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) an 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 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 (0.9%), 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. Of the 118 patients noted to have food present results in successful outcomes as a result of allocation of a different time slot and patient education.

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