

Abstract P48 Table 1

Pre-Test Level of Suspicion	Numbers	Suspicion based on SOC appearance	Numbers (Proven malignancy)
High	45	High	12 (3)
		Low	29 (1)
		Unclear	4 (0)
Low	7	High	2(0)
		Low	3 (0)
		Unclear	2 (0)

SOC. Three of those with histological confirmed malignancy had cytology highly suggestive of high-grade dysplasia or adenocarcinoma from previous ERCPs. Another patient had negative histology at SOC but was referred for surgery on the basis of a mass lesion on imaging. One patient developed CCA within 1 year of negative SOC and another was found to have CCA on transplant explant at site of stricture assessed 6 years earlier with SOC. A negative SOC enabled 12 patients to be referred for transplantation.

Conclusion The role of SOC in stricture assessment in PSC remains unclear. In this series SOC picked up 1 case of CCA not detected on standard ERCP as well as not detecting at least 1 case of CCA. Despite improved image quality using Spyglass DS™ SOC visual diagnosis remains challenging. It is hoped that advances in tissue acquisition will improve the yield from targeted biopsies. However, SOC appears to have an important role in assessing strictures where brush cytology is indeterminate.

REFERENCE

1. Njei B, et al. Systematic review with meta-analysis: endoscopic retrograde cholangiopancreatography-based modalities for the diagnosis of cholangiocarcinoma in primary sclerosing cholangitis. *Aliment Pharmacol Ther* 2016;**44**(11–12):1139–51.

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THE NATIONAL PERFORMANCE IN THE MANAGEMENT OF COMMON BILE DUCT STONES IN ENGLAND

¹Harry Martin*, ²Richard Sturgess, ³Adam Coney, ¹George Webster. ¹University College London Hospitals, London, UK; ²Aintree University Hospital NHS Foundation Trust, Liverpool, UK; ³Methods Analytics, London, UK

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Aims Bile Duct Stones (BDS) is a common indication for ERCP. There are British Society of Gastroenterology endorsed national standards for clearance rates with the expectation that 75% or more of initial ERCPs for BDS should result in stone clearance.¹ This paper will examine the NHS data set from all trusts in England to assess the treatment of BDS.

Methods Using ICD-10 codes defined by an accredited clinical coder we examined the Hospital Episode Statistics (HES) data from all of England from 2013/4 to 2018/9 and selected those who had their initial bile duct stones presentations in 2015/6 to 2016/7, which excluded those identified in the previous 2 years. We followed this cohort of patients throughout the period of time from their presentation to the end of 2019 financial year and assessed how many ERCPs each patient underwent. We therefore had 2 years of patients with a primary diagnosis of bile duct stones with at least 2 years of follow up. All data has been limited to NHS hospitals.

Results Over the 4 year follow up period 86,602 of the 183,503 ERCPs (47.2%) done were for BDS. The 2015/6 to 2016/7 cohort was made of 37,468 patients who needed 55,556 ERCPs. 26,146 had only 1 ERCP, which, at best, represents a BDS clearance rate at first ERCP of 69.8%. In addition, the remaining 11,322 (30.2%) patients required 29,410 ERCPs, demonstrating that 52.9% of ERCPs undertaken for those who had an initial BDS presentation between 2015/16 and 2016/17 were repeat procedures. This is shown in graph 1. The cumulative BDS clearance rate of 1, 2 and 3 ERCPs is, at best, 69.8%, 89.7% and 95.9%.

The BSG key performance indicator states that 75% of BDS should be cleared at first ERCP. There are 32/154 (20.8%) hospital trusts/groups where less than 75% of those who presented with BDS needed only 1 ERCP. There are 2 (1.3%) trusts/groups where less than 50% of patients needed only 1 ERCP. From our data there appears to be little correlation between number of ERCPs for BDS performed by trust and BDS clearance. There is significant regional as well as trusts/groups variation in those needing more than 1 ERCP for BDS.

Conclusions We are falling below the minimum standards required for stone clearance at ERCP, leading to findings that, in England, more than 50% of ERCPs for BDS are repeat procedures. The reasons for this require further study but the extra burden of cost on the NHS is significant.

REFERENCE

1. ERCP – The Way Forward, A Standards Framework. ERCP Workign Party [Internet]. Available from: <https://www.bsg.org.uk/resource/ercp-the-way-forward-a-standards-framework-pdf.html>

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GI SAFETY PROFILE OF THE USE OF DOACS IN COMBINATION WITH ANTIPLATELETS IN CARDIOLOGY PATIENTS

Sonia Moteea*, Jessica Morrison, Carole Firth, Sarah Tinker, Sulleman Moreea. *Bradford Teaching Hospital, Scarborough, UK*

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Background DOACs, such as apixaban (Ap), rivaroxaban (R), edoxaban (E) and dabigatran (D), are increasingly used instead of warfarin in atrial fibrillation, acute coronary syndrome and the prophylaxis/treatment of venous thromboembolism. Unlike warfarin, DOACs are used at a fixed dose and do not require close monitoring but the pivotal trials have shown an increased risk of GIB as compared to warfarin.¹ A recent meta analysis showed that the risk of GIB events related to DOACs (except Rivaroxaban) is not significantly greater than with warfarin². There is therefore a need for more real world data.

Aims To review the real world safety profile of DOACs in combination with antiplatelets in patients who have been admitted to the cardiology wards.

Method For the period Jan 2015-Dec 2017 (36 months), we extracted the following data for all patients admitted under the cardiology team from our electronic databases: patient demographics; medication on discharge; patients having a gastroscopy (OGD); indication, finding and outcome at endoscopy.

Result During the study period, 4871 patients were admitted with a diagnosis of acute coronary syndrome (ACS). 729 (15%) patients (456 M, mean age 62 yrs; 273 F, mean age