

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.

Abstract P14 Table 1

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<sup>®</sup>) is a new device that allows resection of tethered epithelial or subepithelial lesions (SELs) in the stomach and duodenum, but data on outcomes are limited<sup>1</sup>. Here we present first UK experience of this technique, including technical feasibility, safety and early outcomes.

**Methods** Data on consecutive patients who underwent endoscopic full thickness resection (eFTR) at two UK teaching hospitals in November - December 2019 were analysed. The procedure was undertaken using the endoscope mounted gastro-duodenal FTRD<sup>®</sup>. Main outcome measures were technical success (target lesion resection with FTRD<sup>®</sup>), total procedural time, specimen size, R0 resection, and adverse events. Need for dilatation to facilitate passage of device past cricopharyngus or the pylorus was also documented.

**Results** All cases were undertaken under general anaesthetic. It was possible to insert the device to the lesion in all cases; in two, dilatation of the pylorus with a 20 mm through the scope balloon was required to facilitate passage of the device to the duodenum. Technical success and histological diagnosis were achieved in 5/5 (100%) cases. Median total procedural time was 23 minutes (range 18–65). Baseline and outcome data of the cases can be seen in table 1.

Two patients were kept for overnight observation and three were discharge on same day as the procedure. One patient reported shivering post procedure, which was thought to be general anaesthesia related, otherwise there were no immediate or delayed complications.

**Conclusions** eFTR of SELs or heavily scarred lesions in the stomach and duodenum is feasible and safe with the gastro-duodenal FTRD<sup>®</sup>. It facilitates acquisition of definite histology aiding diagnosis and R0 resection is possible, providing treatment or avoiding need for ongoing surveillance in selected patients. The device can be challenging to insert and in particular, pre-dilatation of the pylorus to facilitate insertion into the duodenum may be required.

## REFERENCES

1. Meier B, Schmidt A, Glaser N, Meining A, Walter B, Wannhoff A, Riecken B, Caca K (2020) Endoscopic full-thickness resection of gastric subepithelial tumors with the gFTRD-system: a prospective pilot study (RESET trial). *Surg Endosc* 34:853–860

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## SHOULD POST COLONOSCOPY COLORECTAL CANCER BE ADDED TO INDIVIDUAL'S KEY PERFORMANCE INDICATORS?

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**Introduction** Post colonoscopy colorectal cancer (PCCRC) is associated with a number of contributory factors, including poor endoscopist performance metrics. The JAG Global Rating Scale (GRS) tool currently only includes 8-day unplanned admission rates and 30-day mortality rates as a late outcome quality Key Performance Indicator (KPI) to feedback to individual endoscopists. Since 2016, units have been encouraged to subject each PCCRC to a root cause analysis (Rees CJ, et al. *Gut* 2016;65:1923–1929). We aimed to review PCCRC in our institution with a focus on KPI and specialty.

**Methods** This was a retrospective review of PCCRC over a 3-year period (Jan 2017–Dec 2019) at a 2-site hospital in North London serving a population of 500,000. All patients with an endoscopic diagnosis of colorectal cancer (CRC) were identified from the Unisoft GI reporting tool. Patients who had a prior colonoscopy within 3 and 5-years were identified (index colonoscopy). A definite missed cancer was considered as a

PCCRC within 3 years of the index scope, and a probable missed cancer was within 5 years.

**Results** CRC was diagnosed in 618 patients, of whom 3.7% (23) were identified as having a PCCRC [Female 48%; mean age 75 years; 56–90 years]. The 'definite miss rate' was 2.1% (13/618) and the 'probable miss rate' was 1.6% (10/618). The mean time lag from index scope to CRC was 34.4 months. The quality of the bowel prep in the index scope was 'less than good' in 61%. Index scopes were performed by surgeons in 65% (15) of cases. External providers and locums contributed to 22% (5) of PCCRC cases. Polyps were detected in 56% (13/23) of patients at the index scope, and the site of the polyps correlated with the CRC in 3 patients (surgical endoscopists). Curative treatment (surgery ± chemotherapy) was offered to 72% of patients (n=17).

**Conclusions** Our study demonstrates that our department meets quality standard for units which includes a target of <5% PCCRC at 3 years (Rees CJ, et al. *Gut* 2016;65:1923–1929). However, review of individual cases identified higher rates of PCCRC amongst endoscopists with lower volumes of procedures and sub-optimal Adenoma Detection Rates (ADR). At a previous BSG, we have suggested that polyps bigger than 1 cm should be removed only by recognised endoscopists in each unit to minimise the risk of poor polypectomy technique leading to PCCRC. This review endorses the needs for a root cause analysis for each case of PCCRC, but we also recommend that endoscopy leads feed back to individuals their own PCCRC data for ref.

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## ACCEPTABILITY OF KEY PERFORMANCE INDICATORS (KPI) IN THE NATIONAL ENDOSCOPY DATABASE (NED), A DELPHI PROCESS

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**Introduction** Automated Performance Reports to Improve Quality Outcomes Trial (APRIQOT) uses NED to provide endoscopists feedback on colonic detection KPI. Traditional adenoma detection rate is dependent on unavailable histological data. Our aim was to gain expert consensus on which available KPI are acceptable to endoscopists.

**Method** A Delphi panel of UK expert endoscopists was recruited online, purposively for professional background. Panellists interacted using an online form. In round one we provided a summary and acceptability statement for each KPI, participants rated agreement with a 5 point Likert scale and free-text comments. Responses were analysed anonymously. In subsequent rounds participants reviewed all graded consensus statements and comments. Statements were accepted with ≥80% consensus or redrafted. Rounds ran January to April 2019.

**Results** We recruited 21 UK expert endoscopists. 12 were female, 48% gastroenterology background, 29% nursing, 14% surgical and 9% trainees. All statements reached consensus by round 3 (Table 1). The panel agreed KPI adjusted for age, sex and indication were 'more acceptable'. Polyp measure had risks of 'gaming' and distal hyperplastic polyp over reporting, but encompass significant non-adenomatous polyps. Mean number of polyps (MNP) reached consensus after discussing reduction of the 'one and done' phenomenon and using a cap of 5 polyps/colon to mitigate skew from polyposis. Proximal