was 3.9% (n=5) in the 2 week wait (2WW) pathway versus 7.5% (n=11) in the routine referral pathway. This may reflect patients being referred on a routine pathway due to reassurance from investigations in the preceding year.

The post endoscopy cancer rate in the oesophagus, stomach and duodenum were 6.5% (n=9), 6.4% (n=6) and 2.3% (n=1) respectively. The highest rate by individual location was 18.2% (n=2) in the upper third of the oesophagus. 40% of post endoscopy cancers showed an alternate diagnosis at initial endoscopy; Gastritis/Oesophagitis (n=4), Hiatus hernia (n=2), Schatzki ring (n=1).

This group also showed a higher TNM staging compared to the background population; pT 3.30 vs. 2.85 (p=0.16, z = 1.41), pN 2.00 vs. 1.12 (p=0.17, z = 2.37), although this did not reach statistical significance.

**Conclusion** We have a low rate of delay in diagnosis of our UGI cancers, but it is associated with a higher TNM stage which could impact patient prognosis. A large number of cancers were missed on endoscopy, in particular in the upper third of the oesophagus. Endoscopists should take care to obtain clear views on extubation. A large proportion of patients re-present within one year of endoscopy, so clinicians should re-investigate if there are persistent symptoms.

**PTH-026 ROBOSCOPE – 2 CENTRE INITIAL EXPERIENCE**

1Stephen Hearing*, 2Jonathan Fletcher, 3Royal Derby Hospital, Derby, UK; 4Borders General Hospital, Melrose, UK

10.1136/gutjnl-2019-BSGAbstracts.51

**Introduction** Robotic colonoscopy was introduced to UK in 2015. It has previously been used in other European centres. Robotic colonoscopy is an automatic self-propelled, user guided, single use colonoscope which has been developed to enable successful caecal intubation, with reduced discomfort (painless colonoscopy).

**Methods** The technique has been piloted in a number of UK centres, results are presented for initial use in 2 centres.

**Results** Royal Derby Hospital

10 procedures undertaken: 1 was abandoned because of technical problems with the equipment. Of the 9 procedures undertaken, 4 were successful to the caecum, 5 were unsuccessful (3 to hepatic flexure, 2 to sigmoid). Of the 5 that were unsuccessful, all were changed to traditional colonoscopy and successful colonoscopy to the caecum was performed.

Borders General Hospital

17 procedures undertaken: 9 were successful to the caecum, 8 were unsuccessful (4 to hepatic flexure, 4 to sigmoid). Of the 8 that were unsuccessful, all were changed to traditional colonoscopy and successful colonoscopy to the caecum was performed.

**Combined data**

Caecal Intubation rate 48%
Mean Procedure time 74 minutes (23 patients)
Analgesia requirements – 26 patients required opiate and midazolam, 1 patient Entonox only

**Conclusions** In the 2 centres trialling the Robotic colonoscopy, the technique is associated with low caecal intubation rate, long procedure times and analgesia requirements equivalent to traditional colonoscopy. Both units no longer carry out this procedure.

**PTH-027 IMPACT OF CHANGES IN GUIDANCE ON VARICEAL PROPHYLAXIS ON RATE OF VARICEAL HEMORRHAGE IN GLOUCESTERSHIRE**

Melanie Cuffe*, Phoebe Hodges, Victoria Goodall, Coral Hollywood, Gloucestershire Hospitals NHS Foundation Trust, Cheltenham/Gloucester, UK

10.1136/gutjnl-2019-BSGAbstracts.52

**Introduction** Oesophageal varices develop as a consequence of portal hypertension in patients with cirrhosis and account for around 10% of admissions with acute GI bleeding in the UK with a significant in-hospital mortality rate of 15%. In 2015–2016 the BSG and NICE published new guidance recommending endoscopic varical band ligation for primary prevention of bleeding. A subsequent change in local policy sees patients with grade 2 or 3 varices identified during elective upper GI (UGI) endoscopy offered endoscopic varical band ligation routinely. We aimed was to assess the impact of this policy change on the rate of varical haemorrhages.

**Methods** Electronic endoscopy records at Gloucestershire Hospitals NHS Foundation Trust were interrogated to identify procedures performed for variceal surveillance (VS) or UGI bleeding and where the diagnosis was variceal bleeding over two periods: Jan-May 2015 and Oct 2017 to Mar 2018.

**Results** Of the 92 VS procedures performed in the first period, 53 had varices, of which 9 (17%) underwent prophylactic banding.

Of the 246 VS procedures performed in the second period, 166 had varices, of which 52 (31.3%) underwent prophylactic banding.

The proportionate number of variceal bleeds in the first and second period was 8.8% (n=10) and 6% (n=17) respectively.

**Conclusions** The increase in prophylactic banding since the policy change appears to have reduced the proportionate number of variceal bleeds by 2.6%. This is seen alongside a significantly increased number of patients attending for VS, for unclear reasons. This could simply reflect the increasing burden of chronic liver disease. However, given the short interval period it could reflect an improvement in identifying patients suitable for varical screening.

**REFERENCES**


3. Cirrhosis in over 16s: assessment and management. NICE [NG50].


**PTH-028 HIGHER-QUALITY COLON CLEANSING IMPROVES LESION DETECTION DURING COLONOSCOPY: A QUANTITATIVE ANALYSIS OF PHASE 3 TRIALS**

1Andrew Holgate*, 1Soniya Mokashi, 2Jonathan Manning, 3Norgine Pharmaceuticals Ltd, Udornidge, UK; 4Borders General Hospital, Melrose, UK

10.1136/gutjnl-2019-BSGAbstracts.53

**Introduction** Colon cleansing is important for reliable lesion detection during colonoscopy, however the quantitative benefits of improved cleansing quality remain poorly understood. This post hoc analysis of three similarly designed phase 3
randomised clinical trials assessed the treatment-independent trends for overall colon cleansing quality versus overall colon lesion detection.

**Methods** Three multi-centre phase 3 clinical trials compared the cleansing efficacy and safety of the 1L PEG NER1006 (PLENVU®) versus standard bowel preparations in patients aged 18–85 years. Treatment-blinded assessment of colon cleansing quality was performed by both site colonoscopists (SC; who also detected all lesions per local practice) and by central readers (CR). Two validated cleansing scales were used: the Harefield Cleansing Scale (HCS) and the Boston Bowel Preparation Scale (BBPS; only by CR). Patients with documented HCS cleansing grades D–A, overall BBPS scores 0–9, and overall colon lesion counts were included in this analysis. Logistic regression trends were fitted to polyp- (PDR) and adenoma (ADR) detection rates, using cleansing quality as a covariate.

**Results** Out of 1,985 randomised patients, 1,749 patients were included (table 1). With site colonoscopists’ HCS grades, the logistic regression for relative lesion detection demonstrated an odds ratio of 1.17, i.e. for each incremental increase in the HCS colon cleansing grade from D to A there was a 1.17 times increase in both PDR ($P=0.009$) and ADR ($P=0.019$). With central readers, the corresponding increase was 1.24 times for PDR ($P=0.005$) and 1.26 times for ADR ($P=0.006$). With central readers, each incremental increase in the successful BBPS scores 6–9 resulted in a 1.08 times increase in PDR ($P<0.001$) and 1.10 times increase in ADR ($P<0.001$) versus failing BBPS scores 0–5.

**Conclusions** Adopting a better bowel preparation remains a good way to improve quality in colonoscopy. With both HCS and BBPS, an increased overall colon cleansing quality was associated with greater overall colon PDR and ADR across the full range from cleansing failures and up to high-quality cleansing.

**Abstract PTH-028**

<table>
<thead>
<tr>
<th>overall colon cleansing quality</th>
<th>Relative lesion detection</th>
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<tr>
<td>HCS Grade D–A assessed by site colonoscopists</td>
<td>HCS Grade D–A assessed by central readers</td>
<td>Overall BBPS Score 0–9 assessed by central readers</td>
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<tr>
<td>Relative lesion detection, odds ratio (95% CI); P-value</td>
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<td>1.24 (1.07–1.43);</td>
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<td>PDR</td>
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<tr>
<td>ADR</td>
<td>1.10 (1.05–1.15);</td>
<td>0.006</td>
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**Conclusion** CLOSURE OF GASTROCUTANEOUS FISTULAS WITH AN OVER-THE-SCOPE-CLIP (OTSC) – A LARGE TERTIARY HOSPITAL EXPERIENCE

Thomas Hollingworth*, Philip Boger, Emily Clarke, Praful Patel, Charlotte Rutter, Trevor Smith, Imadur Rahman. University Hospital Southampton, Southampton, UK

10.1136/gutjnl-2019-BSGAbstracts.54

**Introduction** Peptic ulcers are the commonest cause of upper Gastrointestinal bleeding (UGIB). Hemospray (Cook Medical, North Carolina, USA) is a novel haemostatic powder aimed to treat UGIB. The aim of this study is to look at outcomes in patients with peptic ulcer GI bleeds treated with hemospray in 13 centres.

**Methods** Data was prospectively collected on hemospray use in UGIBs in the UK, France and Germany (Jan’16-Sept’18). Hemospray was used for peptic ulcer UGIBs as a

**Abstract PTH-029**

| CLOSURE OF GASTROCUTANEOUS FISTULAS WITH AN OUTCOME OF HEMOSPRAY USE IN PEPTIC ULCER UPPER GASTROINTESTINAL BLEEDS: OUTCOMES FROM THE HEMOSPRAY REGISTRY |
|---------------------------------|---------------------------|------------------------------------------------------|
| Thomas Hollingworth*, Philip Boger, Emily Clarke, Praful Patel, Charlotte Rutter, Trevor Smith, Imadur Rahman. University Hospital Southampton, Southampton, UK |

10.1136/gutjnl-2019-BSGAbstracts.55

**PAPER** OUTCOMES OF HEMOSPRAY USE IN PEPTIC ULCER UPPER GASTROINTESTINAL BLEEDS: OUTCOMES FROM THE HEMOSPRAY REGISTRY

1Mohamed Hussein*, 2Durayd Alzuubadi, 3Miguel Fraile, 4Jacob Ortiz Fernandez-sordo, 5Krish Ragunath, 6Radu Rusu, 7John Dunn, 8Johannes Rey, 9Shradha Gulati, 10Huussain Hayee, 11Selena Dixon, 12Duncan Napier, 13John Anderson, 14Alberto Munita, 15Sina Jamei- oskoei, 16Edward Despott, 17Cora Steinheber, 18Martin Goetz, 19Sharmila Subramaniam, 20Pradeep Bhandari, 21Laurence Lovat, 22Emmanuel Coron, 23Ralf Kelsch, 24Rehan Haidy, 25UCLH, UK, 26UCL, UK, 27Nottingham Digestive Diseases Centre, UK, 28Guys and St Thomas Hospitals, UK, 29Kings college Hospital, UK, 30Bradford Teaching Hospital NHS Trust, UK, 31Gloucestershire Hospitals NHS Foundation Trust, UK, 32University Hospital of Nantes, France, 33University Hospital Southampton, UK, 34Belfast NHS Trust, UK, 35Royal Free Hospital, UK, 36Tubingen University Hospital, UK, 37University of Portsmouth, UK, 38Horst Schmidt Klinkenber, Germany

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