

Conclusions Colonoscopists who perform less than the nationally stipulated minimum of 100 procedures per year have significantly lower ADRs. National guidance should be followed with all colonoscopists performing > 100 procedures per year.

REFERENCE

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TIMING OF ERCP AND OUTCOMES IN PATIENTS WITH ACUTE GALLSTONE CHOLANGITIS GRADED BY SEVERITY

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Introduction The optimal timing of endoscopic retrograde cholangiopancreatography (ERCP) in the management of acute gallstone cholangitis is not known. Severity of cholangitis can be classified with the Tokyo 2018 criteria. The European Society of Gastrointestinal Endoscopy published guidance on the recommended timing of ERCP guided by the severity of cholangitis; stipulating that biliary drainage should occur within the following timeframes: mild – elective, moderate – within two to three days and severe – as soon as possible. We aim to analyse the clinical outcomes of patients with acute cholangitis who have been admitted to a tertiary hepatobiliary centre when categorised by severity.

Methods A retrospective analysis of patients admitted to our hospital with acute cholangitis over a 3 year period from June 2016 to June 2019 was carried out. Patients were identified via coding department and endoscopy reporting tool. All patients met 2018 Tokyo criteria for definite cholangitis. Only patients with choledocholithiasis without concurrent biliary pathology were included for analysis. Case notes and electronic database interrogation yielded information for calculation of severity of cholangitis. Statistical analyses were carried out with Kruskal-Wallis test or chi-squared tests where appropriate.

Results A total of 218 patients were identified and 199 patients who underwent ERCP during the index admission were included for analysis. There was a female preponderance (55.8%) and the median age was 73 years (range 19–96). The proportion of severity of cholangitis at presentation was as follows: 51.3% (n=102) mild, 32.6% (n=65) moderate and 16.1% (n=32) severe. The median time taken from admission to ERCP for the 199 patients was 4.8 days (mild 4.4 days, moderate 5.4 days, severe 4.8 days; p=0.31). The median length of stay 7.8 days (mild 7.2 days, moderate 7.8 days, severe 9.5 days; p=0.009). 31.3% of patients with severe cholangitis (n=10) were admitted to intensive care (ITU); 6 of whom required urgent ERCP. For patients with severe cholangitis, the median time in those who required urgent ERCP was 1.5 days vs 5.6 days in those who did not. The overall 30-day all-cause mortality amongst the 199 patients was 1% (n=2; both with severe cholangitis who underwent successful ERCP at 23 hours and 42 hours). 30-day all-cause mortality was 6.3% in the severe group and 0% in both mild and moderate groups (p=0.005).

Conclusions Our results demonstrate no difference in timing to ERCP in patients with acute gallstone cholangitis when categorised by severity. Deaths were observed only in patients with severe cholangitis although the majority of patients with severe disease did not require urgent ERCP. Provision for urgent ERCP has to be available especially for those admitted to intensive care.

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SELF-EXPANDING METAL STENTS IMPAIR ENDOSCOPIC ULTRASOUND (EUS) VASCULAR STAGING OF HEAD OF PANCREAS MASSES

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Introduction Endoscopic ultrasound (EUS) is indicated for vascular staging of pancreatic ductal adenocarcinoma (PDAC) when CT is equivocal. The reported sensitivity of EUS for vascular invasion ranges from 42% to 91%. The presence of a biliary stent may impair EUS assessment of the vascular interface of head of pancreas (HOP) masses due to imaging artefacts. This may be worse with self-expanding metal stents (SEMS). Previous studies of stent effect have been small with conflicting results. The aim of the study was to assess the influence of stents on EUS vascular staging in patients with a HOP mass undergoing surgery with curative intent.

Methods All patients with a solid HOP mass undergoing EUS staging and surgery with curative intent between January 2010 and December 2017 were included. Exclusion criteria included; neoadjuvant chemotherapy, EUS for biopsy only, finding of metastatic disease at laparotomy and surgery > 60 days after staging. Intraoperative surgical assessment was the primary reference standard. When vascular resection was performed histology was additionally correlated. Analysis was performed on an intention to stage basis. Factors with possible impact on diagnostic performances were analysed using logistic regression.

Results 158 patients with prior EUS underwent surgery. 58 cases were excluded and 100 formed the study group. 56 were male, 99 were malignant of which 76 were PDAC. Median age [IQR] 68 years [59–74] median tumour size [IQR] 27.5 mm [20–32]. Median Interval between EUS and surgery [IQR] was 29 days [22–42]; 50 (50%) had an indwelling biliary stent (36 plastic, 14 SEMS). In 7(14%) (6 SEMS, 1 plastic) staging was not possible due to stent artefact. 22 (22%) were found to have some degree of vascular involvement at surgery of which 2 were unresectable, 20 underwent vascular resection of which 10 met histological criteria for vascular invasion. There was a significant difference in accuracy of vascular assessment (p=0.042) among patients without a stent (86%) plastic stent (69.4%) and SEMS (57.1%). On multivariable analysis both plastic OR (0.37 95% CI [0.13–1.07]) and SEMS OR (0.21, 95% CI [0.057–0.81]) reduced accuracy. Sensitivity for vascular involvement (surgical reference) was 13/22 (59%). Using histology as the reference, sensitivity was 7/10 (70%); p=0.7.