poster prompts can be used to serve as a point of reference. ESS should routinely be incorporated into departmental induction and education.

P28 COMPARISON OF ANXIETY AND DEPRESSION SCORES BETWEEN 2-WEEK WAIT AND BARRETT'S SURVEILLANCE ENDOSCOPY REFERRALS

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Introduction BSG guidelines recommend endoscopic surveillance for patients with Barrett's oesophagus (BE), due to the 0.5% annual risk of developing oesophageal adenocarcinoma.[1] Approximately 10% of GP 2-week wait (2WW) referrals result in a cancer diagnosis, and patients on a 2WW pathway should be told of a theoretical risk of cancer.[2] We therefore performed a case-control study, comparing outpatients referred to endoscopy for BE surveillance (BES) and GP 2WW referrals, to ascertain the effect of possible cancer on patients' anxiety and depression under 2 different scenarios.

Methods Patients were recruited as part of the Saliva to Predict Disease Risk (SPIT) study. This is a multicentre study to improve non-invasive prediction of the risk of BE and oesophageal cancer. Ethical approval was gained from the Coventry and Warwickshire Regional Ethics Committee (17/WM/0079). Anxiety and depression was measured using the Hospital Anxiety and Depression Scale (HADS) questionnaire; this was completed at recruitment in the endoscopy department.[3] This is a validated tool consisting of 14 questions, scored from 0 to 3, with 7 questions assigned to each domain. Ordinal logistic regression analysis was performed using R software v3.6.1 to account for the effect of age and gender on HADS.

Results 940 patients, split between 363 BES referrals and 577 2WW referrals were included in the final analysis. Median age was 69 for BES and 66 for NBS ($p=0.002$). 54% of patients were female in the 2WW group compared to 24% in the BES group ($p<0.001$). Accounting for both age and gender, mean HADS anxiety score was 4.76 for BES and 6.61 for 2WW ($p<0.001$, OR=1.76; 95%CI: 1.38–2.24). Mean HADS depression score was 3.57 for BES and 4.60 for 2WW ($p<0.001$, OR=1.51; 95%CI: 1.19–1.92). Interestingly, reduced age and female gender was associated with higher anxiety scores ($p<0.001$ for both), but not depression (p=ns).

Conclusions These results suggest that 2WW patients undergoing endoscopy have higher baseline anxiety and depression than BES patients. Most patients on a BES list would have had at least one previous endoscopy, and may have developed expectations and adaptive mechanisms to their procedure. A previous study found a reduction in depression but not anxiety scores in patients with BE and non-specific symptoms undergoing OGD.[4] Our study partially concurs with this; it may be that 2WW patients have an additional element of anxiety compared to a cohort with non-specific symptoms, which will need further clarification.

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P29 ENDOSCOPIC SUBMUCOSAL DISSECTION (ESD) IN THE WESTERN SETTING – IS TUNNELING TECHNIQUE THE WAY FORWARD?

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Introduction Since the advent of Peroral Endoscopic Myotomy (POEMS), tunneling technique has become a popular way of performing ESD.

After initial distal dissection, proximal end of the lesion is approached,creating a submucosal tunnel. The tunnel wall is then collapsed to remove the lesion. Data from a tertiary referral centre is depicted in table 1, demonstrating tunneling technique is a safe, effective and efficient way to perform ESD, specially in Western settings.

Abstract P29 Table 1

	Average size (cm square)	Mean duration (min)	En- bloc resection	Complications	
Oesophageal (N=15)	17	99	100%	Bleeding- 0	Perforation- 0
Colorectal (N=9)	36	221	100%	Bleeding- 0	Perforation- 0

P30 SERRATED POLYP DETECTION RATE IN BOWEL CANCER SCREENING COLONOSCOPY VARIES FOUR FOLD BETWEEN COLONOSCOPISTS

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Introduction Sessile serrated lesions (SSLs) are precursors for 15–30% of colorectal cancers. SSLs are more subtle and difficult to detect than conventional adenomas. We aimed to analyse factors associated with clinically relevant serrated polyp detection in the UK bowel cancer screening population.

Methods Detailed analysis of the results of 1333 BCSP colonoscopies was performed. Age, gender, FIT vs. Guiac FOBT, endoscope definition (standard definition vs. high definition), screening vs. surveillance procedure and endoscopist were evaluated in relation to serrated polyp detection rate (SPDR), adenoma detection rate (ADR), proximal adenoma detection rate (ProxADR) and advanced ADR (AdvADR). SPDR was defined as percentage of cases with any serrated polyps proximal to the sigmoid colon or serrated polyps $\geq$5 mm in the rectum or sigmoid colon. SPSS was used for statistical analysis.

Results Of 1333 colonoscopies, 119 were excluded (incomplete data, previous colectomy, site check, bowel scope colonoscopies). Overall SPDR was 16.1% (range by endoscopist 7.6 – 31.9%). Overall ADR was 59.12% (range by endoscopist 52.3 – 72%), ProxADR 35.4% (range by endoscopist 25.4 – 52.2%) and AdvADR 25.6% (range by endoscopist 19.7 – 31.9). SPDR was significantly associated with endoscopist ($p<0.001$), but was not associated with age, gender, FIT vs Guiac FOBT, screening vs surveillance procedure or endoscope definition. Mean significant serrated polyps per procedure was 0.254 (range by endoscopist 0.137 – 0.637). ADR was

significantly associated with FIT FOBT, screening procedure, male gender and endoscopist. Mean adenoma per procedure was 1.26 (range by endoscopist 0.95 – 2.01). ProxADR was significantly associated with age, FIT FOBT, screening procedure, male gender and endoscopist. AdvADR was significantly associated with age, FIT FOBT, screening procedure and endoscopist.

Conclusion Serrated polyp detection appears to be dependent on the endoscopist related factors. We found a four-fold difference in SPDR between the highest and lowest detectors and 4–5 fold difference in the mean number of serrated polyps per procedure, even in high performing bowel cancer screening accredited colonoscopists. SPDR was not associated with patient related factors and did not appear to be influenced by the use of high definition endoscopes. An SPDR of 31.9% is the highest reported detection rate by an endoscopist in a screening population and may inform future benchmark setting for SPDR KPI.

P31 HEMOSPRAY IN THE TREATMENT OF VARICEAL BLEEDS: OUTCOMES FROM THE INTERNATIONAL HEMOSPRAY REGISTRY

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Introduction Early treatment for variceal bleeding is recommended within 12 hours to improve outcomes. Endoscopic therapy in acute variceal bleeding can be technically difficult and not always successful and a bridge is sometimes required towards definitive therapy. Aim of this study was to look at outcomes in patients with upper gastrointestinal bleeds (UGIB's) secondary to varices.

Methods Data was collected prospectively (Jan'16- Nov'19) from 16 centres in the USA, UK, Germany, France and Spain. Hemospray was used during emergency endoscopy for a variceal UGIB as a monotherapy, dual therapy or rescue therapy once standard methods have failed. Haemostasis was defined as cessation of bleeding within 5 minutes.

Results 12 patients had Hemospray treatment following a variceal UGIB (10 male, 2 female). 10 oesophageal varices, 2 gastric varices. The median Rockall was 8 (IQR, 7–8). The median Blatchford was 15 (IQR, 13–17).

The immediate haemostasis rate was 75%. There were no re-bleeds. 4 patients were treated with Hemospray monotherapy, 3 with combination therapy and 5 with rescue therapy. Hemospray was always given after oesophageal banding/injection sclerotherapy in the combination/rescue therapy cohorts. 4/9 patients died within 7 days, 3 out of these 4 patients did not achieve initial haemostasis with Hemospray.

Outcomes in the Hemospray subgroups (table 1).

Abstract P31 Table 1

	Monotherapy (n=4)	Combination (n=3)	Rescue (n=5)
Median Blatchford score	15 (IQR, 14–16)	15 (IQR, 8–17)	12 (IQR, 11–14)
Median Rockall score	8 (IQR, 8–9)	8 (IQR, 6–9)	8 (IQR, 7–8)
Haemostasis (%)	3/4 (75%)	2/3 (66%)	4/5 (80%)
Rockall 7 & 8 predicted re-bleeding rate 25–40%			
Re-bleed	0	0	0
Rockall 8 predicted mortality rate: 40–45%			
7-day mortality (%)	1/3 (33%)	2/3 (66%)	1/3 (33%)

Conclusions The immediate haemostasis rate was 75% in variceal UGIBs following treatment with Hemospray. In this cohort there is no re-bleeding. This suggests that Hemospray may play a role as bridging therapy in variceal bleeds which are difficult to control, towards repeat definitive therapy.

P32 USE OF HEMOSPRAY IN THE TREATMENT OF LOWER GASTROINTESTINAL BLEEDS: OUTCOMES FROM THE HEMOSPRAY REGISTRY

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Introduction Lower Gastrointestinal bleeding (LGIB) accounts for 20% of GI bleeds, with significant mortality in the elderly and those with comorbidities. There is limited data on the use of Hemospray in LGIB's. The primary aim was to look at its safety and efficacy in the treatment of LGIB's.

Methods Data was prospectively collected on the use of Hemospray in LGIB's in 16 Centres in the UK, USA, Germany, France and Spain (January 2016 – November 2019). Hemospray was used as a monotherapy, combination therapy or rescue therapy. Haemostasis was defined as the cessation of bleeding within 5 minutes of Hemospray application.

Results 24 patients with LGIB's were recruited (16 male, 8 female). The cause of bleeding included malignancy (6/24,25%), post procedure (polypectomy/ESD)(5/24,21%), inflammation/angiodysplasia (7/24, 29%). The median lesion diameter was 20 mm (IQR, 25–50). 9/24 (38%) patients were on antiplatelets/anticoagulants.

Immediate haemostasis was achieved in 22/24 (92%) patients. 2/19 (11%) had a re-bleed within 7 days, 4/19 (21%) had a re-bleed within 30 days. 2/21 (10%) died within 30 days (all cause mortality). The two patients that failed treatment had surgery. In combination Hemospray was always used as a second or third modality. There was a 78% haemostasis rate in patients on anticoagulants/antiplatelets, 100% immediate haemostasis on patients on no anticoagulants.