Cox proportional hazards analysis. The ability of the PIB score (incorporating weighted scores for male EAC more than 12 months after initial diagnosis. Demographic and clinical variables were abstracted. Recruited from three medical centers. Progressors were defined as those with the development of high grade dysplasia (HGD) or esophageal adenocarcinoma (EAC) are based solely on progression to high grade dysplasia (HGD) or esophageal adenocarcinoma (EAC). The progressors were defined as those with the development of HGD or EAC. The PIB score was also able to risk-stratify patients in this validation cohort with the high risk group. The risk in the high risk group was three fold higher than the low risk group (P = 0.024). The risk in the intermediate group was twofold higher but not statistically significantly higher (P = 0.13). The PIB score had a c-statistic value of 0.76 in the original cohort. In this cohort the c-statistic value was lower at 0.64, suggesting moderate performance.

**RESULTS:** 415 patients were included. 84% were men, with a mean (SD) age of 61.5 (9.9) years. 67% were ever smokers and most (76.7%), had NDI in Barrett’s. Mean (SD) maximal BE length was 5.9 (3.2) cm. Eighty-two patients (19.1%) progressed to HGD (n = 45) or EAC (n = 17) over a median (IQR) follow up of 7.5 (12.8) years. Annual incidence rates of progression to EAC and EAC/HGD were 0.3% and 2.0% respectively. Univariate and multivariable predictors of progression are displayed in Table 1. The PIB score divided patients into three groups (Table 2) with progressively increasing rates of progression. The risk in the high risk group was three fold higher than the low risk group (P = 0.024). The risk in the intermediate group was twofold higher but not statistically significantly higher (P = 0.13). The PIB score had a c-statistic value of 0.76 in the original cohort. In this cohort the c-statistic value was lower at 0.64, suggesting moderate performance.

**CONCLUSION:** Male sex and BE length predicted progression in this independent multicenter cohort. The PIB score was also able to risk-stratify patients in this validation cohort with the high risk group being 3x more likely to progress compared to the low risk cohort.

**INTRODUCTION:** Endoscopy surveillance guidelines in Barrett’s esophagus (BE) to detect progression to high grade dysplasia (HGD) or esophageal adenocarcinoma (EAC) are based solely on dysplasia grade. Lower rates of progression, identification of predictors (and scores) of progression may help to focus surveillance or intervention in those at higher risk. We aimed to assess predictors of progression and externally validate the Progression in Barrett’s (PIB) score in an independent multicenter prospective BE and EAC cohort.

**METHODS:** The EA and Barrett’s esophagus (EAE) registry is a prospective cohort of patients recruited from three medical centers. Progressors were defined as those with the development of HGD or EAC more than 12 months after initial diagnosis. Demographic and clinical variables were abstracted. The annual incidence rate and predictors of progression were assessed using univariate and multivariable Cox proportional hazards analysis. The ability of the PIB score (incorporating weighted scores for male EAC more than 12 months after initial diagnosis. Demographic and clinical variables were abstracted. Recruited from three medical centers. Progressors were defined as those with the development of high grade dysplasia (HGD) or esophageal adenocarcinoma (EAC). The progressors were defined as those with the development of HGD or EAC.

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**CONCLUSION:** Male sex and BE length predicted progression in this independent multicenter cohort. The PIB score was also able to risk-stratify patients in this validation cohort with the high risk group being 3x more likely to progress compared to the low risk cohort.

**INTRODUCTION:** High-resolution manometry using the Chicago Classification is standard in the evaluation of esophageal motility. When the relaxation of the esophageal junction is impaired and achalasia excluded, esophageal junction outflow obstruction (EJO-OO) is diagnosed and the esophageal body is essentially ignored. We sought to characterize the function of the esophageal body in consecutive patients with EJO-OO.

**METHODS:** Retrospective review of the esophageal manometry findings in consecutive patients where there was computer recognition of EJO-OO collected over a 2-month period. In each case, the esophageal body was reviewed manually and results reported independent of the suggested computer diagnosis.

**RESULTS:** 116 patients underwent manometry over a 2-month period and 30 (26%) were identified as having EJO-OO. The indications for testing included chronic cough (n = 5), GERD (n = 4), dysphagia (n = 9) and esophageal evaluation associated with severe lung disease or transplantation (n = 8). The mean IRP was 20.8 (range 16-33.6) and did not vary depending on indication (P = 0.816). Computer interpretation was EJO-OO in all patients without mention of the esophageal body. After review, 11 (37%) had an additional esophageal diagnosis. In effective esophageal motility (IEM) was the most prevalent among them (IEM-8, achalasia-2, jackhammer esophagus-1, P = 0.020). The frequency of an additional esophageal diagnosis was significantly different between GERD (9%) and dysphagia (66%, P = 0.004), but not between other groups (i.e. 40% in cough and 37.5% in transplant group). An esophageal body diagnosis was significantly more likely in patients with IRP > 20 (80%) compared with those with IRP < 25 (28%, P = 0.028).

**CONCLUSION:** 1-EJO-OO is common in patients referred for esophageal manometry. 2-An additional esophageal body diagnosis is common in those with EJO-OO. 3-Esophageal diagnoses are more common in patients with dysphagia and in those with a very high IRP. The body of the esophageal is important in cases of EJO-OO and should be reported independent of the computer-generated interpretation of the Chicago Classification.