PTH-054 **INCIDENCE OF FOOD IN THE UPPER GASTROINTESTINAL (GI) TRACT DURING ENDOSCOPY, FACTORS INVOLVED AND OUTCOME**

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Introduction At the Northern General Hospital, patients are asked to fast for up to six hours prior to endoscopy. Despite this, some procedures are reported to be unsuccessful due to the presence of food. This service evaluation looks at the incidence of food reported, factors involved and its outcomes.

Methods Retrospective analysis of 8756 patients who underwent elective gastroscopy from July 2016 to June 2017 at the Northern General Hospital. Data was obtained from databases, patient clinical files and procedure logs.

Results Of the 8756 patients, 118 (1.3%) were noted to have food present during their endoscopy. A number of factors were looked at to see whether they correlated with the presence of food during endoscopy: time of day, age, and indication for endoscopy.

Scopes were categorised into AM (8 am–1 pm), PM (1 pm–5 pm), evening (5 pm–8 pm) and out of hours (8 pm–midnight) according to the time they were carried out. The number of scopes reported to have food present were looked at across the different time frames and the results were as follows: AM: 56 (1.2%), PM 32 (1.0%), evening: 26 (2.7%), out of hours 5 (2.7%).

The average age of patients reported to have food during their endoscopy was 59 (range 16–97) which matched an average of 59 (range 16–97) where there was no food reported.

The number of scopes reported to have food present were looked at for each indication for endoscopy and the results were as follows: abnormal investigations (3.8%), vomiting (2.4%), reassessment (1.9%), GI bleed (1.5%), dysphagia (1.5%), dyspepsia (1.3%), anaemia (1.0%), weight loss (0.7%), tumour (0%), stent removal (0%).

53 (44.9%) of patients reported to have food present were re-scoped: 5 (9.4%) as emergencies and 48 (90.6%) as elective scopes. Of the elective re-scopes, 44 (91.7%) were reported to have no food present and 4 (8.3%) had food reported for a second time. Of the successful re-scopes 3 (6.8%) were given a different time slot, 21 (47.7%) were given further patient education in regards to starvation advice and 7 (15.9%) received both a different time slot and patient education.

Conclusions From this service evaluation the following Conclusions can be drawn: evening scopes were noted to have a higher rate of presence of food, age did not influence presence of food and scopes which were carried out as a result of abnormal investigations had a higher prevalence of food reported. Re-scoping of patients noted to have food present resulted in successful outcomes as a result of allocation of a different time slot and patient education.

PTH-055 **OUTCOMES OF A TERTIARY CENTRE'S REAL WORLD EXPERIENCE WITH COLONIC SELF EXPANDING METAL STENTS (SEMS)**

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Introduction colonic self-expanding metal stents (SEMS) are recommended in the management of malignant strictures, with obstruction. Published studies have low caseloads and may not reflect real world practice.

Methods All cases coded with endoscopic or image guided insertion of stent or tubal prosthesis (codes H214, H243, H244, H273, H274, H314) were reviewed to identify colonic SEMS cases. Electronic notes, endoscopy and radiology reports were reviewed. Data on, site of SEMS, indication, insertion method immediate late complications 30-day mortality were noted.

Results Episodes were coded of which 101 colonic stent insertions. SEMS insertions included local and tertiary referrals, either planned or in an emergency setting. Of the 101 cases, 58.4% of patients were male (n=59), with a median age of 75 years (range 28–95 years). The majority of SEMS (91.1%, n=92) were inserted endoscopically with fluoroscopy, with the remaining nine cases being inserted radiologically, by multiple operators. Indications for insertion included palliative (n=72) or curative (n=21) malignancy (defined by treatment intention on MDT outcome), with 4 cases being for benign disease. Most patients (79.2%) requiring SEMS had obstructive symptoms. Complications included cases of perforation (%) of unknown cause. One case had an 8 day unplanned readmission. Cases of stent migration (%) cases of stent occlusion secondary to tumour in-growth (%) cases (3.96%) of delayed perforation (which were felt to be tumour related). All cause 30 day mortality rate was 14.9% (n=15), with only 7 cases (6.93%) relating to stent failure or complication.

Conclusions This large real-world data review highlights complication rates of SEMS in a heterogeneous population with multiple operators over 7 years of both emergency and planned procedures for malignant colonic strictures. Colonic SEMS is a relatively safe therapeutic option for the palliative management of colonic malignancy with obstruction

PTH-056 **HEMOSPRAY USE IN ACUTE GASTROINTESTINAL BLEEDING- A 4 YEAR SINGLE CENTRE EXPERIENCE**

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Introduction Upper GI bleeding (UGIB) has a mortality of about 10% in UK despite advances in treatment. The current guidelines recommend dual modality of treatment which could include injection of adrenaline, argon photocoagulation or using endoscopic clips to achieve haemostasis. A recent addition to therapeutic options is Hemospray. Since June 2013, there have been reports from UK that it is useful as an adjunct in treatment of UGIB with most reporting success rates of 77%–85%. It has been suggested that it may not be reliable when used as the only mode of treatment. We report our experience using the product in our centre over 4 years (2013 to 2017).

Methods A retrospective review of patients using trust endoscopy database (Endosoft) between July 2013 & July 2017. We looked at electronic records of patients who underwent an endoscopy and needed Hemospray as a mode of treatment for managing an acute gastrointestinal (GI) bleed.

Results 45 consecutive patients (M=31), with median age 72 years (range 35–91 years) were included. The mean