(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

### 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 (29–72)</td>
<td>67 (23–90)</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>

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 bleed were controlled endoscopically and endoscopy directly changed the APT plan in only 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 review 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 antplatelets (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).

**Conclusion**

P48

**THE USE OF CHOLANGIOSCOPY FOR STRicture ASSESSMENT IN PRIMARY SCLEROSING CHOLANGITIS (PSC)**


**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. 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
SOC. Three of those with histological confirmed malignancy had cytology highly suggestive of high-grade dysplasia or adenocarcinoma from previous ERCPs. Another patient had negative histology at SOC but was referred for surgery on the basis of a mass lesion on imaging. One patient developed CCA within 1 year of negative SOC and another was found to have CCA on transplant explant at site of stricture assessed 6 years earlier with SOC. A negative SOC enabled 12 patients to be referred for transplantation.

Conclusion The role of SOC in stricture assessment in PSC remains unclear. In this series SOC picked up 1 case of CCA not detected on standard ERCP as well as not detecting at least 1 case of CCA. Despite improved image quality using Spyglass DS™ SOC visual diagnosis remains challenging. It is hoped that advances in tissue acquisition will improve the yield from targeted biopsies. However, SOC appears to have an important role in assessing strictures where brush cytology is indeterminate.

REFERENCE

P48

Abstract P48 Table 1

<table>
<thead>
<tr>
<th>Pre-Test Level of Suspicion</th>
<th>Numbers</th>
<th>Suspicion based on SOC appearance</th>
<th>Numbers (Proven malignancy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>45</td>
<td>High</td>
<td>12 (3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Low</td>
<td>29 (1)</td>
</tr>
<tr>
<td>Low</td>
<td>7</td>
<td>Unclear</td>
<td>4 (0)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>High</td>
<td>2 (0)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Low</td>
<td>3 (0)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unclear</td>
<td>2 (0)</td>
</tr>
</tbody>
</table>

P49

THE NATIONAL PERFORMANCE IN THE MANAGEMENT OF COMMON BILE DUCT STONES IN ENGLAND

Harry Martin*, Richard Sturgess, Adam Ceney, George Webster. University College London Hospitals, London, UK; Aintree University Hospital NHS Foundation Trust, Liverpool, UK; Methods Analytics, London, UK.

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Aims Bile Duct Stones (BDS) is a common indication for ERCP. There are British Society of Gastroenterology endorsed national standards for clearance rates with the expectation that 75% or more of initial ERCPs for BDS should result in stone clearance. This paper will examine the NHS data set from all trusts in England to assess the treatment of BDS.

Methods Using ICD-10 codes defined by an accredited clinical coder we examined the Hospital Episode Statistics (HES) data from all of England from 2013/4 to 2018/9 and selected those who had their initial bile duct stones presentations in 2015/6 to 2016/7, which excluded those identified in the previous 2 years. We followed this cohort of patients throughout the period of time from their presentation to the end of 2019 financial year and assessed how many ERCPs each patient underwent. We therefore had 2 years of patients with a primary diagnosis of bile duct stones with at least 2 years of follow up. All data has been limited to NHS hospitals.

Results Over the 4 year follow up period 86,602 of the 183,503 ERCPs (47.2%) done were for BDS. The 2015/6 to 2016/7 cohort was made of 37,468 patients who needed 55,556 ERCPs, 26,146 had only 1 ERCP, which, at best, represents a BDS clearance rate at first ERCP of 69.8%. In addition, the remaining 11,322 (30.2%) patients required 29,410 ERCPs, demonstrating that 52.9% of ERCPs undertaken for those who had an initial BDS presentation between 2015/16 and 2016/17 were repeat procedures. This is shown in graph 1. The cumulative BDS clearance rate of 1, 2 and 3 ERCPs is, at best, 69.8%, 89.7% and 95.9%, respectively.

The BSG key performance indicator states that 75% of BDS should be cleared at first ERCP. There are 32/154 (20.8%) hospital trusts/groups where less than 75% of those who presented with BDS needed only 1 ERCP. There are 2 (1.3%) trusts/groups where less than 50% of patients needed only 1 ERCP. From our data there appears to be little correlation between number of ERCPs for BDS performed by trust and BDS clearance. There is significant regional as well as trusts/groups variation in those needing more than 1 ERCP for BDS.

Conclusions We are falling below the minimum standards required for stone clearance at ERCP, leading to findings that, in England, more than 50% of ERCPs for BDS are repeat procedures. The reasons for this require further study but the extra burden of cost on the NHS is significant.

REFERENCE

P50 GI SAFETY PROFILE OF THE USE OF DOACS IN COMBINATION WITH ANTIPLATELETS IN CARDIOLOGY PATIENTS

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10.1136/gutjnl-2020-bsgcampus.125

Background DOACs, such as apixaban (Ap), rivaroxaban (R), edoxaban (E) and dabigatran (D), are increasingly used instead of warfarin in atrial fibrillation, acute coronary syndrome and the prophylaxis/treatment of venous thromboembolism. Unlike warfarin, DOACs are used at a fixed dose and do not require close monitoring but the pivotal trials have shown an increased risk of GIB as compared to warfarin. A recent meta-analysis showed that the risk of GIB events related to DOACs (except Rivaroxaban) is not significantly greater than with warfarin. There is therefore a need for more real world data.

Aims To review the real world safety profile of DOACs in combination with antiplatelets in patients who have been admitted to the cardiology wards.

Method For the period Jan 2015-Dec 2017 (36 months), we extracted the following data for all patients admitted under the cardiology team from our electronic databases: patient demographics; medication on discharge; patients having a gastroscopy (OGD); indication, finding and outcome at endoscopy.

Result During the study period, 4871 patients were admitted with a diagnosis of acute coronary syndrome (ACS), 729 (15%) patients (456 M, mean age 62 yrs; 273 F, mean age...