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

Edmund Derbyshire*, Geoff Fitzgerald, Andy Goss, Mercy Mbouyongha, Sanchoy Sarkar. *Royal Liverpool and Broadgreen University Hospitals NHS Trust, Liverpool, UK*

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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% 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

^{1,6}MC Donnelly*, ^{5,6}E Saffouri, ²J Pugmire, ³K Siau, ^{4,6}U Basavaraju, ^{5,6}AJ Stanley, ^{5,6}AJ Morris. ¹Royal Infirmary of Edinburgh; ²University of Glasgow; ³JAG, UK; ⁴Aberdeen Royal Infirmary; ⁵Glasgow Royal Infirmary; ⁶Scottish Society of Gastroenterology

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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.

Abstract PTH-012 Table 1

Variable	Pre-bundle period	p-value	Post-bundle period	Bundle not used	p-value	Bundle used
DEMOGRAPHIC VARIABLES						
Number of patients	459 (51.4%)	n/a	434 (48.6%)	205 (53.4%)	n/a	179 (46.6%)
Age (years)	64.7 [63.0–66.4]	0.772	64.4 [62.7–66.0]	65.8 [63.4–68.1]	0.043	62.2 [59.5–64.8]
Male	264 (57.8%)	0.530	266 (61.4%)	123 (60.0%)	0.395	113 (63.1%)
Female	193 (42.2%)		167 (38.6%)	82 (40.0%)		66 (36.9%)
GBS score	6.3 [0–19]	0.011	7.4 [0–20]	7 [0–18]	0.141	8.0 [0–20]
Varices	27 (7.3%)	0.007	51 (13.3%)	24 (13%)	0.733	24 (14%)
BUNDLE VARIABLES						
Blatchford (GBS) recorded	163 (38.4%)	<0.001	225 (57.3%)	86 (42.4%)	<0.001	122 (74.0%)
Target haemoglobin stated	53 (35.3%)	0.083	78 (44.8%)	34 (36.6%)	0.039	35 (53.0%)
Transfusion threshold appropriate	58 (13.3%)	0.012	83 (19.6%)	40 (19.6%)	0.880	36 (20.2%)
Rebleeding plan	121 (33.2%)	<0.001	196 (50.7%)	83 (44.9%)	0.028	95 (56.55%)

Conclusions Implementation of the UK AUGIB bundle in Scottish hospitals resulted in significant improvements in quality standards including documentation of risk scoring, target haemoglobin, transfusion thresholds and re-bleed plan.

PTH-013 DEVELOPMENT OF THE UPPER GI RECORDED IMAGE QUALITY INDEX (UGI-RIQI) SCORE AND QUALITY ASSURANCE TOOL

¹Thomas Dove*, ²Esther Hawkes, ¹James Berrill, ¹Bee Lee, ¹Peter Neville, ¹Neil Hawkes. ¹Cwm Taf University Health Board, Cardiff, UK; ²University of Southampton, Southampton, UK

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Background Endoscopic images saved on the Electronic Reporting System are the only visible representation of completeness of examination and pathological findings. Together with the endoscopy report these become the only reference for other clinicians not present at the original endoscopy on which to base further decisions. Standards for image recording form a component part of the Quality Standards in Upper Gastrointestinal (UGI) endoscopy.¹

Aims and methods We aimed to develop a systematic scoring system for quality of images recorded at UGI endoscopy and validate this UGI Recorded Image Quality Index (UGI-RIQI) scoring system. We searched the HICSS Endoscopic Reporting System for endoscopists performing regular UGI endoscopy (n=14) between January and June 2018. All images and the endoscopy report for the first 10 cases with pathological findings for each endoscopist were obtained, ordered into folders and the data anonymised. An UGI-RIQI scoresheet was devised, based on the validated lower GI RIQI tool,^{2,3} assessing 4 domains: Representation, Image Labelling, Extent of examination and Image Quality, and the clinical utility (CU) of the image set - rating its ability to inform further decision-making. The UGI-RIQI total score range was 0 to 12. 140 image sets were scored by 3 independent assessors. Cohen's kappa values for intra observer variation were calculated for individual domains and total RIQI scores. These results informed recommended RIQI standard levels of performance. The correlation of these levels and CU scores was tested with Spearman's test.

Results 140 data sets were reviewed by 3 assessors generating 420 domain scores. Inter-rater agreement (IRA) for assessors for the total RIQI score were in the moderate to good range

(0.6, 0.46 and 0.47). Performance levels were defined in terms of total RIQI score: poor 0–6, below standard 7–8 and meets standards 9–12. The correlation between the derived RIQI levels and clinical utility scores were high (0.71, 0.64 and 0.71).

Conclusions The UGI-RIQI tool provides a method for assessing the quality of image capture across ten procedures with scores in 4 domains. The UGI-RIQI score correlates well with clinical utility of the images, with acceptable inter-rater reliability. It shows potential both as an audit and training tool to improve performance in this area of endoscopic practice.

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PTH-014 DIAGNOSTIC PERFORMANCE OF ERCP GUIDED BILIARY BRUSH CYTOLOGY- EXPERIENCE FROM A NON-HPB CENTRE IN UK

Mohamed Elzubier*, Debasis Majumdar, Vikramjit Mitra. *South Tees Hospital, Middlesbrough, UK*

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Introduction Biliary brush cytology is an important investigation in the assessment of bile duct strictures. A meta-analysis¹ showed that the pooled sensitivities and specificities of biliary brush cytology for the diagnosis of malignant biliary strictures were 45% and 99% respectively when done in tertiary centres. The aim of this study was to evaluate the diagnostic performance of ERCP guided brush cytology for the assessment of biliary strictures in our organisation.

Methods We carried out a retrospective review of all biliary brushings (identified from our endoscopy database) obtained during ERCP between January 2012 and April 2017. Data collected included patient demographics, cross-sectional imaging, cytopathological classification (based on locally agreed terminology) and treatment modality. Final diagnosis was confirmed from biliary brush cytology, histology obtained by other methods (endoscopic ultrasound, cholangioscopy, PTC or ultrasound guided biopsy), surgical resection specimens or cross-sectional imaging discussed at MDT setting (if histology negative). Patients were followed up for at least 6 months.