Abstract P36 Figure 1 Endoscopy -related PCCRC rate, unit mean, 95% & 99% confidence limits

(1), c (9), d (3). However, in reviewing cases with 2 colonoscopies within 6/12 of diagnosis 3 additional misses were found making a total of 24 endoscopy related PCCRC.

The unadjusted PCCRC was 5.1% vs Endoscopy-related 3.1%

The funnel plot of Endoscopy related PCCRC rates (figure 1) indicated 3 outlying endoscopists

Conclusions The limitation of this study was only locally diagnosed CRC were ascertained. Around 5% of our colonoscopies were on patients from a neighbouring trust and additionally patient migration is possible. However, the Audit released by Bowel Cancer Intelligence for 2011–2013 recorded our unadjusted PCCRC at a similar 3.8%.

The case reviews identified 12/39 cases that were clearly not PCCRC (category c & d). This is a substantial barrier to the non-case reviewed PCCRC methodology if used to critique endoscopist's practice. 46% of unadjusted PCCRC cases were not related to endoscopic recognition.

3 Endoscopists (2 locums) were identified with statistically higher PCCRC rates.

Approximately 1 in 1000 colonoscopies may miss a lesion leading to a PCCRC. For individual endoscopist with >200 colonoscopies in this period, PCCRC cases per colonoscopy varied from 3/419 to 0/3176.

P37 COMPLICATION RATES IN FIRST 30 DAYS POST PEG AND RIG INSERTION: SINGLE TERTIARY CENTRE EXPERIENCE

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Introduction Gastrostomy tubes for enteral nutrition are most commonly inserted via percutaneous endoscopic gastrostomy (PEG) or radiologically inserted gastrostomy (RIG) techniques. However, there is no consistent evidence of the safety and efficacy of PEG compared to RIG. 30-day mortality has become considered as the most important surrogate index for evaluating the safety and efficacy of percutaneous gastrostomy.¹ Prophylactic antibiotics have become standard of care in PEGs but not for RIGs. The British Society of Gastroenterology (BSG) has recommended that antibiotic prophylaxis should be given to patients undergoing PEG insertion.² The aim of this Audit was to compare the first 30-day complication rates between PEGs and RIGs following their insertion.

Method 1 year retrospective analysis of total 200 procedures, PEGs (n=100) and RIGs (n=100) undertaken within the Newcastle Hospitals NHS FT (Freeman Hospital & Royal Victoria Infirmary) between September 2019 and August 2018. Relevant information was obtained from endoscopy records, patient e-records, radiology and microbiology results.

Results The main indication for PEG was CVA/Neurodegenerative disorders. However, the most common indication for RIG placement was Head and Neck cancers. Gender split in PEGs (57 M & 43 F), whereas in RIGs (78 M & 22 F). Average age for PEGs 66 years and RIG it was 62 years. In RIG, infection rate was significantly higher (23/100, 23%) compared to PEG (4/100, 4%, $p < 0.001$). Additional complications associated with a RIGs were dislodgement (5/100, 5%), leak 2% (2/100), severe pain requiring imaging 2% (2/100), migration 2% (2/100) and perforation 1% (1/100). In contrast PEG had fewer complications; infection 4/100 (4%), persistent pneumoperitoneum 1/100 (1%) and persistent pain requiring imaging 1/100 (1%). Out of 100 PEGs procedures 99 received prophylactic antibiotic where as in RIGs none received any prophylactic antibiotics.

Conclusion We have identified that RIG is associated with more complications especially higher rate of infection (gastrostomy site infection) 23% versus 4%. RIG was associated with other complications as well namely migration, perforation & severe pain, however the incidence was low. We suspect that the high incidence of infection rate in RIGs is associated with their non-use of prophylactic antibiotics. Therefore, we recommend using prophylactic antibiotics in RIG placement similar to its wide use in PEG procedures.

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P38 HIGH PREVALENCE OF LIVER DISEASE AND OBESITY AMONGST A COLONOSCOPY POPULATION

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Introduction Western populations demonstrate a growing burden of obesity and Non-Alcoholic Fatty Liver Disease (NAFLD).^{1 2} Our aim was to assess the burden of liver disease, obesity and metabolic syndrome amongst a population attending for colonoscopy.

Methods The OSCAR study was a cross sectional study recruiting eligible patients from 12 sites attending for colonoscopy. Patients' completed a medical history and lifestyle questionnaire (including AUDIT-C [screening questionnaire; ≥ 5 requires further assessment for alcohol excess]), provide blood samples, and had height/weight/waist circumference measured. Age-adjusted FIB-4 score, Fatty Liver Index³ (FLI) were measured (>60 highly predictive of hepatic steatosis).

Here we report the prevalence of liver disease, obesity and metabolic syndrome.

Results 1430 patients were recruited (BCSP 410 [29%]; symptomatic 1020 [71%]).