Abstract P48 Table 1

Pre-Test Level of Suspicion	Numbers	Suspicion based on SOC appearance	Numbers (Proven malignancy)
High	45	High	12 (3)
		Low	29 (1)
		Unclear	4 (0)
Low	7	High	2 (0)
		Low	3 (0)
		Unclear	2 (0)

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

1. Njei B, et al. Systematic review with meta-analysis: endoscopic retrograde cholangiopancreatography-based modalities for the diagnosis of cholangiocarcinoma in primary sclerosing cholangitis. *Aliment Pharmacol Ther* 2016;**44**(11–12):1139–51.

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.¹ 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

1. ERCP – The Way Forward, A Standards Framework. ERCP Workign Party [Internet]. Available from: <https://www.bsg.org.uk/resource/ercp-the-way-forward-a-standards-framework-pdf.html>

P50

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

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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.¹ A recent meta analysis showed that the risk of GIB events related to DOACs (except Rivaroxaban) is not significantly greater than with warfarin². 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

66 yrs) died during their admission, 2 of whom had an OGD for GIB prior to death but neither was on a DOAC. The remaining 4142 patients (2677 M, mean age 63.8 yrs; 1465 F, mean age 67.5 yrs) were on the following at discharge: monotherapy Aspirin (A) 556, Clopidogrel (C) 190, Ticagrelor (T) 0, R 83, Ap 12, E 3; warfarin therapy 59.

dual therapy A+C/T/DOAC 1573; triple therapy (A+C/T +DOAC) 35

C + (A/DOAC/T)- 508; triple therapy (C+A/T+DOAC) 28

T + (A/DOAC/C)- 1089; triple therapy (T+A/C + DOAC) 6

There were 449 gastroscopies (11%) done during the study period and for 6 months thereafter. The indications were: GIB – 68 (15%) (46M mean age 62, 23F, mean age 66), anaemia 215 (48%), dyspepsia 157 (35%).

Out of 68 patients with suspected GIB, there were 3 cases of active bleeding at the time of the OGD – X1 DU (on A), X1 Mallory Weiss tear, X1 duodenitis (both on A+T). There was 1 oesophagitis without active bleeding and the remaining 64 OGDs did not show any abnormality. There were no cases of acute GIB in patients on DOACs in this cohort.

Including the 2 patients who had a GIB and died (mortality 0.05%), there were in total 5 cases of acute GIB at the time of OGD (0.12% severe GIB risk).

Conclusion Allowing for the retrospective nature of the study, the short follow up for some patients and the lack of information on the concurrent use of PPIs, our real world study shows a very low GIB risk for cardiology patients on antiplatelets ± DOACs (0.12%). The mortality in this cardiology cohort was also very low. This compares well with the published 1% risk for GIB for patients on DOACs for all other indications.² Our results are therefore very reassuring.

REFERENCES

1. Holster, *et al.* *Gastroenterology*. 2013; **145**: 105–112.e15
2. Gu, *et al.* *CGH* 2019 DOI: <https://doi.org/10.1016/j.cgh.2019.05.056>

P51 A VALIDATED PATIENT REPORTED EXPERIENCE MEASURE FOR GASTROINTESTINAL ENDOSCOPY: THE NEWCASTLE ENDOPREM™

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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.¹ Patient Reported Experience Measures (PREMs) should be patient-derived, however, current measures are clinician derived.² 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

1. Rees CJ, *et al.* BSG position statement on patient experience of GI endoscopy. *Gut* 2019; DOI: [10.1136/gutjnl-2019-319027](https://doi.org/10.1136/gutjnl-2019-319027)
2. Brown S, *et al.* Patient-derived measures of GI endoscopy: a meta-narrative review of the literature. *Gastrointest Endosc* 2015;**81**(5):1130–40

P52 MEASURING PATIENT EXPERIENCE OF GI ENDOSCOPY: PSYCHOMETRIC PROPERTIES OF THE NEWCASTLE ENDOPREM™

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Introduction Gastrointestinal (GI) endoscopy and computed tomography colonography (CTC) are widely performed investigations of the GI tract. Patient experience affects future uptake, attendance for surveillance and correlates with outcomes.¹ Current measures of experience are clinician and nurse-derived.² The Newcastle ENDOPREM™ was developed using a rigorous systematic process based on qualitative patient interviews.³ This study aimed to investigate the psychometric properties of the instrument.

Methods Patients aged ≥18 years, undergoing oesophagogastroduodenoscopy (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. 24 of the 59 questions had a ceiling effect (>40% choosing