those where R0 resection was not achieved, 2/3 had residual lesion at follow up; one residual lesion removed by snare, one had clip still in situ and awaiting use of clip cutter to facilitate residual polyp removal. Overall endoscopic clearance rate to date is 89% (8/9).

One patient developed appendicitis at day 6 which required surgery to remove a gangrenous appendix. The patient made an uneventful recovery. Appendicitis rates for this cohort was therefore 14.2% (1/7) when those with prior appendectomy were excluded. No other complications occurred.

Conclusions Removal of adenomas at the appendix base by eFTR is technically feasible and can avoid the need for surgery. Rates of appendicitis in our cohort are significant and similar to published data¹, suggesting the need for careful consent and close observation post procedure.

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PTH-008

ENDOSCOPY REPORTING IN ULCERATIVE COLITIS: IDENTIFYING AREAS OF SUBOPTIMAL PRACTICE TO DEFINE AN INTERVENTION BUNDLE

Tom Calderbank*, Grace Black, Holly Theaker, Mark Samaan, Oliver Tomkins, Maria Aslam, Simona Di Caro, Farooq Rahman, Shameer Mehta, Sara McCartney, Stuart Bloom, Roser Vega, Edward Seward. *Department of Gastroenterology, University College Hospital, London, UK*

10.1136/gutjnl-2019-BSGAbstracts.33

Abstract PTH-008 Table 1

<i>BRIDGE endoscopic reporting criteria</i>	Overall n=227 (%)	Consultant n=109 (%)	Non-Consultant n=118 (%)	p
<i>Description of previous disease extent</i>	6 (3)	2 (2)	4 (3)	0.68
<i>Specific indication for procedure described</i>	181 (80)	83 (76)	98 (83)	0.25
<i>Specific UC therapy at the time of procedure documented</i>	22 (10)	6 (6)	16 (14)	0.045*
<i>Description of symptoms at the time of endoscopy</i>	21 (9)	8 (7)	13 (11)	0.37
<i>Description of maximal extent of endoscopically visible disease</i>	196 (86)	95 (87)	101 (86)	0.85
<i>Mayo score</i>	131 (58)	64 (59)	67 (57)	0.79
<i>UCEIS score</i>	3 (1)	0 (0)	3 (3)	0.25
<i>Segmental biopsy description</i>	190 (84)	85 (78)	105 (89)	0.031*
<i>Overall summary of findings</i>	178 (78)	86 (79)	92 (78)	0.87
<i>Recommendations for treatment documented</i>	68 (30)	29 (27)	39 (33)	0.31
<i>Follow-up instructions documented</i>	176 (78)	81 (74)	95 (81)	0.27
<i>Median overall score out of 11 reporting items</i>	5	5	5	0.07

Introduction The importance of endoscopic evaluation as part of the management of ulcerative colitis (UC) is becoming increasingly appreciated. However, the quality and completeness of UC endoscopy reports is variable. Previous studies have demonstrated that standardisation of reporting can optimise practice and there now exists expert consensus on which items should be included in a high quality UC endoscopy report.

Our aim was to identify areas of suboptimal practice which could inform the design of an intervention bundle to improve reporting. We also aimed to identify any groups of endoscopists to whom the interventions should be specifically directed.

Methods Reports of 227 lower GI endoscopies (103 flexible sigmoidoscopies, 124 colonoscopies) performed on UC patients at UCLH between April–October 2018 were reviewed. Reports were evaluated against 10 endoscopic reporting items recommended by the Building Research in Inflammatory Bowel Disease Globally (BRIDGE) groups expert consensus exercise¹, as well as documentation of UCEIS scores. Thus, each report was given a mark out of 11. Subgroup analyses were carried using Mann-Whitney (continuous) or Fishers exact (categorical) tests.

Results The rate at which each reporting item was documented is shown in table 1. Description of previous disease extent (3%), UC therapy (10%) and symptoms (9%) at the time of the procedure were all infrequently reported. However, perhaps the most clinically relevant finding was that an objective measure of disease activity was missing in nearly half of reports.

Subgroup analysis demonstrated that non-consultants (trainees and nurse endoscopists) were significantly more likely to report UC therapies ($p=0.045$) and biopsy location ($p=0.031$). No other significant differences were observed for individual reporting items or overall score (median 5/11 in both groups, $p=0.07$).

Conclusions Our data demonstrates that many endoscopic UC reports are not consistent with optimal practice based on expert consensus. We identified areas that could potentially be optimised using an interventional bundle. Most importantly, the use of an endoscopic index. The interventional bundle should involve all endoscopists and could include such measures as local training sessions, hard-copy and online training materials, pooling of UC procedures on dedicated lists and integration of template reports into reporting software.

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PTH-009 CAPSULE ENDOSCOPY IN COELIAC DISEASE: THE ROLE OF FLEXIBLE SPECTRAL IMAGING COLOUR ENHANCEMENT

¹Stefania Chetcuti Zammit*, ¹Mark E McAlindon, ²Pierre Ellul, ³Emanuele Rondonotti, ⁴Cristina Carretero, ¹David S Sanders, ¹Reena Sidhu. ¹Sheffield Teaching Hospitals, Sheffield, UK; ²Gastroenterology Department, Mater Dei Hospital, Msida, Malta; ³Gastroenterology Unit, Valduce Hospital, Como, Italy; ⁴Department of Gastroenterology, University Clinic of Navarra, Pamplona, Spain

10.1136/gutjnl-2019-BSGAbstracts.34

Introduction Flexible spectral imaging colour enhancement (FICE) is a form of virtual chromoendoscopy that is incorporated in the capsule reading software and that can be used by reviewers to enhance the delineation of lesions in the small bowel. This has been shown to be useful in the detection of pigmented (ulcers, angioectasias) lesions. However, its application to coeliac disease (CD) images from small bowel capsule endoscopies (SBCEs) has rarely been studied.

Methods This was a European, multicentre study that included 5 expert capsule reviewers who were asked to evaluate a number of normal and abnormal deidentified images from SBCEs of patients with CD to determine whether the use of FICE and blue light can improve the detection of CD related changes.

Results Sensitivity and specificity of conventional white light in the delineation of CD related changes were 100%. The next best image modification was FICE 1 with a sensitivity of 88% and a specificity of 96%. There was no difference between conventional white light, FICE and blue light for the identification of CD related changes. There was a low agreement (Fleiss Kappa 0.107; $p=0.147$) between expert reviewers in selecting the best image modification that detected CD related changes.

Conclusions FICE and blue light were not found to be superior to conventional white light in the delineation of macroscopic changes related to CD on SBCEs.

PTH-010 ARE ANTICOAGULANT AND ANTIPLATELET MEDICATIONS RESTARTED APPROPRIATELY AFTER AN UPPER GI BLEED?

John Creamer*, Melanie Cuffe Ben Arnold, Rachel Perry, Anya Robinson, Alex DiMambro. Gloucestershire Hospitals NHS Foundation Trust, Gloucester, UK

10.1136/gutjnl-2019-BSGAbstracts.35

Introduction Failure to restart anticoagulant and antiplatelet medication appropriately after achieving haemostasis following an upper gastrointestinal bleed (UGIB) is associated with an increased risk of cardiovascular events and higher patient mortality¹. This audit aimed to look at how long such medication was held for against NICE and the European Society of Gastrointestinal Endoscopy (ESGE) guidelines² which suggest aspirin should be continued immediately post-haemostasis and warfarin/direct oral anticoagulants (DOACs) restarted after 7–15 days.

Methods Electronic records were reviewed to identify all inpatient OGDs performed for suspected UGIB between 1st January and 31st December 2018 in patients taking anticoagulant or antiplatelet medication. Individual records were scrutinised to review the duration agents were held and whether a recurrent UGIB or cardiovascular event occurred within 90 days. Cases with no confirmed bleeding at endoscopy and low clinical suspicion of UGIB were excluded.

Results There were 26 confirmed UGIB in patients taking aspirin, of which 6 (23%) had aspirin continued immediately post-haemostasis. Of the remaining 20 patients, only 9 (45%) had clear documentation as to why aspirin was stopped or held longer.

There were 41 cases of UGIB in patients on anticoagulation (8 on warfarin, 33 on DOACs). In 12 cases a clear decision was documented to stop anticoagulation long-term. One patients' records were unavailable. In the remaining 28 patients, 6 (21%) had anticoagulation re-started at 7–15 days post haemostasis, while 14 (50%) had anticoagulation re-started earlier