adrenaline/clips (27.5%), foreign body removal (0.4%), polypectomy (8.3%).

Only 4 (1.67%; 2 females) patients developed pancreatitis, all prior to implementation of indomethacin into the local protocol. They had a median age of 47.0 ± SD3.20 years, 11 ± SD29.4 passes, 90 ± SD52.0 min, 150 cm ± SD64.2 cm of SB examined and median hospital stay of 14 ± SD3.70 days. 3 had polypectomies. 2 episodes occurred in the same patient. All had evidence of pancreatitis on CT scan. None of the patients received indomethacin before DBE.

Mean amylase (51.6 ± SD22.7 vs 143.0 ± SD143.9 IU/L p = 0.0001) and CRP (13.0 ± SD46.1 vs 17.3 ± SD81.7 mg/L p = 0.0001) after the procedure were significantly higher than before the procedure. Females had a significantly higher amylase than males post procedure (155.2 vs 130.7 IU/L p = 0.017). Mean amylase 3 hours after DBE was significantly lower in patients who received indomethacin (114 ± 152) (p = 0.044). 83.9% had a rise in amylase in the indomethacin group compared to 92.2% controls (p = 0.064).

Whilst there was no correlation between post-procedure amylase (p = 0.552), CRP (p = 0.058) and duration of the procedure, there was a significant association between amylase post procedure and length of SB examined. (Spearman’s rho 0.186; p = 0.005)

Conclusions This study identifies a role for rectal indomethacin in patients undergoing antegrade DBE. We have demonstrated that rectal indomethacin reduces amylase post DBE and no patients given indomethacin experienced pancreatitis. Larger studies are required to assess if this also transforms into lowering risk or severity of pancreatitis.

**Abstract PTH-023 Figure 1** Non-dysplastic cases depicted by blue bars with number of cases as each length corresponding to height of the bar. Each individual case of dysplasia is depicted as illustrated in the key above.

**PTH-024** RISK FACTORS FOR BLEEDING DURING ENDOSCOPIC RESECTION FOR VISIBLE LESIONS IN BARRETT’S OESOPHAGUS

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Introduction Endoscopic resection (ER) is the preferred initial treatment for early cancer and dysplasia with visible lesions arising in Barrett’s oesophagus (BE). An intra-procedural bleeding risk of 10% is typically quoted, with most controlled by endoscopic intervention. There is little data on risk factors for bleeding during oesophageal piecemeal ER.

Studies on colonic polypectomy have shown older age and the presence of depressed lesions are associated with increased bleeding risk. Previous studies on gastric ESD have shown lesion size was the main risk factor. We sought to identify variables associated with an increased risk of bleeding.

Methods Data were collected retrospectively for patients who had undergone ER for BE at a tertiary endotherapy centre using PC. Amongst these were 17 cases of dysplasia (12%; 6 indefinite for dysplasia, 7 low grade dysplasia, 4 high grade dysplasia). The remaining 127 cases (88%) were non-dysplastic.

Distribution of length of BE is displayed in figure 1.

Of the non-dysplastic cases, 46 (36%) had a BE length of <3 cm of whom 20 (43%) had surveillance interval of 3–5 years, 18 (40%) were discharged and 8 (17%) had a surveillance interval of 2 years. 81 (64%) had a BE length of ≥3 cm, of whom 74 (92%) had surveillance interval of 2–3 years, 1 (1%) for 1 year, 4 (5%) for 4–5 years, 1 (1%) was discharged and 1 (1%) died.

Conclusions Whilst we reported 70% of our BE length using PC, a measure now recommended as a quality standard, a further 19% could have been reported this way. Our data show that only 10% (13) of our 127 non-dysplastic BE cases had an incorrect surveillance interval chosen, less than the figures suggested by JAG who estimate that 30% of patients undergo surveillance at incorrect intervals or where not indicated at all. Of the 207 OGDs analysed, 135 (65%) were carried out by one of our 2 consultants with specialist interest in BE or our BE specialist nurse endoscopist. We therefore support the advice that BE surveillance should be performed on dedicated lists in order to improve endoscopic quality reporting and choice of correct surveillance interval.

**References**

K Christodoulou*, AR Farooqi, KT Shaw, IR Sargeant, DL Morris. East and North Hertfordshire NHS Trust, Stevenage, UK

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