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

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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.

REFERENCES

1. Beg S, et al. *Gut* 2017;0:1–14. doi:10.1136/gutjnl-2017-314109.
2. Samuel D, et al. *Gut* 2016; 65:Suppl 1 A224-A225 doi:10.1136/gutjnl-2016-312388.420.
3. Samuel D, et al. *Gut* 2016;65:Suppl 1 A278 doi:10.1136/gutjnl-2016-312388.522.

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