

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.

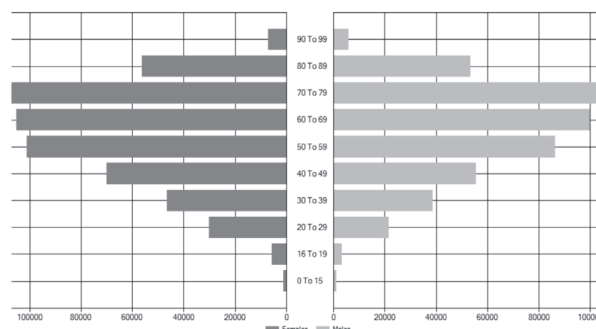
Methods Data from all OGDs uploaded to NED from 2016 to the 28th January 2020 was accessed and analysed using the standard output from the NED website.

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

The most common diagnoses were: Normal (31%), Hiatus Hernia (27%), Non-erosive Gastritis (17%), Reflux Oesophagitis (11%). Other frequent diagnoses were: Barrett's oesophagus (7%), Erosive Gastritis (6%), Gastric Polyp(s) (5%), Non-erosive Duodenitis (5%), Oesophageal Varices (2%), Erosive Duodenitis (2%), Duodenal Ulcer (2%), Gastric Ulcer (2%). 'Other' was included in the diagnosis field in 18% of OGDs.

(NB: Multiple indications and diagnoses can be entered for a procedure, hence sum of percentages is greater than 100% for these categories)

Conclusion The majority of procedures were performed in the ≥ 50 age group, peaking between ages 70 to 79, although a quarter of all procedures were performed in people younger than 50. Close to half of OGDs are performed without sedation.

Procedure uploads to the NED continue to increase exponentially year on year. The volume of data and high proportion of sites uploading allows unparalleled insights into OGD practice in the UK.

P13 UNCOVERING THE ENDOSCOPIC PORTAL HYPERTENSION BURDEN IN SIERRA LEONE – AND STARTING TO TREAT IT

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Introduction Portal hypertension (PHT) may cause life-threatening bleeding from oesophageal or gastric varices, but if identified can be managed endoscopically or medically. Worldwide, cirrhosis is most commonly due to viral hepatitis. In Sierra Leone, hepatitis B prevalence is estimated at 10%. Little is known about the rates of cirrhosis or PHT due to a lack of diagnostics. The World Health Organisation (WHO) aims to reduce viral hepatitis mortality by 65% by the year 2030 in sub-Saharan Africa. Sierra Leone's new endoscopy service can collect data on PHT rates, and through face-to-face and remote training can offer endoscopic management of varices. Here we describe the rate of PHT, and use a case report to demonstrate impact.

Methods The database of endoscopies performed was interrogated, from the inception of the service in 2016 to November 2019. Cases with PHT were identified, and where possible, the cause of PHT sought. Details of endoscopic therapies were recorded. A case report of one subject was recorded.

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Case	Age	Sex	Indication	Location	Lesion size	Resection size	R0	Histology
1	60	Male	SEL	Antrum	24	29	Yes	Fibroid polyp
2	66	Male	SEL	Fundus	10	12	Yes	Grade 1 neuroendocrine tumour (NET)
3	80	Female	SEL	Duodenum (first part)	10	12	Yes	Grade 1 NET
4	64	Female	SEL	Duodenum (first part)	12	18	No	Grade 1 NET
5	68	Female	Suspected non-lifting recurrent adenoma	Duodenum (second part)	24	27	Yes	Pancreatic heterotopia

Results

- 448 procedures, 55% male, median age 44 (12–98)
- 35 had PHT changes, 86% male, median age 47 (25–75)
- 20 cases had oesophageal varices, 7 had gastric varices, 8 had both
- 12 with stigmata of recent bleeding, 1 actively bleeding
- Banding has been performed 9 times (2 by visiting UK team, 7 by SL team)
- Hepatitis B was the most frequent cause of liver disease

Case Report Pt A (31M) has been admitted to the government hospital on 4 occasions over 2 years with circulatory collapse and evidence of GI bleeding. Blood transfusions were required (Hb level 45). Endoscopy was never offered, but after promotion of the endoscopy service he was referred to Choithram hospital. He underwent OGD with band ligation, and recommendation for further treatment made. His hepatitis B status was established (HbsAg +ve). Endoscopic identification and treatment of his PHT will reduce his morbidity, his need for future admissions, and hopefully allow him to return to work.

Conclusions Portal hypertensive changes are frequently identified at endoscopy. Therapy to varices, or recommendations for medical treatment of PHT will reduce the morbidity associated with cirrhosis. As sub-Saharan Africa attempts to reduce the impact of viral hepatitis, the Sierra Leone endoscopy team will be able to play a part by identifying and treating the PHT complications arising from cirrhotic liver disease. We demonstrate that the skills required for this can be taught in a resource-poor environment.

REFERENCE

1. Hepatitis B in sub-Saharan Africa: strategies to achieve the 2030 elimination targets. CW Spearman, et al. *Lancet Gastroenterol Hepatol* 2017; **2**:900–909

P14 INITIAL UK EXPERIENCE IN USE OF THE GASTRODUODENAL FULL THICKNESS RESECTION DEVICE

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Introduction The gastroduodenal full thickness resection device (FTRD[®]) is a new device that allows resection of tethered epithelial or subepithelial lesions (SELs) in the stomach and duodenum, but data on outcomes are limited¹. Here we present first UK experience of this technique, including technical feasibility, safety and early outcomes.