Abstract AWE-06 Table 1

		Monotherapy (n = 51)	Combination therapy (n = 17)	Rescue Therapy (n=7)
Blatchford	Median	10	9	11
	IQR	7–12	7–14	10–13
Rockall	Median	8	8	7
	IQR	7–9	7–9	4–7
Haemostasis achieved		51/51(100%)	15/17(88%)	7/7(100%)
Rockall 7 and 8: Predicted rebleed rate: 25–40%				
Re-bleed		4/44(9%)	2/14(14%)	1/7(14%)
Rockall 7 predicted mortality rate: 20–30%				
Rockall 8 predicted mortality rate: 40–45%				
All cause 7-day mortality		2/44(5%)	0/14	0/7
All cause 30-day mortality		9/44(21%)	3/14(21%)	0/7

secondary to tumours as a monotherapy, dual-therapy with standard haemostatic techniques or rescue therapy. Haemostasis was defined as the cessation of bleeding within 5 minutes of the application of hemospray.

Results 75 patients with tumoural UGIBs were recruited (51 males, 24 females, 22/75 (29%) oesophageal, 49/75 (65%) gastric, 4/75 (5%) duodenal). The median rockall score was 8 (IQR, 7–9).

Immediate haemostasis was achieved in 73/75 (97%) of patients, 7/65 (11%) had a rebleed, 12/65 (18%) died within 30 days (all-cause mortality). Based on the baseline average total rockall score, the expected rebleed rate is 25–40%, and expected mortality rate was 40–45% in our cohort.

100% immediate haemostasis was achieved in duodenal and gastric tumours, and 91% in oesophageal tumours.

Outcomes with mono/combination therapy and rescue therapy (table 1)

Conclusions Hemospray is effective for achieving immediate haemostasis in UGIBs secondary to upper GI tumours, which are considered difficult to treat.

When considering average rockall score the rebleed and mortality rate is better than predicted rates. Haemostasis is achieved in the majority allowing for patient stabilization and providing time for surgery/radiotherapy.

using this device, which is the largest patient cohort in the UK to date.

Method Between April 2017 and December 2018, we have used the Apollo OverStitch device in 23 patients who had regained weight after an initial RVGB. All patients were discussed initially at our bariatric MDT. All patients underwent a prior gastroscopy to ensure a stoma size of at least 2 cm. All cases were done under general anaesthetic.

Results Here we report the follow up data for our cohort. 91% of patients were females. Mean weight loss at early follow up (mean 82 days) was 6.7% and at late follow up (mean 342 days) was 9.9%. One patient had a re-do procedure, having dropped from 104 kg to 95 kg and then further to 88.8 kg. There were no procedure related complications.

Conclusion Endoscopic revision of the RYGB stoma using the Apollo OverStitch device is an effective method of achieving further weight loss in these patients. The effects are sustained at 1 year. We are now developing our technique to incorporate more bites for each suture placed, as well as following the first line of sutures with a second in order to achieve a tighter effect on reducing the stoma size. We have done a further 7 patients since, making our cohort the largest in the UK. We propose that this management option be considered in all patients with weight regain after RYGB and a gastro-jejunal stoma >2 cm at gastroscopy.

AWE-07 APOLLO OVERSTITCH DEVICE FOR ENDOSCOPIC REVISION OF ROUX-EN-Y GASTRIC-BYPASS, UPDATES FROM THE LARGEST UK SERIES

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10.1136/gutjnl-2019-BSGAbstracts.25

Introduction The Apollo OverStitch is a minimally invasive endoscopic suturing device which allows full thickness suturing without the need for surgery

Roux-en-Y gastric bypass (RYGB) can achieve up to 60% weight loss 2 years after surgery but 30% of patients will regain their weight within 2 years. The options for this group of patients are limited; redo surgery can be challenging with a greater risk of complications. Endoscopic revision of the gastro-jejunal anastomosis using the Apollo OverStitch device now offers an alternative option in these patients to achieve further weight loss. Here we report our experience

Posters

PTH-001 SEMS IS A RISK FACTOR FOR POST-ERCP PANCREATITIS: EXPERIENCE FROM A HIGH-VOLUME UK HOSPITAL

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10.1136/gutjnl-2019-BSGAbstracts.26

Introduction Studies have attempted to examine the risk of post-ERCP pancreatitis (PEP) with the placement of biliary self-expandable metal stent (SEMS) with conflicting results. The aim of this study is to investigate whether biliary SEMS is a potential risk factor for PEP.

Methods All patients who underwent ERCP between January 2016 and May 2017 at Gastrointestinal Endoscopy Unit at