PTU-030
SMALL BOWEL AND OTHER GI LESIONS IN OBSCURE GASTRO-INTESTINAL BLEEDING – LOW DOSE ASPIRIN VS. NSAIDS. SCREENING PHASE OF THE MASTERS TRIAL

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Introduction While NSAIDs can affect any part of the GI tract, little is known about the effect of aspirin in the small bowel or colon. In this prospective analysis, we compared upper GI, small bowel, and colonic findings in patients taking aspirin vs. those taking NSAIDs while being considered in the screening phase of the MASTERS Trial (Misoprostol for the Healing of Small Bowel Ulceration in Patients with Obscure Blood Loss while Taking Low-Dose Aspirin or Non-Steroidal Anti-inflammatory Drugs).

Method For MASTERS, obscure occult bleeding was defined as having absence of potentially bleeding lesions on colonoscopy and endoscopy, and in the presence of one or more of the following: positive faecal occult blood test; iron deficiency anaemia; or drop in Hb, ≥2 g/dl from baseline. Suitable patients underwent small bowel video capsule endoscopy (Omom systems, China).

Results DEMOGRAPHY: 127 patients were assessed: 80 taking aspirin alone without NSAIDs and 47 taking NSAIDs alone without aspirin; they all had colonoscopy while smaller numbers undergoing upper GI or capsule endoscopy. The aspirin group had older patients (median 69 vs. 61 years, p=0.016). UPPPER GI ENDOSCOPY: In the aspirin group (n=56), 5% had oesophagitis, 4% peptic ulcers, 5% erosions, and 32% had other findings, compared with 5%, 11%, 8%, and 32%, respectively, in the NSAID group (n=38).

SMALL BOWEL LESIONS: As shown in Table-1, no significant differences were seen between the users of aspirin or NSAIDs. COLONOSCOPY: In the aspirin group (n=80), 34% had diverticular disease, 5% cancer, and 8% had other disorders, compared with 34%, 2%, and 9%, respectively, in the NSAID group (n=47). However, the aspirin group had 33 patients (41%) with colonic polyps vs. 7 (15%) in the NSAID group, [unadjusted OR 4.0 (95% CI, 1.6–10.0), p=0.003]. This remained significant after adjusting for age and sex [OR 3.5 (95% CI, 1.3–9.3), p=0.012].

<table>
<thead>
<tr>
<th>Abstract PTU-030 Table 1</th>
<th>Small bowel lesions, median (IQR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin alone n=80</td>
<td>NSAIDs alone n=21</td>
</tr>
<tr>
<td>Denuded areas</td>
<td>6 (4–10)</td>
</tr>
<tr>
<td>Red spots</td>
<td>9 (6–17)</td>
</tr>
<tr>
<td>Ulcers</td>
<td>3 (2–5)</td>
</tr>
<tr>
<td>Erosions</td>
<td>4 (3–6)</td>
</tr>
<tr>
<td>Band-like strictures</td>
<td>1 (0–2)</td>
</tr>
</tbody>
</table>

Conclusion (1) In this prospective analysis, patients with obscure occult bleeding and using aspirin have similar prevalence and range of lesions in the small bowel and upper GI tract as those using NSAIDs. (2) The use of NSAIDs was associated with fewer patients with colonic polyps. These results might help in planning and interpreting the investigations of obscure bleeding. They might also be relevant to colon cancer chemoprevention.

Disclosure of Interest None Declared

PTU-031
OUTCOMES FROM AN INTERNATIONAL MULTICENTRE REGISTRY OF PATIENTS WITH GASTROINTESTINAL BLEEDING UNDERGOING ENDOSCOPIC TREATMENT WITH HEMOSPRAY

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Introduction Acute gastrointestinal bleeding (G.I.B) carries a poor prognosis unless prompt endoscopic haemostasis is achieved. Hemospray is a novel proprietary mineral blend that forms a mechanical barrier over the bleeding site when applied endoscopically. The primary aim of this international multicentre registry is to collect data on the successful endoscopic haemostasis of GI bleeding with Hemospray. Secondary outcomes are re-bleeding (within 72 hours), device safety and adverse events related to the treatment.

Method Data were collected prospectively (January 2016 – October 2016) on the use of Hemospray in acute upper and lower G.I.B, from two initial centres in the international registry. The use of hemospray in GI bleeding was at the endoscopist’s discretion. Hemospray use was either as monotherapy, as dual therapy with standard endoscopic measures or as rescue therapy once standard methods had failed.

Results To date 36 cases have been recruited (27 male and 9 female). Hemospray was used in 15 patients (42%) as monotherapy, in 17 patients (47%) in combination with other modalities and in 4 patients (11%) used as rescue therapy where other modalities failed. The Forrest Classification of the bleeding lesion were in 7 (19%) cases Forrest Ia bleed, 23 (64%) Ib, 2 (6%) Ib, 2 (6%) IIa, 2 (6%) IIb and 2 (6%) Forrest III bleed. Sources of G.I.B included Peptic Ulcer disease 17 (47%), Post endoscopic Therapy 8 (22%), Malignancy 6 (17%), inflammation 2 (6%), Duodenal diverticulum bleed 1 (3%), Post Radiation bleed 1 (3%) and Variceal Bleed 1 (3%). 8 patients (22%) were anticoagulated at the time of emergency endoscopy. 31 patients (86%) achieved immediate haemostasis after hemospray endoscopic therapy. There were 5 cases (14%) of re-bleeding of which 2 (6%) were immediate and 3 (8%) occurred more than 7 days later. Hemospray was used in combination with other modalities in all these 5 cases. Of these 3 passed away, 1 required radiological embolisation and 1 patient was stabilised with conservative management. There were no reported immediate or delayed complications from the treatment.

Conclusion Early data from our registry show a high rate of immediate haemostasis (86%) with hemospray and an excellent safety profile. The imminent expansion of this registry to other centres in Europe will provide invaluable data on the efficacy of Hemospray in various disease and patient types over the coming years.

Disclosure of Interest None Declared
PTU-030 Small bowel and other gi lesions in obscure gastro-intestinal bleeding – low dose aspirin vs. nsaids. screening phase of the masters trial

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