

including gastroenterologist, allergist, dietitian, psychologist and clinical nurse specialist. Of those, 32 children with eosinophilic oesophagitis (EoE) alone were excluded. Hence, 76 patients [61%, (n=46) non IgE mediated allergy, 4% (n=3) IgE mediated allergy, 27% (n=20) combined IgE, non-IgE and EoE, 10% (n=7) had other food triggered conditions) were retrospectively reviewed.

**Results** 97% (n=74) of children were following exclusion diets for  $\geq 12$  months, with a mean of 5 excluded foods (median 4, IQR 2, 6). At the follow-up, the mean number of foods excluded had reduced to 3 (median 2.5, IQR 1, 5);  $p < 0.0001$ . Milk (n = 59; 78%) was the most common excluded food, whilst fish/shellfish (n=18; 24%) was the least. Over 12 months 55% (n=42) of patients introduced at least 1 food into their diet and 16% (n=12) of patients reintroduced between 75–100% of excluded foods. The dietitians provided on average 3 contacts to patient, in the form of face-to-face appointments or telephone appointments (range 1–16).

**Conclusion** In children with GIFA, long-term unnecessary food exclusions should be avoided, due to the relationship with poor growth, feeding difficulties and nutritional deficiencies (Meyer, 2018) Despite the fact that the majority of them had been following long-term exclusion diets, over half of patients were able to reintroduce at least one food into their diet.

In this cohort, the MDT approach, which brings together professionals from different backgrounds to pave the most effective management plan for the patient, has shown to be highly beneficial in supporting patients and their families to reintroduce foods into their diets. However this requires ongoing support for many families' in-between medical appointments to achieve this goal.

This small centre outcome demonstrates some positive impacts of MDT approach, which should become the standard model of care in children with complex GIFA.

## REFERENCES

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### GUIDELINE VS CLINICAL PRACTICE, LOOKING BEYOND ESPGHAN POLYPOSIS WORKING GROUP RECOMMENDATIONS FOR FAP SCREENING

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**Introduction/Background** Current guideline for the initial endoscopic assessment for suspected polypoid disease of the colon have been created by professional bodies such as ESPGHAN.

In instances where there is a family history of FAP and genetics demonstrates a relevant mutation, in clinical practice, we refer to the above guideline to determine the age for initial endoscopic assessment and subsequent surveillance is further determined by the findings of the initial endoscopy.

This guideline recommends only a lower GI endoscopy for the initial test and do not recommend a concomitant UGI scope till age 25 years (Recommendation 5- ESPGHAN FAP Screening guideline).

We report two cases where an initial combined upper and lower GI endoscopies showed >100 gastric, 10 to 50 colonic

polyps and 50 to 100 Gastric polyps, >100 colonic polyps respectively and discuss the relevance of these guidelines for such instances.

**Aim;** To review the relevance of current guidelines with regard to the extent of initial endoscopy that is recommended in suspected cases of FAP in children.

**Subjects and Methods** Patient 1: 13 years old boy referred by geneticist as noted to have significant alteration in APC gene raising possibility of APC syndrome. At presentation, history of upper abdominal pain, dyspepsia. No bleeding PR, pallor. Mum had colectomy when 22 years old. Upper GI endoscopy done along with colonoscopy in view of upper abdominal pain and dyspepsia. Upper GI endoscopy revealed numerous (>100) small (<5 mm diameter) gastric polyps in body and antrum. 2 slightly larger polyps were noted at lower oesophagus near gastro oesophageal junction. Histology reported as gastric fundic gland polyp. H pylori not detected. Colonoscopy revealed 10 to 50 colonic polyps (some 2 mm, rest <2 mm diameter). Histology reported as adenomas with low grade dysplasia.

Patient 2: 12 years old boy referred by geneticist, father known to have FAP. Ophthalmology screening showed changes on the retina. Genetic test showed mutation in APC gene. First colonoscopy revealed scattered polyps throughout colon (<50). Histology reported as tubular adenoma of low dysplasia. No upper GI endoscopy done. Noted to have vague upper abdominal pain at the time of second colonoscopy 18 months later. Otherwise asymptomatic. Upper GI endoscopy done along with Colonoscopy in view of upper abdominal pain. Upper GI endoscopy revealed multiple (50 to 100) small gastric polyps (<5 mm diameter) in gastric body. Histology reported as fundic gland polyps. H pylori negative. Colonoscopy revealed >100 Colonic (2 mm) polyps. Histology reported as adenoma with low grade dysplasia.

**Results** Deviation from current guidelines has yielded a positive finding of multiple gastric polyps.

**Summary and Conclusion** Current guideline do not provide advice for further management and surveillance when gastric polyps are incidentally discovered on concomitant UGI endoscopy undertaken for other clinical reasons in patients with FAP.

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### HELICOBACTER PYLORI CULTURE IN ROUTINE PRACTICE: A PAEDIATRIC RETROSPECTIVE STUDY

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**Introduction** Helicobacter pylori is usually acquired in early childhood. The systematic use of standard eradication therapy regimes has resulted in a rising prevalence of antibiotic-resistant strains and a decreasing efficiency of H. pylori eradication therapy. The latest ESPGHAN guidelines (2016) suggest only investigating H. pylori in paediatric patients who would benefit from treatments and to base the eradication therapy on susceptibility testing.

Our local practice has been to test symptomatic children with H. pylori stool antigen and to treat with a standard