Abstract PTH-34 Table 1 Site of primary cancer diagnosis

Oesophageal	9 (25.9)
Pancreatic	9 (25.9)
Hepatobiliary	5(14.2)
Other	8 (22.7)
Colon	3 (8.5)
Gastric	1 (2.8)

Conclusion Telephone triage demonstrated that primary care compliance with national TWW guidance was low. Risk stratification via telephone triage resulted in more appropriate investigations and earlier detection of non-upper GI cancer with less unnecessary endoscopies. Crucially, the majority of cancers diagnosed were not UGI, and would have been missed on STT endoscopy alone. During short term follow up no delayed cancer diagnoses were made. This study suggests telephone triage is an effective tool to reduce endoscopy waiting lists whilst carefully utilising radiological resources.

REFERENCES

- British Society of Gastroenterology. BSG rationale around current advice to all Endoscopy Units. 2020. <https://www.bsg.org.uk/covid-19-advice/bsg-rationale-around-current-advice-to-all-endoscopy-units/> (accessed 20th April 2021)
- Rutter MD, Brookes M, Lee TJ, Rogers P, Sharp L. Impact of the COVID-19 pandemic on UK endoscopic activity and cancer detection: A National Endoscopy Database Analysis. *Gut* 2021; **70**: 537–43.

PTH-35 OUT-OF-HOURS DEDICATED TRANS-NASAL ENDOSCOPY SERVICE – A MODEL FOR ENDOSCOPY RECOVERY DURING COVID PANDEMIC

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Introduction Trans-nasal endoscopy (TNE) using an ultra-thin endoscope has been shown to be safe and tolerable. In the COVID era, capacity in endoscopy is limited both in rooms due to backlogs and staff shortages, and in recovery due to social distancing. TNE is advantageous over conventional OGD (c-OGD) as it requires fewer nursing staff, no need for recovery, and can be performed outside of the endoscopy department. Commonly perceived disadvantages are poor completion rates and inadequate biopsy size. We sought to evaluate a novel TNE service, using a room outside of endoscopy setting in twilight hours (4–7pm).

Methods Nine endoscopists (4 consultants, 3 Fellows, 2 nurse endoscopists) were trained in TNE technique. Procedures were undertaken using Fujinon and Olympus ultra-thin endoscopes. All were performed with oral xylocaine and nasal phenylephrine/lidocaine spray, and without sedation. Paediatric biopsy forceps were used as required. Using Artificial Intelligence software (natural language processing - EndoMineR) patient reporting systems were interrogated to assess TNE and histology results.

Results 220 TNE procedures were performed between October 2019 and Dec 2020, 96 pre COVID-19 pandemic (to March 2020). 12 were performed with addition of Entonox. The patient characteristics are outlined in table 1.

Abstract PTH-35 Table 1

Median age (years)	45.0 +/- 15.6 (range 19.6 to 97.9)
Gender	
Male	108 (49.1%)
Female	112 (50.9%)
Indication for endoscopy	
Pain / reflux	79
Dyspepsia	35
Dysphagia	28
Oropharyngeal symptoms including globus	17
EoE assessment	14
Nausea / vomiting	11
Barrett's surveillance	11
Anaemia / bleeding	8
Weight loss	3
Other	14

Completion rate was 94% (208/220), with failure due to failed nasal intubation (n=6), patient discomfort (n=5), and difficulty navigating the D1/D2 junction (n=1); 4/12 were subsequently completed via oral route. There were no immediate complications documented.

Of 467 biopsies taken across 100 procedures, the average size of the largest biopsy was 4.57mm³. There was no difference in size of biopsy from different locations in UGI tract. No set of biopsies was reported as insufficient for diagnosis, including 39 for eosinophilic oesophagitis (EoE) and 11 for Barrett's oesophagus (BE).

Conclusions These data show TNE is safe and has a high completion rate (94%). Biopsy size was acceptable, and able to provide sufficient tissue for diagnosis in all cases. The number of biopsies for assessment of EoE and BE was sufficient, despite large number needed, confirming previous reports on tolerability of the procedure

In an era of extreme pressure on endoscopy services, we demonstrate that a novel dedicated TNE service can be employed to reduce waiting times without loss of quality.

PTH-36 IDENTIFICATION & SERVICE EVALUATION OF A PRIMARY SCLEROSING CHOLANGITIS COHORT USING NATURAL LANGUAGE PROCESSING

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Introduction Primary sclerosing cholangitis (PSC) is a rare and difficult to treat condition. PSC is strongly associated with malignancy, therefore screening and surveillance are paramount. PSC however does not have a unique UK ICD-10 diagnostic code, hence reliable patient cohort identification and thorough service evaluation is challenging. We used natural language processing (NLP) to identify the PSC patient cohort at University Hospital Southampton (UHS) and audited associated outcomes against recently updated British Society of Gastroenterology (BSG) management guidelines.

Methods Records of all patients with PSC at our institution between 2008–2020 were identified using our NLP methodology. We used fuzzy matching to analyse clinical records, and tokenized and lemmatized key paragraphs to identify key diagnostic patterns and exclude diagnostically uncertain or exclusive sentences. Anonymised discharge summaries, clinic letters,