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

¹Abdullah Abbasi*, ¹Gareth Byrne, ¹Umair Kamran, ²Keith Siau, ¹Sriha Hebbar. ¹University Hospital of North Midlands, Stoke-on-trent, UK; ²Queen Elizabeth Hospital Birmingham, Birmingham, UK

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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

^{1,2}Mohamed Hussein*, ²Durayd Alzoubaidi, ³Michael O'Donnell, ⁴Alvaro de la Serna, ⁵Ioannis Varbobitis, ⁶Tricia Hengehold, ⁷Jacobo Ortiz Fernandez-Sordo, ⁷Johannes W Rey, ⁸Bu Hayee, ⁹Edward Despott, ⁹Alberto Murino, ¹⁰Sulleman Moreea, ¹¹Phil Boger, ¹²Jason Dunn, ¹³Inder Mainie, ¹⁴David Graham, ⁶Daniel Mullady, ⁶Dayna Early, ³Melissa Latorre, ⁵Krish Ragunath, ¹⁴John Anderson, ¹⁵Pradeep Bhandari, ¹⁶Martin Goetz, ¹⁷Ralf Keisslich, ¹⁸Emmanuel Coron, ⁴Enrique Rodriguez de Santiago, ³Tamas Gonda, ³Seth Gross, ^{1,2}Laurence Lovat, ^{1,2}Rehan Haidry. ¹UCLH, UK; ²UCL, UK; ³NYU Langone, USA; ⁴Hospital Universitario Ramon y Cajal, Spain; ⁵Nottingham University Hospitals, UK; ⁶Washington University School of Medicine in St. Louis, USA; ⁷Klinikum Osnabrück, Germany; ⁸Kings College Hospital, UK; ⁹Royal Free Hospital, UK; ¹⁰Bradford Teaching Hospitals, UK; ¹¹University Hospital Southampton, UK; ¹²Guy's and St Thomas, UK; ¹³Belfast Health and Social Care Trust, UK; ¹⁴Gloucestershire Hospitals, UK; ¹⁵Portsmouth Hospitals, UK; ¹⁶Klinikum Sindelfingen-Böblingen, Germany; ¹⁷Horst Schmidt Kliniken, Germany; ¹⁸Centre Hospitalier Universitaire, France

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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.

Abstract PTU-24 Table 1 Outcomes of treatment with Hemospray monotherapy

	Peptic ulcer (N =62)	Malignancy (n = 72)	Post endoscopic therapy (N=23)	Lower GI bleeds (N = 22)	Angiodysplasia (N =5)	Inflammation (N =22)	Variceal (N =7)
Haemostasis	56/62 (90%)	72/72 (100%)	23/23 (100%)	21/22 (96%)	5/5 (100%)	21/22 (96%)	4/7 (57%)
Rockall	7 (IQR, 7-8)	8 (IQR, 7-9)	6 (IQR, 5-6)	n/a	7 (IQR, 6-7)	7 (IQR, 6-8)	8 (IQR, 7-8)
Re-bleed	7/44 (16%)	11/63 (18%)	1/20 (5%)	5/19 (26%)	1/5 (20%)	4/19 (21%)	1/3 (33%)
7-day mortality	6/50 (12%)	5/63 (8%)	1/20 (5%)	2/20 (10%)	0	5/20 (25%)	3/6 (50%)
30-day mortality	15/50 (30%)	17/63 (27%)	1/20 (5%)	4/20 (20%)	0	10/20 (50%)	3/6 (50%)

Results 62 patients with peptic ulcer bleeds were treated. There was an immediate haemostasis of 90% (56/62), re-bleed rate of 16% (7/44) (Table 1). 69% were Forrest 1a/1b ulcers.

72 patients with malignancy related bleeds. There was a haemostasis rate of 100% and a re-bleed rate of 18% (11/63). There was a haemostasis rate of 100% with post endoscopic therapy bleeds. 48% were post endoscopic mucosal resection.

22 patients with lower GI bleeds were treated. 36% secondary to colonic tumours. There was a haemostasis rate of 96% (21/22) and re-bleed of 26% (5/19). A 100% haemostasis was achieved in 5 patients treated for gastric angiodysplasia with one re-bleed.

Conclusions Results show high haemostasis and comparable re-bleed rates with Hemospray monotherapy treatment. It may play a potential role in actively bleeding peptic ulcers in difficult anatomical positions to help bridge towards definitive therapy. These data may represent the evolution of new treatment paradigms as experience with haemostatic powders increases.

PTU-25 DELIBERATE FOREIGN BODY INGESTION DURING COVID-19

Andrew Phillips*, Kate Axe. Nevill Hall Hospital, Abergavenny, UK

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Introduction For patients with Foreign body ingestion (FBI) 10-20% of FBI require endoscopic investigation¹. Common non-food objects swallowed include paperclips, coins, pens, batteries & razors.

92% of non-food ingestion is deliberate (DFBI), considered a type of deliberate self-harm (DSH)². DFBI is often recurrent, leading to high healthcare costs.

Our team noted an increase in OGD for DFBI during the COVID-19 pandemic, we compared our experiences in 2020 with those of 2018 & 2019 and reviewed their management.

Method Retrospective case notes study for OGD referrals for 'foreign body'. Data obtained from EMS endoscopy and Clinical Workstation (CWS). PEG change/removal and OGD post object passage were excluded.

Results Between 2018 & 2020, 23 procedures were performed for DFBI; 13/23 (57%) needed General Anaesthetic (GA). 7/23 of procedures (30%) used an overtube, 6 (86%) under GA.

Abstract PTU-25 Table 1

	2018	2019	2020
Total FBI	10	20	31
Referral			
Total DFBI	2 (20%)	4 (20%)	17 (55%)
Number of patients	2	2	9
Objects	Batteries	Toothbrush, coins	Bra wire, batteries, pen, glasses, paperclip, screws, toothbrush, blades

No object was found in 2 OGD. Surgical management was required in 2 OGD. In 29/61 procedures one or more objects was retrieved.

Discussion 2020 demonstrated a marked increase in OGD for FBI, of which 55% were DFBI compared with 20% in preceding years. All patients were ≤40 years of age. Commonest objects were long e.g. pens or high risk e.g. batteries/razors. However, a wider variety of objects were swallowed during the pandemic.

Our outcomes reflect those in published data¹, with most procedures successful when objects were known to be in the stomach.

DFBI is often spontaneous and stress related, rather than a suicide attempt, on a background of complex personality disorder. It is thought DFBI gives a psychological 'gain' in forcing care, with multiple healthcare contacts resulting from the act².

Care plans are common in other forms of DSH but lacking in DFBI. These may benefit repeat attenders, ensuring endoscopy only performed when strictly necessary and minimising the psychological gain from the act.

Mental health issues have increased during the pandemic, this has impacted on already stretched endoscopy services with increase in DFBI, possibly due to decreased access to psychiatric services. This act is resource intensive and difficult to manage, a care plan should be considered after admission with DFBI.

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