Endoscopic submucosal dissection (ESD) is a potentially curative, minimally-invasive alternative to major surgery for the endoscopic management of superficial gastric and colorectal neoplasms. Due to its several advantages pocket-creation method (PCM) appears to simplify ESD. Since 2017, we have combined PCM with saline-immersion therapeutic endoscopy (SITE), as this could improve view quality (through refractive magnification, and minimal lense fogging) and lesion lifting (through buoyancy).

The aim of our study is to review our experience of SITE-PCM-ESD cases from July 2017 to November 2019. Demographic, endoscopic, histopathological data were analysed.

ESDs were performed in 39 patients, mean age: 65-years. Six lesions were removed from the stomach, 1 from the caecum, 6 from the ascending colon, 14 from the sigmoid and 12 from the rectum. En-bloc pure-SITE-PCM-ESD resection was achieved in 28 patients (71.79%); in 3 patients (7.69%) the procedure was not completed due to the suspicion of invasive malignancy and these patients were referred for surgery.

Details of the cases managed by pure SITE-PCM-ESD are described as follows. Median specimen size was of 38 mm. Histopathological examination showed: 2 villous-adenomas with low-grade dysplasia, 7 tubular-adenomas with low-grade dysplasia, 3 tubular-adenomas with high-grade dysplasia, 2 tubulovillous-adenomas with high-grade dysplasia, 11 tubulovillous-adenomas with low-grade dysplasia, 1 adenocarcinoma, 7 neuroendocrine tumors, 1 serrated-adenoma with low-grade dysplasia, 1 hyperplastic gastric polyp and 1 sessile-serrated lesion without dysplasia. R0-resection rate was 94.44%. Lymphovascular infiltration was suspected in the one case of malignancy (2.56%). Two patients suffered from early post-procedural rectal bleeding, warranting further endotherapy; no further complications were identified. To date, 28 patients (77.77%) have completed endoscopic follow-up; none of these patients have presented any evidence of disease recurrence.

Our series of SITE-PCM-ESD showed favorable results in term of efficacy and safety. Further comparative randomised control studies are required to further evaluate potential advantages of this technique.

P43 DOES SAME SESSION ENDOSCOPIC ULTRASOUND AND ERCP AFFECT DIAGNOSTIC RATES OR OUTCOMES?

^{1,2}Francesc Adlard*, ¹Bidour Awadelkarim, ¹Manu Nayar, ¹Kofi Oppong, ¹John Leeds. ¹Freeman Hospital, Newcastle Upon Tyne, UK; ²UCL, London, UK

10.1136/gutjnl-2020-bsgcampus.118

Introduction Endoscopic ultrasound and ERCP are complementary modalities and some units offer same session procedures. This offers the opportunity to provide a 'one-stop-shop' which may speed up the patient pathway by providing rapid diagnostics and therapy in the same session. It is unknown whether there is any effect on diagnostic tissue acquisition rates, biliary cannulation rates, procedure success rates or adverse event rates particularly in those having conscious sedation. The aim of this study was to evaluate these outcomes in a large tertiary referral HPB centre.

Patients and Methods Retrospective analysis of all EUS and ERCP procedures over the period 2018 - 2019 was performed. Patients having same session EUS and ERCP were

identified and demographics, indication, total amount sedation given, order of procedure, results of brushings or needle sampling (definite malignancy or benignity), desired duct cannulation rate, successful intervention rate (duct cleared or stent inserted for drainage) and 7 day adverse event rate was calculated. Patients undergoing both EUS and ERCP more than 7 days apart had the same details recorded as a control group.

Results 393 patients were included in the study (median age 69 years, 188 males, 206 for a malignant indication). 243 patients underwent same session EUS/ERCP and 150 were included in the control group. There were no significant differences in median age, sex distribution or procedure order between the two groups. Patients having same session EUS/ERCP were significantly more likely to be for a malignant indication (155/243 vs. 51/150 OR 3.4 95% CI 2.2 - 5.2, $p < 0.0001$). Patients undergoing same session EUS/ERCP received significantly less opiate (50 mg vs. 100 mg, $p < 0.0001$) and midazolam (5 mg vs 6 mg, $p < 0.0001$) compared to separate session respectively. There was no significant difference in trainee involvement (135/243 vs 71/150), diagnostic yield (93/133 vs. 40/62), median number of needle passes at FNA (2 vs. 2), desired duct cannulation rate (212/243 vs 131/150), successful intervention rate (209/243 vs 130/150) or adverse event rates (12/243 vs. 8/150).

Conclusions Same session EUS/ERCP is feasible and more common in patients referred for suspected malignancy. There is no difference in diagnostic sampling rate, cannulation rates, success rates or adverse event rates when combining the two procedures. More information is needed to determine whether there is economy in list dynamics, cost effectiveness and patient preference.

P44

REGULAR INDIVIDUAL FEEDBACK ON KEY PERFORMANCE INDICATORS IMPROVES POLYP AND ADENOMA DETECTION IN COLONOSCOPY

Samuel Lim*, Giovanni Tritto, Sebastian Zeki, Sabina De Martino. Guys and St Thomas' Hospital, London, UK

10.1136/gutjnl-2020-bsgcampus.119

Introduction Monitoring of key performance indicators (KPIs) is paramount to standardise and improve quality in endoscopy. Adenoma detection rate (ADR) is considered the best surrogate marker for colonoscopic diagnostic accuracy, having been inversely associated with interval cancer risk and mortality. Polyp detection rate (PDR) is easier to calculate, albeit less robust than ADR. The aim of this study was to assess whether regular routine feedback on KPIs to individual endoscopists has a significant impact on the department's ability to improve ADR, PDR and other KPIs.

Methods Individual and collective endoscopy data were extracted from our endoscopy reporting software and other electronic patient records, analysed and collated at 6-monthly intervals since January 2012. ADR was determined using an automated natural language processing software (EndoMineR) to query the presence of colonic adenomas from pathology reports for all colonoscopies. PDR and other KPIs were also routinely calculated. Every endoscopist received a feedback letter every 6 months containing their individual performance indicators, along with anonymised indicators for all the other endoscopists, aggregate departmental performance and national benchmarks. Linear regressions were calculated for

Abstract P44 Figure 1

departmental ADR and PDR, along with ADR/PDR ratio and other KPIs at 6-monthly intervals from January 2012 to December 2019.

Results An average of 2460 ± 366 colonoscopies were performed in every 6-month period by 42 ± 4 endoscopists. Collective ADR and PDR were 12% and 19%, respectively, at the beginning of the study period. Figure 1 shows a continuous improving trend in collective performance was recorded since the provision of individual feedback started. Departmental ADR improved from the initial 12% to 22% (Slope $.10 \pm .01$; $R^2 .84$, $p < 0.0001$), and PDR from 19% to 30% (Slope $.10 \pm .01$; $R^2 .78$, $p < 0.0001$) in the last 6-month period. Interestingly, the ADR/PDR ratio (overall 0.68 ± 0.05 , mean $\pm$ SD) also increased over time from a baseline of 0.63 to a final figure of 0.73 (Slope $.001 \pm .0003$; $R^2 .52$, $p < 0.01$). Other KPIs showed similar improving trends. The number of non-neoplastic polyps detected did not increase during the study period.

Conclusions Our data show that regular written feedback to endoscopists about their individual and departmental KPIs, along with expected benchmarks, improves adenoma detection and overall endoscopy performance. The parallel improvement of ADR/PDR ratio suggests that the above result is not due to increased removal of no-risk polyps, which is a potential unintended consequence of PDR monitoring. Concomitant monitoring of ADR and PDR may be important to prevent 'gaming' behaviour and ensure that a genuine quality improvement is achieved.

P45 TIME TO MOVE ONTO CHROMOENDOSCOPY AS STANDARD?

Nivin Rezwan*, Wei Jin Lim, Debasish Das. *Kettering General Hospital, Kettering, UK*

10.1136/gutjnl-2020-bsgcampus.120

Introduction BSG introduced the guidelines for Barrett's oesophagus surveillance in 2013, which recommended the Seattle biopsy protocol to detect dysplasia. We reviewed the adherence rate to biopsy protocol for Barrett's surveillance service in Kettering General Hospital.

Methods List of gastroscopies performed between January 2016 to January 2019 with indication 'Barrett's surveillance' were obtained. Endoscopy report was obtained via ADAM software. Exclusion criteria includes procedures that were unsuccessful, performed for alternate indications, normal findings. Endoscopy finding including Prague classification, number of biopsies and histopathology were tabulated in Excel

spreadsheet. Adherence rate was analysed in subgroups of Barrett's segment length. Chi-Square test of independence was applied for statistical significance.

Results Total of 254 gastroscopies were included for analysis following exclusion criteria applied. Overall adherence to protocol was 78%. Adherence rate reduced with increase in length of Barrett's segment, with 97.9% adherence rate with length < 4 cm, and sharp reduction to 38.5% adherence with length 6–7 cm, and 25% with length ≥ 12 cm.

192 Barrett's diagnosed patients had maximum segment length < 6 cm, and 62 had ≥ 6 cm. There was statistical significance in difference ($p < 0.0001$) in adherence rate when comparing group with length < 6 cm (92.2%) and length ≥ 6 cm (33.9%). The incidence of detecting combined low- or high-grade dysplasia was however higher in the group with Barrett's length ≥ 6 cm (12.9%), when compared to length < 6 cm (3.1%) which was statistically significant ($p = 0.0033$). **Conclusions** Adherence to Seattle biopsy protocol is low and not proving useful in long Barrett's segment, despite initial improvement of adherence following the AsPECT trial. Chromoendoscopy with targeted biopsy may be the way forward to detect dysplastic lesions in long segment Barrett's. Further studies are required to evaluate this.

P46 INCREASE IN PATIENTS REFERRED VIA THE CANCER PATHWAY (CWT) WITHOUT CONSEQUENT INCREASE IN CANCERS DIAGNOSED

Shi Jie Looi*, David Nylander. *Newcastle Upon Tyne Hospitals Nhs Foundation Trust, Newcastle Upon Tyne, UK*

10.1136/gutjnl-2020-bsgcampus.121

Introduction There is increasing pressure on endoscopy services in the UK due to increasing demands with reports showing that acute trusts are failing to get patients who are referred via the CWT seen within the specified 14 days. According to the most recent NHS England's 'Waiting time for suspected/diagnosed cancer patients annual report', the proportion of patients with suspected lower gastrointestinal (LGI) cancer failing to be seen within the stipulated 2 weeks has increased from 7.1% in 2015/16 to 10.4% in 2018/19. To assess the impact of these demands in our organisation, we carried out a comparative audit of CWT patients over 5 weeks starting 28th May in 2018 and 2019 to determine the following:

- If there had been a true increase in referrals
- The proportions seen within 2 weeks and proportion of cancers found
- In the patients with cancer, if there had been LGI investigation in the previous 3 years

Method The names of all patients referred via the cancer (CWT) pathway are kept on the trust database. One author interrogated the electronic case records of all patients referred to the trust within the designated period in 2018 and 2019 to get demographic details, time to first hospital encounter and final diagnosis.

Results Referral symptoms from most to least common were: haematochezia, change in bowel habit, anaemia, weight loss, tenesmus, nausea/vomiting, abdominal discomfort/pain. The commonest non-malignant findings were as follows: No pathology (39%), diverticulosis (18%), benign colonic polyps