Abstract P9 Table 1 Haemostatic efficacy of PuraStat®

Indication	Procedures n=204 (n)	Immediate haemostasis n=100 (n,%)	Prevention of delayed bleeding n=177 (n,%)
High risk resection	198	90/98 (91.8%)	169/173 (97.7%)
UGIB	6	2/2 (100%)	4/4 (100%)
Overall	204	92/100 (92.0%)	173/177 (97.7%)

bleeding in 177 cases (see Table 1). PuraStat® was additionally used in 22 radiation proctopathy cases, as sole therapy in 14 and secondary therapy in 8, with improvement in patient reported symptom score and haemoglobin. The average volume of PuraStat® used across all indications was 0.43 mls for haemostasis and 2.33 mls for prevention of delayed bleeding. No PuraStat® related complications were reported.

Conclusions Our data shows PuraStat® is safe and effective for a range of indications, with most use within high risk resections. It shows high efficacy in both immediate haemostasis and prevention of delayed bleeding. We believe PuraStat® is a promising new agent in the prevention and management of gastro-intestinal bleeding.

P10 IS PRE-ENDOSCOPY FASTING ADVICE CONSISTENT ACROSS ENDOSCOPY UNITS IN ENGLAND?

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Introduction There is a lack of guidance regarding the recommended duration of fasting pre-gastroscopy. Endoscopy guidelines advise a low fibre diet the day before colonoscopy and continuing bowel preparation up to 2 hours pre-procedure. Current practice in England regarding pre-endoscopy fasting advice is unclear.

Methods Data on pre-endoscopy fasting advice for fluids and solids were sought from all English endoscopy units by accessing online patient information leaflets (PIL) and direct contact with the units.

Results Data were obtained from 137 of 143 (96%) endoscopy units. 54 Trusts (38%) had online PIL.

Most instructions used specific timings, but some were vague (e.g. lunch).

Gastroscopy

89% of Trusts stopped solid food 6 hours prior to gastroscopy.

11% advised a longer fasting period, range 8 to >12 hours.

58% of Trusts stopped clear fluids 2 hours before.

42% advised longer periods, range 3 to 8 hours.

Colonoscopy

Moviprep was used by 85% of Trusts. 17% followed the company's leaflet instructions with regards to solid foods. 77% had longer fasting periods (hourly intervals from 7 am). 6% stopped solid foods the entire day before. 6% had a shorter fasting period.

68% of Trusts stopped clear fluids 2 hours before.

12% had longer periods, range 3 to 6 hours.

20% had shorter periods, 18% allowing clear fluids until the procedure.

Conclusions Anaesthetic guidelines recommend stopping clear fluids 2 hours before and solid food 6 hours before an elective procedure to reduce the risk of aspiration. These guidelines are probably relevant for gastroscopy, however 11% of Trusts had a longer fasting period (>6 hours) for solid foods and 46% (>2 hours) for clear fluids. 77% of Trusts had a longer fasting period than required for Moviprep. Unnecessary prolonged fasting has adverse consequences such as dehydration and patient discomfort. Conversely 18% allowed clear fluids up until a colonoscopy, which in a sedated patient may increase the risk of aspiration.

Guidelines recommend completing bowel preparation within 2–5 hours of the colonoscopy to optimise the quality of bowel cleanliness; this was only true for 3% of Trusts.

We have demonstrated wide variation in pre-endoscopy fasting advice across endoscopy units in England, with many units using fasting advice inconsistent with guideline recommendations.

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P11 UTILISATION AND REPRODUCIBILITY OF WEO PCCRC ALGORITHMS IN A REAL-WORLD SETTING

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Introduction Colorectal cancer (CRC) diagnosed following a colonoscopy in which no CRC is found is termed Post-Colonoscopy CRC (PCCRC). The World Endoscopy Organisation (WEO) consensus statements recommend review of individual PCCRC cases, including categorisation of cases into interval/non-interval CRCs, and root cause analysis (RCA) to determine most plausible explanation.

Our study aim was to test the usability, reproducibility and outcomes of the WEO categorisation.

Methods All CRC cases diagnosed from January 2015 to December 2016 in a single NHS trust were identified. Each was cross-referenced with local endoscopy and pathology databases. Cases where non-diagnostic colonoscopy was performed prior to CRC diagnosis were included. All colonoscopies going back to 2007 (when endoscopy reporting system introduced) were reviewed.

Each CRC was entered into a spreadsheet, with headings based on WEO RCA checklist for PCCRCs. We performed 2 separate assessments: (1) RCA to identify WEO most plausible explanation for PCCRC; and (2) WEO PCCRC subtype categorisation, which looks at screening/surveillance intervals (table 1).

Inter-observer agreement was measured using Cohen's kappa (k). Cases with inter-rater variation were analysed further using patient notes and then discussed by a panel to determine causes of variation and attempt to reach consensus.

Results Among 527 patients with CRC, 48 PCCRCs were identified. In 32 cases, the prior colonoscopy occurred within

Abstract P11 Table 1

Most Plausible Explanation (Colonoscopy <4 years prior to CRC diagnosis) (n=32)	Independent Review		Following Discussion
	Assessor 1	Assessor 2	Consensus
Likely incomplete resection of previously identified lesion	1	0	0%
Detected lesion, not resected	3	3	9%
Possible missed lesion, prior examination adequate	20	21	66%
Possible missed lesion, prior examination negative but inadequate	8	8	25%
Colonoscopy >4 years prior to CRC diagnosis (n=16)			
Likely new CRC	16	16	n/a

Categorisation of PCCRC (n=48)	Independent Review		Following Discussion
	Assessor 1	Assessor 2	Consensus
Interval Type - Detected before recommended interval	6	9	15%
Non-Interval type A - Detected at recommended interval	6	6	12%
Non-Interval type B - Detected after recommended interval	13	13	31%
Non-Interval type C - No interval had been recommended	23	20	42%

4 years of CRC diagnosis (table 1). Median age was 73 (range 48–93), 56% of cases were male.

Consistent most plausible explanation was found in 31/32 (97%) cases, showing almost perfect agreement (k=0.94). Categorisation into interval and non-interval types was consistent in 37/48 (77%) cases, showing substantial agreement (k=0.67).

Following panel discussion, consensus was reached for most plausible explanation and categorisation of PCCRC in all cases. 66% of PCCRCs within 4 years of diagnosis were attributed to 'possible missed lesion, prior examination adequate'. 73% of cases were categorised as Non-interval Type B or C. Full results are in table 1.

Conclusion Using readily available data, PCCRC cases can be categorised by most plausible aetiology with almost perfect inter-rater agreement. Categorisation of PCCRC subtype was more challenging, reflecting uncertainties in surveillance intervals and endoscopic plans. Further discussion, with additional clinical information, led to agreement in all cases.

The majority of PCCRC cases were categorised as 'probable missed lesions following an adequate colonoscopy'. The high number of Non-interval type B PCCRCs suggests a significant proportion of PCCRC cases could be avoided with adherence to recommended surveillance intervals.

P12 NATIONAL ENDOSCOPY DATABASE (NED): THE FIRST MILLION

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Introduction The National Endoscopy Database (NED) is populated by data extracted automatically from endoscopy reporting systems (ERSs) of endoscopy services in the UK. 406 out of 520 UK endoscopy sites are currently uploading. We aimed to provide an overview of oesophagogastroduodenoscopies (OGDs) stored on NED.

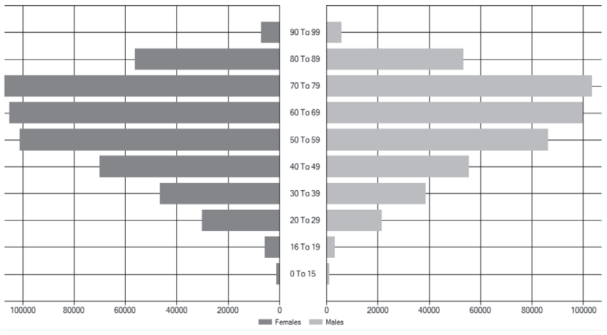
Methods Data from all OGDs uploaded to NED from 2016 to the 28th January 2020 was accessed and analysed using the standard output from the NED website.

Results 1,010,741 OGDs have been uploaded to NED. 651,270 of those are from 2019, compared to 281,883 in 2018 and 21,457 in 2017, indicating the ongoing roll-out of NED across the UK.

47% of procedures were performed on male patients, 52% on female and 1% unspecified. 27% of OGDs were performed on patients <50, detailed age distribution is seen in figure 1.

13% of procedures were on in-patients, 65% on out-patients, while 22% were unspecified. 51% of procedures were routine, 37% urgent, 3% emergency, and 3% surveillance. 7% were not specified. 49% of procedures were unsedated.

The most common indications were: Dyspepsia (17%), Heartburn/Reflux (15%), Anaemia (15%), Dysphagia (14%), Abdominal Pain (12%). Other frequent indications were: Weight Loss (7%), Nausea/Vomiting (6%), Melaena (5%), Haematemesis (3%), Barrett's Oesophagus (3%), Varices Surveillance (2%). 'Other' was included in the indication field in 37% of OGDs.



Abstract P12 Figure 1