appropriateness of follow up timing between BO experts (those performing >50 gastroscopies for surveillance or therapy per year) and non-experts, was further analysed by referer on the order request. There was a significantly better adherence to follow up timing when the referrer was an expert ($p=0.011$).

Conclusions High quality endoscopic surveillance relies both on high quality endoscopy as well as appropriate decision making around the timing of surveillance. Adherence to guidelines for the timing of follow up endoscopy is poor particularly in short segment Barrett's and particularly by non-expert Barrett's endoscopists. This argues for better vetting by experts to decide the timing of follow up endoscopies.

PTH-70 ASSESSMENT OF CONCORDANCE BETWEEN OESOPHAGEAL HRM + PHMETRY, AND BARIUM SWALLOWS

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Introduction To determine the sensitivity and specificity of barium swallow in reference to the gold standard HRM + 24 hour pH studies to identify abnormalities in peristalsis, lower oesophageal sphincter (LOS) relaxation and detection of gastro-oesophageal reflux (GOR) in symptomatic patients. Concordance of oesophageal peristalsis and LOS relaxation between conventional oesophageal manometry and barium swallow has been well documented in synchronous and asynchronous studies. However, research comparing barium swallow and oesophageal HRM is limited and there is sparse data evaluating the ability of barium studies to detect GOR in comparison to 24 hour pH studies.

Methods 88 patients with GOR and/or dysphagia uncontrolled by medication, who have undergone HRM +/- 24 hour pH studies and a barium swallow within 12 months of each other, were identified. Consecutive patients were selected upon referral to Northern General Hospital between February 2018 and June 2019, with the exception of those without a gastroscopy to rule out structural abnormalities and those who have a history of upper gastrointestinal surgery. Of the 88 patients initially included in the study, data for 48 subjects was available to be blindly reviewed. The barium swallow images were then blindly reviewed by a consultant radiologist and oesophageal manometry + 24 hour pH results were reviewed by a clinical scientist to determine if inter-observer variability is a confounding variable.

Results 88 patients met inclusion criteria; of which we had available data on peristalsis for 88, data on LOS relaxation for 85 and reflux for 72. Referenced to HRM, barium swallow indicated 40% sensitivity and 53% specificity for identifying abnormal peristalsis, 61% sensitivity and 98% specificity for detecting abnormal LOS relaxation and 51% sensitivity and 72% specificity for detecting reflux. When assessing concordance between the reviewed manometry and barium swallows, there was little change within the peristalsis and reflux parameters, with the greatest change observed for LOS relaxation.

Conclusion In this tertiary centre, concordance between HRM and barium swallow is poor, and specifically, barium swallow is lacking in ability to identify abnormalities in oesophageal

peristalsis and the reviewed data suggests that inter-observer variation is a factor causing discrepancies in the assessment of LOS relaxation. Further, in those patients whose results were changed when reviewed, these changes are unlikely to have affected their clinical management.

PTH-71 EXPLORING THE ROLE OF DEDICATED SERVICES FOR BARRETT'S OESOPHAGUS CARE IN UK NHS HOSPITALS

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Introduction Barrett's oesophagus (BO) services in the UK are run with different models. Though it is not currently advised in guidelines, studies suggest a benefit from dedicated services showing better adherence to surveillance protocols and concomitant dysplasia detection [1,2]. As the extent of BO dedicated services in the UK has not been reported in the literature, we aimed to gain insight into the extent of this practice in NHS trusts.

Methods Adult NHS endoscopy units in the UK known to the Joint Advisory Committee (excluding paediatric units) were contacted via phone or email and asked to complete a 6-question survey about the BO endoscopy service provided in their unit.

Results In total, 249 departments (~95%) were contacted with a response rate of 62.2% (155/249). Of these 140/155 (90.3%) performed BO surveillance in their unit and 83/140 (59.3%) reported having a dedicated service. When asked who was running the service, most reported a mixture of gastroenterologists, surgeons, nurses and fellows, with 22/83 (26.5%) reporting a single clinician. Regarding specific interventions and techniques, having a dedicated BO service was significantly associated with the use of high-resolution white light (92.8% vs 70% $p<0.0001$) and acetic acid (84.3% vs 50% $p<0.0001$). There was no significant difference for virtual chromoendoscopy techniques ($p=0.12$) or dye chromoendoscopy ($p=0.12$).

Having a dedicated endoscopy BO service was associated with local availability of radiofrequency ablation (43.4% vs 18.3% $p=0.002$), endoscopic ultrasound (63.9% vs 30% $p<0.0001$), endoscopic mucosal resection (60.24% vs 38.3% $p=0.015$) and endoscopic submucosal dissection (34.9% vs 5% $p<0.0001$). However, many trusts without these services also reported a dedicated BO endoscopy service suggesting practice in non-tertiary setting. There was no significant difference in provision of a dedicated BO service when accounting for JAG accreditation status ($p=0.9$).

Trusts which reported a dedicated endoscopy service were significantly more likely to also have a dedicated Barrett's clinic (54.2% vs 16.7% $p<0.0001$) and have a named lead for Barrett's within their unit (86.8% vs 33.3% $p<0.0001$).

Conclusions Dedicated services for BO are provided in the NHS, and our study suggests that quality of care indicators such as use of high-resolution white light endoscopy are linked with dedicated services. Studies should be undertaken to measure the outcomes for patients with cost benefit analysis to determine the efficacy and efficiency of this service to determine best practice.