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PTU-26 HORIBE VS CONVENTIONAL RISK SCORING: PREDICTING NEED FOR ENDOSCOPIC INTERVENTION IN ACUTE UPPER GASTROINTESTINAL BLEED

[1]Eilidh Mcgowan*, [1]Thomas Riley, [2]Keith Siau, [1]Martin Crossdale, [1]Matthew Saxton, [1]Wisam Jafar. [1]*Department of Gastroenterology, Stockport Foundation Trust., Stockport, UK*; [2]*Department of Gastroenterology, Dudley Group Hospitals NHS Foundation Trust., Dudley, UK*

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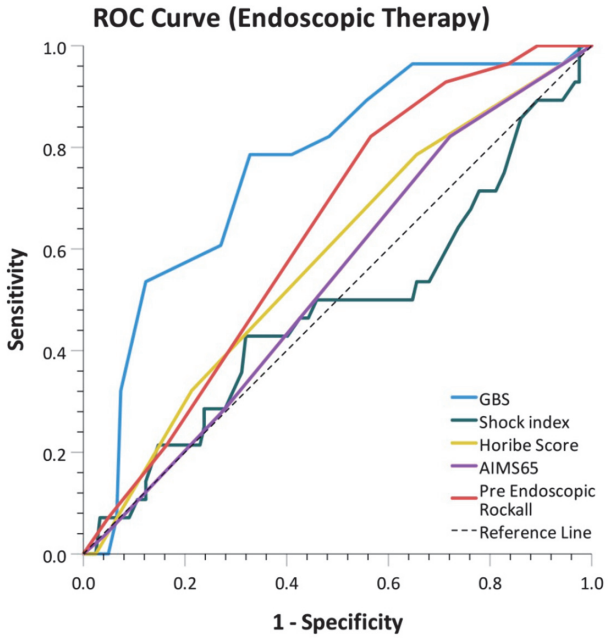
Introduction The recently developed Horibe score was shown to be superior to the Glagow Blatchford Score (GBS) in predicting endoscopic therapy in acute upper gastrointestinal bleeding (AUGIB). However, this has not been validated in the UK. We aimed to compare the Horibe score [1] with other AUGIB risk assessment tools to identify the optimal risk stratification tool for predicting endoscopic therapy in AUGIB.
Methods All patients presenting to Stockport Foundation Trust over a 7 month period (1st June 2019 to 1st January 2020) who underwent gastroscopy for AUGIB were included. Glasgow Blatchford score was calculated prospectively on admission with the Horibe(1), Shock index, Pre-endoscopy Rockall and AIM65 being calulcated retrospectively. Receiver operating characteristics (ROC) curves for each risk assessment score were generated to determine their ability to predict endoscopic therapy, with pairwise comparisons made between ROC curves to determine statistical significance.
Results Of the 150 patients included for analysis, endoscopic therapy was delivered in 28 patients (18.7%). This outcome was best predicted by the GBS (AUROC 0.759; 95% confidence interval 0.664-0.855) [Figure 1]. GBS performed significantly better than the Horibe score (AUROC 0.583, P=0.009), AIMS65 (AUROC 0.538, P=0.001), pre-endoscopic Rockall (AUROC 0.635, P=0.027) and shock index (AUROC 0.481, P<0.001). On sensitivity analysis, the GBS remained superior in patients with and without cirrhosis. A GBS threshold of ≥10 provided the optimal sensitivity (78.6%) and specificity (67.2%) for predicting endotherapy.
Conclusion The GBS appears superior to the Horibe score for predicting endoscopic therapy in AUGIB. In line with the BSG AUGIB care bundle [2], our evidence suggests that GBS should be used as the risk stratification tool of choice in AUGIB.



Abstract PTU-26 Figure 1 ROC curve (Endoscopic Therapy)

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PTU-27 IMPACT OF COVID-19 ON UGI TRACT STENTING AND DILATATION SERVICES- PRIORITISE, KEEP SCOPING AND TRAINING

Chia Chuin Yau*, Shiran Esmaily, Deepak Dwarakanath, John Hancock, Mitra Vikramjit. *University Hospital of North Tees, Stockton on Tees, UK*

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The COVID-19 pandemic profoundly affected endoscopy services including therapeutic gastroscopy across the UK. The BSG issued guidance for managing endoscopy services safely throughout this period. At the beginning of the pandemic in March 2020, a symptom-based questionnaire was used to screen patients for COVID-19 prior to their endoscopic procedures in our hospital (COVID-19 swabs were only carried out if patients presented with COVID-19 symptoms). From 18 May 2020 onwards, in addition to the above approach, all patients attending endoscopic procedures underwent a SARS-CoV-2 nasopharyngeal swab 1-3 days prior to the procedure. We describe our experience of UGI stenting and dilatation during the initial wave of COVID-19 pandemic in the UK.
Aim of the study To assess the impact of COVID-19 pandemic on technical and clinical success of luminal dilatation and stenting in the UGI tract and ascertain the risk of procedure related complications.
Methods A retrospective audit of a prospectively maintained endoscopy database was carried out between 18th March and 31st July. All patients were followed for 30 days. Full PPE were used.
Results 42 procedures [31 were oesophageal dilatation (21 peptic stricture, 9 radiotherapy stricture, 1 achalasia), 8 oesophageal stent insertion (6 for primary oesophageal cancer, 1 metastatic cancer and 1 secondary to external compression from lung cancer) and 3 pyloric dilatation all benign] were carried out- mean age 65 years, 64.3% males, 81% of procedures were carried out as outpatients. All procedures were performed under fluoroscopy. 41/42 (97.6%) patients had a confirmed histology prior to their procedure – one patient who underwent oesophageal dilatation had a peptic stricture on endoscopy (no biopsy or cross-sectional imaging). 39/42 (92.9%) patients had undergone a CT scan and/or barium swallow prior to their first procedure. All procedures were technically and clinically successful (100%).There were no procedure related complications or mortality. There were no COVID positive swabs in the 30- day post procedure period during the entire study period. Trainees were present in 21/42

(50%) of the procedures. None of the consultants or trainees who were involved with these procedures were diagnosed with COVID-19 during this period. One of the nursing staff member, who regularly assisted in the fluoroscopy room, was involved in a non-fluoroscopic diagnostic endoscopic procedure in a COVID-19 patient (not known at the time of the procedure) and subsequently tested positive for COVID-19.

Conclusion Our study confirms that a high quality stenting and dilatation service of the upper gastrointestinal tract together with specialist registrar training can be delivered safely and effectively during the COVID-19 pandemic in appropriately prioritised symptomatic patients.

PTU-28 FACTORS ASSOCIATED WITH SPONTANEOUS PASSAGE OF RADIOLOGICALLY CONFIRMED CBD STONES THROUGH A VIRGIN DUODENAL PAPILLA

Mohammed Gariballa*, Hussam Ahmed, Rachael Wilkinson-Hall, Amer Al-Joudeh. *Sheffield Teaching Hospitals, Sheffield, UK*

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Introduction Spontaneous passage of common bile duct (CBD) stones is a commonly observed clinical phenomenon that eliminates the need for invasive and costly endoscopic retrograde cholangio-pancreatography (ERCP). The aim of this study was to identify factors associated with spontaneous passage of CBD stones before index ERCP.

Methods This retrospective study was conducted in a university teaching hospital. It included patients with a virgin duodenal papilla who underwent ERCP to remove radiologically confirmed CBD stones between April 2018 and October 2019. The primary outcome was the presence/absence of stones on cholangiography where absence indicated spontaneous passage since radiological detection. Data collected retrospectively included patient demographics; scan modality to confirm stones; scan to ERCP time interval, stone number (single vs multiple); largest stone size (mm) and liver function tests (LFT) pre- ERCP.

Student t test was used for comparison of categorical and numerical variables. Chi- Squared test for comparison of categorical variables and Mann Whitney for comparison of the scan to ERCP time intervals. A binominal logistic regression was performed on a subgroup of patients for whom stone size was documented.

Results 427 patients underwent an index ERCP within the study period. Following application of the exclusion criteria 360 patients were included in the final analysis. The absence of a CBD stone on cholangiography was observed in 50 (13.9%) patients. Mean age was 68.1+/-16.8 years (Females 52.8%). CBD stones were confirmed by different imaging modalities (MRCP: 273, CT scan: 66, USS: 21). The presence of a single CBD stone on imaging was significantly associated with stone passage ;176 (48.9%) patients had a single CBD stone ($P < 0.05$). 62% (31/50) of passed stones were single.

In a subgroup analysis of 142 patients in whom stone size was documented, stone size was found to affect CBD stone passage. Mean stone size of 7.4+/- 3.04 mm was observed in patients with spontaneous passage (15 patients) vs 9.77 +/- 4.76 mm in those who did not (127 patients), $P < 0.014$. However, on multivariate binominal logistic regression analysis of this subgroup no factors achieved statistical significance including stone size (OR 0.837).

No significant association observed between stone passage and age (P=0.108), gender (P= 0.50), abnormal LFTs Pre-ERCP (P=0.40) or the median scan to ERCP time interval [Median of 4 days (IQR 3, 7.25) and 5 days (IQR 3, 24) days respectively (P=0.075)].

Conclusions A significant proportion of CBD stones will spontaneously pass. This study suggests solitary stones are more associated with spontaneous passage than multiple stones. A robust prospective study is needed to further investigate if stone size has any significant influence on spontaneous CBD clearance.

PTU-29 UPPER GASTROINTESTINAL BLEEDING AND COVID-19 – A TERTIARY CARE CENTRE EXPERIENCE

Michael Ding*. *On Behalf of OGRES research group (Oesophago Gastrointestinal Researchers into Endoscopy Systems), Queen Elizabeth Hospital Birmingham, Birmingham, UK*

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Introduction Concurrent upper gastrointestinal bleeding (UGIB) in patients with COVID-19 infection has a reported mortality of 21.7% in a recent study[1]. The threshold for emergency endoscopy was revised during the pandemic in the United Kingdom. We present the largest UK centre dataset to date on upper gastrointestinal bleeding(UGIB) in patients with COVID-19, evaluating incidence and outcomes.

Methods We performed a retrospective cohort analysis of patients treated for COVID-19 (polymerase chain reaction [PCR] positive) from 1/1/20-31/8/20. Patients coded for UGIB (haematemesis/melaena) within this cohort were identified. Binomial logistic regression was used to determine odds ratios of death adjusting for age, sex, UGIB status, Haemoglobin (Hb), heart rate, urea, systolic blood pressure(BP) and body mass index(BMI) (Table 1).

Results 1200 patients were included: 3.8%(n=46) had UGIB with a median GBS score of 8 (interquartile range [IQR] 6–13), (Male=23, median age 74 [IQR 61–84] years). 26% (n=12/46) of patients with UGIB underwent oesophagogastro-

Abstract PTU-29 Table 1 Odds ratio of mortality

	OR	95% CI	p
Age	1.05	1.04-1.07	<0.001
Male	1.20	0.89-1.61	0.232
Upper GI Bleed	1.03	0.48-2.15	0.947
Hb	0.99	0.99-1.00	0.139
Heart Rate	1.02	1.01-1.02	<0.001
Urea	1.05	1.03-1.07	<0.001
Systolic BP	0.99	0.99-1.00	0.200
BMI	0.99	0.97-1.01	0.476

OR: odds ratio; CI: confidence interval.