87.5% (n=7/8) required repeated courses (≥ 12 weeks). One responded after an initial six weeks course. Subgroup analysis within the BOT cohort showed no difference between response rates in patients who had prior TS therapy and those who went direct to BOT from PPI (83.3% vs 75%, $p>0.05$).

Conclusions Our data suggests a high clinical response rate in patients receiving BOT in line with the results of the Eos-1 trial (85% remission rate following 12 weeks treatment). Optimal timing with regards to treatment escalation requires further evaluation but our data suggest that prior TS use is not associated with a difference in response rates with BOT. Prospective analysis with clinical-histological and endoscopic assessment is superior but currently challenging due to COVID-19. Clinical evaluation could be enhanced by using a standardised questionnaire for EoE but this will require further evaluation.

PTH-64 AN AUDIT OF BRAVO CAPSULE USE IN A TERTIARY REFERRAL CENTRE

¹Robert Perry*, ¹Alexander Dennis, ¹Maaz Tareen, ²Muaad Abdulla, ²Amit Thakor, ¹Nikolaos Kamperidis. ¹St Marks Hospital, London, UK; ²Watford General Hospital, Watford, UK

10.1136/gutjnl-2021-BSG.243

Introduction Wireless pH monitoring is an increasingly used modality in the assessment of gastro-oesophageal reflux disease (GORD). BSG guidelines recommend the use of wireless pH monitoring in patients who have symptoms suggestive of GORD but who have either previously been intolerant, or would likely be intolerant, to catheter-based pH monitoring. Evidence has shown that wireless monitoring using the Bravo capsule system is better tolerated than conventional catheter-based techniques, meaning less disruption of daily activities for patients. This better tolerability allows for longer periods of monitoring and potentially higher diagnostic yield.

Methods We performed a retrospective audit looking at the use of the Bravo capsule at our centre. The objective was to look at the adherence to the BSG guidelines and to collect relevant clinical information on patients referred to help inform future decisions on how to most effectively use the service. Data was collected using electronic patient records. We looked at results over a 20-month period comprising 84 patients in total.

Results We found the Bravo capsule to be an extremely well-tolerated procedure with only 1 of our 84 patients not tolerating the capsule insertion. Diagnostic yield was high, with 84% of patients having DeMeester scores above 14.72 and 78% having a total reflux time over 4.2%. 49% of patients were referred for consideration of surgery whilst the remainder were managed medically. The majority of patients (78.6%) had previously been intolerant of, or had borderline results from, catheter-based pH testing prior to being referred for the Bravo capsule which is consistent with BSG guidance. Most patients had an OGD prior to referral (91.7%). Of these patients 68% showed either a hiatus hernia, oesophagitis or peptic ulcer whilst 30% were normal. In our subgroup analysis we found that patients referred with a cough had a significantly lower DeMeester than those referred for other indications. We also found that patients with a previously nor-

mal catheter-based monitoring test had a lower mean DeMeester.

Conclusions Overall, our results showed that referrals for capsule-based pH monitoring were generally being performed according to BSG guidance. Our subgroup analysis should help inform further study into which patient groups benefit most from Bravo capsule referral.

PTH-65 EOSINOPHILIC OESOPHAGITIS IS OFTEN NOT EXCLUDED IN EMERGENCY FOOD-BOLUS OBSTRUCTION PRESENTATIONS – A MISSED OPPORTUNITY

Dominic King*, Samuel Smethurst, Rohan Aggarwal, Dominic King, Nigel Trudgill. Sandwell and West Birmingham hospitals NHS Trust, West Bromwich, UK

10.1136/gutjnl-2021-BSG.244

Introduction Oesophageal food bolus obstruction (FBO) presents as an emergency and frequently requires endoscopic removal of the bolus. Eosinophilic oesophagitis (EOE) is an atopic disorder that typically presents with food bolus obstruction. Guidelines for the diagnosis of EOE recommend six oesophageal biopsies from at least two sites. Early detection and treatment of EOE can prevent significant morbidity.

The aim of this study was to examine local practice in excluding EOE in those presenting with FBO.

Methods We conducted a retrospective review of acute FBO presentations in those over 16 years of age at Sandwell & West Birmingham NHS trust between 2014 and 2020. Cases of foreign body in the oesophagus were identified using the International Classification for Disease (ICD-10) code T18.1. Oesophageal cancers, severe reflux oesophagitis, peptic strictures, and foreign bodies other than food were excluded. Patient electronic records were examined for endoscopy findings and adherence to guidance on biopsies to exclude EOE.

Results 119 patients were identified. 38 (32%) had cancer, a peptic stricture, severe oesophagitis or a foreign body other than food or incomplete data and were excluded. 81 patients were examined (median age 58 (IQR 44-72), 78% male): 55 (68%) underwent endoscopy - 71% at presentation and 29% within 6 months. Of 26 patients without an index endoscopy, 19 (73%) were admitted under ENT and only one of these patients had a subsequent endoscopy and biopsies.

In those undergoing endoscopy at presentation, 23 (59%) had oesophageal biopsies taken (median 4 (IQR 2-6) biopsies), but only 6 (26%) were performed according to guidelines - 59% had multilevel but too few biopsies, while 41% had only single level biopsies. Repeat endoscopy was arranged for 5 (13%) patients who did not have biopsies taken at index endoscopy but only two had biopsies taken then. In total, only 14% of patients who had biopsies taken at index or follow-up endoscopy were in line with guidelines. Six (10%) patients met diagnostic criteria for EOE.

Conclusions The diagnostic yield for EOE was high at 10% in this FBO cohort as expected. However, both undertaking endoscopy (particularly after ENT admission) and the recommended biopsies to exclude EOE were inconsistent. Significant improvements in the management of FBO are needed to prevent missed EOE diagnoses.