Endoscopic submucosal dissection (ESD) is a potentially curative, minimally-invasive alternative to major surgery for the endoscopic management of superficial gastric and colorectal neoplasms. Due to its several advantages pocket-creation method (PCM) appears to simplify ESD. Since 2017, we have combined PCM with saline-immersion therapeutic endoscopy (SITE), as this could improve view quality (through refractive magnification, and minimal lense fogging) and lesion lifting (through buoyancy).

The aim of our study is to review our experience of SITE-PCM-ESD cases from July 2017 to November 2019. Demographic, endoscopic, histopathological data were analysed.

ESDs were performed in 39 patients, mean age: 65-years. Six lesions were removed from the stomach, 1 from the caecum, 6 from the ascending colon, 14 from the sigmoid and 12 from the rectum. En-bloc pure-SITE-PCM-ESD resection was achieved in 28 patients (71.79%); in 3 patients (7.69%) the procedure was not completed due to the suspicion of invasive malignancy and these patients were referred for surgery.

Details of the cases managed by pure SITE-PCM-ESD are described as follows. Median specimen size was of 38 mm. Histopathological examination showed: 2 villous-adenomas with low-grade dysplasia, 7 tubular-adenomas with low-grade dysplasia, 3 tubular-adenomas with high-grade dysplasia, 2 tubulovillous-adenomas with high-grade dysplasia, 11 tubulovillous-adenomas with low-grade dysplasia, 1 adenocarcinoma, 7 neuroendocrine tumors, 1 serrated-adenoma with low-grade dysplasia, 1 hyperplastic gastric polyp and 1 sessile-serrated lesion without dysplasia. R0-resection rate was 94.44%. Lymphovascular infiltration was suspected in the one case of malignancy (2.56%). Two patients suffered from early post-procedural rectal bleeding, warranting further endotherapy; no further complications were identified. To date, 28 patients (77.77%) have completed endoscopic follow-up; none of these patients have presented any evidence of disease recurrence.

Our series of SITE-PCM-ESD showed favorable results in term of efficacy and safety. Further comparative randomised control studies are required to further evaluate potential advantages of this technique.

P43 DOES SAME SESSION ENDOSCOPIC ULTRASOUND AND ERCP AFFECT DIAGNOSTIC RATES OR OUTCOMES?

[1,2]Francess Adlard*, [1]Bidour Awadelkarim, [1]Manu Nayar, [1]Kofi Oppong, [1]John Leeds. *[1]Freeman Hospital, Newcastle Upon Tyne, UK; [2]UCL, London, UK*

10.1136/gutjnl-2020-bsgcampus.118

Introduction Endoscopic ultrasound and ERCP are complimentary modalities and some units offer same session procedures. This offers the opportunity to provide a 'one-stop-shop' which may speed up the patient pathway by providing rapid diagnostics and therapy in the same session. It is unknown whether there is any effect on diagnostic tissue acquisition rates, biliary cannulation rates, procedure success rates or adverse event rates particularly in those having conscious sedation. The aim of this study was to evaluate these outcomes in a large tertiary referral HPB centre.

Patients and Methods Retrospective analysis of all EUS and ERCP procedures over the period 2018 - 2019 was performed. Patients having same session EUS and ERCP were identified and demographics, indication, total amount sedation given, order of procedure, results of brushings or needle sampling (definite malignancy or benignity), desired duct cannulation rate, successful intervention rate (duct cleared or stent inserted for drainage) and 7 day adverse event rate was calculated. Patients undergoing both EUS and ERCP more than 7 days apart had the same details recorded as a control group.

Results 393 patients were included in the study (median age 69 years, 188 males, 206 for a malignant indication). 243 patients underwent same session EUS/ERCP and 150 were included in the control group. There were no significant differences in median age, sex distribution or procedure order between the two groups. Patients having same session EUS/ERCP were significantly more likely to be for a malignant indication (155/243 vs. 51/150 OR 3.4 95% CI 2.2 - 5.2, $p<0.0001$). Patients undergoing same session EUS/ERCP received significantly less opiate (50 mg vs. 100 mg, $p<0.0001$) and midazolam (5 mg vs 6 mg, $p<0.0001$) compared to separate session respectively. There was no significant difference in trainee involvement (135/243 vs 71/150), diagnostic yield (93/133 vs. 40/62), median number of needle passes at FNA (2 vs. 2), desired duct cannulation rate (212/243 vs 131/150), successful intervention rate (209/243 vs 130/150) or adverse event rates (12/243 vs. 8/150).

Conclusions Same session EUS/ERCP is feasible and more common in patients referred for suspected malignancy. There is no difference in diagnostic sampling rate, cannulation rates, success rates or adverse event rates when combining the two procedures. More information is needed to determine whether there is economy in list dynamics, cost effectiveness and patient preference.

P44 REGULAR INDIVIDUAL FEEDBACK ON KEY PERFORMANCE INDICATORS IMPROVES POLYP AND ADENOMA DETECTION IN COLONOSCOPY

Samuel Lim*, Giovanni Tritto, Sebastian Zeki, Sabina De Martino. *Guys and St Thomas' Hospital, London, UK*

10.1136/gutjnl-2020-bsgcampus.119

Introduction Monitoring of key performance indicators (KPIs) is paramount to standardise and improve quality in endoscopy. Adenoma detection rate (ADR) is considered the best surrogate marker for colonoscopic diagnostic accuracy, having been inversely associated with interval cancer risk and mortality. Polyp detection rate (PDR) is easier to calculate, albeit less robust than ADR. The aim of this study was to assess whether regular routine feedback on KPIs to individual endoscopists has a significant impact on the department's ability to improve ADR, PDR and other KPIs.

Methods Individual and collective endoscopy data were extracted from our endoscopy reporting software and other electronic patient records, analysed and collated at 6-monthly intervals since January 2012. ADR was determined using an automated natural language processing software (EndoMineR) to query the presence of colonic adenomas from pathology reports for all colonoscopies. PDR and other KPIs were also routinely calculated. Every endoscopist received a feedback letter every 6 months containing their individual performance indicators, along with anonymised indicators for all the other endoscopists, aggregate departmental performance and national benchmarks. Linear regressions were calculated for