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 $47.0 \pm SD3.20$ years, $11 \pm SD29.4$ passes, $90 \pm SD52.0$ min, $150 \text{ cm} \pm SD64.2 \text{ cm}$ of SB examined and median hospital stay of $14 \pm SD3.70$ 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 ($51.6 \pm SD22.7$ vs $143.0 \pm SD143.9$ IU/L $p=0.0001$) and CRP ($13.0 \pm SD46.1$ vs $17.3 \pm SD81.7$ 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 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.

PTH-023 BARRETT'S SURVEILLANCE IN A DISTRICT GENERAL HOSPITAL: DO WE FOLLOW GUIDELINES FOR NON-DYSPLASTIC BARRETT'S?

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Introduction BSG 2013 guidelines for diagnosis and management of Barrett's oesophagus (BE) recommend surveillance intervals based on the length of BE, histology, and presence of intestinal metaplasia. Practice for BE surveillance varies nationally. East and North Hertfordshire NHS Trust is a district general hospital with a population of approx. 6 00 000. Since the 2013 guidelines most BE surveillance is done by 2 consultants and a specialist nurse.

Methods A retrospective review of all gastroscopies performed for the indication of BE surveillance from 1/1/16 – 31/12/16. These were audited against BSG 2013 guidelines specifically looking at use of Prague criteria (PC), histology and selection of surveillance intervals. All endoscopies were performed using high definition video-endoscopes.

Results 207 OGDs for BE surveillance were reviewed (median age 68 [29–90], 75% males). 144 (70%) recorded BE length using the PC. 23 (11%) had either no or minimal Barrett's (<1 cm), of whom 15 (65%) were discharged. In the remaining 40 OGDs (19%) length of BE was unclear in 11 reports, able to be partially deduced from the free text in 20 cases, and fully deduced in 9 cases.

Analysis of surveillance intervals was performed only on the 144 OGDs where length of BE was documented fully

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.

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 OEESOPHAGUS

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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

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 ($p=0.004$).

Abstract PTH-024 Figure 1

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.

PTH-025 ARE ENDOSCOPISTS PLANNING ON ADHERING TO BSG QUALITY STANDARDS IN UPPER GI ENDOSCOPY GUIDANCE

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Introduction The BSG and AUGIS recently published a position statement, 'Quality Standards in upper gastrointestinal endoscopy', outlining minimal standards in diagnostic gastroscopy. These new standards may represent a significant change of practice for some endoscopists and would need to be adopted by a majority to enforce change. The purpose of this survey was to determine how much of a change in practice these standards represent and to gauge the initial likely acceptance.

Methods Six simple questions were selected from the new recommendations to determine current and future practice in a multiple choice design. A questionnaire was sent to 467 UK based endoscopists using Survey Monkey.

Results The response rate was 31.7%(148) and the majority (78%) of the respondents were Gastroenterologists.

Abstract PTH-025 Table 1

Question	I already do this	I plan to do this	I do not intend to change my practice
Photo-documentation should be made of 8 relevant anatomical landmarks	38.5%	35.1%	26.4%
Inspection time during a diagnostic OGD should be reported for surveillance procedures (e.g Barrett's)	10.3%	42.9%	46.8%
The presence of an inlet patch should be photo-documented	61.9%	22.2%	15.9%
Biopsies from two different regions in the oesophagus should be taken to rule out eosinophilic oesophagitis in those presenting with dysphagia/food bolus obstruction.	90.1%	9.0%	0.9%
Where Iron deficiency anaemia is being investigated, separate biopsies from gastric antrum and body should be taken	19.7%	37.0%	43.3%
The presence of gastric polyps should be recorded, with number, size, location and morphology described and representative biopsies taken	60.6%	11.8%	27.6%

Conclusions Our results demonstrate that a number of the recommendations are contentious and are currently not being planned to be adopted by a significant proportion of endoscopist. Some of the recommendation such as biopsies for eosinophilic oesophagitis in the context of dysphagia are current practice for the majority of endoscopists and are planned to be adopted by the remainder. Whilst other standards such as recording inspection time for surveillance procedures and gastric antral biopsies for iron deficiency anaemia are only currently practiced in the minority and the majority are not planning to adopt. Interestingly the current adherence, planned uptake and no planned change in practice mirrored