

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