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) post 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 vs 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.
between November 2012 – October 2017. Age, anticoagulant use, Paris classification of the lesion, number of ER specimens resected, and histology of the resected tissue were recorded. From 2015 an e-noting system was used to collect blood pressure readings pre, during and post procedure, and the highest mean arterial pressure (MAP) was calculated. Bleeding was classified as mild (controlled by snare tip), moderate (controlled by coagulation graspers/clips), or severe (necessitating admission). Patients who had a moderate or severe bleed were grouped for comparison.

Results A total of 212 EMR procedures were performed in the study period. 144 were used for analysis as blood pressure recordings were available. Mean age was 71, and 76.4% were male. 28 patients bled during the procedure (19.4%), of which two had a bleed requiring admission (1.4%).

There was no difference between the MAP in patients who bled during the procedure and those who did not. The mean number of ER specimens resected in total was 2.7 (range 1–12), with a greater number of resections in patients who suffered a moderate-severe bleed (3.4 vs 2.6, p=0.034).

Both depressed lesions (Paris III) and pedunculated lesions (Paris Ip) conferred an increased risk of bleeding (p=0.002 and 0.011 respectively). Oesophageal cancers with a stage greater than T1b were associated with an increased bleeding risk (p=0.004).

Conclusions In this study, bleeding risk was associated with the area of the ER, with a greater risk when more ER specimens were resected. Paris type Ip and III lesions conferred an increased risk of bleeding, as did resection of an oesophageal cancer with a stage greater than T1b. This may reflect increased angiogenesis associated with lymphovascular invasion.

Age, sex, anticoagulant use and intra-procedural MAP made no difference to the risk of bleeding. Importantly all bleeds were controlled by endoscopic measures and mortality was zero.

In Conclusion, in patients where a wide field ER is anticipated, caution with regards to bleeding and appropriate planning for cessation of haemorrhage with endoscopic techniques should be exercised.