Methods All IBD patients with endoscopic stent placement between 2011 and 2018 were included. Relevant demographic and clinical data were abstracted from the electronic medical record and presented using descriptive methods.

Results Fifteen patients (mean age 46.7; 59.75% females) including eight with refractory Crohn's disease and seven with IPAA failure were assessed for average of 257 days after index endoscopy. Patients with refractory Crohn's disease presented with stenotic/stricturing disease (n=3, Antroduodenal, duodenal, and ileocolonic anastomosis), fistulizing disease (n=2, colovesicular, biliary-duodenal), leak (n=1, pelvic leak/abscess) or both stenotic as well as fistulizing disease (n=2 ileal, colorectal anastomosis). Patients with IPAA failure presented with pouch strictures (n=2 pre-pouch ileum, at the ileal-pouch anastomosis), leak/fistula (n=2 pre-pouch ileum, tip of the J pouch) or stricture and a fistula (n=3). Four of the IPAA failure were attributed to undiagnosed Crohn's disease.

20% patients were current smokers, 26.6% on steroids, and 46.7% on immunosuppression. 46% patients were rescue cases and had previous surgeries or interventional radiology procedures prior to index endoscopy. Types of stents used: Niti-S (5), Solus double pigtail biliary (1), ureteral double-pigtail stent (2), WallFlex (1), Axios (2), Viabil (5) and ALI-MAXX-ES (1); stent diameter ranged from 3.33–20 mm and length from 10–200 mm. Ten required adjunct therapy in addition to stent: APC (2), hemoclip (1), OVESCO (3), endostitch (3), dilation (3), Glue(1). 100% had immediate clinical success (defined as ability to deploy the stent along with recanalization or no contrast leakage). On final follow up for average of 257 days, 33% patients had a sustained endoscopic response and 20% are currently responding to ongoing endoscopic management while endoscopic intervention served as an effective bridge to successful surgery in 33% patients. 14% patients failed both endoscopic and surgical interventions and are currently palliated with drains. None of the patients during endoscopic follow-up developed acute complications that could be attributed to endoscopic intervention.

Conclusions Minimally invasive endoscopic management of complicated IBD is a safe and alternative management option for otherwise high-risk for adverse outcome patients.

PTH-099 SURGERY FOR RECURRENT DISEASE FOLLOWING RIGHT-HEMICOLECTOMY IN CROHN'S DISEASE: ANALYSIS OF HOSPITAL EPISODE STATISTICS

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10.1136/gutjnl-2019-BSGAbstracts.158

Resectional surgery is common in patients with Crohn's Disease (CD). However, it is not curative and most develop endoscopic recurrence within a year, with the potential to develop stricturing at the anastomotic site. We examined the proportion of Crohn's patients undergoing further surgical intervention following right hemicolectomy at a national level. **Methods** Hospital Episode Statistics were examined to establish a cohort of all CD subjects who had undergone right hemicolectomy between 2007–2013 in England. Subjects were followed up for 4 years and resectional surgery at the same site

was analysed. Multivariable logistic regression assessed factors associated with further surgery at the same site.

Results 7491 adult patients with CD had a right hemicolectomy between 2007–2013. 45.1% were male, median age was 34 (IQR 25–44) and 88.6% were White. Most subjects had no comorbidities based on Charlson score (96.7%). Right hemicolectomies for CD increased year on year across England from 987 in 2007 to 1140 in 2013. 60% of these initial operations were elective. 9% of subjects had further resectional surgery at the same site within the 4 year follow up period. Median time to further surgery was 472 (IQR 263–945) days. 52% of subsequent surgery was performed on subjects whose initial surgery was an emergency. When factors associated with subsequent surgery were analysed, only an initial emergency right hemicolectomy was found to be associated (OR1.78 (95%CI 1.51–2.09) $p<0.001$) (table 1). If initial hemicolectomy was during an emergency admission, there was a 12.1% chance of needing surgery for recurrent disease at the same site.

Conclusions Right hemicolectomy for CD increased in England during the study period. 9% of subjects will have further surgery and an initial emergency surgical procedure was associated with the need for later surgery. Future research will focus on the indication for further surgery and examine intervention requirements over a longer follow up period.

Abstract PTH-099 Table 1 Multivariable logistic regression: factors associated with further surgery after right hemicolectomy for CD

Demographic		OR	Lower 95% CI	Upper 95% CI	P value
Sex	Male	Base			
	Female	0.89	0.76	1.04	0.148
Age	18–24	Base			
	25–30	1.01	0.79	1.29	0.957
	31–38	1.13	0.89	1.44	0.307
	39–47	1.01	0.79	1.30	0.914
	48–60	0.97	0.75	1.25	0.809
Ethnicity	White	Base			
	Asian	1.00	0.61	1.61	0.985
	Other	0.91	0.57	1.46	0.704
Deprivation	1 (Most Deprived)	Base			
	2	0.96	0.76	1.22	0.757
	3	0.98	0.77	1.26	0.891
	4	0.82	0.63	1.07	0.145
	5	0.79	0.60	1.04	0.089
	5 (Least Deprived)	Base			
Index Surgery	Emergency	1.78	1.51	2.09	<0.001
Admission	Elective	Base			
Method					
Charlson	0	Base			
Score	1–4	1.18	0.65	2.11	0.590
	5+	1.49	0.88	2.54	0.139
Index	2007	Base			
Surgery	2008	1.14	0.83	1.56	0.423
	2009	1.23	0.91	1.67	0.179
	2010	1.12	0.82	1.52	0.492
	2011	0.93	0.68	1.28	0.650
	2012	1.26	0.93	1.70	0.131
	2013	0.97	0.71	1.32	0.828