Abstract P5 Table 1 Weight loss and outcome

outcome	3 Month (n = 51)	6 Month (n = 60)	12 Month (n = 31)	P value[a] (comparing baseline and 6 months)	P value[b] (comparing 6 and 12 months)
Mean absolute weight loss (kg)	12.86 ± 11.58	11.43 ± 16.44	35.16 ± 34.99	P= <0.001	P= 0.001
Mean%TBWL	6.81 ± 5.59	6.33 ± 8.09	18.90 ± 18.64	P= <0.001	P= <0.001
Mean%EWL	10.04 ± 8.36	9.42 ± 11.93	27.92 ± 27.88	P= <0.001	P= <0.001
% Patients with >10%TBWL	21.6%	33.3%	58.3%	—	—

adjusted and left in stomach for a period of 12 months. Its use in super obese patients has not been studied.

Aim to retrospectively evaluate the effectiveness of SAB3 in super-obese patients (BMI≥50 kg/m²) as bridge to definitive surgery and report the complications associated with it.

Methods Super obese patients who had SAB inserted and completed ≥6 months of follow up were included in the study. The absolute weight loss, mean percent excess weight loss (%EWL) and the% total body weight loss (%TBWL) at 3, 6 and 12 months was recorded from hospital electronic system.

Results A total of 60 patients with a mean (±SD) age, initial BMI and weight of 41 years (± 12), 68.59 kg/m² (± 9.57) and 183.45 kgs (± 32.81), respectively had SAB inserted. Data was available on 51, 60 and 31 patients at 3, 6 and 12 months. The mean%EWL at these time points was 10.04 (± 8.36), 10.45 (± 9.85) and 27.92 (27.88).% Patients with >10%TBWL at same time points was 21.6%, 35% and 58%, respectively (table 1 below). 21 (40.4%) patients went on to have a definitive bariatric surgery to date. Complications associated with SAB were abdominal pain in 16.7% (10), severe enough in 6 for unplanned SAB removal, gastroesophageal reflux 13.3% (8), intestinal obstruction 1.7% (1), migration 1.7% (1), deflation in 6.7% (4), nausea/vomiting 12% (7).

Conclusion SAB placement in our center was safe, tolerable and achieved the desired weight loss in majority of the super-obese patients. The rate of SAB early removal was in keeping with real world literature.

P6 SAME DAY BOWEL PREPARATION FOR COLONOSCOPY LEADS TO BETTER OUTCOMES; RESULTS OF A NATIONAL SURVEY

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10.1136/gutjnl-2020-bsgcampus.81

Introduction Adequate bowel preparation is an essential prerequisite to high quality colonoscopy. Previous studies suggest that split dose bowel preparation and timing the colonoscopy 4–6 hours after completion of the preparation results in optimal bowel cleansing. However, anecdotal evidence suggests that bowel preparation instructions do not consistently recommend split dosing; or optimise timing. The aim of this study was to survey the instructions given to guide bowel preparation and compare this to outcome measures.

Methods All NHS trusts in the UK were surveyed with a standard email requesting data between January 2018 and January 2019. Data requested included: type of prep, timing of prep, pre endoscopy diet, adequacy rates and adenoma detection.

Results Response rate was 79% (n=128). Seven were excluded due to insufficient data. Moviprep was the first line bowel preparation in 79%, 19% used magnesium sulfate/picosulphate and 2% used Klean prep. Only 10 units advised patients to split prep so that they took a dose of bowel preparation on the same day (SD) as their morning procedures, whereas 111 units advised patients to take bowel prep the day before (DB). In the DB group, the median time in which the second dose of bowel preparation was advised to be consumed was 8 pm (range 2 pm-9 pm, 95% confidence interval ± 2.72 hours); 12.5 hours prior to the first morning procedure (assuming a first appointment of 830 am). In the SD group, the rate of inadequate bowel preparation was 5.1% (1885/37224), compared with 7% (25107/361409) (p<0.0001) in the DB group. 15 of the trusts in the DB group, also provided adequacy rates divided between morning and afternoon procedures. Within this subgroup, all afternoon procedures received a portion of bowel preparation on the day, whereas all the morning procedures were advised to consume their bowel preparation the day prior. Morning procedures had rate of inadequate bowel preparation of 7.6% (2523/33072), whereas afternoon appointments was 6.6% (1836/27635) (p<0.0001).

Conclusion Most endoscopy units do not appear to give instructions devised to optimise the timing of bowel preparation prior to colonoscopy. This results in an increased rate of reported inadequate bowel cleansing. Splitting the dose of bowel preparation and tailoring the timing of preparation to the proposed timing of colonoscopy has the potential to significantly reduce the risk of missed lesions and the need for a repeat colonoscopy. If optimisation were to lead to the reduction of inadequate colonoscopies seen in this dataset, it could be extrapolated that an estimated 14000 fewer colonoscopies would have poor bowel preparation, saving a potential £8.4 million/year if these no longer required a repeated procedure.

P7 DOES INDIVIDUALISED FEEDBACK IMPROVE COLONOSCOPY KEY PERFORMANCE INDICATORS?

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10.1136/gutjnl-2020-bsgcampus.82

Introduction Colonoscopy is the gold standard examination of the bowel. Detection and removal of polyps leads to a reduced risk of subsequent colorectal cancer. Higher adenoma detection rate has been associated with a reduced post colonoscopy colorectal cancer rate. The BSG recommends a minimum performance standard, the key performance indicators (KPIs), which each independent endoscopist should achieve, to ensure quality. Monitoring of each endoscopists' KPIs, and offering individual feedback to those falling below the standard, may lead to improvement. In this study we assessed the response in KPIs following such feedback.

Methods KPIs between January 2017 and January 2018 were obtained from local ERS derived audit and endoscopists with KPIs below the minimum requirement were offered individual feedback by the clinical lead. Number of procedures, Polyp Detection Rate (PDR) and Caecal Intubation rate (CIR) were compared with data from colonoscopies performed between January 2019-January 2020 with data obtained from National Endoscopy Database. Opinion on individualised KPI reporting was measured across the department using Survey Monkey.

Results Nine endoscopists (seven gastroenterologists, one surgeon, and one nurse endoscopist) were offered feedback as minimum quality standards were not met, all of whom took part in the feedback process. Six endoscopists' CIR was below the minimum requirement. Three endoscopists' CIR and PDR were below the minimum requirement. Two endoscopists performing less than 10 procedures per year, elected to cease performing colonoscopy. Four endoscopists with inadequate CIR improved following feedback. 1 endoscopist with insufficient PDR improved with feedback.

11 endoscopists responded to the survey. 82% reported checking their KPI at least annually, with the majority (45%) feeling that this should be reported quarterly. A formal individualised KPI report was felt to be useful by 64% of respondees.

Conclusions Providing individualised feedback did help individuals' KPIs in this cohort. We have demonstrated that using the NED data KPIs can be monitored with ease. A larger study involving multiple sites would give greater power to whether this could lead to a significant improvement in outcomes. Majority of endoscopists feel that an individualised KPI report will be helpful.

P8 DOES AN EDUCATIONAL VIDEO IMPROVE BOWEL PREPARATION IN PATIENTS FIRST COLONOSCOPY? A UK MULTI-CENTRE RCT

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10.1136/gutjnl-2020-bsgcampus.83

Introduction Colonoscopy is the gold standard for investigation of the large bowel. Adequate bowel preparation is vital to an effective procedure. A well-informed, motivated patient, who understands the process to prepare the bowel and will adhere to it, is more likely to have adequate bowel preparation. The aim of this study is to assess whether an educational video for patients undergoing colonoscopy can lead to an improvement in bowel preparation.

Methods Participants referred for their first colonoscopy and receiving Moviprep were eligible for recruitment. Those recruited, were randomised 1:1 to access to the educational video or the control group. All participants were also provided with standard written instructions. The educational video was developed in collaboration with Nottingham Trent University graphics department. Primary end point was adequacy of bowel preparation, defined as a Boston Bowel Preparation Scale (BBPS) of 2 or greater in each segment. BBPS was scored at the time of the examination by the endoscopist performing the examination. Endoscopists received training on BBPS via an online video.

Abstract P8 Table 1

Risk Factor	Adequate preparation	Inadequate preparation	P value
<3 motions/week	37/424 (9%)	13/89 (15%)	NS
Diabetes Mellitus	47/424 (11%)	20/89(22%)	<0.05
Parkinson's disease	8/424 (2%)	5/89 (6%)	<0.05
Cirrhosis	7/424 (2%)	4/89 (4%)	NS

Results 513 participants were recruited, from 6 centres, with 254 participants randomised to access to the education video. The mean age was 58 (range 18–88). 265 (52%) of whom were female. 54 patients in the control group had inadequate prep, compared with 35 participants in the intervention group (p value <0.05, CI 0.381 to 0.967). The rate of adequate bowel preparation was not significantly different between centres. There was no significant difference between recognised risk factors for poor bowel preparation between the two groups. The association of adequacy of bowel preparation and risk factors for poor bowel preparation is shown below.

Conclusions Many factors affect the quality of bowel preparation. This study demonstrates that an educational video leads to a greater proportion of adequate bowel preparation compared with standard instructions alone. The number needed to treat to prevent one excess inadequate bowel preparation in this study is 14. Widespread adoption of enhanced patient education, such as this educational video, could lead to improved adequacy of bowel preparation.

P9 OUTCOMES FROM THE UK PURASTAT® REGISTRY: MULTICENTRE OBSERVATIONAL STUDY OF PURASTAT® USE IN GASTROINTESTINAL BLEEDING

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10.1136/gutjnl-2020-bsgcampus.84

Introduction PuraStat® is a novel haemostatic agent without the risk of thermal injury, perforation or loss of mucosal views associated with other treatments such as heat therapy, clips or haemostatic powders. Our aim was to evaluate the efficacy of PuraStat® in the prevention and treatment of gastro-intestinal bleeding.

Methods This is a prospective analysis of PuraStat® use in the UK, with 6 tertiary referral centres open to recruitment. Data was collected on procedure & lesion details, haemostasis management and complications for endoscopies where PuraStat® was used.

Results 226 procedures were included across 3 indications: 198 high risk resection, 6 upper gastro-intestinal bleeding (UGIB) and 22 radiation proctopathy. PuraStat® was used for immediate haemostasis in 100 bleeding episodes, of which 92 were as primary agent and 8 as secondary agent (after failure of alternative initial therapy) and for prevention of delayed