



Abstract P44 Figure 1

departmental ADR and PDR, along with ADR/PDR ratio and other KPIs at 6-monthly intervals from January 2012 to October 2019.

**Results** An average of  $2460 \pm 366$  colonoscopies were performed in every 6-month period by  $42 \pm 4$  endoscopists. Collective ADR and PDR were 12% and 19%, respectively, at the beginning of the study period. Figure 1 shows a continuous improving trend in collective performance was recorded since the provision of individual feedback started. Departmental ADR improved from the initial 12% to 22% (Slope  $.10 \pm .01$ ;  $R^2 .84$ ,  $p < 0.0001$ ), and PDR from 19% to 30% (Slope  $.10 \pm .01$ ;  $R^2 .78$ ,  $p < 0.0001$ ) in the last 6-month period. Interestingly, the ADR/PDR ratio (overall  $0.68 \pm 0.05$ , mean  $\pm$  SD) also increased over time from a baseline of 0.63 to a final figure of 0.73 (Slope  $.001 \pm .0003$ ;  $R^2 .52$ ,  $p < 0.01$ ). Other KPIs showed similar improving trends. The number of non-neoplastic polyps detected did not increase during the study period.

**Conclusions** Our data show that regular written feedback to endoscopists about their individual and departmental KPIs, along with expected benchmarks, improves adenoma detection and overall endoscopy performance. The parallel improvement of ADR/PDR ratio suggests that the above result is not due to increased removal of no-risk polyps, which is a potential unintended consequence of PDR monitoring. Concomitant monitoring of ADR and PDR may be important to prevent 'gaming' behaviour and ensure that a genuine quality improvement is achieved.

#### P45 TIME TO MOVE ONTO CHROMOENDOSCOPY AS STANDARD?

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**Introduction** BSG introduced the guidelines for Barrett's oesophagus surveillance in 2013, which recommended the Seattle biopsy protocol to detect dysplasia. We reviewed the adherence rate to biopsy protocol for Barrett's surveillance service in Kettering General Hospital.

**Methods** List of gastroscopies performed between January 2016 to January 2019 with indication 'Barrett's surveillance' were obtained. Endoscopy report was obtained via ADAM software. Exclusion criteria includes procedures that were unsuccessful, performed for alternate indications, normal findings. Endoscopy finding including Prague classification, number of biopsies and histopathology were tabulated in Excel

spreadsheet. Adherence rate was analysed in subgroups of Barrett's segment length. Chi-Square test of independence was applied for statistical significance.

**Results** Total of 254 gastroscopies were included for analysis following exclusion criteria applied. Overall adherence to protocol was 78%. Adherence rate reduced with increase in length of Barrett's segment, with 97.9% adherence rate with length  $< 4$  cm, and sharp reduction to 38.5% adherence with length 6–7 cm, and 25% with length  $\geq 12$  cm.

192 Barrett's diagnosed patients had maximum segment length  $< 6$  cm, and 62 had  $\geq 6$  cm. There was statistical significance in difference ( $p < 0.0001$ ) in adherence rate when comparing group with length  $< 6$  cm (92.2%) and length  $\geq 6$  cm (33.9%). The incidence of detecting combined low- or high-grade dysplasia was however higher in the group with Barrett's length  $\geq 6$  cm (12.9%), when compared to length  $< 6$  cm (3.1%) which was statistically significant ( $p = 0.0033$ ). **Conclusions** Adherence to Seattle biopsy protocol is low and not proving useful in long Barrett's segment, despite initial improvement of adherence following the AsPECT trial. Chromoendoscopy with targeted biopsy may be the way forward to detect dysplastic lesions in long segment Barrett's. Further studies are required to evaluate this.

#### P46 INCREASE IN PATIENTS REFERRED VIA THE CANCER PATHWAY (CWT) WITHOUT CONSEQUENT INCREASE IN CANCERS DIAGNOSED

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**Introduction** There is increasing pressure on endoscopy services in the UK due to increasing demands with reports showing that acute trusts are failing to get patients who are referred via the CWT seen within the specified 14 days. According to the most recent NHS England's 'Waiting time for suspected/diagnosed cancer patients annual report', the proportion of patients with suspected lower gastrointestinal (LGI) cancer failing to be seen within the stipulated 2 weeks has increased from 7.1% in 2015/16 to 10.4% in 2018/19. To assess the impact of these demands in our organisation, we carried out a comparative audit of CWT patients over 5 weeks starting 28th May in 2018 and 2019 to determine the following:

- If there had been a true increase in referrals
- The proportions seen within 2 weeks and proportion of cancers found
- In the patients with cancer, if there had been LGI investigation in the previous 3 years

**Method** The names of all patients referred via the cancer (CWT) pathway are kept on the trust database. One author interrogated the electronic case records of all patients referred to the trust within the designated period in 2018 and 2019 to get demographic details, time to first hospital encounter and final diagnosis.

**Results** Referral symptoms from most to least common were: haematochezia, change in bowel habit, anaemia, weight loss, tenesmus, nausea/vomiting, abdominal discomfort/pain. The commonest non-malignant findings were as follows: No pathology (39%), diverticulosis (18%), benign colonic polyps

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	2018	2019	
Number of patients referred	183	254	
Median age (range) at referral	69 (29–90)	67 (23–94)	
Percentage with first encounter in 14 days (%)	76	30	P<0.0001
Percentage going direct to investigation (%)	27	33	P=0.175
Percentage of referrals with previous lower GI investigation (%)	12.6	14.6	
Proportion with a final diagnosis of cancer (%)	4.9	3.5	P=0.46

(11%). Table 1 shows the numbers and other findings in the 2 cohorts.

In the patients with cancer, the primary symptom at referral was as follows: rectal bleeding (83%); altered bowels (61%); anaemia (50%) and weight loss (13%). None of the patients with cancer had a prior LGI investigation within 3 years leading to diagnosis though this was the case in 14% of all referrals.

**Conclusions** Our audit demonstrates a 39% increase in the number of patients referred via CWT pathway in a year with a consequent significant decrease in the proportion of patients having their first hospital encounter within 2 weeks. There was also a non-significant decrease in cancer incidence. A significant minority had prior LGI investigation and none of these patients were found to have cancer

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#### THE ROLE OF ENDOSCOPY IN SUSPECTED GASTROINTESTINAL BLEEDING AFTER ACUTE CORONARY SYNDROME

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**Introduction** Upper gastrointestinal bleeding (UGIB) is a significant complication in patients on antiplatelet therapy (APT) after acute coronary syndrome (ACS) and decisions around endoscopic intervention and ongoing APT are critical. We sought to examine the safety and outcome of endoscopy in this cohort of patients.

**Methods** We performed a systematic search of inpatient endoscopy records covering a 4-year period at a single hospital using keywords (ACS, STEMI, NSTEMI, DAPT) and a retrospective review of clinical records. For statistical analysis we used t-test, chi-square test, and Fisher's exact test as appropriate.

**Results** We identified 31 cases, mean age 68 years (SD = 12.7 years), 58% male, median haemoglobin at scope 83 g/dL (IQR = 68–95 g/dL), and mean urea at presentation 14.0 mmol/L (SD = 10.3 mmol/L). At presentation 81% patients were on dual antiplatelets (DAPT) and 45% had a cardiac stent in situ.

Haematemesis was strongly associated with endoscopic intervention, with a likelihood ratio of 5.5 ( $p = 0.027$ ). Raised urea was associated with 90-day mortality (MD = 16.5 mmol/L, 95% CI [4.0, 28.9],  $p = 0.017$ ), endoscopic diagnosis of an ulcer (MD = 11.2 mmol/L, 95% CI [2.4, 19.9],  $p = 0.017$ ), and presence of a culprit lesion at endoscopy (MD = 7.3 mmol/L, 95% CI [0.02, 14.6],  $p = 0.049$ ).

We did not find a significant association between mortality or endoscopic finding with age, troponin, presenting haemoglobin or number of co-morbidities.

Diagnoses at endoscopy were ulcers 36% (duodenal 16%, gastric 13%, oesophageal 7%), normal 26%, gastritis 23%, polyp 7%, angiodysplasia 7% and suspected cancer 3%. After initial endoscopy, 41% remained on DAPT although in the subset of patients with a cardiac stent in situ, 62% continued DAPT. 26% required endoscopic intervention to stop the bleeding and 6% underwent a second OGD for re-bleed. There were no complications related to endoscopy and no patients required interventional radiology or surgery for uncontrolled bleeding.

Continuation of DAPT before endoscopy despite suspected GIB was strongly associated with the presence of a cardiac stent (LR = 9.9,  $p = 0.005$ ). Conversely, presence of blood (LR = 7.0,  $p = 0.018$ ) and a culprit lesion (LR = 4.6,  $p = 0.034$ ) were strongly associated with DAPT being stopped. Endoscopic findings changed the APT plan in 25% of cases.

30-day and 90-day mortalities were 13% and 23% with none directly attributed to GIB.

**Conclusions** Endoscopy is safe and effective in patients with UGIB following acute cardiac events. Haematemesis was predictive of endoscopic intervention to stop bleeding, whilst raised urea indicated increased mortality and presence of a culprit lesion. All bleeds were controlled endoscopically and endoscopy directly changed the APT plan in only one-quarter of cases.

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#### THE USE OF CHOLANGIOSCOPY FOR STRICTURE ASSESSMENT IN PRIMARY SCLEROSING CHOLANGITIS (PSC)

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**Introduction** PSC carries a 15–20% lifetime risk of developing cholangiocarcinoma (CCA). The distinction between benign and malignant strictures in this patient cohort is uniquely challenging. A 2016 meta-analysis has shown that single operator cholangioscopy (SOC) with targeted biopsies appears to be the most accurate method.<sup>1</sup> We report our experience of SOC and PSC stricture assessment.

**Methods** In 2 tertiary UK referral centres all patients who had a Spyglass DS™ SOC for stricture assessment in PSC were retrospectively enrolled. From clinical records and the endoscopy reporting tool patient demographics, degree of suspicion on referral, degree of suspicion during the endoscopy, histological diagnosis, and eventual diagnosis were assessed. Pre-test suspicion of malignancy was judged as high (eg. new stricture; presentation with obstructive jaundice; rising CA19.9; lesion on imaging) or low (eg. pre-transplant stricture assessment).

**Results** Data on 49 patients who had undergone 52 ERCPs and Spyglass DS™ SOC was analysed.

Four cases of malignancy were confirmed; 3 had a high level of suspicion at SOC and 1 had a low level of suspicion

Nine cases (17.3%) had prior suspicious brushings locally which warranted further investigation. Three of these had CCA confirmed and 6 had no evidence of malignancy on