



**Abstract P63 Figure 1** ROC curves for urea trend versus absolute urea concentrations

Serum urea level  $>6.5$  mmol/L and change in urea concentration  $>1.3$  fold from baseline predicted the need for endotherapy with a sensitivity/specificity of 85%/32% and 85%/46%, respectively; the latter predicted severe AUGIB ( $X_2=10.2$ ,  $p=0.001$ ). The corresponding area under the receiver operating curve (AUROC) were 0.59 (95% CI 0.49–0.69) and 0.71 (95% CI 0.61–0.81) (figure 1). In a subgroup analysis of patients with chronic kidney disease ( $n=46$ ), AUROC for urea trend was 0.65 compared to that of absolute urea levels (0.53). There were no significant associations between urea concentrations, acute and chronic kidney disease with rebleeding rates at 72 hours, inpatient mortality and readmissions for AUGIB.

**Conclusions** We demonstrate that an increase in urea concentration of  $>1.3$  fold from baseline is superior at predicting severe AUGIB requiring endoscopic intervention and is a useful discriminator in patients with chronic kidney disease.

**P64 THE IMPACT OF ENDOSCOPIC SUBMUCOSAL DISSECTION ON THE COMPLEX POLYP SERVICE**

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**Background** Endoscopic excision of complex polyps is a rapidly evolving treatment, and particularly endoscopic submucosal dissection (ESD) might represent an option for superficial malignant invasion. Limited data is available in western series for clear indications for ESD.

**Methods** We prospectively collected data between February 2017 and December 2018 of excision of complex polyps. We compared short term outcomes data between piecemeal and en-bloc excision, with both Endoscopic Mucosal Resection (EMR) and ESD, and outcomes in endoscopically resected polyps that were incidentally found to be malignant.

**Results** 189 patients (80 females, mean age 69.9, sd 11.8) underwent 207 polypectomies. Of these, in 124 we employed a piecemeal technique, and en-bloc resection in 83 (41 EMR

and 42 ESD, 13 of which were performed in 2017 and 29 in 2018). There was no difference in the rates of complications between the en-bloc and the piecemeal groups. We experienced no perforation or need for transfusion in either group. In 8 patients (6.5%) of the piecemeal group there was polyp recurrence, whilst no recurrence was seen in the en-bloc group.

Histology showed cancer in 14 specimens within the en-bloc group. Out of these, 10 patients underwent surgical resection, and residual cancer was found only in one case. In the other 4 patients endoscopic surveillance showed no recurrence. Histology confirmed cancer in 6 patients within the piecemeal group. Of these, 3 underwent surgical resection and 3 to endoscopic surveillance with one recurrence.

**Conclusions** In our cohort, en-bloc resections appeared to be as safe as piecemeal polyp resections, but with lower recurrence rates. In our practice rates of ESD increased two-fold over the 2-year period, and it might represent a treatment option for superficial submucosal malignant invasion. Future studies are warranted to address the role of ESD for polyp cancers.

**P65 THE OVESCO OTSC FOR ACUTE UPPER GASTROINTESTINAL BLEEDING – A LARGE PROPENSITY SCORE-MATCHED UK SERIES**

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**Introduction** There have been no significant improvements in the outcomes of upper gastrointestinal (GI) bleeding over the last few years. The aim of this study was to determine whether the use of the OVESCO™ over the scope clip (OTSC) was associated with a lower rebleed-rate and mortality compared to conventional endoscopic therapy.

**Methods** Consecutive episodes of upper GI haemorrhage treated with the OTSC were identified from a prospective database in a UK tertiary centre over a 3-year period. Treatment with OTSC was delivered for patients with high-risk features or failed conventional endoscopic therapy.

Over the same time period, all patients with upper GI haemorrhage treated with conventional endoscopic therapy were retrospectively identified, and a propensity score-matched cohort was assembled. Patient demographics, 7-day re-bleed rate, 30-day re-bleed rate and 30-day mortality rates were compared. T-test and Pearson's Chi-square statistic were used to statistically describe the results.

**Results** 617 episodes of upper GI haemorrhage were identified requiring endoscopic intervention over three years. 71 high-risk lesions were treated in the OTSC group, vs 89 high-risk lesions in the matched control group (conventional endoscopic therapy).

The sites of lesions treated with the OTSC included oesophagus (10%), stomach (22%) and duodenum (68%). The lesions were described as Forrest 1a-18%, 1b-33%, 2a-32%, 2b-17%. Pathology included ulcers (78.9%), Mallory-Weiss tears (9.6%) Dieulafoy (7.0%) post-angiographic coil ulcer (1.4%) post-EMR (1.4%) anastomotic bleed (1.4%).

Compared to the control group, the OTSC group had lower 7-day re-bleeding rate (19.3% vs 2.8%,  $p < 0.01$ ) and a lower 30-day re-bleeding rate (25.0% vs 7.0%,  $p < 0.01$ ). There was a trend toward reduction in all-cause mortality in the OTSC group (14.8% vs 8.5%,  $p=0.20$ ) but a significantly