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.

**Results**

<table>
<thead>
<tr>
<th>Group</th>
<th>Procedure Type</th>
<th>Conversion Rate</th>
<th>Conversion Subtotal</th>
<th>No. Conversion</th>
<th>Duration (days)</th>
<th>LOS (days)</th>
<th>PPF Dose (mg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>GA</td>
<td>18 (94.7%)</td>
<td>18</td>
<td>2</td>
<td>1.54</td>
<td>3.3</td>
<td>298 ± 21.8</td>
</tr>
<tr>
<td>B</td>
<td>PPF/GA</td>
<td>2 (18.2%)</td>
<td>2</td>
<td>0</td>
<td>0.82</td>
<td>1.54</td>
<td>307 ± 0.73</td>
</tr>
</tbody>
</table>

**Discussion**

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.
Conclusions

Majority of procedures can safely be carried out as day case with associated reduced lengths of stay. The mean length of procedure under propofol was significantly shorter. Adding propofol procedures on to GA lists increased list capacity by approximately an additional 1 procedure per list. Both GA and propofol procedures are overall safe with low rates of complications and no procedure-related mortality. This safety data provides the platform to perform more complex endoscopy under propofol sedation, especially during the pandemic.

**HTH-5**

**COULD MACHINE LEARNING (ML) IMPROVE INDICES FOR PREDICTING OUTCOME OF AUGIB?**

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**Introduction**

Risk stratification scores for acute upper gastrointestinal bleeding (AUGIB) have limitations. ML models using multiple variables have the potential to improve predictive value.

**Methods**

Patients undergoing at least one endoscopy were selected from the 2007 UK upper gastrointestinal bleeding (UGIB) audit1 for developing ML models predicting 28-day all-cause mortality and rebleeding. Input variables were divided into pre-endoscopy & endoscopy features (demographics, presentation, co-morbidity, concomitant drugs, biochemical parameters, pre-endoscopic management and first endoscopy findings). Random forest with 100 estimators or trees was used as a prediction model. Shapley additive explanations (SHAP)2 identified the most relevant features in each model. MissForest3 imputed missing data. Outcome prediction from ML models for pre-endoscopy and combined pre-endoscopy & endoscopy were compared to Rockall scores. 5-fold cross-validation compared performance, reported as average areas under receiver operating characteristic curve (AUC).

**Results**

5004 patients were included (mean age 66yr, 60% male). 28-day all-cause mortality was 6.7% (n=335) with 9.3% (n=465) rebleeding. All-cause mortality predicted by ML was independent of endoscopy (AUC 0.84, 95% CI 0.82-0.85, pre-endoscopy; 0.84, 95% CI 0.82-0.85, pre & endoscopy) vs 0.76, 95% CI:0.75-0.77 for Rockall. Rebleeding predicted by ML was enhanced by endoscopy (AUC 0.64, 95% CI: 0.63-0.66 pre-endoscopy; AUC 0.75, 95% CI:0.75-0.77 pre & endoscopy) vs AUC 0.67, 95% CI:0.66-0.68 for Rockall. The SHAP tool reported 10 most relevant features (Figure 1).

**Conclusion**

Pre-endoscopy ML models performed better than Rockall scores for predicting mortality. Endoscopy appeared to enhance ML prediction of rebleeding. Comparison with other risk scores was not possible from the dataset, but ML models from electronic records could develop dynamic decision support tools.

**REFERENCES**


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**HTH-6**

**PREDICTORS OF LYMPH NODE INVOLVEMENT AND METASTASIS IN CRC CASES DIAGNOSED AT ST MARK’S HOSPITAL**

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**Introduction**

Colorectal cancer (CRC) is a leading cause of morbidity and mortality in England. Both 1- and 3-year