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

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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?

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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

than this. Five patients had a further UGIB within 90 days, which was associated with age (80% over the age of 80) and early reintroduction of anticoagulation (40%). 80% of repeat bleeds occurred on rivaroxaban, consistent with data suggesting it may have a higher risk of GI bleeds in elderly patients.

Conclusions Every UGIB is unique and generic guidelines will not always apply for valid clinical reasons. However, failure to follow such guidelines when appropriate leads to an increased risk of adverse events and documentation of reasons for deviating from clinical guidelines is often inadequate. The introduction of a national GI bleed proforma to remind physicians of guidelines and allow clear documentation of decisions regarding anticoagulant or antiplatelet medication may improve compliance and reduce morbidity post-UGIB.

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Abstract PTH-010 Figure 1 Days to restarting anticoagulation after achieving haemostasis

PTH-011 A FEASIBILITY STUDY FOR THE USE OF ENDOCUFF VISION IN BOWEL SCOPE SCREENING

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Introduction The success of bowelscope screening (population colorectal cancer screening aged 55 with a one off flexible sigmoidoscopy) in improving colorectal cancer outcomes is reliant on adenoma detection. The adenoma detection rate has been a concern within bowelscope screening (BoSS) and a national quality assurance standard has been set at 6.7%. The use of Endocuff Vision has been shown to improve adenoma detection rate in colonoscopy both within the Bowel Cancer Screening Programme and symptomatic service. There is currently a randomized controlled trial underway (B-ADENOMA) to answer the question on the effectiveness of the use of Endocuff Vision in BoSS. This was a feasibility study to assess Endocuff Vision in BoSS.

Methods Endocuff Vision was used during BoSS examinations at Liverpool & Wirral Bowel Cancer Screening Centre during a 3 month study period. A standardised proforma was completed after each examination by endoscopists, which included ratings of patients tolerability, endoscope handling, assistance in detecting pathology. Quality indicators were compared prior to and during the study.

Results 838 BoSS flexible sigmoidoscopies were performed prior to the study. Endocuff Vision was used in 133

procedures; 19.5% of all BoSS examinations during the study period. 4.5% were not successful. Endoscopists reported good or excellent patient tolerability in 83.5%, endoscope handling in 85.8% and assistance in detecting pathology in 68.8%. However, subjective narrative from endoscopists included more negative than positive comments on a ratio of 4:1. Comfort scores decreased significantly: 83.0% reporting no or minimal discomfort prior to the study to 78.7% during the study ($p=0.03$, OR 1.33 95% CI 1.02 – 1.71). Adenoma Detection Rate was 11.02% for the Endocuff Vision assisted examinations. Polyp Detection Rate increased from 18.5% prior to the study to 22.6% during the study period ($p=0.05$, OR 1.28 95% CI 1.00–1.65). Adenoma Detection Rate increased from 9.55% to 11.6% (79/681) ($p=0.19$, OR 1.24 95% CI 0.90–1.73). **Conclusions** This study illustrates that Endocuff Vision can be successfully used in Bowel Scope Screening. Endoscopists felt it aided the procedure and pathology detection. However, the discordance between the negative comments and ratings may suggest that more familiarity with the device is required. Patient comfort may be compromised but potential benefits include improved polyp and adenoma detection rates.

PTH-012 IMPLEMENTATION OF UK ACUTE UPPER GI BLEEDING BUNDLE RESULTS IN SIGNIFICANT IMPROVEMENTS IN QUALITY STANDARDS

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Introduction The 2015 NCEPOD report ‘Time to Get Control’ highlighted the need to improve the quality of care of patients with acute upper GI bleeding (AUGIB). The BSG Endoscopy Quality Improvement Project created an evidence based care bundle for AUGIB targeting ward based management of patients within the first 24 hours (The UK AUGIB bundle). The impact of implementation of the UK AUGIB bundle has not been assessed in clinical practice.

Methods An audit of the impact of the UK AUGIB bundle was undertaken in 15 Scottish hospitals on behalf of the Scottish Society of Gastroenterology. Data were collected relating to demographics and management of patients with AUGIB within the first 24 hours of presentation, for a six-week period pre- and post-implementation of the UK AUGIB bundle. A period of bundle promotion was undertaken in all centres between the data collection cycles. Outcome measures included documentation of bundle implementation, risk scores and transfusion strategy. Caldicott approval was obtained in each site.

Results A total of 459 patients were included in the pre-bundle audit period, and 434 patients in the post-bundle audit period. Following implementation the AUGIB bundle was utilised in 41.2% of patients. The table 1 demonstrates patient demographics and the impact of bundle implementation.

Data were analysed using STATA 14.0. Chi-2 tests were used for categorical variables. For continuous variables, t-tests and Wilcoxon rank sum tests were used according to variable distribution.

No significant differences were observed in use of PPI in high risk bleeders, use of terlipressin/antibiotics in variceal haemorrhage or resumption plan for antithrombotics, with high pre-bundle performance in these domains.