



Abstract P63 Figure 1 ROC curves for urea trend versus absolute urea concentrations

Serum urea level >6.5 mmol/L and change in urea concentration >1.3 fold from baseline predicted the need for endotherapy with a sensitivity/specificity of 85%/32% and 85%/46%, respectively; the latter predicted severe AUGIB ($X_2=10.2$, $p=0.001$). The corresponding area under the receiver operating curve (AUROC) were 0.59 (95% CI 0.49–0.69) and 0.71 (95% CI 0.61–0.81) (figure 1). In a subgroup analysis of patients with chronic kidney disease ($n=46$), AUROC for urea trend was 0.65 compared to that of absolute urea levels (0.53). There were no significant associations between urea concentrations, acute and chronic kidney disease with rebleeding rates at 72 hours, inpatient mortality and readmissions for AUGIB.

Conclusions We demonstrate that an increase in urea concentration of >1.3 fold from baseline is superior at predicting severe AUGIB requiring endoscopic intervention and is a useful discriminator in patients with chronic kidney disease.

P64 THE IMPACT OF ENDOSCOPIC SUBMUCOSAL DISSECTION ON THE COMPLEX POLYP SERVICE

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Background Endoscopic excision of complex polyps is a rapidly evolving treatment, and particularly endoscopic submucosal dissection (ESD) might represent an option for superficial malignant invasion. Limited data is available in western series for clear indications for ESD.

Methods We prospectively collected data between February 2017 and December 2018 of excision of complex polyps. We compared short term outcomes data between piecemeal and en-bloc excision, with both Endoscopic Mucosal Resection (EMR) and ESD, and outcomes in endoscopically resected polyps that were incidentally found to be malignant.

Results 189 patients (80 females, mean age 69.9, sd 11.8) underwent 207 polypectomies. Of these, in 124 we employed a piecemeal technique, and en-bloc resection in 83 (41 EMR

and 42 ESD, 13 of which were performed in 2017 and 29 in 2018). There was no difference in the rates of complications between the en-bloc and the piecemeal groups. We experienced no perforation or need for transfusion in either group. In 8 patients (6.5%) of the piecemeal group there was polyp recurrence, whilst no recurrence was seen in the en-bloc group.

Histology showed cancer in 14 specimens within the en-bloc group. Out of these, 10 patients underwent surgical resection, and residual cancer was found only in one case. In the other 4 patients endoscopic surveillance showed no recurrence. Histology confirmed cancer in 6 patients within the piecemeal group. Of these, 3 underwent surgical resection and 3 to endoscopic surveillance with one recurrence.

Conclusions In our cohort, en-bloc resections appeared to be as safe as piecemeal polyp resections, but with lower recurrence rates. In our practice rates of ESD increased two-fold over the 2-year period, and it might represent a treatment option for superficial submucosal malignant invasion. Future studies are warranted to address the role of ESD for polyp cancers.

P65 THE OVESCO OTSC FOR ACUTE UPPER GASTROINTESTINAL BLEEDING – A LARGE PROPENSITY SCORE-MATCHED UK SERIES

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Introduction There have been no significant improvements in the outcomes of upper gastrointestinal (GI) bleeding over the last few years. The aim of this study was to determine whether the use of the OVESCO™ over the scope clip (OTSC) was associated with a lower rebleed-rate and mortality compared to conventional endoscopic therapy.

Methods Consecutive episodes of upper GI haemorrhage treated with the OTSC were identified from a prospective database in a UK tertiary centre over a 3-year period. Treatment with OTSC was delivered for patients with high-risk features or failed conventional endoscopic therapy.

Over the same time period, all patients with upper GI haemorrhage treated with conventional endoscopic therapy were retrospectively identified, and a propensity score-matched cohort was assembled. Patient demographics, 7-day re-bleed rate, 30-day re-bleed rate and 30-day mortality rates were compared. T-test and Pearson's Chi-square statistic were used to statistically describe the results.

Results 617 episodes of upper GI haemorrhage were identified requiring endoscopic intervention over three years. 71 high-risk lesions were treated in the OTSC group, vs 89 high-risk lesions in the matched control group (conventional endoscopic therapy).

The sites of lesions treated with the OTSC included oesophagus (10%), stomach (22%) and duodenum (68%). The lesions were described as Forrest 1a-18%, 1b-33%, 2a-32%, 2b-17%. Pathology included ulcers (78.9%), Mallory-Weiss tears (9.6%) Dieulafoy (7.0%) post-angiographic coil ulcer (1.4%) post-EMR (1.4%) anastomotic bleed (1.4%).

Compared to the control group, the OTSC group had lower 7-day re-bleeding rate (19.3% vs 2.8%, $p < 0.01$) and a lower 30-day re-bleeding rate (25.0% vs 7.0%, $p < 0.01$). There was a trend toward reduction in all-cause mortality in the OTSC group (14.8% vs 8.5%, $p=0.20$) but a significantly

lower haemorrhage related mortality in the OTSC group (4.5% vs 1.4%, $p=0.02$).

Conclusions This is one of the largest series of patients treated with OTSC for upper GI haemorrhage, demonstrating a significant reduction in both early and late rebleeding in addition to haemorrhage related mortality and thus needs to part of the treatment armamentarium.

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COLD PIECEMEAL ENDOSCOPIC MUCOSAL RESECTION (EMR) FOR LARGE ADENOMAS/SERRATED POLYPS ARE SAFE AND FEASIBLE

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Background Conventional EMR carries a risk of delayed bleeding, perforation and post polypectomy syndrome. Incomplete polyp resection could lead to recurrence and post colonoscopy cancer.

Methodology Prospective databases from our institution including 113 consecutive patients with 149 polyps (>1 cm in size) resected by cold EMR between 2016 and 2018 were included. Demographics, clinicopathological and polyp characteristics, surveillance and recurrence data were analysed.

Results Male: female was 2:1 with a median age of 65 years (35–83). Median polyp size was 19 mm (10–40 mm). one hundred and seventeen polyps (78%) were in the proximal colon. Histology of resected polyps were :47 adenomas (32%) and 102 sessile serrated polyps of which 3 had dysplasia (2.9%).

Most common sites were transverse colon (23.5%), caecum (20.8%) and ascending colon (17.4%). 78.8% of polyps were found proximal to splenic flexure.

Intra procedural oozing was witnessed during resection and settled without any haemostatic interventions in 98.6% of cases. 2 cases needed application of clips to achieve haemostasis. One patient was admitted following the procedure with abdominal pain and managed conservatively. There were no delayed bleeding or perforation. A surveillance colonoscopy (6–36 months) were carried out in 80 patients (71%) and the remainder of the patients either awaiting a planned surveillance or discharged from surveillance programme.

Overall recurrence rate following cold EMR was 3.7% (4/108) and successfully treated with cold snare resection.

Conclusions Cold EMR for large adenomas and serrated polyps appears to be safe and feasible without any immediate or delayed complications.

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10% POUIG LITTLE TOO MUCH – 6YR DGH EXPERIENCE

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Introduction An upper Gastro-Intestinal (GI) cancer detected within 3 years of Oesophago-Gastro-Duodenoscopy (OGD) is considered as a failure to diagnose cancer earlier, termed Post OGD Upper GI Cancer (POUGIC). POUIG rates of less than 10% are now auditable key performance indicator (KPIs) set out in quality standards.¹ Our aim was to examine

Abstract P67 Table 1

| | | 2014– 2016 | 2017– 2019 | Total in 6 years |
|--------------------|---------|---------------|---------------|---------------------|
| Diagnosed Upper GI | Overall | 148 | 205 | 353 |
| Cancer | Missed | 6 (4%) | 13 (6.3%) | 19 (5.3%) |
| Oesophageal | Overall | 78 | 83 | 161 (45.6%) |
| | Missed | 2 | 5 | 7 |
| GOJ | Overall | 10 | 16 | 26(7.3%) |
| | Missed | 1 | 1 | 2 |
| Gastric | Overall | 57 | 100 | 157(44.4%) |
| | Missed | 3 | 7 | 10 |
| Duodenal | Overall | 3 | 6 | 9(2.5%) |
| | Missed | 0 | 0 | 0 |

POUGIC rates over two consecutive 3-year periods (2014–2016 and 2017–2019).

Methods A retrospective review into all diagnosed upper GI cancer patients, identified from upper GI cancer database, was carried out between 01/01/2014 -31/12/2016 and 01/01/2017 -31/12/2019. Data was extracted using electronic records on patients who had standard light gastroscopy within 3-year period prior to diagnosis at both study intervals. Three independent endoscopists ratified missed cancers.

Results A total of 353 patients had newly diagnosed upper GI cancers in the time period 2014–2019. There was male preponderance (69%) with a median age of 73.5 at diagnosis. The results from two consecutive 3-year periods are shown in following Table 1.

Of the missed cancers, index gastroscopy was performed by consultant grade in 15, nurse endoscopist in 3 and supervised trainee in 1 patient.

42% (8/19) of these patients did not have photographs of the cancer site, 6 patients had photographs showing normal areas, which subsequently developed cancer. 5 had photographs but were difficult to ascertain whether those areas were the ones developing malignancy later.

Conclusions Missed cancer rate at our centre is 4% and 6.3%, over 2 consecutive 3-year period. Our observation is lower than the published acceptable rates¹ and comparable to other centres.^{2 3 4} There is argument to revise the standard in line with national average and mandate photographic evidence of landmark as a quality control of diagnostic OGD.¹

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ACCREDITATION DEFERRAL AT JAG ASSESSMENT: WHERE DO ENDOSCOPY SERVICES NEED TO IMPROVE?

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Introduction Endoscopy services are expected to meet standards in four domains to achieve JAG accreditation: clinical quality, patient experience, training and workforce. At a JAG