Abstracts

Endoscopic Management of Buried Bumper Syndrome

Angad Singh*, Andrea Cartwright, Rizwan Kassam, Javaid Subhani. Basildon University Hospital, Basildon, UK.

Introduction Buried Bumper Syndrome (BBS) is an uncommon, yet potentially serious complication of percutaneous gastrostomy tube (PEG) placement with a quoted incidence of 1%. Usually identified during routine nursing assessment, release of a buried bumper can be achieved via external manipulation, endoscopically or via surgery.

Aim Review the frequency and success of endoscopic treatment of BBS.

Methods At Basildon University Hospital a 4-level stepwise approach was adopted for management of Buried Bumper Syndrome, with each level representing an escalation of therapy.

• 26. Forrest classification applicable to 22 patients 1A (n=3, 15%), 1B (n=10, 46%), 2A (n=3, 15%), 2B (n=3, 15%), 2C (n=2, 9%).
• 27. 100% (n=7) of UGIB related to malignancy responded to Hemospray (adjunct and monotherapy included)
• 28. 30 day mortality was 24% (n=11) with 3 deaths directly attributed to GI bleeding (4 palliative secondary to malignancy and 4 multifactoral in elderly patients).

Conclusions Our 4 year experience suggests that Hemospray can be a useful adjunct to conventional endoscopic therapy for acute GI bleed with success rates comparable to previous reports (nearly 85% in our cohort), with a rebled rate of 14%. Our findings suggest it could be useful as monotherapy for bleeding related to malignancies where other therapy may be impractical. More studies with larger numbers are needed to add to the evidence base.

Abstract PTH-056 Table 1

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Number n=45</th>
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<tbody>
<tr>
<td>Duodenal ulcer</td>
<td>14 (32%)</td>
</tr>
<tr>
<td>Oesophageal/gastric ulcer</td>
<td>4 (9%)</td>
</tr>
<tr>
<td>Malignancy related</td>
<td>7 (15%)</td>
</tr>
<tr>
<td>Iatrogenic bleeding</td>
<td>7 (15%)</td>
</tr>
<tr>
<td>Other including unclear cause of bleed</td>
<td>13(29)</td>
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</tbody>
</table>

Hemospray (adjunct and monotherapy included)

• 23. 39 (86%) patients had Hemospray as adjunct therapy & all patients had complete haemostasis documented at the end of index procedure.
• 24. It was used as the only modality of therapy successfully in 6 patients (4 with malignancy and 2 iatrogenic bleeds)
• 25. Overall, 645 patients had a documented rebled after discharge but within 4 weeks; 4 had bleeding vessels and were on warfarin or Ticagrelor; 2 patients had tumour related recurrent bleeding.
• 26. Forrest classification applicable to 22 patients 1A (n=3, 15%), 1B (n=10, 46%), 2A (n=3, 15%), 2B (n=3, 15%), 2C (n=2, 9%).

Conclusion This is a relatively infrequent endoscopic dilemma with only 27 instances over a 8.5 year study period. However with rare scenarios the referral pathway can be unclear. Only one endoscopist managed Level 3 releases and by default they became the routine destination for Nutrition team referrals. This allowed a 66% success rate but disappointingly 22% of the patients had recurrent episodes. Recommendations 1) Education of the institutions caring for these patients. 2) Single endoscopists to develop expertise in each centre 3) If successful, attempt to site a new PEG in a second area despite the difficulty.

Smart Colonoscopy: Using Big Data to Identify Predictors of Normal Colonoscopic Examinations

Matt Stammers, Sreedhari Thalasekaran, Pradeep Bhandari. Queen Alexandra Hospital, Portsmouth, UK.

Introduction Endoscopy workload is increasing at a faster pace than available resources. The NHS has a wealth of data, which if used properly can improve resource allocation in future.

The aim of this study was to review mass colonoscopy data to identify those factors most associated with a normal examination, in order to help rationalise future resource utilisation.

Methods We constructed a standardised, anonymised database, containing all colonoscopies performed locally between 01/01/