conscious sedation: average midazolam dose was 7 mg; fentanyl 141 mcg; buscopan 24 mg.

Macroscopic assessment of strictures and indeterminate lesions correlating with malignancy had a sensitivity, specificity and accuracy of 90% (95%CI 79–97), 83% ((95% CI 71–96) and 86% (78.5%–92%) respectively. Histological correlation with final diagnosis increased over the study, from 77% in 2015 to 87% in 2017. Complete stone clearance rose from 50% in 2014 to 85% by 2017. 70% of patients had complete stone clearance at 1st attempt. 4.3% of patients developed complications post SOC. Post-ERCP pancreatitis (PEP) was the commonest adverse event (2.4%; n=5/206).

Conclusions The role of SOC in tertiary centres for identification of biliary lesions and management of difficult choledocholithiasis continues to grow. The South West service is centralised to one centre with a clear improvement in diagnostic accuracy for malignancy and stone clearance rates. Diagnostic accuracy rates mirror figures quoted in literature, most recently Japanese data in 2017.^{1 2} Adverse events were lower than those widely reported, but PEP remains the commonest cause. SOC under conscious sedation is both safe and effective.

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PTH-034 DO FAECAL CALPROTECTIN LEVELS INFLUENCE COLONOSCOPY RATES?

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Introduction Faecal Calprotectin (FC) often helps clinicians to decide the need for colonoscopy in patient with variety of bowel symptoms. Many clinicians are uncomfortable with intermediately raised FC and tend to opt for colonoscopies to avoid the risk of missing an organic disease. The aim of this audit is to assess the influence the FC level on the rate colonoscopies and pathology found.

Methods Data were collected from Northampton General Hospital database for all FC specimens tested between April 2015 and March 2016. We excluded all IBD patients and patients aged 18 and under. We compared patients who had an intermediately raised FC (IRFC) results (51–150), patients with significantly raised FC (SRFC) results (≥ 151) and a selected manageable sample with negative FC (≤ 50).

Results 2169 patients were tested for FC. 501 had raised FCs. 79 known IBD patients were excluded. The remaining were 217 patient with IRFC and 205 with SRFC. 111 of the FC negative group from August 2015 were studied.

Colonoscopies were done in 91 patients (42%) of the IRFC group, compared to 119 patients (58%) of SRFC. 24 patients (22%) with negative FC had colonoscopy.

Age and gender had no influence on the colonoscopy rate, but FC significantly influenced the rate of colonoscopy referral (χ^2 test, $p < 0.0001$).

Abstract PTH-034 Figure 1 Effect of faecal calprotectin on colonoscopy rate

96% of the patients scoped with FC ≤ 50 had normal colonic mucosa; one patient aged 66 had an adenoma. 78/91 (86%) patients with IRFC, had normal colons, 6 patients were newly diagnosed with IBD and 7 patients were found to have other colonic pathologies. This included 2 cancers seen in patients aged 42 and 55 who had weight loss or rectal bleeding. In the SRFC group, 70/121 (58%) had normal colons. 30 patients (25%) were newly diagnosed with IBD and 21 patients were found to have other colonic pathologies including 6 cancers.

Conclusions Faecal calprotectin significantly influences the rate of colonoscopy referral and outcome. There was good evidence to support colonoscopy in patients with FC > 150 , but 86% of patients had normal colons with FC of 51–150 and a repeat FC in the absence of warning symptoms would be reasonable, particularly in younger patients.

PTH-035 COFFEE GROUND VOMIT: DOES IT JUSTIFY AN URGENT ENDOSCOPY?

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Introduction Coffee ground vomit is vomit that looks subjectively like coffee grounds. It is thought to occur due to the presence of coagulated blood in the vomit and hence is a common indication for inpatient admission and thereafter endoscopy. In an increasingly stretched inpatient endoscopy service it is important not to over burden it with endoscopies that could be performed safely as an outpatient.

Therefore, our aim is to evaluate the need for inpatient gastroscopy in patients who are deemed to have coffee ground vomiting. We hypothesise that patients with coffee ground vomiting do not have significant upper gastro intestinal bleeding requiring endoscopic intervention.

Methods A single centre, retrospective analysis was performed on patients endoscoped for the primary indication of coffee ground vomiting. Data was collected and scrutinised from the Electronic Patient Records (EPR) and Unisoft endoscopy-reporting tool at Barnet and Chase Farm Hospitals, Royal Free London for 12 months of 2017. Gastroscopy reports were studied to see whether endoscopic therapy was required (defined as use of adrenaline injection, banding, clips,