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 ≤ 5 mm (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 ≤ 5 mm (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