

**PTH-74 CO-PRODUCTION OF PATIENT INFORMATION LEAFLET WITH NORTHERN IRELAND BARRETT'S OESOPHAGUS PUBLIC AND PATIENT INVOLVEMENT GROUP**

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10.1136/gutjnl-2021-BSG.253

**Introduction** The Northern Ireland Barrett's oesophagus research Public and Patient Involvement (PPI) group identified an area of unmet need for standardisation of the information provided to patients at the time of their Barrett's oesophagus diagnosis. This study aimed to co-produce a patient information leaflet as an evidence-based resource for Barrett's oesophagus patients.

**Methods** The PPI group first initiated the co-production of the leaflet in May 2020, providing initial ideas based on patient experience and information needs. A scientific literature review in Pubmed was conducted to identify reported information needs of Barrett's oesophagus patients. The leaflet has received two rounds of iterative feedback at 1.5 hour PPI group meetings and clinical input from Consultants in the areas of Gastroenterology, Pathology and Oncology.

**Results** The review of the literature and PPI group feedback identified several important areas for inclusion in the leaflet:

- What is Barrett's oesophagus?
- How is Barrett's oesophagus is diagnosed?
- Risk factors associated with Barrett's oesophagus development
- Symptoms associated with Barrett's oesophagus and ways they are managed,
- Treatment plans including endoscopic surveillance and medications prescribed
- Quantifying the risk of progression to oesophageal adenocarcinoma
- Recommended online information sources

The PPI group highlighted the need for clear images and diagrams alongside the written text to aid patient understanding of Barrett's oesophagus with the clinicians emphasising the need for the leaflet to be short and therefore good optimisation of space. Balancing risk communication of a pre-malignant condition with a relatively low lifetime risk of cancer progression, with recommendations to reduce this risk, was a key focus of discussions and feedback.

**Conclusion** A four A5 page evidenced-based leaflet on Barrett's oesophagus has been developed, aiming to address previously unmet information needs. The next phase will evaluate the leaflet in other Barrett's oesophagus patients and key stakeholders involved in their care. Future plans include the development of an online patient resource.

**PTH-75 THE UTILITY OF PLAIN CHEST RADIOGRAPHS TO DETECT PERFORATION AFTER ENDOSCOPIC STENTING FOR OESOPHAGEAL CANCER**

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10.1136/gutjnl-2021-BSG.254

**Introduction** In line with BSG guidelines (2011), endoscopic placement of self-expanding stents has become standard practice for the palliative management of stenosing oesophageal tumours. Procedural protocol varies between centres. Locally a plain chest radiograph (CXR) is performed 2 hours post stenting to check expansion and for signs of oesophageal perforation prior to commencing clear fluids orally. We aimed to assess compliance with this protocol and evaluate the use of CXR to exclude oesophageal perforation.

**Methods** Consecutive day case and inpatient oesophageal stent procedures were identified from clinical coding between January 2017 and December 2020. Electronic patient records only were interrogated. Data was collected on the use of balloon dilatation, CXR reports, alternative or additional imaging, presence of perforation, and survival post-stent. Basic statistics were performed using Microsoft Excel.

**Results** Seventy patients were identified with a median age of 77 years. There were 80 procedures performed during the study period. Ten patients required redo oesophageal stenting. The majority had a day case procedure (58%). Balloon dilatation was performed prior to stenting in 39% of procedures. Median survival post-stenting was 78 days (IQR 32-174).

A CXR was performed post-stenting in only 89% of cases despite being part of post-procedure protocol. When a CXR was not performed a there was no rationale documented in the electronic records. 13 patients (16.2%) required further imaging, with either computed tomography (CT) or water-soluble contrast swallow, to exclude oesophageal perforation.

Oesophageal perforation was identified in 3 patients (3.75%) post procedure. A CXR was performed in all 3 cases however only one revealed evidence of perforation. One patient had a perforation identified during endoscopy, following a balloon dilatation. The post procedure CXR demonstrated pneumoperitoneum; however subsequent water-soluble contrast swallow showed no leak. Unfortunately, the patient died on day 7 of admission however it was not clear if this was a result of oesophageal perforation. The remaining 2 cases of oesophageal perforation were only identified on CT performed due to high clinical suspicion. Both patients were discharged without further complications. All 3 cases were managed conservatively.

**Conclusions** We have shown that there was not full compliance with local protocol and that CXR was not solely relied upon for diagnosing oesophageal perforation. CXR alone is not sensitive enough to confidently exclude perforation when there is significant clinical concern. It should also be noted that, on the day of procedure, radiology reported CXR's are rarely available leaving more junior staff to interpret the images. An argument could be made for replacing routine post-procedure CXR with clinical criteria to guide use of more sensitive imaging modalities such as CT.

**PTH-76 USE OF ORODISPERSIBLE BUDESONIDE IN THE TREATMENT OF EOSINOPHILIC OESOPHAGITIS: A SINGLE-CENTRE AUDIT**

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10.1136/gutjnl-2021-BSG.255

**Introduction** Eosinophilic oesophagitis (EoE) is a chronic inflammatory condition of the oesophagus. The diagnosis is