Background Lower gastrointestinal bleeding (LGIB) is a common presenting condition in hospital with an estimated incidence of 33–87/100000. Recent national audit in the United Kingdom has shown that the bleeding stops in the majority of the cases without any intervention. In this retrospective study, we aim to describe patient characteristics and to identify factors that predict clinical outcomes.

Methods Haemodynamically unstable patients with ALGB are admitted to the medical high dependency unit (MHDU) at Aberdeen Royal Infirmary for monitoring. Patients with a primary diagnosis of ALGB between 01/05/2015 to 15/09/2017 were identified from the MHDU database. Patients who presented with haematemesis or had upper gastrointestinal (UGI) bleeding found at esophagogastroduodenoscopy were excluded. Patient’s demographic data, laboratory results, medications, endoscopy and radiology reports were collected. Clinically relevant outcomes of the study included 28-day mortality and red cell transfusion requirement. Multivariable logistic regression analysis was used to identify factors independently associated with outcomes.

Results 130 patients (Median Age 73; male predominance 68%) were included in the study after excluding readmissions (n=8) and UGI bleedings (n=9). 51% had major comorbidity, 37% taking antiplatelets and 25% taking anticoagulants. 60% received blood transfusion and 31% required intervention (endoscopic therapy (n=17), mesenteric embolization(n=18) and surgery (n=5)). 72% had diagnostic endoscopy on admission with the majority being flexible sigmoidoscopy (n=74). Median Length of hospital stay was 6 days, and 12% experienced rebleeding on the same admission. 10 patients died within 28 days of admission. Low Haemoglobin (p=0.027), raised C-reactive protein (CRP) (p=0.047) and no endoscopy performed on admission (p=0.014) were associated with 28-day mortality. Low Haemoglobin (p< 0.0001) was also significantly associated with red cell transfusion requirement.

Conclusions In our study, the majority of patients who were admitted with severe ALGB were elderly with a high burden of comorbidities and frequent antithrombotic use. Nevertheless, antithrombotic medication and co-morbidities were not significantly associated with mortality or red cell transfusion requirement.
of stay. In other ways, for some other reasons, especially in our national government insurance, we could not perform those procedures in tertiary hospital as a routine procedure.

**Methods** In this retrospective study, we would evaluate, the length of stay difference between open conventional and laparoscopy cholecystectomy on calculous cholecystitis patients from January until December 2017. The length of stay after these procedures would be recorded. All patients had the same prophylactic antibiotic (2 gram of Cefazolin iv) and 1 gram Paracetamol iv twice daily. The patients who have been done the conversion to open cholecystectomy would be excluded from this study.

**Results** 94 calculous cholecystitis cases were evaluated in this study during 1 year period. 71 cases have been done open conventional cholecystectomy, 23 cases have been performed laparoscopy cholecystectomy. The mean length of stay on the open arm was 1.7 days, and 1.5 days for laparoscopy cholecystectomy. 3 patients on the open conventional arm had biliary pancreatitis and empyema gall bladder, and that case has a longer length of stay (3 days). There was no post-operative complication recorded.

**Conclusions** There was no length of stay difference between open conventional and laparoscopy cholecystectomy on calculous cholecystitis patients.

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**COMPARISON OF 1L ADJUVANT AUXILIARY PREPARATIONS WITH 2L SOLEY POLYETHYLENE GLYCOL PLUS ASCORBIC ACID REGIME FOR BOWEL CLEANING: A META-ANALYSIS OF RANDOMIZED, CONTROLLED TRIALS**

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**Background** The effectiveness of additional usage of adjuvants for bowel preparation is still unclear. This study compared 1L polyethylene glycol plus ascorbic acid with adjuvant drug regimens (1L-PEG-AA, lower-volume) with 2L polyethylene glycol plus ascorbic acid (2L-PEG-A, low-volume) to evaluate whether the adjuvants can be used to reduce the standard dosage of purgative further.

**Methods** The PubMed/MEDLINE, EMBASE, Cochrane Library and Web of Science database were searched up to March 2020 for randomized controlled trials (RCTs). The primary outcome was the efficacy of bowel preparation, and the secondary outcomes were patients’ tolerability and complication rate. The relative risk (RR) and mean difference (MD) with 95% confidence intervals (CI) were pooled for dichotomous and continuous variables separately. The overall quality of evidence was assessed using the GRADEpro guideline development tool.

**Results** Five RCTs with a total of 1013 patients were included, and the majority of patients were outpatients from different hospitals. The pooled data showed no significant difference in the adequate bowel preparation rate (89.3% versus 89.4%, RR 1, 95%CI 0.95–1.05, I²=47%) (figure 1A) as well as in the complication rate (RR for nausea 1.22, 95%CI 0.89–1.65, I²=49%; RR for bloating 0.96, 95%CI 0.73–1.28, I²=0%; RR for vomiting 0.69, 95%CI 0.32–1.50, I²=33%);

**Conclusions** There was no length of stay difference between open conventional and laparoscopy cholecystectomy on calculous cholecystitis patients.

**Abstract IDDF2020-ABS-0085**

**UNDERWATER VERSUS CONVENTIONAL ENDOSCOPIC MUCOSAL RESECTION FOR SMALL SIZE NON-PEDUNCULATED COLORECTAL POLyps: A RANDOMIZED CONTROLLED TRIAL**

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**Background** Underwater endoscopic mucosal resection (UEMR) is a recently developed technique and is performed during...