repeat endoscopic and/or radiological investigations and any supplementary small bowel investigations.

Results 693 patients with IDA were included from January 2016 to September 2017. 86 patients had recurrent IDA. Of those with recurrent IDA, a cause was found in 20 patients (23%), including 4 malignancies (4.6% of all recurrent IDA), 3 cases of Crohn's disease, along with vascular lesions and Upper GI ulceration. For all patients with recurrent IDA and those in whom a cause was identified mean age was 67.6 years and 59.9 years respectively; the mean interval between presentations was 5.5 years (range: 1.1–15.1) and 5.7 years (range: 1.8–13) respectively (NS). There was no significant difference between the haemoglobin levels of patients with a cause found (97 g/L) compared patient where no cause was found (99.1 g/L). In those with recurrent IDA 11/86 (12.8%) of patients had causative pathology identified on repeat routine upper and lower GI investigation, 9/86 (10.5%) had a cause identified following small bowel investigation. The yield of small bowel investigation was 30% in recurrent IDA.

Conclusions A significant proportion of patients have GI pathology on re-investigation of recurrent IDA, including malignancy in 4.6%. We suggest recurrent IDA is re-investigated with bi-directional endoscopy initially, with consideration of small bowel investigation.

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PTH-033 FCSEMS FOR LIVER TRANSPLANT BILIARY STRICTURES ARE ASSOCIATED WITH A HIGH RISK OF POST-ERCP PANCREATITIS

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Introduction Benign biliary strictures are a common complication of liver transplantation, mainly as a result of constriction at the site of biliary anastomosis or ischaemic cholangiopathy. Placement of fully covered self-expanding metal stents (FCSEMS) by ERCP has been shown to be an effective treatment for benign and malignant biliary strictures and offers advantages over plastic stents of greater patency rates and the potential for stricture remodeling. The aim of this study was to assess the incidence of post-ERCP pancreatitis following placement of FCSEMS for benign biliary strictures after liver transplantation in a high-volume centre.

Methods Retrospective analysis of prospectively maintained local databases was performed. Endoscopy reports were reviewed for every ERCP (any indication) performed for liver transplant recipients between 1st January 2014 and 1st January 2018. Patient outcomes were gathered from electronic patient records. Severity of pancreatitis was graded according to the Revised Atlanta Classification. Statistical comparison of two groups was performed with Fisher's exact test.

Results Over a four-year period, 36 out of 393 consecutive liver transplant recipients underwent ERCP for treatment of benign biliary strictures. A total of 97 ERCPs were performed for this patient group (mean 2.7 per patient, range 1–13). Placement of temporary fully covered self-expanding metal

stents successfully achieved long-term stricture resolution in 92% of patients (22/24). However, ERCP involving placement of a first FCSEMS was associated with a considerably higher rate of post-ERCP pancreatitis than any other ERCP performed in this study population (34.5% vs 2.8%, $P < 0.0001$); 89% (8/9) of episodes of pancreatitis were classified as mild, 11% (1/9) as severe.

Conclusions In the experience of a single high-volume centre, placement of FCSEMS by ERCP is an effective treatment for the management of benign biliary strictures, but one that is associated with a particularly high risk of pancreatitis. Patients should give informed consent accordingly. Further research into the mechanisms behind this effect (e.g. sudden occlusion of a normal pancreatic duct) and the effectiveness of additional specific prophylactic measures is underway.

PTH-034 ENDOSCOPIC APOLLO OVERSTITCH SYSTEM IN MANAGEMENT OF ESOPHAGEAL LEAKS; THE FIRST REPORTED UK CASE SERIES

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Introduction Esophageal leaks, either after anastomosis following esophagectomy in malignancy or after esophageal perforation (Boerhaave syndrome), have a mortality rate of 35% which can rise to 100% if not diagnosed early. Traditional management involves adequate resuscitation, broad spectrum antibiotics, parenteral nutrition, percutaneous drainage and timely surgical intervention. The Apollo Overstitch is a minimally invasive endoscopic suturing device which can be mounted over a twin-channel gastroscope and allows full thickness suturing without the need for surgery. It is utilised in bariatric endoscopy but is also very effective in closing perforations and fistulas as well stent fixation to reduce the risk of stent migration. Here we describe the first case series in the United Kingdom of management of esophageal leaks by the Apollo OverStitch device.

Methods Of the 3 cases of esophageal leaks, one case was from an anastomosis after esophagectomy in malignancy and the other 2 were esophageal perforation (Boerhaave syndrome). In addition to the clinical diagnosis of a critically ill patient, esophageal leaks and perforation were diagnosed by contrast enhanced CT scan. Initial management was conservative (antibiotics, antifungals and TPN) due to high respiratory requirements. Gastroscopy under screening was undertaken to identify the leak position. Biological glue was used to close the leak in one case. In another the perforation was sutured using the Apollo device. In all 3 cases a Taewong Beta stent was inserted across the leak/perforation which was then fixed proximally with placement of further sutures to successfully prevent stent migration.

Results Patient recovery was uneventful in all 3 cases, with early introduction of oral intake. In an average of eight weeks post-operatively, patients underwent a repeat gastroscopy and stent removal. Direct visualisation and intra-procedure contrast testing demonstrated an intact oesophagus with no further leak and this was confirmed by contrast enhanced CT. We have also just successfully treated a fourth patient with stent insertion and fixation.