SO. 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

P49 THE NATIONAL PERFORMANCE IN THE MANAGEMENT OF COMMON BILE DUCT STONES IN ENGLAND

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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%.

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
A VALIDATED PATIENT REPORTED EXPERIENCE MEASURE FOR GASTROINTESTINAL ENDOSCOPY: THE NEWCASTLE ENDOPREM™

Introduction Gastrointestinal (GI) endoscopy and computed tomography colonography (CTC) are crucial diagnostic and therapeutic procedures. Measuring patient experience of GI procedures allows evaluation of quality of patient care, identification of areas requiring improvement and, hence, helps optimise patient outcomes. Patient Reported Experience Measures (PREMs) should be patient-derived, however, current measures are clinician derived. This study used the patient’s perspective to develop a PREM for GI procedures. 

Methods The study comprised four phases. Phase 1 – qualitative semi-structured interviews with patients who had recently undergone endoscopy/CTC. Thematic analysis identified important aspects of experience, and determined whether these were similar, or differed, across GI modalities. Phase 2: A draft PREM was developed from the phase 1 analysis and refined by the study team. Further refinement was undertaken in rounds of cognitive interviews with patients. Phase 3: The pilot PREM was prospectively administered, for self-completion, to patients following a GI procedure at four sites in North East England. The psychometric properties of the PREM were investigated. Phase 4: Review and revision.

Results Phase 1: Six themes were identified from 35 patient interviews: anxiety, expectations, information & communication, embarrassment & dignity, choice & control and comfort. These were seen for colonoscopy, OGD and CTC. Phase 2: Themes were structured by procedural stage (before the procedure, at the hospital, during the procedure, after the procedure). The draft PREM was refined iteratively during five rounds of cognitive interviews with 15 patients. Phase 3: Between October 2017 and September 2018 the pilot PREM was prospectively administered, for self-completion, to 1650 patients. The response rate was 48.4% (n=799). The instrument had good psychometric properties and was found to contain 7 subscales. Phase 4: Redundant questions were removed, some wording was refined, and the questionnaire finalised. The final instrument includes 54 questions.

Conclusions The Newcastle ENDOPREM™ assesses all aspects of the GI procedure experience. It will be used for measuring patient experience in clinical practice and within endoscopy trials. The PREM is now undergoing international validation.

REFERENCES

MEASURING PATIENT EXPERIENCE OF GI ENDOSCOPY: PSYCHOMETRIC PROPERTIES OF THE NEWCASTLE ENDOPREM™

Introduction Gastrointestinal (GI) endoscopy and computed tomography colonoscopy (CTC) are widely performed investigations of the GI tract. Patient experience affects future uptake, attendance for surveillance and correlates with outcomes. Current measures of experience are clinician and nurse-derived. The Newcastle ENDOPREM™ was developed using a rigorous systematic process based on qualitative patient interviews. This study aimed to investigate the psychometric properties of the instrument.

Methods Patients aged ≥18 years, undergoing oesophagogastro-duodenoscopy (OGD), colonoscopy or CTC at four sites in North East England were prospectively asked to complete the PREM. Using IBM® SPSS® 24, we examined response rates and patterns, missing values, floor and ceiling effects and item-total correlations. Exploratory factor analysis (EFA) was conducted using principal components analysis. Reliability of factors was assessed using Cronbach’s α.

Results 799 questionnaires were returned from Oct 2017 – Sept 2018 (response rate 48.4%). Respondents were aged 18–95 years (mean 65.3, SD 12.6), 43.3% were male and 41.1% had undergone OGD, 43.3% colonoscopy and 14.4% CTC. Of the 59 questions had a ceiling effect (>40% choosing