Results Only eight articles, amongst them involving 166 patients, met the study criteria. Themes demonstrated repeated hospital admissions towards the end of life, lack of coordinated care in community and barriers in discussion about palliative care in end stage liver disease due to lack of confidence amongst professionals and a negative view about palliative care amongst patients and carers. Emotional, financial and disability related needs of patients and their carers are often neglected. (Table 1)

Conclusions Further research into perspectives of patients with advanced liver disease and their carers regarding palliative and EOL care will help improve the implementation of patient-focused palliative care, advance care planning and EOL care. Research should also be done into the barriers to EOL discussions so that they can be held earlier with the aim of improving patient and carer quality of life and outcomes. It would be interesting to see the comparison of the attitude to, and expectations from, palliative care among patients and their caregivers from different parts of the world where the aetiological spectrum of liver disease, the social construct of health-care and availability of palliative care differs significantly.

PTH-49 SUCCESSFUL ENDOSCOPY RECOVERY STRATEGY AFTER THE FIRST WAVE OF THE COVID-19 PANDEMIC

Paolo Giuffrida*, Iain Ewing, Eleanor Wood, Nora Thoua, Henning Spranger, Jun Liong Chin, Esra Asilmaz, Ray Shidrawi, Laura Marelli. *Homerton University Hospital, London, UK*

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Introduction Endoscopy other than essential or emergency cases was paused in March 2020 during the first wave of the Covid-19 pandemic leading to a significant backlog. In April 2020 the BSG issued new guidance for safe resumption of endoscopy services.

Methods We here described how we managed the endoscopy backlog generated by the first wave of the Covid-19 pandemic in a Covid-minimised unit. We evaluated the impact of service suspension on backlog, recovery strategy, infection control policy, results of pre-procedure Covid-19 testing, and 7/14-day post-procedure Covid-19 symptom screening.

Results 937 elective procedures were cancelled between 23 March and June 2020. A vetting tool linked to the booking system was used to categorise these as High-risk 2-week wait (n=57), Defer 3 months (n=439), Defer 6 months (n=300), Defer 12 months (n=9), Surveillance (n=45), Discharge back to referrer (n=87). Elective procedures restarted on 8 June 2020. Lists were initially booked with 50% reduction in volume compared to pre-Covid-19, to accommodate PPE, downtime and social distancing. We increased endoscopy administration from 2 to 5 staff, to implement 7-day pre-procedure 'SCOTS criteria' telephone screening, 3-day pre-procedure Covid-19 PCR testing, and 7/14-day post-procedure telephone follow-up. We introduced outpatient information leaflet and consent forms regarding Covid-19 risk. Inpatient endoscopy was carried out in the operating theatre until the end of August. On 17 July we removed downtime after lower GI endoscopy increasing capacity. Twice weekly evening lists resumed in August, with an extra evening list added in September. From 1 August until 10 October we used insourcing at weekend. We trialed outsourcing of 2 weekly lists for 4 weeks in August, but did not find this strategy effective. Additional Saturday and evening lists were performed by 6

endoscopists removed from the GIM rota. We were able to clear our waiting list by mid-October so that we could offer mutual aid to a neighboring hospital.

Between June and November we performed endoscopy in 3,481 outpatients. Each patient had pre-endoscopy Covid-19 swab and 20 (0.57%) were positive. 23 out of 3,261 (0.71%) patients developed Covid-19 symptoms after 7 days and 29 (0.89%) after 14 days.

Conclusions We demonstrated effective clearance of the endoscopy backlog in a Covid-19 safe environment over 4 months. Key interventions were advance vetting, increased administrative support, an endoscopy unit located in a separate building, quick implementation of infection control policies, insourcing and freeing of endoscopists from the GIM rota. Learning point was underestimating burnout of endoscopy nursing staff.

PTH-50 MICROSCOPIC COLITIS: MIND THE GAP

¹Shivani Richards*, ²Paul Collins. ¹The University of Liverpool, Liverpool, UK; ²Royal Liverpool University Hospital, Liverpool, UK

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Introduction Microscopic colitis (MC) is a chronic inflammatory disease that affects the colon. Characteristically it causes chronic, watery, non-bloody diarrhoea, which substantially reduces patient quality of life (QoL). MC may be less familiar than other causes of diarrhoea and could lead to delays in diagnosis of MC, or a failure to diagnose this condition.

Aims 1. To assess the timelines of referral, diagnosis and treatment in patients who are subsequently diagnosed with MC

2. To identify treatments initiated and potential culprit drugs in patients with MC

Methods Patients with MC were identified from electronic health records. Patient demographics including smoking status were gathered. Data was obtained on the date of symptom onset, clinical review, diagnosis and treatment intervention (advice on cessation of a potential culprit drug and/or start of treatment.)

Results 304 patients were diagnosed with MC, 230 females and 74 males (3.1:1). The median age of patients was 69 years (range 19-100). 42% of patients were current smokers, of which 54% did not receive smoking cessation advice. 219 patients (92%) were reviewed by a gastroenterologist post-symptom onset, with a median wait of 251 days (range 1-7516) from the time of symptom onset. Of those diagnosed with MC after symptoms, the median wait between symptom onset and diagnosis was 113.5 days (range 1-7286). 57 patients (25%) waited >1 year and 15 patients (7%) waited >5 years before diagnosis. For those initiated on treatment post-diagnosis, the median number of days from symptom onset to commencing treatment was 324 days (range 11-7516). 36 patients had treatment initiated prior to their diagnostic histology report. Most patients (58%) were given budesonide as their first treatment. 38% of patients required additional treatments, 17% required no treatment. Loperamide was given to 46% of patients receiving additional treatments. 67% of patients were taking a potential culprit drug, of these 20% were taking multiple potential culprit drugs (Omeprazole 19.9%, NSAID 18.7%, Lansoprazole 15.6%, Sertraline 8.10%, Beta blocker 6.54%). Of the patients taking a potential culprit drug, 52% were advised to stop the same drug and 4% were advised to stop a different drug.