Introduction Cholangioscopy with electrohydraulic lithotripsy (EHL) is an evolving service to treat choledocholithiasis refractory to standard ERCP and is included in the BSG guidelines. We aimed to assess the safety, efficacy and implications of a new tertiary Spyglass EHL service for treatment of refractory gallstone disease.

Methods A review of prospectively collected data was performed for all EHL Spyglass procedures performed from 01.12.2018 to 31.12.2019 at St Thomas' Hospital. Procedural duration was determined by the time between first and last fluoroscopic image taken. Stone burden was assessed by examination of fluoroscopic images. ERCP Spyglass DS1 and Autolith Touch II EHL Generator was used for all procedures.

Results 57 Spyglass EHL procedures were performed between January 2018 and December 2019 on 40 patients (75% females, 25% males with a mean age of 65). All cases had failed stone clearance at standard ERCP prior to this. Mean diameter of the largest stone was 1.83cm with a range of 1-3.5cm. All stones were < 2cm in patients who achieved ductal clearance in 1 procedure.

Out of 40 patients, 9 were excluded as they were awaiting further EHL for duct clearance. 31/31 (100%) achieved ductal clearance at the last procedure. Ductal clearance was achieved with 1 EHL session in 11/31(35.5%), 2 EHL sessions in 11/31(35.5%), 3 EHL sessions in 7/31(23%) and 4 sessions in 2/31(6%). There was no correlation between number of stones and number or duration of EHL sessions.

The average number of shocks used in one EHL was 1600 shocks. Average time spent on one EHL was 78 minutes. In 2018, 37.1 hours were used for Spyglass EHL in total (this does not include diagnostic Spyglass procedures).

Documented complications occurred in 2/57(3.5%) procedures; 1 peri-pancreatic abscess with necrotic nodes and 1 lingual haematoma secondary to intubation. There were no reported cases of pancreatitis or 30 day mortality.

Conclusions Cholangioscopy with EHL is an effective treatment for refractory choledocholithiasis, achieving 100% ductal clearance, with a low rate of complications. However the procedural duration and number of repeat procedures required based on stones size/burden is difficult to predict. This data will be useful to centres planning to roll out a Spyglass-EHL service.

PTU-6 COMPLETION COLONOSCOPY IN PATIENTS WITH ADENOMAS IDENTIFIED ON FLEXIBLE SIGMOIDOSCOPY; IS IT ALWAYS NECESSARY?

Larissa Good*, Zameer Mohamed, Georgina Chadwick, Carole Collins, Emma Johnston, Samuel Pannick, Moe Kyaw, Krishna Sundaram, Richard Appleby. *West Middlesex University Hospital, London, UK*

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Introduction The BSG guidelines on adenoma surveillance make no recommendation for adenomas identified on flexible sigmoidoscopy (FS). Conventionally, a completion colonoscopy is performed for any patient with an adenoma found on FS. However, Bagshaw and colleagues [1] proposed that this could be limited to 'high risk' lesions found at FS. We assessed this risk stratified approach using data from individuals undergoing initial FS and completion colonoscopy for bright per rectal (PR) bleeding.

Methods We retrospectively identified all patients who had an adenoma detected at FS for bright PR bleeding at West

Abstract PTU-6 Table 1 FS and completion colonoscopy outcomes stratified by age and risk findings (n=29)

FS	Completion Colonoscopy	
	Normal/Low Risk	High Risk/Cancer
<60 Low Risk Finding	13	0
<60 High Risk Finding/Cancer	5	1
>60 Low Risk Finding	6	4
>60 High Risk/Cancer	0	0

Middlesex University Hospital between May 2019 and January 2020, using the audit function on the local endoscopy software.

In addition to demographic information, the study identified the proportion undergoing completion colonoscopy and polyp characteristics. Polyps were stratified 'high risk' according to features proposed by Bagshaw; tubulovillous adenoma (TVA)/villous adenoma (VA)/sessile serrated lesion (SSL) of any size, high grade dysplasia of any size, >3 tubular adenomas (TA), >20 hyperplastic polyps and persistent rectal bleeding.

Results 74 FS were performed for PR bleeding, with 37 (50%) having at least 1 adenoma detected. According to the Bagshaw criteria, 4 patients (11%) had high risk adenoma findings and 1 (1%) had an adenocarcinoma on FS, all were aged <60. 29 (78%) patients with an adenoma at FS had a completion colonoscopy. 5 (17%) had high risk findings or cancer at colonoscopy, of whom only one was <60; this patient had a high risk lesion at initial FS. Of the 13 patients <60 with low risk findings on FS as per the Bagshaw criteria, 0 patients had high risk findings on completion colonoscopy.

Conclusions No patient under 60 with low risk polyps detected at FS, had a subsequent high risk lesion identified on completion colonoscopy. Therefore, the introduction of a risk-based adenoma stratification guidance for completion colonoscopy may prove to be useful among individuals below the National Bowel Cancer Screening Programme age reporting fresh PR bleeding, particularly given ever increasing pressures faced by providers to conduct timely endoscopy procedures.

REFERENCE

1. Bagshaw P, et al. Guidelines for completion colonoscopy after polyps are found at flexible sigmoidoscopy for investigation of haemorrhoidal-type rectal bleeding. *Gut* 2020.

PTU-7 PREDICTORS OF HIGH-RISK ENDOSCOPIC FEATURES IN PATIENTS WITH ACUTE UPPER GASTROINTESTINAL BLEEDING

¹Stephanie Poo*, ²Annelies Sweeney, ²Kar Mun Ang, ²Ahmed El-masry, ²Rigers Cama, ²Rajan Patel, ²Kalpesh Besherdas. ¹London North West Healthcare NHS Trust, London, UK; ²Royal Free London NHS Trust, London, UK

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Introduction The Glasgow Blatchford Score is useful in predicting the need for hospital-based intervention following an acute upper GI bleed (AUGIB); however the accuracy of risk scores for determining risk of rebleed or further intervention is relatively low(1). It is well established that high-risk features during endoscopy (HRE) in AUGIB are associated with poor outcomes. We aimed to evaluate pre-endoscopic parameters to