P26 DOES A SHORTENED MOVIPREP® REGIME WITH REDUCED STARVATION TIME IMPACT THE QUALITY OF BOWEL PREPARATION

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Introduction The efficacy of bowel preparation is internationally recognised as an independent factor for high quality colonoscopy. MoviPrep®, a commonly prescribed colonic lavage, is a low-volume polyethylene glycol (PEG) osmotic colonoscopy preparation that is proven to effectively cleanse the colon). The specific recommendations for taking MoviPrep® are dependent on the time of the colonoscopy but conventionally involves avoiding solid food for more than 24 hours prior to the planned procedure.

It is well recognised that poor bowel preparation is associated with lower caecal intubation rates, prolonged colonoscopy time and increased patient discomfort leading to poor quality colonoscopy. The period of starvation required for conventional bowel preparation is challenging for patients and has been shown to cause a significant burden. Whilst direct causation between the period of starvation and adherence to bowel preparation has not been shown previously it is predictable that patients are more likely to adhere to a bowel preparation regime if the perceived hunger burden is reduced.

Methodology A single centre retrospective analysis comparing the quality of bowel preparation using Moviprep® with standard procedure (last meal for morning procedure 9 am on previous day, for afternoon procedure last meal 1 pm on previous day) and reduced duration of starvation (last meal for morning procedures 1 pm and for afternoon procedures 3 pm) with split dose of Moviprep® administration for morning procedures at 5 pm and 8 pm and for afternoon procedures 7 pm and 6 am on the day of procedure.

Procedures were recorded on Unisoft reporting programme and bowel cleanliness scored using the Aronchick scale. These procedures were audited over this period of change and compared with procedures conducted with conventional bowel preparation regime. The two-time data sets were compared using chi-squared test for statistical significance.

Results There were 6440 colonoscopies performed between October 2018 – December 2019. The results are shown as per table 1 below. There was no significant statistical differences between the two groups (table 1).

Conclusion From this study we conclude that the shortened MoviPrep® regime did not cause a clinically significant reduction in quality of bowel preparation when undertaking colonoscopy. The study also demonstrates however that bowel preparation in both groups was less than good in 30%. We concluded that a shortened duration of hunger followed by split dose standard time MoviPrep® is equal to longer duration of fast. Further work is required to improve the quality of the bowel preparation in all, perhaps by assessment of the low residue diet preceding the period of hunger. In view of the conclusions from this study we continue to implement the shortened duration of fast for bowel preparation.

Abstract P26 Table 1 Bowel cleanliness score following colonoscopy performed with conventional MoviPrep® compared with shortened MoviPrep® regime

Bowel Preparation Outcome	Conventional MoviPrep® Regime	Shortened MoviPrep® Regime	P-value
Excellent	651 (12.5%)	126 (11.2%)	P = 0.6843
Good	2984 (57.5%)	637 (56.8%)	P = 0.7457
Fair	1272 (24.5%)	292 (26.1%)	P = 0.5681
Inadequate	286 (5.5%)	66 (5.9%)	P = 0.8986

P27 ENDOSCOPIC REPORTING OF ULCERATIVE COLITIS ACROSS SOUTH EAST ENGLAND: A SNAPSHOT OF OUR PRACTICE

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Introduction Endoscopic assessment of ulcerative colitis (UC) plays a vital role in determining the management of the disease. The British Society of Gastroenterology and European Crohn's and Colitis Organisation have highlighted the need to standardise reports using endoscopic scoring systems (ESS) to minimise interobserver variation in interpretation of disease activity in the form of Mayo score or Ulcerative Colitis Endoscopic Index of Severity (UCEIS). This multicentre retrospective study is aimed to assess the use of ESS reporting in UC patients undergoing lower gastrointestinal endoscopy.

Methods Endoscopy reports of all adults (aged ≥18) who had a flexible sigmoidoscopy or colonoscopy, for UC assessment, between January and October 2019 were included from 12 sites across 6 trusts in south east England within the Kent, London and Cambridge deaneries. Data was collected on the use of ESS (Mayo/UCEIS), grade and specialty of the reporting independent endoscopist.

Results 1154 reports were analysed: 688 colonoscopies, 466 flexible sigmoidoscopies. The age range was 18 to 89 (median 48). Mayo score was documented in 189 cases (16%), UCEIS in 114 cases (10%). Other scores were used in 11 cases (1%) and no score was documented in 840 cases (73%).

ESS was used in 19 out of 48 (40%) reports by gastroenterology registrars, 67 out of 205 (33%) by nurse endoscopists, 213 out of 710 (30%) by gastroenterology consultants, 4 out of 184 (2%) by surgical consultants and 0 out of 7 (0%) by surgical registrars.

ESS reporting was 30% and 34% in trusts affiliated with a tertiary centre, compared with 10%, 16%, 13%, 52% in the secondary care trusts.

Conclusions In this audit of endoscopic reporting practices in a cross section of south east England trusts, ESS was documented in only 26% of endoscopy reports to describe disease activity in UC, highlighting these indices are underutilised in clinical practice.

In general the Mayo score was preferentially used to UCEIS. Albeit the highest ESS reporting trust used UCEIS more frequently, reflecting variation in local practice.

UC ESS reporting was used less by surgical endoscopists compared with medical and nurse endoscopists. The reason is not clear. The authors propose it may reflect differences in training and exposure to IBD specialist training lists.

We conclude that departments should standardise reporting. ESS can be integrated into endoscopy reporting software,