bending in 177 cases (see Table 1). PuraStat® was additionally used in 22 radiation proctopathy cases, as sole therapy in 14 and secondary therapy in 8, with improvement in patient self-reported symptom score and haemoglobin. The average volume of PuraStat® used across all indications was 0.43 mls for haemostasis and 2.33 mls for prevention of delayed bleeding. No PuraStat® related complications were reported.

Conclusions Our data shows PuraStat® is safe and effective for a range of indications, with most within high risk resections. It shows high efficacy in both immediate haemostasis and prevention of delayed bleeding. We believe PuraStat® is a promising new agent in the prevention and management of gastro-intestinal bleeding.

### Abstract P9 Table 1 Haemostatic efficacy of PuraStat®

<table>
<thead>
<tr>
<th>Indication</th>
<th>Procedures n=204 (n)</th>
<th>Immediate haemostasis n=100 (n,%)</th>
<th>Prevention of delayed bleeding n=177 (n,%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>High risk resection</td>
<td>198</td>
<td>90/98 (91.8%)</td>
<td>168/177 (97.7%)</td>
</tr>
<tr>
<td>UGB</td>
<td>6</td>
<td>22/100 (100%)</td>
<td>4/4 (100%)</td>
</tr>
<tr>
<td>Overall</td>
<td>204</td>
<td>92/100 (92.0%)</td>
<td>173/177 (97.7%)</td>
</tr>
</tbody>
</table>

### P10 IS PRE-ENDOSCOPY FASTING ADVICE CONSISTENT ACROSS ENDOSCOPY UNITS IN ENGLAND?

T Avades*, A Thausingam. Wirral University Teaching Hospital, Wirral, UK 10.1136/gutjnl-2020-bsgcampus.85

**Introduction** There is a lack of guidance regarding the recommended duration of fasting pre-gastroscopy. Endoscopy guidelines advise a low fibre diet the day before colonoscopy and continuing bowel preparation up to 2 hours pre-procedure. Current practice in England regarding pre-endoscopy fasting advice is unclear.

**Methods** Data on pre-endoscopy fasting advice for fluids and solids were sought from all English endoscopy units by accessing online patient information leaflets (PIL) and direct contact with the units.

**Results** Data were obtained from 137 of 143 (96%) endoscopy units. 54 Trusts (38%) had online PIL. Most instructions used specific timings, but some were vague (e.g. lunch).

**Gastroscopy**
- 89% of Trusts stopped solid food 6 hours prior to gastroscopy.
- 11% advised a longer fasting period, range 8 to >12 hours.
- 58% of Trusts stopped clear fluids 2 hours before.
- 42% advised longer periods, range 3 to 8 hours.

**Colonoscopy**
- Moviprep was used by 85% of Trusts. 17% followed the company’s leaflet instructions with regards to solid foods.
- 77% had longer fasting periods (hourly intervals from 7 am).
- 6% stopped solid foods the entire day before.
- 6% had a shorter fasting period.
- 68% of Trusts stopped clear fluids 2 hours before.
- 12% had longer periods, range 3 to 6 hours.
- 20% had shorter periods, 18% allowing clear fluids until the procedure.

**Conclusions** Anaesthetic guidelines recommend stopping clear fluids 2 hours before and solid food 6 hours before an elective procedure to reduce the risk of aspiration. These guidelines are probably relevant for gastroscopy, however 11% of Trusts had a longer fasting period (>6 hours) for solid foods and 46% (>2 hours) for clear fluids. 77% of Trusts had a longer fasting period than required for Moviprep. Unnecessary prolonged fasting has adverse consequences such as dehydration and patient discomfort. Conversely 18% allowed clear fluids up until a colonoscopy, which in a sedated patient may increase the risk of aspiration.

Guidelines recommend completing bowel preparation within 2–5 hours of the colonoscopy to optimise the quality of bowel cleanliness; this was only true for 3% of Trusts.

We have demonstrated wide variation in pre-endoscopy fasting advice across endoscopy units in England, with many units using fasting advice inconsistent with guideline recommendations.

**REFERENCES**
1. Practice Guidelines for Preoperative Fasting and the Use of Pharmacologic agents to reduce the risk of pulmonary aspiration: application to healthy patients undergoing elective procedures. An updated report by the American Society of Anesthesiologists. Anesthesiology 2017; 126:376–93

### P11 UTILISATION AND REPRODUCIBILITY OF WEO PCCRC ALGORITHMS IN A REAL-WORLD SETTING

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**Introduction** Colorectal cancer (CRC) diagnosed following a colonoscopy in which no CRC is found is termed Post-Colonoscopy CRC (PCCRC). The World Endoscopy Organisation (WEO) consensus statements recommend review of individual PCCRC cases, including categorisation of cases into interval/non-interval CRCs, and root cause analysis (RCA) to determine most plausible explanation.

Our study aim was to test the usability, reproducibility and outcomes of the WEO categorisation.

**Methods** All CRC cases diagnosed from January 2015 to December 2016 in a single NHS trust were identified. Each was cross-referenced with local endoscopy and pathology databases. Cases where non-diagnostic colonoscopy was performed prior to CRC diagnosis were included. All colonoscopies going back to 2007 (when endoscopy reporting system introduced) were reviewed.

Each CRC was entered into a spreadsheet, with headings based on WEO RCA checklist for PCCRCs. We performed 2 separate assessments: (1) RCA to identify WEO most plausible explanation for PCCRC; and (2) WEO PCCRC subtype categorisation, which looks at screening/surveillance intervals (table 1).

Inter-observer agreement was measured using Cohen’s kappa (κ). Cases with inter-rater variation were analysed further using patient notes and then discussed by a panel to determine causes of variation and attempt to reach consensus.

**Results** Among 527 patients with CRC, 48 PCCRCs were identified. In 32 cases, the prior colonoscopy occurred within