Conclusions Learning outcomes centre around managing high-risk patients, pre-assessment and endoscopist factors. Developing systems and training are actions in direct response to learning outcomes. Refining data collection methods was identified as a way to improve learning from AEs. There were a variety of methods to disseminate learning and feedback to endoscopists but no discernible mechanisms to share learning between units were identified. There needs to be a more robust way of collecting and collating endoscopy AE data, with a focus on shared learning between services.

PTU-115 TIMING OF ENDOSCOPY AND 30 DAY MORTALITY IN PATIENTS ADMITTED WITH VARICEAL HAEMORRHAGE

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Introduction Variceal haemorrhage carries a high mortality and current UK guidelines recommend endoscopy within 24 hours of admission but this is based on low level of evidence.^{1,2,3} The aim of this evaluation is to assess the association between timing of endoscopy with 30 day mortality in patients admitted with upper gastrointestinal variceal haemorrhage (UGVH). **Methods** A total of 77 cases were retrospectively identified with a diagnosis of UGVH from the 1st of January 2017 to the 31st of December 2017 across three hospital sites in one UK NHS trust. 53 cases were analysed. Patients who did not present with acute UGVH on admission were excluded. Timing of endoscopy was defined as acute (0–12 hours), early (12–24 hours), delayed (>24hours) and calculated from time of admission to time of completion of endoscopy. Outcome measured was 30 day mortality. Fisher's exact test was used for statistical analysis ($p < 0.05$ defined as statistically significant).

Results The mean age of this cohort was 60.5 years old with 62.3% ($n=33$) male and 37.7% ($n=20$) female. Mean and median shock index (SI) at time of presentation were 0.81 and 0.8 (IQR 0.6–0.9) respectively. 73.6% ($n=39$) had procedures performed within 24 hours. 34% ($n=18$) had acute endoscopy, 39.6% ($n=21$) had early endoscopy and 26.4% ($n=14$) had delayed endoscopy. The mean SI for those who had acute endoscopy was highest (0.89) compared to the early (0.78) and delayed endoscopy (0.76) group with mean UKELD scores of 51.6, 52 and 52.5 respectively. Overall 30 day mortality was 15.1% ($n=8$). Mortality rates between each group were as follows: 1) Acute endoscopy- 5.6% ($n=1$), 2) Early endoscopy- 19% ($n=4$), 3) Delayed endoscopy- 21.4% ($n=3$). Statistical analysis showed no association between the different groups and 30 day mortality (acute vs early $p=0.3849$, acute vs delay $p=0.3377$).

Conclusion Mortality rate was lowest in the acute endoscopy group although statistical analysis suggested no significant association between timing of endoscopy and 30 day mortality. One may argue potential benefits of acute endoscopy based on the higher mean SI indicating greater mortality risk but a bigger, prospective multi-centre study is required to show the optimal timing and impact that timing of endoscopy may have on mortality for this cohort.

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PTU-116 DELAYED POST SPHINCTEROTOMY BLEEDING AND MANAGEMENT – 4 YEAR SINGLE CENTRE EXPERIENCE

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Introduction Bleeding from endoscopic sphincterotomy (ES) is an important complication of therapeutic ERCP. The frequency of post sphincterotomy bleeding is estimated at 0.3% to 2%. Delayed bleeding can occur anytime from hours up to two weeks after ES. Although several studies have addressed the risk factors for bleeding after ES, there is less information specifically on delayed bleeding.

Aims This study examines factors that influence delayed post ES related bleeding, and reviews its management and outcomes.

Methods We reviewed the records of patients who underwent an OGD within 4 weeks of having an ERCP procedure performed by a gastroenterologist between 2015 to 2018 at the Royal Gwent and Nevill Hall hospitals.

Results Over a 4 year period, 39 patients had an OGD within 4 weeks after an ERCP procedure. Of these, 17 had experienced delayed post ES bleeding at a median of 6 days (range 1–10). The frequency of delayed post ES bleeding in our centre was 1.8%. Most were male 12/17 (70%) and the mean age was 74 years (range 45–97). Patients presented with melaena (41%), hematemesis (24%), haematochezia (6%) or melaena with hematemesis (30%). Out of the 17 patients, three were on aspirin, two were on clopidogrel and three were on warfarin. One had thrombocytopenia and three had a prothrombin time more than 13 seconds. Two had chronic kidney disease and ischaemic heart disease of which one patient was on regular dialysis. Indications for ES were choledocholithiasis (76%), cholangitis (12%) and malignancy (12%). Endotherapy was applied with the following modalities, singly or in combination: adrenaline injection (2 patients), adrenaline injection and heater probe (1 patient), adrenaline injection and hemospray (4 patients), endoscopic clips (1 patient), adrenaline injection and clips (2 patients) and hemospray alone (1 patient). No endotherapy was offered in 6 patients and were managed conservatively. One re-bled in 24 hours and responded to repeat endotherapy with adrenaline injection and hemospray. Four failed endotherapy and needed angiographic embolization. There were no deaths.

Conclusion This study emphasizes that factors such as thrombocytopenia, antiplatelet drugs, anticoagulants and cholangitis confer an increased risk of delayed post sphincterotomy bleeding. Patients who undergo ERCP with sphincterotomy should be warned about the 1.8% risk of delayed bleeding. Current guidelines suggest that ES can be done safely in patients on

Aspirin. We recommend larger studies to interrogate the safety of continuing Aspirin in such patients.

PTU-117 SPLIT DOSE BOWEL PREPARATION: ASSESSING PATIENTS' WILLINGNESS TO WAKE UP EARLY

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Introduction Split dose preparation has been shown to optimise mucosal cleansing, enhance endoscopic views, and improve pathology detection. Split dosing for morning appointments necessitates waking early to take the second dose at an appropriate time. Many units therefore advise that all the preparation is taken the day before the procedure. Our aim was to assess whether patients would be willing to wake-up early to facilitate split dose preparation.

Methods Consecutive patients attending for bowel cancer screening and symptomatic colonoscopy were invited to complete a standardised questionnaire. The results were collated, and logistic regressions were performed in both groups.

Results 418 patients were asked to complete the questionnaire (119 screening and 299 symptomatic); 8 questionnaires were incomplete (6 screening and 2 symptomatic) and were excluded. The M:F ratio was 1.64:1 and 1.03:1; and ages ranged from 55–74 (mean 64.5) and 17–81 (mean 51.5), in the screening and symptomatic groups respectively. Overall, 89% of screening and 85% of symptomatic patients reported they would be willing to wake up early to take split-dose preparation for morning appointments. 78% of screening and 61% of symptomatic patients would be willing to wake between 4–6 am, to facilitate split dosing for morning scheduled colonoscopies. In the screening patients, 3 factors were found to affect willingness to wake up early: scheduled appointment time, whether they perceived the bowel preparation had a severely unpleasant taste and whether taking the preparation had made them interrupt their journey to the hospital to defaecate.

Conclusions This study indicates that most patients would be willing to wake-up early to take adequately spaced split doses of bowel preparation, irrespective of age, sex, socioeconomic background, indication, or previous colonoscopy. In the screening group, those that felt that the preparation tasted severely unpleasant and those who had to interrupt their journey to hospital to use a toilet, were less likely to be willing to wake early to take bowel preparation. All endoscopy units should be encouraged to invite patients scheduled for morning colonoscopy to wake early to facilitate split dose bowel preparation.

PTU-118 ENDOLUMINAL VACUUM THERAPY FOR THE MANAGEMENT OF BOERHAAVE SYNDROME

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Introduction Boerhaave syndrome is associated with high morbidity and mortality rates. Outcomes are dependent on early recognition and intervention. Until recently, surgery has been

the mainstay of management. However, with recent advances in therapeutic endoscopy, there has been increasing interest in endoscopic options, including endoluminal vacuum therapy (EVT). EVT is a minimally invasive technique, allowing wound debridement and drainage; promoting granulation tissue formation to enable wound healing. EVT has been associated with excellent clinical outcomes, including lower mortality rates when compared to both surgery and oesophageal stenting. EVT has been adopted into practice across Europe for the management of oesophageal perforations. However, in the UK there have only been two cases reported. We report a case of a 66 year old female with Boerhaave syndrome, successfully managed with EVT.

Methods EVT for oesophageal perforation involves the placement of a polyurethane sponge into the wound cavity. The cavity is initially assessed with an endoscope before an overtube is introduced under visual control. The sponge is pushed into the cavity through the overtube. Once the sponge is in place, the overtube is removed; allowing the sponge to unfold. Sponge position is confirmed endoscopically and adjusted if necessary. The sponge is connected via a trans-nasal drain to continuous negative pressure. Sponge exchange is performed every 3–5 days.

Results Having been deemed unfit for surgical intervention, due to difficulties with ventilation and haemodynamic instability, our patient was initially stabilised on the Intensive Care Unit (ICU) with the aid of radiologically placed chest drains and intravenous antibiotics. She was subsequently referred for EVT, using the EsoSPONGE® (B.Braun, Medical Ltd, Sheffield, UK). Her first therapeutic endoscopy took place on Day 10 of admission; revealing a 5 cm defect in the oesophageal wall and an adjacent cavity; major vessels and the chest drains could be visualised endoscopically. The EsoSPONGE was placed into the cavity and connected to suction. She remained on ICU for 3 months and during this period her EsoSPONGE was exchanged 16 times; resulting in resolution of sepsis and healing of the defect. She was successfully stepped down from ICU and has now been discharged.

Conclusions EVT was an effective management strategy for our patient with Boerhaave syndrome. Use of the EsoSPONGE aided drainage of the septic focus and closure of the defect; with this our patient made an excellent recovery. Mortality for this case would otherwise have been extremely high as she was too unstable for surgery. This case supports the evidence that EVT provides a promising approach for the management of Boerhaave syndrome.

PTU-119 ROBOT CONTROLLED MAGNET-ASSISTED CAPSULE GASTROSCOPY IS BETTER TOLERATED AND ACCEPTED BY PATIENTS THAN FLEXIBLE GASTROSCOPY

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Introduction OGD is performed commonly but often poorly tolerated. Capsule endoscopy is well tolerated. Robot controlled magnet assisted capsule endoscopy (MACE) allows control of a capsule endoscope resulting in a non-invasive endoscopic examination of the upper GI tract. No controlled comparisons of patient tolerance and acceptability between MACE and OGD have been performed. Post procedure Endoscopy Concerns Scale (ECS) scores correlate with patient