Results 180 patients (median age 83; range 80–92) were identified with 313 polyps removed. The median ASA grade was 2 (range 1–4) with hypertension, COPD, Cardiac disease and Diabetes the most frequent co-morbidities. 224 (72%) polyps removed were <10 mm in size, 58 (19%) 10–19 mm, 20 (6%) >20 mm (range 20–50 mm) and size was not documented in 9 (3%). In polyps <10 mm in size, 99% had histology showing low grade or no dysplasia. 1% had high grade dysplasia (HGD) and there were no polyp cancers. For polyps 10–19 mm, histology showed low grade or no dysplasia in 81%, HGD in 14% and cancer in 5%. For polyps >20 mm; 30% (6) showed HGD and 5% (1) cancer on histology.

There were 3 (1.6%) peri-procedure complications identified (desaturation and bleeding post polypectomy) none requiring admission. 42 (23%) of the patients died within 5 years of the procedure date. The commonest causes of patient mortality were pneumonia, heart failure and stroke. CRC was the cause of death in 1 patient (0.6%) and in this case the index polypectomy was a polyp cancer.

Conclusions The rate of significant complications in patients ≥80 undergoing colonic polypectomy is low. However, mortality at 5 years is high in patients ≥80 undergoing colonic polypectomy due to co-morbid diseases other than CRC and no significant pathology is seen in diminutive (<10 mm) polyps in this age group. The number of polyps >10 mm in our cohort was small. We would recommend that polypectomy should be avoided for polyps <10 mm in patients ≥80 rather than ≥85 as previously suggested and that polypectomy of polyps >10 mm should only be considered after careful deliberation with the patient.

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PTH-007

CONTEMPORARY STRETTA THERAPY FOR GASTROESOPHAGEAL REFLUX DISEASE IN LIGHT OF PPI CONCERN FRIEND OR FOE?

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10.1136/gutjnl-2018-BSGAbstracts.29

Background Gastroesophageal reflux disease (GORD) is one of the leading gastrointestinal disorders. Patients with GORD often seek alternative therapy for inadequate symptom control, with over 40% not responding to medical treatment. Current treatments include lifestyle modifications, pharmacological therapies, surgical and STRETTA therapy that is a minimally invasive procedure that significantly reduces GORD symptoms, allowing the majority of patients to eliminate or decrease use of PPIs.

Methods and patients A multi-centre retrospective data collected from three Mediclinic Middle East centres in Dubai UAE on (75) patients, period Jan 2015–Nov 2017. Most Patients

evaluated had ambulatory 24 hour pH testing and previous gastroscopy for assessment of LOS. 3 patients had Previous Nissen fundoplication (NF) surgery and 1 had previous gastric bypass. Stretta uses radiofrequency (RF) energy delivered to the tissues of the distal lower Oesophageal sphincter (LOS) and gastric cardia, which decreases LOS compliance, increases LOS muscle mass, and limits the inappropriate transient LOS relaxations responsible for GORD. Patients were followed up 2 wks, 30 days, 3 months and one year.

Results Prior DeMeester score average of 99, with hypotensive LOS pressure. There was a small learning curve (45 ± 7) min for the first 10 procedures; mild to moderate pain during the first 72 postoperative hours was controlled with paracetamol syrup. Two (2.5%) complications; one patient presented with ulcerative esophagitis 7 days after the Stretta treatment, and one patient developed pneumonia 5 days postoperatively. 50 patients (63%) were 50% on reduced PPI dose at two months and 61 patients (77%) were off treatment at 6 months and 70 patients (88%) at 12 months were off all antisecretory medication. The other five patients (6%) were on PRN PPI.

Conclusion In our study 88% of patients were off PPIs at one year. The rising concern of long-term side effects of the popular proton-pump inhibitors have prompted reinterest in endoscopic procedures for GORD and also economic significance as the costs of long-term pharmacological treatment are tremendous. STRETTA delivery significantly improved GORD symptoms with high efficacy and low complication rate endoscopic procedure. This procedure represents an excellent alternative for selected symptomatic gastroesophageal reflux disease patients who are intolerant of or desire an alternative to, traditional medical therapies.

PTH-008

OUTCOMES FROM AN INTERNATIONAL MULTICENTRE HEMOSPRAY REGISTRY

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10.1136/gutjnl-2018-BSGAbstracts.30

Introduction Acute gastrointestinal bleeding (AGIB) carries poor outcomes unless prompt endoscopic haemostasis is achieved. Hemospray is a novel intervention that creates a mechanical barrier over bleeding sites when applied endoscopically. Primary aim of this international prospective multicentre registry is to collect outcomes of patients with AGIB after endoscopic Hemospray application. Secondary outcomes of rebleeding, disease and procedure specific outcomes are also collected.

Method Prospective data (Jan 2016–Jan 2018) from 11 centres across UK, France and Germany collected. Hemospray used as mono therapy, dual-therapy with standard haemostatic techniques or rescue therapy once standard methods failed. Immediate haemostasis defined as cessation of bleeding within 5 min after application of Hemospray. Rebleeding defined as subsequent drop in Hb (>2 g/L), haematemesis, persistent melaena with haemodynamic compromise post therapy.

Results 275 cases recruited worldwide (203 M and 72 F). Median pretreatment Blatchford score (BS) 11 for all cases. 246 patients (89%) achieved immediate haemostasis after endoscopic therapy with Hemospray (table 1). Similar haemostasis rates noted in the Hemospray monotherapy (92%), combination therapy (90%) and rescue therapy (85%) group. Peptic ulcer bleed was the most common pathology (53%) and Forrest Ib the most common lesion type (66%). 29 patients did not achieve immediate haemostasis. Median BS was higher in this group at 13 (IQR 11–16, $p < 0.05$). Forrest Ib was the most common lesion type in this group (76%, $p < 0.05$). 28 cases of rebleeding reported after successful haemostasis. The median BS in these was higher at 13 (IQR 10.25–14.75, $p < 0.05$). Forrest Ib was the most common bleed in this group (50%, $p < 0.05$).

Table 1	Mono-Therapy (n=106)		Combination Therapy (n=116)		Rescue Therapy (n=53)	
	Most Common Pathology	Forrest Classification	Most Common Pathology	Forrest Classification	Most Common Pathology	Forrest Classification
	Peptic ulcer = 42/106 (39%)	Ia = 5/106 (5%) Ib = 77/106 (72%)	Peptic ulcer = 74/116 (64%)	Ia = 2/116 (1%) Ib = 71/116 (61%)	Peptic ulcer = 34/53 (64%)	Ia = 14/53 (26%) Ib = 20/53 (38%)
	Angiodysplasia = 31/106 (29%)	Ia = 12/31 (39%) Ib = 19/31 (61%)	Angiodysplasia = 20/116 (17%)	Ia = 2/20 (10%) Ib = 18/20 (90%)	Angiodysplasia = 4/53 (8%)	Ia = 1/53 (2%) Ib = 3/53 (6%)
	Polyps = 25/106 (24%)	Ia = 18/25 (72%) Ib = 7/25 (28%)	Polyps = 13/116 (11%)	Ia = 10/13 (77%) Ib = 3/13 (23%)	Polyps = 4/53 (8%)	Ia = 1/53 (2%) Ib = 3/53 (6%)
Median BS	11		11		11	
IQR	8–13		8–14		8–14	
Total Haemostasis	97/106 (91%)		104/116 (90%)		45/53 (85%)	
Re-bleed Rate	8/97 (8%)		13/104 (13%)		6/45 (13%)	

Abstract PTH-008 Figure 1

Conclusion These data show high rates of immediate haemostasis (89%). Forrest Type 1b lesions have a higher rate of unsuccessful haemostasis and increased risk of rebleeding after therapy. Patients with rebleeding and unsuccessful treatment had higher BS at baseline. The expansion of this international registry will provide data on the efficacy of Hemospray in various disease and patient types over the coming years.

PTH-009 **AVOIDABLE FACTORS ARE IDENTIFIED IN 70% OF POST COLONOSCOPY COLORECTAL CANCERS (PCCRCs)**

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10.1136/gutjnl-2018-BSGAbstracts.31

Introduction CCRC is cancer arising 6–36 months after a negative colonoscopy. PCCRCs arise from incompletely or unresected lesions, or are missed or new lesions. PCCRC rates are a key quality marker for colonoscopy. The aim of this study was to test the utility of the World Endoscopy Organisation (WEO) algorithm for categorising avoidable factors leading to PCCRC.¹

Methods All PCCRCs diagnosed between 01/06/10 and 31/12/16 at one trust were identified by cross-referencing coding and endoscopy data. A root-cause analysis was undertaken for each using the WEO algorithm (figure 1).

Results 27 PCCRCs were reviewed (age 37–85, median 70). 5 patients had inflammatory bowel disease (IBD), 20 diverticulosis and 1 Lynch syndrome. Chromoendoscopy was used in 1 IBD patient. Adenomas had previously been seen in the cancerous bowel segment in 8 cases (29.6%); 3/8 arose from resected lesions; and 5/8 from unresected lesions. 2/5 unresected lesions were deliberately not investigated further (patient/MDT decision). Bowel preparation was poor in 6 colonoscopies (22.2%). 24 were reported as complete, but only 12 had adequate caecal photographs (44.4%). Overall, follow-up procedures were delayed or not requested in 11 cases (40.7%).

Abstract PTH-009 Figure 1