

duodenoscopy (OGD). Those who did, had higher red cell transfusion requirements than those who did not (median 1050 [IQR 150–1650] vs 0 [IQR 0–675]ml; $p=0.019$). 67% (8/12) had oesophageal or peptic ulceration but only 25%(2/8) required endotherapy. There was one re-bleed which required further endotherapy and one required embolisation.

Overall mortality rate in the UGIB cohort is 41.3%. Increased age, heart rate and urea levels were significantly associated with death but not the UGIB status. LOS was prolonged in the UGIB group compared to the non-UGIB group (15 [IQR 8–27] vs 6 [IQR 3–14] days; $p<0.001$). Subgroup analysis of UGIB patients who underwent OGD compared to those managed conservatively showed no significant difference in mortality (44%vs 33%; $p=0.735$) or LOS (12 [IQR 4–28] vs 16 [IQR 8–27] days; $p=0.349$).

Conclusions The incidence of concurrent UGIB in patients with COVID-19 infection is low and our data suggests that UGIB does not increase the mortality rate in patients with COVID-19 but does increase LOS. Endoscopic intervention did not appear to affect mortality or LOS. Although numbers are small, this data suggests selection criteria used for endoscopy was justified.

REFERENCE

1. Mauro A, *et al.* Upper gastrointestinal bleeding in COVID-19 inpatients: Incidence and management in a multicenter experience from Northern Italy. *Clin Res Hepatol Gastroenterol* 2020.

PTU-30 INADVERTENT WIRE CANNULATION OF THE PANCREATIC DUCT AT ERCP: A RETROSPECTIVE ANALYSIS OF OUTCOMES

Ben Arnold, Ben Collepriest, Rachel Perry*, Benjamin Masterman. *Royal United Hospital, Bath, UK*

10.1136/gutjnl-2021-BSG.103

Introduction The procedural risk factors for post-ERCP pancreatitis (PEP) are well documented and include both wire cannulation and contrast injection of the pancreatic duct (PD). Pancreatic guidewire assisted cannulation (PGWAC) is a widely accepted practise and is often employed when common bile duct (CBD) cannulation proves challenging. Given the potential for severe morbidity and mortality from PEP, endoscopists should aim to minimise the risk of this complication and consider prophylactic PD stenting in to addition other measures including rectal non-steroidal administration.

Methods Retrospective data from of all ERCP procedures performed within a 12-month period at a district general hospital were collected. Endoscopy reports were reviewed for indication, diagnosis, CBD cannulation success, the use of needle knife fistulotomy, the number of PD wire passes, deployment of prophylactic pancreatic stent (PPS) and administration of rectal diclofenac. Electronic hospital records were searched for documentation, biochemistry or imaging confirming PEP within 7 days post-procedure.

Results 218 ERCPs were performed in the study period, cholelithiasis being the most common indication (68.7%). CBD cannulation success was 89.4%. The overall PEP rate was 2.35% (95% CI 1.62-11.67) after excluding 6 cases in which the ampulla was not reached and the risk of PEP was considered negligible. 98% of cases at which cannulation was attempted received rectal diclofenac and those that didn't had contraindications

In the 212 remaining cases, the PD was inadvertently cannulated in 25 cases (11.8%). PEP rates were significantly higher in this group at 12% compared to 1.1% if only the CBD was selectively cannulated (RR 11.04 95% CI 1.9382 to 62.88 $p=P = 0.0068$). 4 patients received a prophylactic pancreatic stent after multiple PD wire cannulation and one patient developed mild PEP.

There was a small but statistically insignificant increased risk of PEP if the wire passed in to the PD multiple times rather than a single pass; 13.3% vs 10% (RR 1.0385 $p=0.7963$). Three patients had injection of contrast into PD with subsequent failed CBD cannulation but none developed PEP.

PWGAC was successful in 18/25 attempts (72%) and in 7 cases needle knife fistulotomy was attempted with 42.8% success. There was incidence of PEP in the needed knife group.

Conclusions Our data would suggest that any wire cannulation of the PD during ERCP poses a significant risk of PEP. Our outcomes post-PD stenting are, so far, disappointing but meta-analyses^{} have demonstrated their benefit in reducing risk of PEP.

Updated meta-analysis of pancreatic stent placement in preventing post-endoscopic retrograde cholangiopancreatography pancreatitis Jin-He Fan, Jun-Bo Qian, Ya-Min Wang, Rui-Hua Shi, and Cheng-Jin Zhao *World J Gastroenterol.* 2015 Jun 28; 21(24): 7577–7583.

PTU-31 OUTCOME FROM A PROSPECTIVE MULTICENTRE TRIAL ON REAL TIME OPTICAL DIAGNOSIS- BLAST STUDY

¹Ejaz Hossain*, ²Erik Schoon, ³Bu Hayee, ⁴Milan Stefanovic, ⁵Saskia Papa, ¹Mohammed Abdelrahim, ¹Pradeep Bhandari. ¹Portsmouth Hospital Nhs Trust, Portsmouth, UK; ²Catharina Hospital, Eindhoven, Netherlands; ³Kings College Hospital, London, UK; ⁴DC Bled, Ljubljana, Slovenia; ⁵Fujifilm Europe, Germany

10.1136/gutjnl-2021-BSG.104

Introduction Blue Light Imaging (BLI) is a new enhanced imaging technology that enhances mucosal surface and vessel patterns. A specific BLI classification was recently developed to enable better characterisation of colorectal polyps (BLI Adenoma Serrated International Classification - BASIC). We aim to use BLI for real time optical diagnosis during colonoscopy to see if it could meet the PIVI standards.

Methods It is a multicentre, prospective study. All endoscopists were trained in BASIC classification. Patients undergoing colonoscopy with 700 series colonoscopes (Fujifilm Co, Tokyo, Japan) on Eluxeo platform from Fujifilm were recruited in the study. Endoscopists were asked to make real time optical diagnosis of colorectal polyps using WLI and BLI. The accuracy, sensitivity, specificity, and negative predictive value of high-confidence optical diagnosis (adenoma vs. non-adenoma) by either BLI or HDWL for polyps up to 10mm was calculated.

Results A total of 370 polyps ≤ 10 mm were detected in 150 patients. The polyp sizes ranged from 1-10mm. 280 (75.6%) polyps were diminutive (≤ 5 mm) and 255 (68.9%) were adenomas. 131 (35.4%) polyps ≤ 5 mm were detected in the recto-sigmoid. The overall accuracy of BLI compared to WL was 91.9% vs 88.9% ($p=0.2$). Overall 82.4% polyps were diagnosed with high confidence with BLI compared to 77.4% with WL. The NPV for diminutive rectosigmoid polyps using BLI was 90.9% and overall post polypectomy surveillance interval was correctly predicted in 92.5% patients according to ESGE guidelines. Further analysis of the polyps using BLI is demonstrated in table 1.

Abstract PTU-31 Table 1

Colorectal polyps ≤ 10 mm (N= 370) 95% CI		
Accuracy	91.8%	89.11% to 95.17%
Sensitivity	96.8%	93.94% to 98.64%
Specificity	75.8%	63.64% to 85.46%
NPV	86.2%	75.71% to 92.61%
Colorectal polyps ≤ 5mm (N=280)		
Accuracy	89.3%	85.68% to 92.29%
Sensitivity	94.2%	90.66% to 96.74%
Specificity	77.1%	67.93% to 84.77%
NPV	84.4%	76.57% to 89.92%
Recto-sigmoid polyps ≤ 5mm (N=131)		
Accuracy	89.5%	85.57% to 91.16%
Sensitivity	95.8%	92.47% to 97.98%
Specificity	78.2%	68.72% to 83.86%
NPV	90.9%	84.40% to 94.87%

Conclusion Real time optical diagnosis in trained endoscopists using WL and BLI along with BASIC meets PIVI criteria for diminutive rectosigmoid polyps.

PTU-32 NATURAL LANGUAGE PROCESSING DRIVEN COMPARISON OF SMALL BOWEL MRI AND CAPSULE ENDOSCOPY REPORTING FOR CROHN'S

^{1,2}Matthew Stammers, ²Hang Phan, ^{1,2}Florina Borca, ¹Bilal Khurshid, ¹Moeed Minto, ¹Sohail Rahmany, ¹Srishti Sarkar, ^{1,2}Robert Livingstone*, ¹Esther Hawkes, ¹Imdadur Rahman, ¹Markus Gwiggner. ¹University Hospital Southampton, Southampton, UK; ²Clinical Informatics Research Unit (CIRU), Southampton, UK

10.1136/gutjnl-2021-BSG.105

Introduction Small Bowel Capsule Endoscopy (SBCE) has an established role in the diagnosis/management of small bowel Crohn's disease (CD). Previous work has suggested its diagnostic yield is comparable to that of Small Bowel MRI (SBMR), but the narrative nature of reporting makes this challenging to evaluate formally.

Methods Anonymised data from the electronic health record were systematically extracted from patients undergoing SBCE at our hospital between Jan 2016- Jan 2020 and categorised according to indication. A subgroup with suspected or established Crohn's disease was identified, and corresponding SBMR and calprotectin results were obtained. Natural

Abstract PTU-32 Table 1

Small Bowel Test	'Crohn's' mentioned as the potential diagnosis	A positive finding of small bowel 'inflammation/ ulceration' described	A positive finding of a 'stricture' described	Terms of uncertainty used in report conclusion	A positive finding of 'thickening' described
SBMR	3.75%(n=5)	6.02%(n=8)	3.01%(n=4)	11.28% (n=15)	6.77%(n=9)
SBCE	14.29% (n=19)	17.29%(n=23)	3.76%(n=5)	2.26%(n=3)	0.75%(n=1)
χ ² & p	8.98 (p=0.003)	8.22 (p=0.004)	0.12 (p=0.115)	8.58 (p=0.003)	6.65 (p=0.009)

language processing (NLP) techniques were used to compare the content and diagnostic accuracy of the reports.

Results Out of 1016 patients undergoing SBCE, 494 patients were suspected as having small bowel CD. Of this cohort, 133 underwent SBCE within 180 days of SBMR. 59 patients had corresponding faecal calprotectin (FC) measured (Mean: 318.12+/-138.39).

Tokenisation demonstrated that the style and content of the SBCE vs SBMR reports were very different in form and structure. The resultant 'word-bags' revealed that SBCE reports had significantly more 'diagnostic' weight, as described in Table 1:

Mean FC was significantly higher in patients with the term 'ulceration' reported on SBCE (703.5+/-353) compared to 'no ulceration' (265.2+/-148.38) (p=0.044) linking the word 'ulceration' with more severe disease descriptions.

Conclusions NLP is a powerful novel tool to compare narrative diagnostic accuracy between SBCE and SBMR not previously described. FC is positively correlated with small bowel 'ulceration' linking descriptive, diagnostic terms to biomarkers. According to our results, SBCE alone rather than SBMR is necessary to investigate small bowel Crohn's disease unless full-thickness stricturing is suspected from clinical symptoms.

PTU-33 DUODENAL INSPECTION DURING GASTROSCOPY; SHOULD THERE BE AN EXEMPTION IN THIS 'STANDARD' FOR BARRETT'S SURVEILLANCE?

Andrew King*, David Nylander, Clare Parker. Newcastle Upon Tyne NHS Trust, Newcastle Upon Tyne, UK

10.1136/gutjnl-2021-BSG.106

Introduction Current British Society of Gastroenterology (BSG) guidance recommends that Barrett's surveillance should adhere to a quadrantic 2 cm biopsy protocol, in addition to sampling any visible lesions (Seattle Biopsy Protocol – SBP)¹. This, together with photographic evidence of intubation of second part of duodenum (D2), are part of the BSG measurable standards for gastroscopy (OGD)².

In long Barrett's segments, OGD can be prolonged and uncomfortable for patients, especially as the majority are performed with anaesthetic throat spray and/or light sedation, which may affect endoscopist compliance with SBP.

We postulated that if endoscopists could be reassured that D2 intubation and examination did not alter management, then they would spend more time on careful oesophageal inspection and adherence to the SBP.

Therefore, we planned our audit to assess:

5. If adherence to SBP was affected by maximal length of Barrett's a) Occurrence of dysplasia and neoplasia b) If duodenal findings led to a change in management

Methods All patients undergoing Barrett's surveillance at Newcastle upon Tyne (an upper GI cancer referral centre) and South Tyneside Hospitals in North East UK between from 01/04/18 to 31/03/19 were identified. Their current and previous OGD reports were reviewed to determine demographics, Barrett's length, adherence to SBP, histology and duodenal findings.

Results A total of 1335 endoscopy reports were reviewed from 390 patients occurring between January 2008 and April 2020. 282 (72%) were males, with an average age of at