PTH-87 CURRENT TREATMENT MODALITIES AND MEDIAN SURVIVAL FOR PATIENTS WITH GASTRIC CANCER AND ISOLATED PERITONEAL METASTASIS

^{1,2}Adler Shing Chak Ma*, ^{1,3}Stephen Lam, ¹Eman Otfy, ¹Abdulfatah Yousfi, ³Adam Stearns, ³Bhaskar Kumar. ¹Norwich Medical School, University Of East Anglia, Norwich, UK; ²Department of Gastroenterology, James Paget University Hospital NHS Foundation Trust, Great Yarmouth, UK; ³Department of Surgery, Norfolk and Norwich University Hospital NHS Foundation Trust, Norwich, UK

10.1136/gutjnl-2021-BSG.266

Introduction Gastric cancer with peritoneal metastases carries a median survival of only 3-7 months without treatment, and no treatment modality in standard practice appears to improve survival beyond a few months. In order to measure the efficacy of emerging modes of treatment, it is essential to describe the treatments patients currently receive and the impact of these on survival – data for which is poorly described in the literature and lacking in the UK setting.

Methods This was a single hospital-based retrospective cohort study which included 50 patients who received a diagnosis of gastric adenocarcinoma with isolated peritoneal disease between the dates 21 March 2012 to 14 January 2020 at a tertiary referral centre. We calculated median survival time for all patients and also by treatment modality.

Results The mean age of patients was 71 years (range 44-90 years). Overall, 26 patients (52%) received systemic chemotherapy, three (6%) gastrectomy, six (12%) endoscopic stenting and 15 (30%) best supportive care. Overall median survival was 6.6 months (IQR 2.4-19.3). At a mean of 16.4 months follow-up, 43 patients (86%) had died. Median survival by treatment modality was as follows: supportive care (2.4 months, IQR 1.2-5.1), endoscopic stent (5.7 months, IQR 3.6-71.2), systemic chemotherapy (11.2 months, IQR 3.7-21.5), and palliative gastrectomy (15.1 months, IQR 6.6 to 55.9).

Conclusions Our results confirm the poor prognosis of gastric cancer patients with isolated peritoneal disease with available treatments only extending survival by a maximum of 4 to 8 months, highlighting the desperate need for new treatment modalities.

PTH-88 HELICOBACTER PYLORI ERADICATION RATES IN A UK LOCAL POPULATION: TIME FOR A STRATEGY CHANGE?

Olivia Greenham*, Neel Kapoor, Jana Waloszkova, Diza Gonclaves, Mohamed Shariff, Anthony Leahy. West Hertfordshire Hospitals Trust, Watford, UK

10.1136/gutjnl-2021-BSG.267

Introduction *Helicobacter pylori* (HP) is a treatable human pathogen with a high prevalence throughout the world. Infection causes peptic ulcer disease, lymphoma and gastric carcinoma, hence the importance of eradication. Antibiotic resistance and human migration present ongoing therapeutic challenges despite decreasing incidence in the UK. We assessed our local HP eradication rates to identify if we need to alter our local treatment strategy.

Methods We performed a retrospective analysis of patients who had a urea breath test (UBT) between March 2019 to January 2021. Patients completed 1st line triple therapy (FLTT) after a positive HP result and had a UBT 6-8 weeks later to assess HP eradication. If patients tested positive they completed further treatments of 2nd line triple therapy (SLTT) and 3rd line quadruple therapy (TLQT). Each patient

had a post treatment UBT performed 6-8 weeks after completion of each therapy and if positive, progressed to the next treatment. Patients who remained positive despite TLQT, had a gastroscopy and biopsies taken for microscopy, culture and sensitivity (MC&S).

Results 151 patients had UBTs following FLTT. 111 (74%) had successful eradication with either FLTT or a combination of FLTT and SLTT. 40 (26%) received quadruple therapy. Out of these, 24 had UBTs performed following treatment. 11 (46%) had a positive UBT after quadruple therapy. 19 patients had MC&S performed. HP was identified in 11 samples with 5 (45%) showing resistance to clarithromycin and 10 (91%) to metronidazole.

Conclusions Our data demonstrates that we need to improve our ability to eradicate HP. Up to a quarter of patients failed FLTT and SLTT. There were also high rates of treatment failure among patients who received TLQT. Contributing factors may include self-selection and underlying microbial resistance.

The samples sent for MC&S showed a high rate of resistance to metronidazole. A UK study in 2010 Savoldi et al. looked at antimicrobial resistance in HP and found resistance to metronidazole as high as 88%. This again suggests that microbial resistance to current treatment regimens is a concern for HP eradication. MC&S is an accurate method for predicting treatment success. NICE guidelines advise that a biopsy is only indicated in certain circumstances including a known allergy, high local resistance rates, and those who remain HP positive despite 2 courses of antibiotics. There are also additional associated costs. However, local resistance rates are largely unknown and using MC&S may negate the need for multiple rounds of testing, antibiotics and help to reduce HP antibiotic resistance.

We have implemented new guidelines at our Trust to use 1st line quadruple therapy with eradication failures offered MC&S. We plan to reaudit this treatment strategy change at a later date.

PTH-89 AN AUDIT OF AGIB ENDOSCOPY SERVICES IN NORTH HAMPSHIRE HOSPITALS TRUST DURING THE COVID19 PANDEMIC

Rebecca Smith*, Ryoan Khang, Corrine Brooks, John Ramage. North Hampshire Hospitals Trust, Basingstoke, UK

10.1136/gutjnl-2021-BSG.268

Introduction All healthcare services have been disrupted as a result of the COVID19 pandemic. However, the full impact of the pandemic is as yet unknown. There is little in the literature to suggest how acute gastrointestinal bleeding (AGIB) services have been impacted, despite their reliance on timely aerosol generating procedures.

Method The North Hampshire Hospitals Trust's endoscopy database was searched for cases between 01/01/2020 and 01/03/2021, including all emergency and urgent procedures, conducted for indications that could be related to AGIB.

805 endoscopies were identified with these search terms, however, 596 were excluded as not being related to AGIB, 1 case was excluded where there was insufficient information. 209 endoscopies were included.

Results 209 endoscopies were conducted for AGIB on 176 patients, with a mean age of 67.4(SD16.5). The median time-to-endoscopy was 20 hours (IQR 8-39). 63.2% of patients