

Abstract P5 Table 1 Weight loss and outcome

outcome	3 Month (n = 51)	6 Month (n = 60)	12 Month (n = 31)	P value <sup>a</sup> (comparing baseline and 6 months)	P value <sup>b</sup> (comparing 6 and 12 months)
Mean absolute weight loss (kg)	12.86 ± 11.58	11.43 ± 16.44	35.16 ± 34.99	P= <0.001	P= 0.001
Mean%TBWL	6.81 ± 5.59	6.33 ± 8.09	18.90 ± 18.64	P= <0.001	P= <0.001
Mean%EWL	10.04 ± 8.36	9.42 ± 11.93	27.92 ± 27.88	P= <0.001	P= <0.001
% Patients with >10%TBWL	21.6%	33.3%	58.3%	—	—

adjusted and left in stomach for a period of 12 months. Its use in super obese patients has not been studied.

Aim to retrospectively evaluate the effectiveness of SAB3 in super-obese patients (BMI ≥ 50 kg/m<sup>2</sup>) as bridge to definitive surgery and report the complications associated with it.

**Methods** Super obese patients who had SAB inserted and completed ≥ 6 months of follow up were included in the study. The absolute weight loss, mean percent excess weight loss (%EWL) and the% total body weight loss (%TBWL) at 3, 6 and 12 months was recorded from hospital electronic system.

**Results** A total of 60 patients with a mean (±SD) age, initial BMI and weight of 41 years (± 12), 68.59 kg/m<sup>2</sup> (± 9.57) and 183.45 kgs (± 32.81), respectively had SAB inserted. Data was available on 51, 60 and 31 patients at 3, 6 and 12 months. The mean%EWL at these time points was 10.04 (± 8.36), 10.45 (± 9.85) and 27.92 (27.88).% Patients with >10%TBWL at same time points was 21.6%, 35% and 58%, respectively (table 1 below). 21 (40.4%) patients went on to have a definitive bariatric surgery to date. Complications associated with SAB were abdominal pain in 16.7% (10), severe enough in 6 for unplanned SAB removal, gastroesophageal reflux 13.3% (8), intestinal obstruction 1.7% (1), migration 1.7% (1), deflation in 6.7% (4), nausea/vomiting 12% (7).

**Conclusion** SAB placement in our center was safe, tolerable and achieved the desired weight loss in majority of the super-obese patients. The rate of SAB early removal was in keeping with real world literature.

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#### SAME DAY BOWEL PREPARATION FOR COLONOSCOPY LEADS TO BETTER OUTCOMES; RESULTS OF A NATIONAL SURVEY

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**Introduction** Adequate bowel preparation is an essential prerequisite to high quality colonoscopy. Previous studies suggest that split dose bowel preparation and timing the colonoscopy 4–6 hours after completion of the preparation results in optimal bowel cleansing. However, anecdotal evidence suggests that bowel preparation instructions do not consistently

recommend split dosing; or optimise timing. The aim of this study was to survey the instructions given to guide bowel preparation and compare this to outcome measures.

**Methods** All NHS trusts in the UK were surveyed with a standard email requesting data between January 2018 and January 2019. Data requested included: type of prep, timing of prep, pre endoscopy diet, adequacy rates and adenoma detection.

**Results** Response rate was 79% (n=128). Seven were excluded due to insufficient data. Moviprep was the first line bowel preparation in 79%, 19% used magnesium sulfate/picosulphate and 2% used Klean prep. Only 10 units advised patients to split prep so that they took a dose of bowel preparation on the same day (SD) as their morning procedures, whereas 111 units advised patients to take bowel prep the day before (DB). In the DB group, the median time in which the second dose of bowel preparation was advised to be consumed was 8 pm (range 2 pm–9 pm, 95% confidence interval ± 2.72 hours); 12.5 hours prior to the first morning procedure (assuming a first appointment of 830 am). In the SD group, the rate of inadequate bowel preparation was 5.1% (1885/37224), compared with 7% (25107/361409) (p<0.0001) in the DB group. 15 of the trusts in the DB group, also provided adequacy rates divided between morning and afternoon procedures. Within this subgroup, all afternoon procedures received a portion of bowel preparation on the day, whereas all the morning procedures were advised to consume their bowel preparation the day prior. Morning procedures had rate of inadequate bowel preparation of 7.6% (2523/33072), whereas afternoon appointments was 6.6% (1836/27635) (p<0.0001).

**Conclusion** Most endoscopy units do not appear to give instructions devised to optimise the timing of bowel preparation prior to colonoscopy. This results in an increased rate of reported inadequate bowel cleansing. Splitting the dose of bowel preparation and tailoring the timing of preparation to the proposed timing of colonoscopy has the potential to significantly reduce the risk of missed lesions and the need for a repeat colonoscopy. If optimisation were to lead to the reduction of inadequate colonoscopies seen in this dataset, it could be extrapolated that an estimated 14000 fewer colonoscopies would have poor bowel preparation, saving a potential £8.4 million/year if these no longer required a repeated procedure.

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#### DOES INDIVIDUALISED FEEDBACK IMPROVE COLONOSCOPY KEY PERFORMANCE INDICATORS?

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**Introduction** Colonoscopy is the gold standard examination of the bowel. Detection and removal of polyps leads to a reduced risk of subsequent colorectal cancer. Higher adenoma detection rate has been associated with a reduced post colonoscopy colorectal cancer rate. The BSG recommends a minimum performance standard, the key performance indicators (KPIs), which each independent endoscopist should achieve, to ensure quality. Monitoring of each endoscopists' KPIs, and offering individual feedback to those falling below the standard, may lead to improvement. In this study we assessed the response in KPIs following such feedback.