14/15 (93%) continue with or were initiated on neuromodulatory medication (Amitriptyline/Duloxetine/Pregabalin/Mirtazapine). 12/15 (80%) did not need any further hospital admissions for symptom management.

Conclusions Ampullary Botox injection is a useful management strategy in managing refractory pancreaticobiliary pain in patients with FBSD post ES.

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PTU-11

ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY IN CHRONIC PANCREATITIS; EXPERIENCE IN A TERTIARY REFERRAL CENTRE

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Introduction Chronic pancreatitis (CP) is a fibroinflammatory condition of the pancreas leading to pancreatic fibrosis, duct distortion and calcification with progressive pain, exocrine and endocrine dysfunction. We sought to assess the effects of endoscopic intervention via Endoscopic Retrograde Cholangiopancreatography (ERCP) on pancreatic duct (PD) remodelling and pain.

Methods Consecutive patients with CP who underwent ERCP with pancreatic intervention at a tertiary centre over a ten-year period were retrospectively analysed. Recorded variables included patient demographics, procedural characteristics and follow-up data. Fishers test was used to calculate statistical significance.

Results 51 patients (36 male) with PD strictures and intraductal calcification were identified. The median age was 50 (range 20 – 82 years old). 131 ERCPs were undertaken (one procedure in 23, two- three in 19, four- five in 3, six and above in 6). Alcohol was the commonest aetiology in 39.22% (n=20), followed by idiopathic 25.5% (n=13) and obstructive stone disease 21.57% (n=11). 43.14% (n=22) were smokers and 41.18% (n=21) were consuming alcohol.

Technical success was achieved in 84.31% (n=43). 72.09% (n= 31) had a main PD stricture. 62.79% (n= 27) had main PD stones of which 33.33% (n=9) were larger than 5mm. 88.37% (n=38) underwent pancreatic endotherapy. Dilatation of pancreatic strictures was carried out in 44.74% (n=17), with 94.74% (n=36) undergoing pancreatic stenting. Sequential pancreatic stenting was utilised in 66.16% (n=24). In total there were 81 stents inserted over the study period. Plastic stents were the most commonly used at 62.96% (n=51), followed by Niti-S™ BUMPY™ Pancreatic Stent 30.86% (n=25) and Fully Covered Self Expanding Metal stents (FC-SEMS) 4.94% (n=4) and one ARCHIMEDES Biodegradable pancreatic stent. The median duration of sequential stenting was 17 months (range 1- 65 months).

42.11% (n=16) had resolution of their strictures with intervention and 57.89% (n=22) had improvement in pain. Patients with intraductal stones <5mm were more likely to have improvement in pain with endoscopic therapy than those

>5mm (15 vs 2, P= 0.0001). Patients having sequential stenting were more likely to have improvement in their strictures (14 vs 2, p= 0.0157). The same effect on pain was not apparent with sequential stenting (17 vs 7, p= 0.2979). There were 2 episodes of pancreatitis and 6 episodes of stent migration.

Conclusions Pancreatic endotherapy is more effective in patients with intraductal stones less than 5mm. Sequential stenting seems to have a beneficial effect on pancreatic strictures which may impact disease progression.

PTU-12

SMALL POLYPS AT COLONOSCOPY AND THE NICE CLASSIFICATION: LIKELY CAUSES OF OPTICAL DIAGNOSIS ERROR

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Introduction There is increasing interest in optical diagnosis (OD) for small colonic polyps with a 'resect and discard' strategy. During OD the endoscopist assigns the polyp diagnosis as high or low confidence using the NICE or equivalent classification. Our aim is to assess factors that result in an incorrect OD where a high confidence optical diagnosis is made by an experienced endoscopist.

Methods In the early phase of a prospective feasibility study of optical diagnosis (DISCARD3), eight bowel cancer screening colonoscopists optically diagnosed 639 diminutive polyps during Feb-Nov 2020. Each polyp diagnosis was evaluated by the colonoscopist as high or low confidence using the NICE criteria. All retrieved polyps were sent for histopathology.

In 112 polyps the high confidence optical diagnosis did not match the final histology result. A root cause analysis was performed as part of the ongoing training and implementation of optical diagnosis. Each of these polyp photos were assessed by a blinded endoscopist who scored photo quality with 1 point for each of the following criteria (score range 0-3): clean surface; complete view; and correct focal distance. A score of 3 was considered adequate to apply the NICE criteria.

In addition, the likely cause of the optical diagnosis error was categorised as:

1. NICE mismatch - NICE criteria could not be fully applied to the polyp (eg mixture of NICE type 1 and type 2 features).

- NICE not applied – NICE criteria could be applied but was done incorrectly.
- Inadequate photo for NICE – where photo quality was inadequate for NICE criteria to be applied.
- Specimen processing error – where there is high confidence that the optical diagnosis was correct with suspected specimen processing/retrieval error.

Results Of 112 polyps, 91% (102/112) had clean surface, 60% (67/112) had complete view, and 27% (30/112) had correct focal distance. The photo quality scores were inadequate in 93/112 cases (score 0: 5%, 6/112; 1: 29%, 32/112; or 2: 49%, 55/112) and adequate in 19/112 cases (score 3: 17%, 19/112).

The assumed cause of the optical diagnosis error was NICE mismatch in 31/112 (27.7%) cases, NICE not applied in 19/

112 (17.0%), inadequate photo for NICE in 59/112 (52.7%) and histology processing error in 3/112 (2.7%).

Conclusions Adequacy of polyp photo is critical to quality assurance of OD. In this study a significant proportion of OD errors had corresponding inadequate photodocumentation with incorrect focal distance the main photographic issue. This may affect application of the NICE criteria. In cases where photos were adequate, understandable error occurred where lesions had a mixture of NICE 1 and 2 features.

PTU-13 LEARNING CURVE OF OPTICAL DIAGNOSIS WITH A RESECT AND DISCARD STRATEGY FOR SCREENING COLONOSCOPY

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Introduction Advanced endoscopic imaging allows optical diagnosis of diminutive polyps. Performance thresholds for optical diagnosis have been set to allow a 'resect and discard strategy' which may streamline patient care and reduce histopathology need. Aim: to assess early implementation and quality assurance of this strategy in a bowel cancer screening unit setting (1.1 million population).

Methods In this prospective feasibility study, 8 bowel cancer screening colonoscopists completed a validated optical diagnosis training module and performed all procedures during Feb-Oct 2020. All ≤ 5 mm polyps had white-light and narrow-band images. Endoscopists classified the optical diagnosis as high or low confidence. All polyps had standard histopathology.

Performance was analysed in 2 month time periods with active feedback given. There was repeat histology review of inaccurate high confidence optical diagnoses.

Results In the 8 months to date, 639 polyps were optically diagnosed (468 high confidence and 171 low confidence) from 283 patients who were divided into 4 time periods.

The proportion of low confidence diagnoses increased from 15% in periods 1-2 to 29% in period 4.

In periods 1-2, 1/8 endoscopists achieved the 90% accuracy threshold. In periods 3 and 4, 2/8 and 4/8 endoscopists achieved the threshold respectively. Overall, accurate diagnoses increased from 81% to 86% (period 1 to 4). Of those who reached the threshold by period 4 the mean number of high confidence calls was 60 (range 41-99).

For periods 1-4, the positive and negative predictive values for optical diagnosis of an adenoma were 89.3% and 64.4% respectively.

Abstract PTU-13 Table 1

		Histology		Total
		Adenoma	Non-adenoma	
Optical diagnosis	Adenoma	275	57	332
	Non-adenoma	33	103	136
Total		308	160	468

Conclusions The learning curve for optical diagnosis in a bowel cancer screening setting varies between individual operators. Over time, and with feedback, there is a gradual increase in optical diagnosis accuracy and in the number of colonoscopists achieving the 90% threshold accuracy target, with a corresponding decrease in the percentage of high confidence calls.

PTU-14 PATIENT ACCEPTABILITY OF DIMINUTIVE POLYP OPTICAL DIAGNOSIS WITH RESECT AND DISCARD STRATEGY IN SCREENING COLONOSCOPY

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Introduction Colonoscopy with polypectomy reduces the rate of subsequent colorectal cancer and associated mortality. Most polyps resected are diminutive and have a low cancer risk. Currently, these diminutive polyps are resected and examined histologically. Using advanced imaging technologies some studies show we can distinguish adenomas from non-adenomas optically. This could potentially avoid unnecessary polypectomies and associated histology costs in cases where there is high confidence in the diagnosis of the polyps allowing polyps to be resected and discarded. The aim of this study is to assess the acceptability of such a strategy for patients in real life clinical practice.

Methods Two hundred and fifty patients undergoing a bowel cancer screening colonoscopy procedure, where optical diagnosis was used as part of the DISCARD3 study, were invited to participate in a patient experience survey. This was carried out over February - October 2020 at a London bowel cancer screening centre (screening population 1.1 million) with 209 patients included (41 patients excluded: 33 did not complete, 8 did not consent).

Patients were asked to rate the following questions (responses: 5 point scale from strongly disagree to strongly agree):

2. My colonoscopy was comfortable

1. I would be happy for any polyps found during my colonoscopy to be assessed by the person carrying out the procedure at the time (rather than to wait for laboratory results to get the diagnosis)
2. If a future colonoscopy is advised I would prefer to be informed immediately after the initial procedure rather than wait to be told later by telephone or in the outpatient department
3. I feel confident that the person carrying out the procedure could accurately diagnose polyps without sending them to the laboratory
4. I felt highly satisfied with the procedure today Patients were also asked about their previous experience (responses: Yes, No or N/A):
5. If you have had a previous colonoscopy, did you notice any difference in the procedure today compared with previously?

Results Most patients found their procedure comfortable (85.2%; 178/209) and were satisfied with their procedure (97.6%; 204/209). Most agreed or strongly agreed that they would be happy for polyps to be assessed optically (78.9%;