abnormal reflux. Interestingly, 4 patients with normal motility (CC) did have ineffective swallows (<40% swallows), and the removal of these patients, resulted in the redefined cohort having no abnormal proximal reflux. Across all patients reflux bolus exposure time correlated with gastroesophageal pressure gradient (GEPG) \((r=0.479;p=0.009)\), which became stronger when only patients with normal motility were examined (CC: \(r=0.664;p=0.018\); redefined: \(r=0.881;p=0.004\)). There was no association in hypo-contractility, likely due to the presence of ineffective motility, which correlated with reflux bolus exposure time \((r=0.422;p=0.133)\). Patients with hypo-contractility had a lower Forced Vital Capacity percent predicted \((49%(40–68)%\) than patients with normal motility \((67%(61–72)%p=0.04)\).

Conclusions Ineffective oesophageal motility was associated with increased reflux exposure, with many events reaching the proximal oesophagus, irrespective of whether patients had hypo- or normal motility; likely driven in part by increased GEPG. Furthermore, such motility abnormalities appear to associate with pulmonary dysfunction.

**P332** INTRA-SPHINCTERIC BOTULINUM TOXIN INJECTION IN THE MANAGEMENT OF FUNCTIONAL BILIARY PAIN: IS IT EFFECTIVE?

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**Introduction** The management of Type III sphincter of oddi dysfunction (SOD), or functional biliary pain syndrome, remains challenging. Evidence from the EPISOD study suggests that there is no role for biliary or pancreatic endoscopic sphincterotomy in treating functional biliary or pancreatic pain.\(^1\) Intra-sphincteric ampullary botulinum toxin injection has been reported to be effective in managing pancreaticobiliary pain by a combination of its anti-spasmodic effect on the sphincter of oddi and its general anti-nociceptive properties. We have been using ampullary botulinum toxin injection in conjunction with neuromodulatory drug therapy in managing functional bilo-pancreatic pain and review our experience of this management strategy.

**Methods** A retrospective review of case notes over a 5-year period (2014–2019) was performed. The diagnosis of Type III SOD or functional biliary pain was made in post cholecystectomy patients following extensive laboratory, radiological and endoscopic investigations. Patients with typical pre-cholecystectomy pain, normal duct size and normal liver function tests were identified as Type III SOD or functional biliary pain, in conjunction. The BMI recording period was between 1 am to 6 am when no activity was observed. WBM was performed for 2 days using Given Imaging Bravo capsule that was placed endoscopically 6 cm above the Z-line. The diagnosis for pathological reflux was based on combined 48 hours.\(^2\)

Statistical \(t\)-test was used to compare BMI between normal and pathological states on WBM study. Receiver operating curve (ROC) was plot to assess for critical BMI threshold to predict pathological reflux on WBM. Fisher exact test along with odds ratio (OR) were calculated to assess the critical BMI threshold. Positive predictive value (PPV) for GORD and negative predictive value (NPV) for absence of GORD were also computed with respect to the BMI critical threshold.

**Results** Total number patients selected were 212 (F: M=150:62, aged 20–81 years old). The mean BMI recording period was 33 minutes (20–130 minutes).

**Conclusion** We have previously shown wireless Bravo pH monitoring (WBM) to increase the diagnostic yield of GORD in patients with normal multichannel impedance-pH monitoring (ZPM).\(^1\) The decision factor to further investigate these patients on WBM after normal ZPM is unknown. This study examines the baseline mucosal impedance (BMI) to predict the outcome of WBM.

**Method** This is a retrospective study of patients with normal ZPM study (off PPI therapy) who underwent WBM (off PPI therapy) between 2010 and 2019. ZPM was performed using Sandhill Scientific catheters (ZAI-BG-44) and distal BMI was measured up to 7 cm from the manometric gastro-oesophageal junction. The BMI recording period was between 1 am to 6 am when no activity was observed. WBM was performed for 2 days using Given Imaging Bravo capsule that was placed endoscopically 6 cm above the Z-line. The diagnosis for pathological reflux was based on combined 48 hours.\(^2\)

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