We describe our experience in the endoscopic management of migrated PS.

Methods A retrospective review of all ERCPs at our tertiary unit from January ’13 –February ’19 was performed to identify cases of migrated PS.

Results Twelve patients were identified; 10 received PS placement at other UK hospitals, 1 abroad and 1 at our unit. PS indications were prophylaxis of post-ERCP pancreatitis (PEP) in 9 and following pancreatic endotherapy in 3 (one for sphincter dysfunction, one for ductal stricture and one for cyst drainage). The migrated PS were 5 cm (n=11) or 7 cm (n=1) long with diameter of 3Fr (n=1), 5Fr (n=10) and 7Fr (n=1). Seven were straight and 5 single pigtail. 9 PS migrated after reported correct placement (of which 6 (67%) were straight). Two were inadvertently deployed within the pancreatic duct (PD); in one case there was no information regarding placement. The site of PS migration was within the pancreatic head (n=3), body (n=3) and tail (n=6).

After MDM review one patient was referred directly for surgery where a PD stricture precluded endoscopic access. Endoscopic removal was attempted in 11 patients and successful in 9 (82%). 7 patients required two procedures. The median interval from stent placement to retrieval was 5 weeks (range 2–20). All patients had a previous pancreatic sphincterotomy. Techniques used for successful retrieval were: stent grabbers (n=2) and pancreatoscopy with SpyBite® for- grabbers (n=3), extraction balloon/stent grabbers (n=1), snare/sphincterotomy. Techniques used for successful retrieval were: stent grabbers (n=3), extraction balloon/stent grabbers (n=1), snare/stent grabbers (n=2) and pancreatoscopy with SpyBite® for ceps (n=3). Endoscopic removal was unsuccessful in 2/11 patients where pigtail stents had hooked into a side branch. In all cases a 5 cm/3Fr prophylactic PS was placed post retrieval and 8 received rectal diclofenac (one contraindicated). Mild post-ERCP pancreatitis (PEP) occurred in one case. Endoscopic removal was attempted in 11 patients and successful in 9 (82%). 7 patients required two procedures. The median interval from stent placement to retrieval was 5 weeks (range 2–20). All patients had a previous pancreatic sphincterotomy. Techniques used for successful retrieval were: stent grabbers (n=3), extraction balloon/stent grabbers (n=1), snare/stent grabbers (n=2) and pancreatoscopy with SpyBite® for ceps (n=3). Endoscopic removal was unsuccessful in 2/11 patients where pigtail stents had hooked into a side branch. In all cases a 5 cm/3Fr prophylactic PS was placed post retrieval and 8 received rectal diclofenac (one contraindicated). Mild post-ERCP pancreatitis (PEP) occurred in one case.

Conclusion Endoscopic retrieval of proximally migrated PS was successful in 82% of patients. Migrated PS retrieval is challenging, and should only be attempted by endoscopists experienced in pancreatic endotherapy following case review within a specialist MDM. The mechanism of migration is unclear and spontaneous proximal migration of an appropriately placed single pigtail PS is unlikely to occur. Apparent migration in these cases most likely arises from incorrect deployment, potentially due to difficulty distinguishing the stent from the pushing device, emphasising the need for caution during PS placement. The optimal retrieval technique depends upon PS type, position, and PD anatomy. In our experience use of an extraction balloon alone was never successful. Failure of endoscopic retrieval was highest with pigtail stents and those >2 cm from the papilla.

**METHODS**

**ENDOSCOPIC RESECTION OF NON-AMPULLARY DUODENAL POLYPS: A RETROSPECTIVE SINGLE CENTRE EXPERIENCE**

Nishmi Gunasingam*, Mehul Patel, Shraddha Gulati, Aymn Haji, Bu’Hussain Hayee. King’s College Hospital NHS Foundation Trust, London, UK

10.1136/gutjnl-2019-BSGAbstracts.47

**Introduction** Current literature estimates that complete endoscopic resection (ER) of duodenal adenomas can be achieved in 79–100% of cases, but complication rates are high and adenoma recurrence is encountered in up to 37% of cases (Basford & Bhandari, 2012). We present our retrospective experience.

**Results** Technological advances and improvements in endoscopic techniques have increased the number of endoscopic resections performed in recent years. In our single centre experience endoscopic resection was attempted in 11 patients and successful in 9/11 (82%). Failure of endoscopic retrieval was highest with pigtail stents and those >2 cm from the papilla.

**Conclusion** Endoscopic removal was attempted in 11 patients and successful in 9 (82%). 7 patients required two procedures. The median interval from stent placement to retrieval was 5 weeks (range 2–20). All patients had a previous pancreatic sphincterotomy. Techniques used for successful retrieval were: stent grabbers (n=3), extraction balloon/stent grabbers (n=1), snare/stent grabbers (n=2) and pancreatoscopy with SpyBite® forceps (n=3). Endoscopic removal was unsuccessful in 2/11 patients where pigtail stents had hooked into a side branch. In all cases a 5 cm/3Fr prophylactic PS was placed post retrieval and 8 received rectal diclofenac (one contraindicated). Mild post-ERCP pancreatitis (PEP) occurred in one case.

**Conclusions** Endoscopic retrieval of proximally migrated PS was successful in 82% of patients. Migrated PS retrieval is challenging, and should only be attempted by endoscopists experienced in pancreatic endotherapy following case review within a specialist MDM. The mechanism of migration is unclear and spontaneous proximal migration of an appropriately placed single pigtail PS is unlikely to occur. Apparent migration in these cases most likely arises from incorrect deployment, potentially due to difficulty distinguishing the stent from the pushing device, emphasising the need for caution during PS placement. The optimal retrieval technique depends upon PS type, position, and PD anatomy. In our experience use of an extraction balloon alone was never successful. Failure of endoscopic retrieval was highest with pigtail stents and those >2 cm from the papilla.

**METHODS**

**THE INCIDENCE & INVESTIGATION OF IRON DEFICIENCY ANAEMIA IN PATIENTS PRESENTING WITH ACUTE CORONARY SYNDROME**

Paul Harrow*, Jessica Joseph, Rachael Hall, Sean Preston. Royal London Hospital, London, UK

10.1136/gutjnl-2019-BSGAbstracts.48

**Introduction** Co-presentation with anaemia and acute coronary syndrome (ACS) is common. Anaemia is an independent risk factor for poor outcomes after ACS. Bleeding is the most common non-cardiac complication of ACS therapy. There are few studies existing on these patients. In this retrospective study we reported the incidence and characteristics of anaemia in patients presenting with NSTEMI (n=55) or STEMI (n=58) between 2015 and 2016 to a large tertiary centre.

**Methods** Patients were identified using an ICD10 code-based search. Data were collected from electronic patient notes and the pathology system. Endoscopy reports one year prior to and after the ACS were reviewed.

**Results** 45% patients with NSTEMI and 28% STEMI were anaemic at presentation with ACS. This was a microcytic anaemia in 36% patients. Iron saturations were tested or a recent result was available in 29% patients and ferritin was tested in 19% patients. These tests were more frequently performed in patients who had NSTEMI. When tested, iron saturations were low in 76% patients and ferritin was low in 29%.

**METHODS**

**ENDOSCOPIC RESECTION OF NON-AMPULLARY DUODENAL POLYPS: A RETROSPECTIVE SINGLE CENTRE EXPERIENCE**

Nishmi Gunasingam*, Mehul Patel, Shraddha Gulati, Aymn Haji, Bu’Hussain Hayee. King’s College Hospital NHS Foundation Trust, London, UK

10.1136/gutjnl-2019-BSGAbstracts.47

**Introduction** Current literature estimates that complete endoscopic resection (ER) of duodenal adenomas can be achieved in 79–100% of cases, but complication rates are high and adenoma recurrence is encountered in up to 37% of cases (Basford & Bhandari, 2012). We present our retrospective experience.

**Results** We describe our experience in the endoscopic management of migrated PS.

**Conclusion** Endoscopic retrieval was attempted in 11 patients and successful in 9 (82%). 7 patients required two procedures. The median interval from stent placement to retrieval was 5 weeks (range 2–20). All patients had a previous pancreatic sphincterotomy. Techniques used for successful retrieval were: stent grabbers (n=3), extraction balloon/stent grabbers (n=1), snare/stent grabbers (n=2) and pancreatoscopy with SpyBite® forceps (n=3). Endoscopic removal was unsuccessful in 2/11 patients where pigtail stents had hooked into a side branch. In all cases a 5 cm/3Fr prophylactic PS was placed post retrieval and 8 received rectal diclofenac (one contraindicated). Mild post-ERCP pancreatitis (PEP) occurred in one case.

**Conclusions** Endoscopic removal was attempted in 11 patients and successful in 9 (82%). 7 patients required two procedures. The median interval from stent placement to retrieval was 5 weeks (range 2–20). All patients had a previous pancreatic sphincterotomy. Techniques used for successful retrieval were: stent grabbers (n=3), extraction balloon/stent grabbers (n=1), snare/stent grabbers (n=2) and pancreatoscopy with SpyBite® forceps (n=3). Endoscopic removal was unsuccessful in 2/11 patients where pigtail stents had hooked into a side branch. In all cases a 5 cm/3Fr prophylactic PS was placed post retrieval and 8 received rectal diclofenac (one contraindicated). Mild post-ERCP pancreatitis (PEP) occurred in one case.

**Conclusions** Endoscopic retrieval of proximally migrated PS was successful in 82% of patients. Migrated PS retrieval is challenging, and should only be attempted by endoscopists experienced in pancreatic endotherapy following case review within a specialist MDM. The mechanism of migration is unclear and spontaneous proximal migration of an appropriately placed single pigtail PS is unlikely to occur. Apparent migration in these cases most likely arises from incorrect deployment, potentially due to difficulty distinguishing the stent from the pushing device, emphasising the need for caution during PS placement. The optimal retrieval technique depends upon PS type, position, and PD anatomy. In our experience use of an extraction balloon alone was never successful. Failure of endoscopic retrieval was highest with pigtail stents and those >2 cm from the papilla.