

61.5% of the cases showed high grade budding while low grade budding was seen in only 38.5%. This tells us 69.2% fell under T3 stage of which 88.89% had high grade TB while only 11.11% had low grade budding.

Of the 4 present cases of LVI, 75% had high grade TB & 25% had low grade budding.

Of the 3 margin involved cases, 67% had high grade TB while 33% had low grade budding.

Conclusion: To conclude, TB is a valuable prognostic factor and indicator of aggressive diseases. Presence of TB correlates to unfavorable clinicopathological features. It also provides an important value of risk stratification.

1. Risk stratification
2. High grade TB benefit from esophagectomy.

406 REVIEWING THE DYSPLASIA DURING LONG FU OF BARRETT'S ESOPHAGUS. SHOULD WE RELY ON THE DIAGNOSIS OF DYSPLASIA?

S Szachnowicz¹ A Duarte¹ B Mattos¹ K Iriya² E Bianchi¹ F Seguro¹ J da Rocha¹ R Sallum¹ I Ceconello¹

1. *Discipline of Digestive Surgery, Department of Gastroenterology - University Of Sao Paulo - School Of Medicine - Sao Paulo - Brazil, São Paulo, Brazil*
2. *Department of Pathology - University Of Sao Paulo - School Of Medicine - Sao Paulo - Brazil, São Paulo, Brazil*

Barrett's esophagus (BE) is a complication of severe gastroesophageal reflux disease (GERD). The major concern aspect is its association to dysplasia and esophageal adenocarcinoma. The endoscopic treatment of the epithelium, as well as the follow-up (FU) period, should be guided according to the diagnosis and the worst degree of dysplasia found in the last endoscopies. However, we are aware of the great difficulty and variation among pathologists in diagnosing and grading dysplasia in BE.

Methods: Aim: Review new diagnoses of low- and high-grade dysplasia (LGD and HGD) in BE with specialized pathologists during long-term FU in clinical or surgical treatment for GERD

From January 1980 to July 2019, 738 patients with BE were FU (average of 98 months), with routine endoscopic examination each 2 years with multiple biopsies, in patients with BE without dysplasia. 48 patients were diagnosed with any grade of dysplasia on FU endoscopic biopsies. The biopsies were reviewed by specialized pathologists and evaluated epidemiologic data, clinical or surgical treatment for the GERD and about the confirmation, downgrade or upgrade of dysplasia degree.

Results: 48 patients were reviewed, 32 males. The medium age was 61,9 YO (29 -93). Only 18 patients were in follow-up after surgical treatment for GERD. 9 patients had first diagnosis of in situ Adenocarcinoma, after review 8 were confirmed and treated and 1 were downgrade to HGD. 8 patients had first HGD and after review, 2 were upgrade to Adenocarcinoma, 4 were confirmed as HGD (endoscopic treatment) and 2 downgraded to no dysplasia BE. 31 patients had first LGD. 2 had upgrade to HGD/Adeno, 8 are in FU annually and 21 were downgrade to non dysplastic BE.

Conclusion: The diagnosis of dysplasia in BE remains a challenge. 23 of 48 (47%) of our patients once marked with any grade of dysplasia, were downgrade after pathological review and FU to non dysplastic BE. These difficulty of appropriate dysplasia degree diagnosis could make some mistakes in BE treatment and surveillance.

408 THE PRESENCE OF LYMPHATIC, VENOUS AND PERINEURAL INFILTRATION FOLLOWING ESOPHAGECTOMY WITHOUT NEOADJUVANT THERAPY TO IDENTIFY PATIENTS AT RISK OF RECURRENCE.

K Hardy¹ J Chmelo² R Khaw² M Navidi² A Phillips²

1. *Newcastle University Medical School, Newcastle upon Tyne, United Kingdom*
2. *Northern Oesophago-Gastric Cancer Unit, Royal Victoria Infirmary, Newcastle upon Tyne, United Kingdom*

Staging and prognostication in esophageal cancer patients is based on their TNM stage. Previous research has suggested venous invasion (VI), lymph

vessel invasion (LI) and perineural invasion (PNI) as adverse prognostic indicators in patients with advanced disease receiving neoadjuvant treatment. The aim of this study was to assess the incidence and prognostic significance of these factors in patients with cancer of the esophagus or gastro-esophageal junction (GEJ) who were treated with unimodality surgery.

Methods: A contemporaneously maintained database was used to identify patients who underwent a primary 2-field transthoracic esophagectomy for adenocarcinoma or squamous cell carcinoma of the esophagus or gastro-esophageal junction. Between January 2000 and January 2018. Patients who died in hospital, underwent palliative resections or where the presence (or absence) of VI, LI or PNI was not reported were excluded. Patients were staged using UICC-TNM 7.

Results: 279 patients were included. VI was present in 99 (35%) patients, LI in 120 (43%), and PNI in 120 (43%). Median overall survival was 140 months (95% confidence interval (CI): 79.3–200.7) when PNI, LV and VI were absent, 55 months (95% CI: 42.2–67.8) when one factor was present, 18 months (95% CI: 5.4–30.6) with two factors and 31 months (95% CI: 17.6–44.4) with all three factors present. Univariable analysis revealed that LI, PNI and VI are significant prognostic indicators for length of disease-free survival ($p < 0.001$) with LI an independent prognostic factor on multivariable analysis ($p = 0.05$).

Conclusion: These findings suggest the importance of the presence of LI, VI and PNI in patients undergoing unimodality esophagectomy for cancer of the esophagus. It may provide additional information for identifying patients that are high risk who may be candidates for adjuvant therapy.

40 INTRODUCING AN INTERACTIVE ONLINE-REPORT FROM THE SWEDISH NATIONAL QUALITY REGISTER FOR ESOPHAGEAL AND GASTRIC CANCER—OPEN NREV

G Linder¹ M Lindblad² J Johansson³ F Lindberg⁴ U Smedh⁵ E Moritz⁴ J Hedberg¹

1. *Department of Surgical Sciences, Uppsala University, Uppsala, Sweden*
2. *Division of Surgery, Department of Clinical Science, Intervention and Technology Karolinska Institutet (CLINTEC), Centre for Digestive Diseases, Karolinska University Hospital, Stockholm, Sweden*
3. *Department of Clinical Sciences, Surgery, Lund University, Skane University Hospital, Lund, Sweden*
4. *Department of Surgical and Perioperative Sciences, Umeå University, Umeå, Sweden*
5. *Department of Surgery, Institute of Clinical Sciences, Sahlgrenska Academy, Gothenburgh, Sweden*

The Swedish National Quality Register for Esophageal and Gastric Cancer (NREV) was introduced in 2007 and is the sole quality registry in Sweden for patients with esophageal and gastric cancer. Previously, selected variables from the registry was made available to both caregivers and the public through a downloadable annual report.

We aimed to make quality indicators readily available to all interested parties; caregivers, patient groups, hospital staff, researchers, administrators and health-political decision-makers.

Methods: A database was compiled with registry data presented for all years since 2007 and updated every six months. Several graphical and numeric presentations were implemented. Both medical expertise and a patient representative were involved in choosing relevant quality indicator variables as well as designing the web interface.

Results: Registry Coverage, Quality indicators/lead times, Treatment and Outcomes were the four main focus areas. All areas contained selectable sub-variables and the user was given the choice to present data on a national or regional level. Alterations in chosen variables or selection-base resulted in real time changes in the online report. Thus, a variable national or regional report could be tailored to the users' needs. All data could be presented as comparative diagrams, crude tables or as time-trend analysis, as exemplified by figure 1.

Conclusion: An interactive online platform to display population based results and time-trends for important quality indicators in the diagnosis and treatment of esophageal and gastric cancer is now available for all. The main purpose, to make anonymized data available, was achieved by OPEN-NREV. We propose that presenting data in this manner is of interest to patients, caregivers, scientists and decision makers.