Abstract PTU-111 Figure 1

duration of the break and the difference in PICI (Pearson coefficient -0.014, $P=0.788$).

Conclusions A break in practice of ≥ 2 wks appears to result in a small but statistically significant decrement in colonoscopy completion metrics as measured by PICI and CIR.

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PTU-112 RISK FACTORS FOR EROSIVE TOOTH WEAR IN PATIENTS WITH GORD: A PROSPECTIVE CROSS-SECTIONAL CASE CONTROL STUDY

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Introduction Some patients with GORD develop ETW referred to as GE(GORD-Erosion group) whereas others don't and these are referred to as GNE(GORD-no-erosion group). The latest gold standard reflux monitoring is impedance-pH monitoring to identify the type of reflux and correlate the symptoms to each type of reflux. Basic Erosive Tooth Wear Examination (BEWE) is a scoring system to classify the affected tooth surfaces. This study used these two techniques which have not been used previously aiming to assess the risk factors and predictive values associated with presence of ETW in patients with GORD.

Methods Patients referred for assessment of GORD to the Oesophageal Laboratory at Guy's Hospital were recruited (REC Ref 18/NE/0099). Participants were consented and given a validated Reflux Symptom Questionnaire 7-day recall (RESQ) to assess the frequency and intensity of GORD symptoms. Data reported from the impedance results were: total acid exposure, acid exposure in upright position and acid exposure in supine position. A clinical assessment of ETW was done using BEWE; a validated index dividing the mouth into 6 areas and each is scored from 0 to 3 (0=no ETW, 1=initial loss of surface texture, 2=loss of hard tissue <50% of

surface area and 3=loss of hard tissue $\geq 50\%$ of surface area). Those with a cumulative score of ≥ 12 and at least 1 oral area scoring 3 were included in the GE-group opposed to those scoring <12 were included in the GNE-group.

Data were not normally distributed and hence median (IQR), Kruskal-Wallis and ROC curve were applied, ($P<0.05$) considered significant.

Results RESQ-7: 151 GORD patients recruited: GE(n=76), GNE(n=75). Median(IQR) frequency and intensity of GORD for hoarseness, cough and difficulty swallowing were significantly different between groups: frequency[GNE:7(2,11.5) and GE:12.5(2,17.5); $P=0.007$], intensity[GNE:4(2,7) and GE:6.6(3,10); $P=0.006$]. ROC curve for the total frequency and intensity illustrates that patients with total frequency an intensity of ≥ 26 and ≥ 37 most probably will have ETW, respectively.

Impedance-pH-monitoring patients reported: heartburn, chest-pain, regurgitation, cough, hoarseness, acid taste in the mouth, throat acid, belching and epigastric pain, with no statistical significance between the GE and GNE groups. Total acid exposure and acid exposure in upright position were highly significant when comparing GE(n=53) and GNE(n=56) ($P=0.0007$).

Conclusion The risk of developing ETW is frequency score of 26 and above using the RESQ-7 and intensity score of 37 and above. Hoarseness, coughing and difficulty in swallowing were the significant risk factors for presence of ETW in patients with GORD. These atypical symptoms of GORD may indicate the presence of acid higher up in the oesophagus and therefore more likelihood of acid reaching the mouth.

PTU-113 HOW COMMONLY IS PANCREATIC CANCER DIAGNOSED FOLLOWING AN ENDOSCOPIC ULTRASOUND THAT DID NOT DIAGNOSE CANCER?

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Endoscopic Ultrasound (EUS) with tissue sampling has an established role in the diagnosis of pancreaticobiliary (PB) disease. Malignancy occurring following colonoscopy or gastroscopy that does not diagnose cancer is a recognised phenomenon and has been extensively investigated. There is little data on pancreatic cancer (PC) occurring following an EUS without evidence of cancer. We have studied the frequency, time course and potential risk factors for post EUS PC.

Methods PB EUS in England between Jan 2007 – Dec 2016 were identified in Hospital Episodes Statistics. Subjects with a diagnosis of PC made between 6 and 18 months after index PB-EUS were cases of post EUS PC. A logistic regression model examined risk factors for post EUS PC.

Results 79,490 PB EUS procedures were performed in 69,120 subjects, with 8,859 diagnosed with PC within 6 months of index EUS. 563 (0.9%) subjects had post EUS PC (71% 6 to 12 months and 29% 12 to 18 months post EUS): median age was 70 (IQR 61–71) years and 57% were male. The following factors were associated with post EUS PC: chronic pancreatitis (odds ratio 3.11(95%CI 2.24–4.31), $p<0.001$); Charlson comorbidity score >5 (1.44 (1.04–1.98), $p=0.028$); and increasing age (1.01(1.00–1.02), $p=0.005$) Ethnicity, gender and EUS volume were not associated with post EUS PC (table 1). Post EUS PC rates varied in individual providers from: 1.0% in providers undertaking 8 to 111 PB EUS over the study period to 1.1% in providers undertaking 112 to 782 PB EUS and 0.7% in providers undertaking >782 PB EUS.

Conclusions 0.9% of subjects undergoing a PB EUS that did not diagnose PC were diagnosed with PC between 6 and 18

months later. Post EUS PC was associated with chronic pancreatitis, co-morbidity and increasing age.

PTU-114 LEARNING FROM ADVERSE EVENTS: A STUDY OF JAG ENDOSCOPY UNITS

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Introduction To meet JAG accreditation standards, endoscopy services are expected to have processes to identify, respond to and learn from adverse events (AEs). Units provide evidence to demonstrate they have met the set standard through audits of mortality and readmission after endoscopy. We conducted the first analysis of UK-wide learning outcomes from AEs based on mortality and readmission data. The aims were to understand how evidence is collected, describe relevant learning outcomes and resultant actions and processes used to share learning.

Methods A retrospective analysis of JAG 30-day mortality and 8-day readmission evidence from 2013–2018 was undertaken, assessing methods of data collection and documentation of learning outcomes. Data from evidence files were extracted and thematically analysed to identify and categorise learning outcomes and action points. This study was approved by the JAG research committee.

Results Complete data was available for 59 units. 42 units (71%) used the JAG audit proforma in providing evidence. Where no JAG proforma was utilised, data was sourced from other audit summaries (14%), PowerPoint slides (8%) or other tabulated data (7%). 35 units (59%) documented learning outcomes following readmission or mortality, with 85% stating that outcomes were discussed in a formalised meeting.

Learning outcomes and action points are summarised below:

Abstract PTU-113 Table 1 Multiple Logistic Regression of factors associated with post EUS PC

	Odds Ratio	P value	Lower 95% CI	Upper 95% CI
Age				
Increasing years	1.01	0.005	1.00	1.02
Sex	<i>Baseline male</i>			
Female	0.84	0.063	0.70	1.01
Deprivation Quintile	<i>Baseline 1</i>			
2	0.88	0.409	0.66	1.18
3	0.74	0.047	0.55	1.00
4	0.82	0.175	0.62	1.09
5	0.79	0.112	0.59	1.06
Unknown	1.00			
Ethnicity	<i>Baseline White</i>			
Asian	1.13	0.688	0.62	2.05
Black	1.29	0.472	0.65	2.58
Mixed	0.56	0.564	0.08	4.08
Other	2.13	0.004	1.27	3.57
Unknown	15.01	0.000	11.78	19.14
Charlson score	<i>Baseline 0</i>			
1–5	1.15	0.235	0.91	1.46
> 5	1.44	0.028	1.04	1.98
Chronic pancreatitis at index EUS	<i>Baseline No</i>			
Yes	3.11	0.000	2.24	4.32
Centre volume tertile	<i>Baseline > 782 (Highest volume)</i>			
< 8	4.54	0.171	0.52	39.56
8–111	3.15	0.268	0.41	24.02
112–782	2.70	0.337	0.36	20.42

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Learning Outcomes	Action Points
High-risk patients	Systems
1. Increasing numbers	• Updating referral pathways
• Case selection	• Updating vetting pathways
• Clear communication	• Review of bowel preparation protocols
• Clear documentation	• Updating patient information leaflets
• Careful planning Pre-assessment	• Post-procedure safety-netting
• Screening renal function	Training
• Screening patients with renal impairment	• Guidance updates
• Clear instruction for bleeding risks Endoscopist factors	• Upskilling
• Decision-making	• Nurse education Improving AE
- Therapy	Data
- Procedure cessation	• Real time data analysis
• Knowledge	• Increasing audit frequency
• Skills	Shared Learning & Feedback
	• Face-to-face feedback
	• Email feedback
	• Promoting reflective practice
	• Unit meetings