**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, down-time and social distancing. We increased endoscopy administration from 2 to 5 staff, to implement 7-day pre-procedure Covid-19 PCR testing, 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.

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**PTH-50 MICROSCOPIC COLITIS: MIND THE GAP**

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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.
Conclusion Patients with MC are diagnosed within a median of just over 3 months of symptom onset. Some patients are still referred and diagnosed long after symptom onset. There may be patients with chronic diarrhoea in the community who are undiagnosed. There is some variation in prescribing practice for MC. Standardisation of management pathway in the UK would assist with management (Münch A, et al. Frontline Gastroenterology 2020;11:228–234).

PTH-51 PATIENT SAFETY MATTERS: CARE CLOSER TO HOME IN GASTROENTEROLOGY HIGH COST DRUG MANAGEMENT DURING COVID-19

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Introduction The Covid-19 pandemic has been a strong catalyst in driving the reconfiguration of gastroenterology outpatient models of High Cost Drug (HCD) delivery. This service evaluation aims to explore the impact of multiple quality improvement initiatives synchronously implemented by the HCD pharmacists and the gastroenterology clinical team, to improve medication safety and HCD treatment access.

Methods The Plan-Do-Study-Act (PDSA) quality improvement methodology was applied to three key service areas, from March 2020 to May 2021: i) 95 Hepatitis B (HB) patients receiving FP10 HCD prescriptions were reviewed by the clinical team for switch to the hospital outpatient pharmacy model (HOP), enabling HCD collection from their local pharmacy. Conversely, Hepatitis C (HCV) patients struggled to reach the hospital catchment area within the last 10 years based on recommendations from the 2018 BSG HCD guidelines.

Results A total of 51 patients with HCD were identified. Mean age 66 [age range 31 to 92], 11 male and 40 female [78% F; 22% M].

PTH-52 PBC MANAGEMENT IN A RURAL SETTING. HOW DO WE COMPARE TO NATIONAL STANDARDS?

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Introduction The South West Acute Hospital (SWAH) serves the most rural population in Northern Ireland. The British Society of Gastroenterology (BSG) updated guidelines on the treatment and management of Primary Biliary Cholangitis (PBC) in 2018.1 We audited our PBC patients to assess management of patients with PBC, and identify areas for improvement.

Methods Patients were identified by searching PAS and the Northern Ireland Electronic Care Record (NIECR). ICD-10 code K74.3 was used - 'Chronic nonsuppurative destructive cholangitis' – as primary and secondary diagnosis. We audited the notes of all patients who had a diagnosis of PBC in our hospital catchment area within the last 10 years based on recommendations from the 2018 BSG PBC guidelines.

Results A total of 51 patients with PBC were identified. Mean age 66 [age range 31 to 92], 11 male and 40 female [78% F; 22% M].

Conclusion Patients with MC are diagnosed within a median of just over 3 months of symptom onset. Some patients are still referred and diagnosed long after symptom onset. There may be patients with chronic diarrhoea in the community who are undiagnosed. There is some variation in prescribing practice for MC. Standardisation of management pathway in the UK would assist with management (Münch A, et al. Frontline Gastroenterology 2020;11:228–234).