JAG recommends auditing PCCRC rate as a KPI in colonoscopy with an aspirational rate of 3.6%.^{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.

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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 persisting 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 high. Careful selection of patients is a key factor. We suggest that all low-risk patients should have a EUS before ERCP.

PTU-24 THE ROLE OF HEMOSPRAY AS A MONOTHERAPY TREATMENT OF GASTROINTESTINAL BLEEDS

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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 hemospray application.