165/209) and felt confident in the ability of the endoscopist to do this (90.9%; 190/209). 85.2% (178/209) would be happy to be informed of their colonoscopy surveillance interval immediately after the procedure.

Conclusions In this small but representative sample, optical diagnosis of diminutive polyps using a resect and discard strategy appears to be an acceptable approach for patients within a bowel cancer screening programme. To achieve similar levels of acceptability in standard clinical practice patients may require additional and enhanced information about the concept and application of a resect and discard strategy.

PTU-15 PCCRCs IDENTIFIED FROM POPULATION-BASED DATA MAY BE RE-CLASSIFIED AS DETECTED CANCERS FOLLOWING LOCAL DATA ANALYSIS

Ahmira Ahmad*, Adam Humphries, Angad Dhillon, Misha Kabir, Brian Saunders, Ana Wilson, Siwan Thomas-Gibson. *Wolfson Unit for Endoscopy, Imperial College London, London, UK*

10.1136/gutjnl-2021-BSG.88

Introduction A recent population-based cohort study showed variation in post-colonoscopy colorectal cancer (PCCRC) rates across providers. Aim: to analyse PCCRC cases using local data in order to determine the cause and evaluate whether clinician and/or patient factors are primarily responsible.

Methods A retrospective root cause analysis was performed, in accordance with World Endoscopy Organisation recommendations, on a sample of 52 cases reported as PCCRCs from a national dataset (CORECT-R) during 2005-2013. 6 cases were excluded (3 missing data, 3 duplicates).

First, we confirmed if the case was a true PCCRC and if so, the most plausible explanation. We then evaluated whether responsibility for the PCCRC was primarily due to clinician and/or patient factors.

Results Of 46 included cases, 35 were confirmed as PCCRCs. 11 cases did not meet the PCCRC definition (8 detected cancers, 3 data errors).

The mean age for PCCRCs was 68 years old (range 39-93). The primary endoscopist was an independent non-consultant endoscopist, consultant, or nurse endoscopist in 51.4%

(18/35), 45.7% (16/35), and 2.9% (1/35) of cases respectively. Caecal intubation was reported in 94.3% (33/35) of cases with adequate caecal photodocumentation in 54.3% (19/35) of cases (reviewed by two blinded endoscopists). Rectal retroflexion was performed in 42.9% (15/35) of cases.

Primary responsibility for the PCCRC cases was in 74.3% (26/35) the clinician, 11.4% (4/35) the patient (surgery refused) and 14.3% (5/35) both clinician and patient (see Table 1).

Conclusions Local data helps confirm and evaluate PCCRC cases identified from national datasets. Clinician-factors were responsible for the majority of PCCRC cases. Lack of caecal and rectal retroflexion photodocumentation occurred frequently in PCCRC cases and may be a marker of suboptimal examination. In a significant proportion of cases where a lesion was detected patients refused surgery which ultimately led to the PCCRC.

PTU-16 UTILITY OF NASOBILIARY DRAINAGE IN CHOLESTASIS; A TERTIARY CENTRE EXPERIENCE

Wafaa Ahmed*, Rebecca Jeyaraj, David Reffitt, Phillip Harrison, Michael Heneghan, Deepak Joshi. *Kings College Hospital NHS Trust, London, UK*

10.1136/gutjnl-2021-BSG.89

Introduction Nasobiliary drainage (NBD) is a technique that has been successfully used to manage intrahepatic cholestasis, bile leak and obstructive cholangitis. It involves placing a catheter via Endoscopic Retrograde Cholangio-pancreatography (ERCP) to allow continuous external drainage of bile thereby bypassing the ileum where bile salts would be reabsorbed. We sought to assess the efficacy of placement on markers of cholestasis and patient symptoms.

Methods Consecutive patients with undergoing NBD over a ten-year period were retrospectively analysed. Recorded variables included patient demographics, procedural characteristics and response to therapy. Wilcoxon signed-rank test was used for paired samples.

Results 25 patients (14 male) underwent 31 procedures. The mean age was 31 years old (range 2-67 years old). One procedure was carried out in 21 patients, with two having 2 and one having 5. The most common aetiologies were hereditary cholestatic disease (n=9, 36%) followed by drug induced cholestasis (n=4, 16%), idiopathic cholestasis (n=4, 16%) and post-surgical (n=2, 8%). The indications for drainage were: cholestasis (n=20, 80%), bile leak (n=3, 12%), cholangitis (n=2, 8%) and cholangiocarcinoma (n=1, 4%).

Sphincterotomy was performed in 11 (35.48%). Normal biliary anatomy was encountered in 15 (48.39%) patients. In the patients with a bile leak, ileus was also present. Intravenous antibiotics were administered to 24 (77.42%) patients. Median hospital stay was 18 days (range 1-91).

Duration of NBD was available for 22 (70.9%) cases. They remained sited for a median of 8.5 days (range 1-54 days). There was an overall improvement in bilirubin (17% improvement, 5.77% SD, p=0.0344), and ALP (12% improvement, SD 4.38%, p=0.0465). All patients with pruritis as their primary symptom had symptomatic improvement. Clinically significant pancreatitis occurred in 2 (6.45%) patients. The majority tolerated placement of the drainage catheters (n= 29, 94%).

Abstract PTU-15 Table 1 Breakdown of most plausible explanation for confirmed PCCRC cases and primary responsibility

Most plausible explanation	Primary responsibility			Total
	Clinician	Clinician and Patient	Patient	
Possible missed lesion, prior examination adequate	4	0	0	4 (11.4%)
Possible missed lesion, prior examination negative but inadequate	12	1	0	13 (37.1%)
Detected lesion, not resected	4	4	4	12 (34.3%)
Likely incomplete resection of previously identified lesion	6	0	0	6 (17.1%)
Likely new cancer	0	0	0	0 (0%)
Total	26 (74.3%)	5 (14.3%)	4 (11.4%)	