population and should be offered CD testing. Migraine should be added to current testing guidelines.

Colon and anorectum

HFR-7 PREVENTABLE EARLY COLORECTAL CANCER IN CYSTIC FIBROSIS: IS THERE 'SCOPE' FOR A UK SCREENING PROGRAMME?

Karuna Sapru*, John Walmsley, Javid Iqbal, Rowland Bright-Thomas, Peter J Barry, Andrew M Jones, Dipesh Vasant. *Manchester University NHS Foundation Trust, Manchester, UK*

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Introduction Adults with cystic fibrosis (CF) have a high incidence of premalignant colorectal polyps and early colorectal cancer (CRC), forming the basis for CRC screening recommendations for patients with CF ≥ 40 years of age in the USA¹. Despite this, there are no equivalent UK guidelines for CRC screening in CF. In the absence of a national screening programme, we evaluated the current utility and diagnostic yield of colonoscopy, the incidence of CRC, and the proportion of patients that would potentially benefit from CRC screening programme at a CF centre.

Methods Data were collected from a prospectively maintained database of all patients with CF attending the Manchester Adult Cystic Fibrosis Centre (MACFC) between 2010 and 2020. Patients included were all ≥ 30 years of age and had to have undergone a colonoscopy within the 10-year study period.

Results Overall, 709 patients with CF attended MACFC, 361 (51%) were aged ≥ 30 years, and 135 (19%) were ≥ 40 years old, and would have fulfilled the criteria for CF CRC screening colonoscopy in USA.¹ Only 33/361 (9%) of CF patients ≥ 30 years of age (mean age 44.8 ± 11.0 years) underwent 39 colonoscopies between 2010-2020. Of the 33 CF patients that underwent an index colonoscopy, the majority (31/33, 94%) were for symptomatic indications, and only 2/31 (6%) were for screening in the context of a family history of CRC. Colonoscopy completion rate was 94.9%. Extended bowel preparation was used in 14/39 (36%) of procedures. Diagnostic views were achieved with standard preparation in 18/25 (72%) vs. 12/14 (85.7%) with extended preparation ($p=0.44$). At colonoscopy, in 11/33 (33%) of CF patients aged ≥ 30 years, 20 polyps were detected and removed, 5/20 (25%) of these polyps were 10-20mm size, overall polyp retrieval rate was 80%, and of those polyps retrieved 93.8% were premalignant and 87.5% were proven adenomas. The majority of the patients that underwent colonoscopy were ≥ 40 years of age (24/33, 73%), and this group also accounted for most of those who were found to have polyps (8/11, 72.7%). Over 10 years of follow-up, no patients in this study developed post-colonoscopy CRC. However, of the CF patients ≥ 40 years of age that did not have a colonoscopy (111/135, 82.2%), four subsequently developed CRC, three of whom died from complications of their cancer.

Conclusion This 10-year experience from a CF centre suggests that colonoscopy screening is rarely performed in those ≥ 40 -years of age despite the known increased of premalignant polyps and early CRC, and supports the development of a UK screening programme, especially given the increasing life-expectancy in CF.

REFERENCES

1. Hadjiliadis D. *Gastroenterology* 2018;**154**(3):736-745.

Gastroenterology service

HTH-2 MYCHART APPLICATION IN ADDRESSING IBD PATIENTS' CONCERNS AND IMPACT ON SERVICE UTILISATIONS

Alexandra Agorogianni*, Krithivasan P Raman, Edel Mcdermott. *Addenbrookes Hospital, Cambridge University Hospitals, Cambridge, UK*

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Introduction MyChart is an electronic patient portal within the electronic patient record provider EPIC. We asked patients to complete an electronic survey via MyChart. A threshold was set that any patient who recorded a severe disease activity score (MAYO >3 , HBI >8) or signaled they had a concern on their questionnaire created a 'BPA' message that was routed to our clinical nurse specialists. Our aim was to assess the impact of this on addressing patients' concerns and service utilization.

Methods We reviewed the electronic notes of all IBD patients who received infliximab in the month of September 2020. Notes were reviewed for demographics, status on MyChart, number of questionnaires filled, type of concerns raised and outcomes of concerns, number of inpatients and outpatient appointments pre- and post- the introduction of the online questionnaire.

Results 141 IBD patients on infliximab were identified. 3 were excluded (2 had insufficient details, 1 did not commence on infliximab eventually). 77 males (55.8%), mean age of 27 years. 110 (78.70%) were diagnosed with Crohn's, 24 with UC (17.0%) and 4 with unspecified type (2.8%). 104 (75.1%) were active on My Chart and 83 (78.3% of MyChart population, 58.9% of total ($n=138$)) completed the infliximab questionnaire.

44 patients (53%) raised concerns on the questionnaire with a total of 54 concerns (10 of the patients had 2 concerns). 33 (61.1%) of the concerns were addressed through MyChart communication alone, 16 (29.6%) required an outpatient IBD nurse review and 3 (5.6%) required an outpatient medical review. 2 concerns (3.7%) were not addressed. The mean time to address these concerns were 6 days. There were no significant differences in terms of mean age, gender and type of IBD between the two groups. A greater proportion of those who did not fill in the questionnaire were found to be in clinical remission (83.6% vs 67.5%).

Abstract HTH-2 Figure 1 Flow diagram

Of those who did not fill in the MyChart questionnaire, 3 required an unscheduled admission and 1 had an unscheduled outpatient clinic review. Following introduction of MyChart questionnaire, patients were found to have significantly less unscheduled outpatient reviews (14.4% vs 21.9%), scheduled outpatient reviews (64.4% vs 75.6%) and inpatient admissions (4.8% vs 13.4%) (Figure 1).

Conclusions Three quarters of the patient population were found to be active on My Chart with the majority filling in the infliximab questionnaire. Clinical remission appears to be a factor in influencing decision to fill in the questionnaire. My Chart proved to be effective in communicating and addressing patient's concerns and prevented unwarranted outpatient appointments and inpatient admissions. There were no adverse events and patients' concerns were addressed promptly in 96% of cases.

HTH-3 STRUCTURED, STEPWISE, MULTIDISCIPLINARY TEAM APPROACH TO MANAGING BURIED BUMPER SYNDROME (BBS): IMPROVING PATIENT OUTCOMES

Angus Kitchin*, Wolf-Rudiger Matull, Daniel Pearl. *Somerset NHS Foundation Trust, Taunton, UK*

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Introduction BBS is a serious complication seen in up to 2.4% of long term percutaneous endoscopic gastrostomy (PEG) tubes. In BBS, a shelf of gastric mucosa gradually extends to cover the circular edge of the internal PEG flange, becoming completely buried in more advanced cases which endangers feeding tube (FT) patency. For vulnerable patients dependent on FTs for nutrition, hydration and medication, this complication may lead to harm. Various endoscopic and surgical techniques have been employed to manage this. Here we report our case series, to demonstrate how a structured multidisciplinary team (MDT) approach and advanced endoscopic management can improve patient outcomes.

Methods We present a case series of 30 patients at a regional referral centre for BBS management (2007-2020). The original service involved sporadic management by various endoscopists. Since 2013, patients with endoscopic or clinically suspected BBS have been referred to a specialist MDT clinic, with involvement from a consultant, dietitian, specialist nutrition nurse, learning disability liaison team and their carer. This facilitates a best interest approach to aid decision making, and identifies (and plans for) patient factors which could present a barrier to a successful outcome. Two dedicated interventional endoscopists perform endoscopic needle-knife extraction, combined with balloon assisted PEG manipulation (with anaesthetist-delivered sedation or general anaesthetic) in theatres. The objective was to achieve the highest chance of successful endoscopic FT replacement through the established tract at the index therapeutic procedure, reducing conversion to surgery and length of stay (LOS).

The primary aim of this case series was to compare the care that patients received before (group A) and after (group B) this service improvement initiative. Statistical analysis used Fisher's exact and unpaired t-tests.

Results Results are expressed as group B (n = 19) vs group A (n = 11). In group B, less patients required surgery to replace their FT (1 [5.3%] vs 4 [36.4%], $p < 0.05$), more FTs were replaced in the pre-existing tract (18 [94.7%] vs 2 [18.2%], p

< 0.001), mean LOS was shorter (4.2 vs 10.5 days, $p < 0.05$) and there were fewer complications (2 [10.5%] vs. 4 [36.4%], $p = 0.16$).

Overall, endoscopic vs surgical management was associated with a shorter LOS (5.3 vs 12 days, $p < 0.05$). There was no 30 day mortality or 8 day readmission in either group.

Conclusions We have outlined a management approach to BBS which is associated with better procedural success (reduced rates of surgery, reduced LOS, reduced requirement for a new gastrostomy tract). Careful, nuanced decision making utilizing MDT skills facilitated the best possible outcomes for this vulnerable group of patients.

HTH-4 SAFETY AND FEASIBILITY OF ANAESTHETIST-LED PROPOFOL SEDATION FOR ADVANCED HPB ENDOSCOPY IN A REGIONAL CENTRE

¹Sardar Chaudhary*, ²Naveen Kirodian, ¹Sandeep Siddhi, ¹Umesh Basavaraju. *¹Department of Digestive Diseases, Aberdeen Royal Infirmary, Aberdeen, UK; ²Department of Anaesthetics, Aberdeen Royal Infirmary, Aberdeen, UK*

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Introduction Limited anaesthesiology resources for deep sedation within endoscopy have meant that complex and lengthy hepatopancreatobiliary (HPB) endoscopy procedures are usually done under GA. We looked at the safety and feasibility of provision of propofol sedation on established GA lists at our unit.

Methods We performed a retrospective analysis of anaesthetist-led propofol (PPF)/GA lists over 24 months since its inception at a single institution providing regional complex HPB endoscopy service. Health records for all patients were evaluated. Primary outcomes were complication rates, duration of procedure and average number of additional procedures per list. Results were compared with retrospective pre-propofol period data.

Results We identified 108 patients undergoing endoscopy during this period. Mean age was 59.6 (range 15-93). 66% procedures were performed under GA and 34% using PPF. Majority of procedures were performed as elective day cases (80.2% vs 19.8%; $P < 0.05$). Most were ERCP (56.5%) followed by EUS (25.9%) and combined ERCP+EUS (13.9%). A small number of non-HPB endoscopy procedures (3.7%) were also performed on these lists and were excluded from the final analysis. 15.4% had a previous failed HPB procedure under conscious sedation. Majority of patients were ASA 2 (61.5%) or ASA 1 (19.2%) and ERCP complexity was predominantly Cotton grade 2 (46%) or 3 (46%). The mean number of procedures increased from 1.72 on GA only lists to 2.7 in mixed GA and PPF lists ($p = 0.28$). The mean duration of procedure was 53.4 minutes (95% CI, 58.8-48) for GA compared with 39.6 minutes for PPF (95% CI, 45.4-33.8; $p < 0.005$). Average dose of PPF administered was 307 ± 36 mg. The overall mean length of stay for GA cases was 4.3 days vs 3 days for PPF ($p = 0.53$). This reduced to 1.54 days and 0.73 days respectively if the procedure was performed as a day case ($p = 0.03$). 11.5% patients suffered delayed endoscopic complications (compared with 19.4% in pre-propofol period; $p = 0.08$) whereas only 2.9% of patients had anaesthetic-related adverse events (2 had GA and 1 PPF). 7-day readmission rate was 2.9% (5.5% in pre-propofol period; $p = 0.41$) and 30-day all cause mortality was 1.9% (12.5% in PPE; $p < 0.005$).