Abstract PTU-20 Table 1  Accuracy of OD surveillance intervals compared with histopathology-derived intervals

<table>
<thead>
<tr>
<th>Group</th>
<th>Confidence in optical diagnosis of polyps &lt;1cm</th>
<th>Cases</th>
<th>Accuracy of optical diagnosis BSG surveillance interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>High confidence only</td>
<td>47.4%</td>
<td>100% (65/137)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(65/65)</td>
</tr>
<tr>
<td>B</td>
<td>Mixed (high/low) confidence</td>
<td>52.6%</td>
<td>98.6% (72/72)</td>
</tr>
</tbody>
</table>

surveillance intervals. We analysed the effect of OD on the accuracy of surveillance interval in a bowel cancer screening setting.

Methods Eight screening colonoscopists used an OD approach for polyps <1cm in 250 patients between Feb-Nov 2020 in the early phase of a prospective feasibility study (DISCARD3). After OD (white light+NBI) all polyps were resected and retrieved for histopathology where possible. Cases with polyps ≥1cm were excluded.

Cases were divided into 2 groups:

3. Group A: all polyps <1cm and only high confidence OD
   - Group B: all polyps <1cm and mixed (high/low) confidence OD

Each patient had an OD surveillance interval assigned and this was compared to histopathology alone.

Results Of 205 patients, 137 were included (68 excluded: 36 had no polyps, 13 had large colorectal cancers, 10 flexible sigmoidoscopies, 7 did not consent, 1 abandoned procedure, 1 missing data). See Table 1.

65/137 (47.4%) patients had polyps <1cm and only high confidence OD (Group A). In 65/65 (100%) cases the OD surveillance interval matched the histology surveillance interval.

72/137 (52.6%) patients had polyps <1cm and mixed (high/low) confidence OD (Group B). In 71/72 (98.6%) cases the OD surveillance interval matched the histology surveillance interval. The one case where surveillance interval changed was a serrated polyp which was found to have dysplasia on histology.

The overall accuracy of OD surveillance intervals compared with histology surveillance intervals was 99.3% (136/137). There were no unexpected polyp cancer cases.

Conclusions OD of polyps <1cm, with a resect and discard strategy, does not appear to adversely affect BSG surveillance intervals across different levels of OD confidence.

PTU-21  SINGLE OPERATOR CHOLANGIOSCOPY – DOES CONSCIOUS SEDATION HAVE A ROLE? A RETROSPECTIVE SINGLE CENTRE EXPERIENCE

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Background: Single operator cholangioscopy (SOC) has an important role in the diagnosis and management of biliary strictures and complex biliary stones. The evidence base is evolving, but with small numbers in reported studies. The majority of published literature discusses SOC under general anaesthetic; typically propofol. We compared successful stone clearance, stricture assessment and safety under conscious sedation and propofol.

Methods A single centre retrospective analysis was performed of consecutive SOCs over 8 years at Bristol Royal Infirmary (tertiary referral centre for SW England and South Wales). Parameters included sedation/propofol usage, stone clearance, electrohydraulic lithotripsy (EHL), histology, final diagnosis and complications.

Results Between Jan 2013 – Nov 2020, 471 SOCs were performed on 352 patients (175f, 177m); mean age 65.7 years (17-92), referred from 18 centres. 15 SOCs were performed in 2013 compared to 99 in 2019 before restrictions from the COVID19 pandemic.

228 therapeutic SOCs + EHL were performed for stone clearance, 79.8% (n=182/228) under conscious sedation (median fentanyl dose 150mcg; midazolam 7mg; comfort score 2). Complete stone clearance rose from 79.7% in the conscious sedation group to 89.2% in with propofol sedation, although the difference was not significant (p=0.19).

243 diagnostic SOCs were performed, 88.9% under conscious sedation. Similar to therapeutic SOCs, median fentanyl dose 150mcg; midazolam 7mg; and comfort score 2. Overall macroscopic assessment of strictures correlating with malignancy had a sensitivity, specificity and diagnostic accuracy of 90.2% (95% CI 82.7-95.2), 92.6% (95% CI 86.3-96.5) and 91.5% (87.0-94.8%) respectively. Diagnostic accuracy with macroscopic assessment was comparable between patients receiving conscious sedation (91.4%; 95% CI 86.6-94.9) vs propofol sedation (92%; 95% CI 74.0-99.0). Diagnostic accuracy with histological assessment appeared greater in patients receiving propofol sedation (95%; 95% CI 75.1-99.9) compared to conscious sedation (84.7%; 95% CI 78.5-89.6).

28 adverse events were recorded (5.9%), with post ERCP cholangitis (2.3%) and pancreatitis (2.1%) the commonest causes. Complications were marginally higher in patients receiving propofol sedation (6.8%; n=5/73) vs those receiving conscious sedation (5.8%; n=23/398) but the difference was not significant (p=0.72).

Conclusions This is the largest single centre retrospective analysis of SOCs. Successful stone clearance is similar to results found in literature from smaller studies. There was a trend to greater successful stone clearance with propofol. Conscious sedation has previously been described as a risk factor for inadequate visualisation, but we found very similar high levels of diagnostic accuracy in both groups. Both were generally well tolerated with low rates of adverse events.

PTU-22  IDENTIFYING AND IMPROVING RATES OF POST-COLONOSCOPY COLORECTAL CANCER (PCCRC)

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Introduction Bowel cancer is the fourth commonest cancer in the UK; accounting for over 40,000 new cancer diagnoses and 16,000 deaths per year.1 PCCRC (post-colonoscopy colorectal cancer) rate – cancer found within 6 to 36 months after a negative colonoscopy2 – is improving. However, there remains a large variation amongst providers, with rates from 3.6- 9.3%.3 Early detection leads to improved outcome and
JAG recommends auditing PCCRC rate as a KPI in colonoscopy with an aspirational rate of 3.6%. \textsuperscript{3,4}

Methods A retrospective review of data at a district general hospital was used to calculate PCCRC rate and identify learning for quality improvement. New CRC diagnoses were identified using a regional cancer database over a one year period and colonoscopy data was collected from the local endoscopy reporting tool from the previous 3 years. The proportion of those who had received a negative colonoscopy in the preceding 3 years was used to calculate the PCCRC rate. Individual cases were reviewed to identify scope for improvement.

Results There were 182 new colorectal cancer diagnoses from 01/04/2019-31/03/2020. Of these, six patients (3.3\%) had a negative colonoscopy in the preceding 6 to 36 month window. PCCRC was more common in older, male patients with a history of underlying bowel disease and previous CRC. Two of the six patients had genetic risk factors for CRC and two had recurrence at the anastomosis having had previous resections for CRC.

Conclusions Data review identified those at highest risk of a missed lesion and has been used to prioritise surveillance colonoscopies in our service. This pragmatic approach to identifying PCCRC rate can be easily replicated in other trusts. With ever increasing pressures on endoscopy capacity during the COVID-19 pandemic this could ensure high-risk patients are prioritised leading to earlier diagnosis and improved outcome.

REFERENCES

PTU-24 THE ROLE OF HEMOSPRAY AS A MONOTHERAPY TREATMENT OF GASTROINTESTINAL BLEEDINGS
1.\textsuperscript{1}Momeny Husein*, 1Dhurayt Alzoubaidi, 2Michael O’Donnell, 3Alvaro de la Serna, 3Ioannis Vardabos, 4Tricia Hengehold, 5Jaco Porto Fernandez-Sordo, 6Johannes W Rey, 7Bu Hayee, 8Edward Despott, 9Alberto Murino, 10Sulleman Moreea, 11Phil Boger, 12Jason Dunn, 13Inder Mainie, 14John Anderson, 15Pradeep Bhandari, 16Martin Goetz, 17Horst Schmidt Kliniken, Germany
3Melissa Latorre, 5Krish Ragunath, 10Sulleman Moreea, 11Phil Boger, 12Jason Dunn, 13Inder Mainie, 14John Anderson, 15Pradeep Bhandari, 16Martin Goetz, 17Horst Schmidt Kliniken, Germany
8Bu Hayee, 9Edward Despott, 9Alberto Murino, 10Sulleman Moreea, 11Phil Boger, 12Jason Dunn, 13Inder Mainie, 14John Anderson, 15Pradeep Bhandari, 16Martin Goetz, 17Horst Schmidt Kliniken, Germany
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Introduction Dual endoscopic therapy has been considered the standard of care for endoscopic management of GI bleeding. We aimed to look at the outcomes of Hemospray as a monotherapy treatment for GI bleeds.

Methods Data was collected on patients with GI bleeds treated with Hemospray monotherapy in 18 centres. Haemostasis was defined as cessation of bleeding within 5 minutes of hemostasis application.

PTU-23 EFFECTIVENESS AND OUTCOMES OF SINGLE SESSION EUS -ERCP – EXPERIENCE FROM TERTIARY CARE CENTRE
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Introduction Endoscopic retrograde cholangiopancreatography (ERCP) is a well-established technique for removal of common bile duct stones. However, stone(s) might pass out in the time lag between imaging and ERCP procedure, and the patient might become asymptomatic with improved biochemical markers. The primary outcome of this study was to look at efficacy and outcomes of single setting EUS-ERCP for low-risk patients with previously confirmed/suspected small CBD stones.

Method A three year (September 2017 to September 2020) prospectively maintained database of EUS-ERCP patients was retrospectively reviewed. Data was collected from electronic hospital records and analysed on IBM SPSS. We evaluated the reason of combined procedure along with long term outcome.

Results Total of 112 patients were included in the study. There were total of 80 females and 32 males with ages ranging from 26 – 94 (Median 68). 51% patients (n = 57) did not have ERCP performed based on EUS findings. Of the 57 patients who did not have an ERCP, 14 patients were referred for cholecystectomy, 24 had previous cholecystectomy and 19 were either referred to another speciality for follow up for another diagnosis or discharged without further intervention. All patients who were referred for ERCP following post cholecystectomy OTC findings (n=6) did not require ERCP after assessment with EUS.

Only 4 patients that did not have ERCP re-presented with biliary associated pathologies. One of these patients had persistent symptoms, and so an ERCP and sphincterotomy was performed but no stones were found and sphincter of oddi dysfunction was diagnosed, one patient had gall stone pancreatitis (deemed unfit for cholecystectomy due to raised BMI), and finally two patients were admitted with biliary sepsis while awaiting cholecystectomy.

Patients with a previous history of cholecystectomy (n=35) were significantly more likely to not require ERCP based on EUS findings (p=0.043).

Patients who only had EUS performed had an average procedure time of 7.7 minutes (range 2 – 26 minutes). The average procedure time for a combined EUS-ERCP procedure was 29 minutes.

Conclusion Combined EUS and ERCP was found to be an effective approach in low-risk patients. More than half of the patients who had EUS didn’t even require ERCP, thereby reducing the risk from an un-necessary procedure. The procedure duration (even in combined procedures) was not significantly different. Careful selection of patients is a key factor. We suggest that all low-risk patients should have a EUS before ERCP.