leads to variability in their management with potential implications for patient outcomes.

This descriptive study aimed to evaluate current practice regarding the management of non-ampullary SDAs and assess the need for a consensus.

Methods 40 internationally renowned advanced endoscopists from multiple international centres were surveyed regarding their management of non-ampullary SDAs. 12 questions investigating factors influencing whether to offer ER, pre-ER work-up, procedural risk and post-ER management were evaluated.

Results The survey was completed by 19 endoscopists with 18 confirming they endoscopically manage non-ampullary SDAs. Most endoscopists offered ER on a case-by-case basis with patient age (72%), comorbidities (44%) and lesion size (39%) reported as integral to decision making. No guidelines were used by 94% but multi-disciplinary team discussion prior to ER was arranged routinely by 67% and in select cases by 22% of endoscopists. Endoscopists completed further investigation prior to ER including endoscopic ultrasound (39%) and cross-sectional imaging (22%). The degree of risk involved in duodenal resection quoted to patients including haemorrhage (range 1–50%, median 15%) and perforation (0.7–10%, median 3%) was variable.

Both anti-coagulation and anti-platelets were restarted a median of 3 days (IQR 2–7 days) following duodenal resection. Post-procedural proton pump inhibitors (PPIs) were routinely prescribed by 94% of endoscopists however therapy duration was variable (median 29 days, IQR 14–30 days). Post-procedure patients were admitted routinely by 39% and in specific cases by 56% of endoscopists. Two endoscopists reported prescribing rectal non-steroidal anti-inflammatory drugs following ER of D2 adenomas.

Conclusions There is widespread variability in the pre- and post-procedural management of non-ampullary SDAs in major international centres. The majority of endoscopists manage patients on a case by case basis following MDT discussion and advocate PPI therapy post resection. There is a need to develop a consensus of opinion to help standardise the management of non-ampullary SDAs

P244 A REGIONAL REVIEW OF GASTRIC POLYP REPORTING AT GASTROSCOPY: WHAT LESSONS CAN BE LEARNED?

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10.1136/gutjnl-2020-bsgcampus.318

Introduction TReNDD NI is a regional trainee research network (TRN) formed in Northern Ireland with the mission statement of improving the consistency and standard of care delivered to our patients. Our inaugural project is centered upon the identification, documentation and management of gastric polyps that are identified endoscopically. As rotating trainees we are ideally placed to identify variations in practice across healthcare Trusts within our region and using BSG guidelines we aim to optomise practice.

Methods The TRN appointed a project manager who delegated data collection to trainee colleagues throughout region. The project was supervised by the co-chairs of the TRN and supported by consultants regionally. Statistical analysis was carried out, by one of our members, using Stata. Data was collected for patients undergoing Upper GI endoscopy, within Northern Ireland, from 1st July'18 to 1st July'19. Patients with an ICD10 coded diagnosis of Gastric Polyp (K31.7) or Benign Neoplasia of Stomach (13.1) were included. The number randomiser was used to select 30 patients from each Trust. Endoscopic reporting records were interrogated to confirm that all cases had documented polyps. Diagnosis and managements was confirmed using patient electronic care records (ECR).

Results The cohort analysis and demographic breakdown can be seen in table 1. The reporting standards show an accurate documentation of the number of polyps in 50% of cases and morphology in 72%. Just over one-third of cases (37%) had accurate documentation of polyp size. Biopsies were carried out, according to BSG Guidelines, in 79% of cases. Those who had undergone an OGD for anaemia, Barretts' oesophagus and dyspepsia had higher rates of completed documentation. The number of polyps documented for those with dyspepsia showed the strongest specific correlation (P=0.019), which suggests a possible positive reporting bias. There was a statistically significant difference noted between trusts relating to both documentation of biopsies taken and PPI usage (P<0.001).

Abstract P244 Table 1 Basic patient demographics

	n
No. patients in cohort	90
Gender	
Male	42
Female	48
Age	
Mean	68
Range	28–96
Indication	
Anaemia	23
Dyspepsia	12
Barrett's oesophagus follow up OGD	11
Dysphagia	11
Weight loss	9
Other indication	21
Indication data not recorded	3

Conclusion Documentation of gastric polyps has important implications for patient management, surveillance and future care. Documentation could be improved within all trusts with some significant variation in practice noted. Reasons for these differences may include different endoscopic reporting tools and varying endoscopist practice. More work is needed to further evaluate this. We have engaged with trusts to enhance documentation quality during upper GI endoscopy.