developed for gastroenterology and surgical trainees and consists of a series of one day training events spread over several months to supplement departmental colonoscopy training and uses a variety of classroom based and simulation training. To facilitate the teaching of NTS we developed a video of a simulated case to form the basis of discussion.

Methods A video was made of a simulated case that could be used to highlight NTS. As the attached video demonstrates the video highlighted a case where the use of non-technical skills could be optimised. This was used as a starting point for discussion with delegates.

Pre and post course confidence ratings were collected on a variety of areas including human factors, mean ratings were calculated and mann-whitney U test applied.

Results Eight candidates completed the course, four surgical and four gastroenterology trainees. Six had already the JAG basic skills course. Confidence rating in human factors improved from a mean of 5.9 (out of 10) to 8.12 (p 0.03)

Conclusions Emphasis on non-technical skills training is imperative to improve and ensure patient safety and minimise adverse events. The teaching of non-technical skills may not always be explicit within working departments. Whilst simulation can be a useful teaching tool for NTS it can be time consuming. This video demonstrates a resource-low method by which this could be taught as part of a wider endoscopy course. Whilst we only measured self-ratings rather than assessing performance trainees confidence rating in human factors significantly improved suggesting this is a useful teaching tool.

**PTH-071** COMBINED ENDOSCOPIC CLOSURE OF COLOVESICAL FISTULA

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**Introduction** Colovesical fistulas (CVFs) occur as a complication of diverticulitis, cancer, or Crohn’s disease. The sigmoid colon is the most frequently involved segment. The most common presenting symptoms are pneumaturia and dysuria, followed by faecaluria, abdominal pain and, rarely, haematuria. The diagnosis is usually made clinically but can be confirmed by cystoscopy, sigmoidoscopy, barium enema, CT scan, MRI, or virtual colonoscopy. The usual management for symptomatic patients is colonic resection (which can be performed laparoscopically) but this approach is associated with morbidity and mortality. Only a few cases of endoscopic management by clip closure, using through-the-scope (TTS) or over-the-scope (OTS) clips have been described in the literature. Here, we present a case of a CVF, which was managed with multiple TTS clips, thus avoiding surgical intervention.

**Methods** A frail 84 year old man had a background history of coronary artery bypass graft, aortic valve replacement (tissue valve), dialysis dependent chronic renal failure and sigmoid diverticular disease. He was investigated for pneumaturia and recurrent urinary tract infections 12 months ago and was diagnosed on CT scan as having CVF secondary to sigmoid diverticular disease. He developed faecaluria. He was referred by the colorectal surgeon for endotherapy as he was considered too frail for any surgical intervention. A combined simultaneous cystoscopy and flexible sigmoidoscopy (using a gastroscope) was undertaken under conscious sedation. The cystoscopy identified a fistula in the dome of the bladder (on left side). The sigmoid colon was carefully examined and revealed diverticular disease but no obvious fistula was visible. Hence, indigocarmine solution (16 mg/litre), warmed to body temperature, was instilled into the bladder via the cystoscope and the blue solution was eventually seen to emerge in the sigmoid colon through the fistula. This site was marked with a Resolution 360 clip (Boston Scientific). After this, 4 further clips were placed onto the fistula in order to close it. Finally, the site was marked with a tattoo, in case a repeat procedure was needed in the future.

**Conclusion** DBE facilitated endotherapy is a precise, safe and minimally invasive approach to the effective management of severe bleeding caused by small bowel diverticula.
Conclusion Although there are many surgical options available for management of CVF, only a few case reports exist regarding non-surgical management of CVF. We recommend that combined endoscopic management of CVF should be considered in patients who are too frail for surgery or have multiple co-morbidities.

**PTH-072** ENDOSCOPIC MANAGEMENT OF PHYTOBEZOAR IN PATIENT WITH PRADER-WILLI SYNDROME

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Introduction Prader-Willi syndrome (PWS) was first described in 1956 and is now recognised as a multisystemic complex genetic disorder caused by lack of expression of genes on the paternally inherited chromosome 15. Clinical features include hyperphagia, obesity and diabetes. A phyto-bezoar is a type of bezoar, or trapped mass in the gastrointestinal tract, that consists of indigestible plant material. We report a case of phyto-bezoar due to hyperphagia in a patient with PWS, which was successfully treated endoscopically.

Methods A 22 year old man with PWS was admitted with a one day history of severe abdominal pain associated with distention and nausea but no vomiting. He was opening his bowels and passing wind. He had a history of anxiety and had spinal surgery for scoliosis at age 10 years. He was a vegetarian and had been living in a residential home for three years where his meals were regulated. On examination, he was not obese (BMI 20 kg/m^2) and had a distended, tender abdomen. Routine blood tests (FBC, U+E) were normal. Initial abdominal x-ray showed a very distended stomach containing food material. An abdominal CT scan confirmed these findings and worryingly the report mentioned ‘imminent danger of perforation.’ The surgeons reviewed the patient and referred him for possible endotherapy prior to considering surgery. Hence, a gastroscopy was performed under conscious sedation using a twin channel gastroscope (Olympus GIF 2T200). A large phyto-bezoar was seen in the stomach. There was no gastric necrosis or pyloric obstruction and the duodenum was normal. The phyto-bezoar was softened with water and fragmented into smaller pieces with a 3 cm Trapezoid basket (Boston Scientific). The smaller pieces of the phyto-bezoar were sucked out slowly using the large channel gastroscope. Eventually the entire phyto-bezoar was removed in this manner; the whole procedure taking 90 minutes.

Results Eventually the entire phyto-bezoar was removed in this manner; the whole procedure taking 90 minutes.

Conclusion Gastric bezoars can cause outlet obstruction, ulceration, and subsequent bleeding, whereas small intestinal bezoars present with small bowel obstruction and ileus. The currently available treatment options for a gastric phyto-bezoar include dissolution of the bezoar by Coca-Cola®, removal by endoscopic devices, laparotomy, and laparoscopic surgery. Gastric rupture and necrosis are a known cause of mortality in patients with PWS. Hence, timely endoscopic management can help avoid these complications and the need for surgery.