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Abstract P46 Table 1

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients referred</td>
<td>183</td>
<td>254</td>
</tr>
<tr>
<td>Median age (range) at referral</td>
<td>69 (29–67)</td>
<td>90 (94)</td>
</tr>
<tr>
<td>Percentage with first encounter in 14 days (%)</td>
<td>76</td>
<td>30</td>
</tr>
<tr>
<td>Percentage going direct to investigation (%)</td>
<td>27</td>
<td>33</td>
</tr>
<tr>
<td>Percentage of referrals with previous lower GI investigation (%)</td>
<td>12.6</td>
<td>14.6</td>
</tr>
<tr>
<td>Proportion with a final diagnosis of cancer (%)</td>
<td>4.9</td>
<td>3.5</td>
</tr>
</tbody>
</table>

(11%). Table 1 shows the numbers and other findings in the 2 cohorts.

In the patients with cancer, the primary symptom at referral was as follows: rectal bleeding (83%); altered bowels (61%); anaemia (50%) and weight loss (13%). None of the patients with cancer had a prior LGI investigation within 3 years leading to diagnosis though this was the case in 14% of all referrals.

Conclusions Our audit demonstrates a 39% increase in the number of patients referred via CWT pathway in a year with a consequent significant decrease in the proportion of patients having their first hospital encounter within 2 weeks. There was also a non-significant decrease in cancer incidence. A significant minority had prior LGI investigation and none of these patients were found to have cancer

We did not find a significant association between mortality or endoscopic finding with age, troponin, presenting haemoglobin or number of co-morbidities.

Diagnoses at endoscopy were ulcers 36% (duodenal 16%, gastric 13%, oesophageal 7%), normal 26%, gastritis 23%, polyp 7%, angiodysplasia 7% and suspected cancer 3%. After initial endoscopy, 41% remained on DAPT although in the subset of patients with a cardiac stent in situ, 62% continued DAPT. 26% required endoscopic intervention to stop the bleeding and 6% underwent a second OGD for re-bleed. There were no complications related to endoscopy and no patients required interventional radiology or surgery for uncontrolled bleeding.

Continuation of DAPT before endoscopy despite suspected GIB was strongly associated with the presence of a cardiac stent (LR = 9.9, p = 0.005). Conversely, presence of blood (LR = 7.0, p = 0.018) and a culprit lesion (LR = 4.6, p = 0.034) were strongly associated with DAPT being stopped. Endoscopic findings changed the APT plan in 25% of cases.

30-day and 90-day mortalities were 13% and 23% with none directly attributed to GIB.

Conclusions Endoscopy is safe and effective in patients with UGIB following acute cardiac events. Haematemesis was predictive of endoscopic intervention to stop bleeding, whilst raised urea indicated increased mortality and presence of a culprit lesion. All bleeds were controlled endoscopically and endoscopy directly changed the APT plan in one-quarter of cases.

P47 THE ROLE OF ENDOSCOPY IN SUSPECTED GASTROINTESTINAL BLEEDING AFTER ACUTE CORONARY SYNDROME

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10.1136/gutjnl-2020-bsgcampus.122

Introduction Upper gastrointestinal bleeding (UGIB) is a significant complication in patients on antiplatelet therapy (APT) after acute coronary syndrome (ACS) and decisions around endoscopic intervention and ongoing APT are critical. We sought to examine the safety and outcome of endoscopy in this cohort of patients.

Methods We performed a systematic examination of inpatient endoscopy records covering a 4-year period at a single hospital using keywords (ACS, STEMI, NSTEMI, DAPT) and a retrospective review of clinical records. For statistical analysis we used t-test, chi-square test, and Fisher’s exact test as appropriate.

Results We identified 31 cases, mean age 68 years (SD = 12.7 years), 58% male, median haemoglobin at scope 83 g/dL (IQR = 68–95 g/dL), and mean urea at presentation 14.0 mmol/L (SD = 10.3 mmol/L). At presentation 81% patients were on dual antiplatelets (DAPT) and 45% had a cardiac stent in situ.

Haematemesis was strongly associated with endoscopic intervention, with a likelihood ratio of 5.5 (p = 0.027). Raised urea was associated with 90-day mortality (MD = 16.5 mmol/L, 95% CI [4.0, 28.9], p = 0.017), endoscopic diagnosis of an ulcer (MD = 11.2 mmol/L, 95% CI [2.4, 19.9], p = 0.017), and presence of a culprit lesion at endoscopy (MD = 7.3 mmol/L, 95% CI [0.02, 14.6], p = 0.049).

P48 THE USE OF CHOLANGIOSCOPY FOR STRICTURE ASSESSMENT IN PRIMARY SCLEROSING CHOLANGITIS (PSC)


10.1136/gutjnl-2020-bsgcampus.123

Introduction PSC carries a 15–20% lifetime risk of developing cholangiocarcinoma (CCA). The distinction between benign and malignant strictures in this patient cohort is uniquely challenging. A 2016 meta-analysis has shown that single operator cholangioscopy (SOC) with targeted biopsies appears to be the most accurate method.1 We report our experience of SOC and PSC stricture assessment.

Methods In 2 tertiary UK referral centres all patients who had a Spyglass DS™ SOC for stricture assessment in PSC were retrospectively enrolled. From clinical records and the endoscopy reporting tool patient demographics, degree of suspicion on referral, degree of suspicion during the endoscopy, histological diagnosis, and eventual diagnosis were assessed. Pre-test suspicion of malignancy was judged as high (eg, new stricture; presentation with obstructive jaundice; rising CA19.9; lesion on imaging) or low (eg, pre-transplant stricture assessment).

Results Data on 49 patients who had undergone 52 ERCPs and Spyglass DS™ SOC was analysed.

Four cases of malignancy were confirmed; 3 had a high level of suspicion at SOC and 1 had a low level of suspicion.

Nine cases (17.3%) had prior suspicious brushings locally which warranted further investigation. Three of these had CCA confirmed and 6 had no evidence of malignancy on