Abstract PTU-33 Table 1 shows degree of adherence to the SBP and the prevalence of dysplastic/malignant change

Length (cm)	N	Adherence to Seattle protocol (%)	Indefinite for dysplasia (%)	Low-grade dysplasia (%)	High-grade dysplasia (%)	Malignancy* (%)
<3	406	94.44	0.51	0.51	1.52	0
3 to 8	666	82.92	5.11	5.05	1.49	0.36
>8	182	76.57	4.80	2.28	4.35	4.59

*All malignancy were adenocarcinoma.

diagnosis of 61; 64 years old for females. Barrett's length was not recorded in 81 cases and excluded from the final analysis.

Duodenal inspection findings were: Normal - 96.2%; Duodenitis - 3.4%; Duodenal ulcer (clean base) - 0.4%

Conclusions Our audit demonstrates:

- As Barrett's length increases, the risk of high grade dysplasia and malignancy increases, but conversely, the degree of adherence to the SBP decreases.
- Duodenal inspection rarely identified significant pathology, and the management of the Barrett's oesophagus superseded the management any duodenal findings.

We conclude that in the absence of new symptoms suggesting duodenal pathology, Barrett's surveillance should be considered a distinct examination from a diagnostic OGD. The endoscopist should not need to inspect the duodenum, allowing more time to focus on careful oesophageal inspection and strict adherence to the SBP.

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PTU-34 SMALL BOWEL CAPSULE ENDOSCOPY: A COMPARISON AGAINST EUROPEAN SOCIETY OF GASTROINTESTINAL ENDOSCOPY PERFORMANCE MEASURES

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Introduction In 2019, the European Society of Gastrointestinal Endoscopy (ESGE) published its first performance measures[+] for use by small bowel capsule endoscopy (SBCE) services. There is no published data on performance of UK SBCE services against these metrics. We aimed to evaluate the quality of the SBCE service at a district general hospital.

Method A standardised proforma was designed to capture the performance metrics listed by ESGE. Data was collected retrospectively from SBCEs performed between January 2019 and September 2020 at a single hospital site. Data was drawn from the SBCE procedure report, reported by a consultant gastroenterologist, using Miroview software, and from electronic medical records. Discrepancies were resolved by consensus by two reviewers.

Results 50 patients underwent SBCE in the study period; 1 was excluded from the study due to a referral error. We included 49 patients, of which 30 were male, with a median age of 62. Our SBCE service met 5/10 of the targets (Table 1). 'Lesion detection' was the performance metric met least often (39%), with 'use of standard terminology', 'indication for SBCE' and 'capsule retention rate' being the best met metrics (100%). Data on 'reading speed' was not collected.

Abstract PTU-34 Table 1 SBCE service results against the ESGE quality metrics

Domain	Performance metric	Minimum (≥%)	Target (≥%)	Result % *(n)*
Pre-procedure	Indication for SBCE	95	95	100 (*49*)
	Adequate bowel preparation	95	95	86 (*26*)
	Patient selection	95	95	77 (*7*)
Procedure completion	Caecum/stoma visualised	80	95	84 (*41*)
Pathology identification	Lesion detection rate	50	50	39 (*19*)
	Timing of SBCE for overt bleeding	90	90	83 (*10*)
	Use of standard terminology	90	90	100 (*49*)
	Reading speed of SBCE	90	95	0 (*0*)
Pathology management	Appropriate referral for DAE	75	90	80 (*4*)
Complications	Capsule retention rate	<2	<2	0 (*0*)

Conclusion This analysis is the first to compare a UK SBCE service against newly-released ESGE quality improvement criteria, and the first to report patient-level data from any service.

We identified areas of good performance and targets for quality improvement. The Miroview application used by the service for recording reports encourages data capture for some of these quality metrics. Others, such as reading speed and adequacy of bowel preparation need to be more actively recorded when the procedure is reported. A proforma has been devised to assist high quality capsule reporting for the future.

The results from this single-centre study support the need for a larger, multi-centre UK study, assessing UK SBCE service quality on a national level.

[+]Spada C, McNamara Det al. Performance measures for small-bowel endoscopy: a European Society of Gastrointestinal Endoscopy (ESGE) Quality Improvement Initiative. Endoscopy. 2019;51(06):574-598.

PTU-35 ENDOSCOPIC BIPOLAR RADIOFREQUENCY ABLATION FOR TREATING MALIGNANT BILIARY OBSTRUCTION: SYSTEMATIC REVIEW AND META-ANALYSIS

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Introduction Early evidence suggests using radiofrequency ablation (RFA) as an adjunct to stenting may improve outcomes in patients with malignant biliary obstruction. RFA can be deployed either at the initial stent insertion or to clear tumour ingrowth in a previously placed stent.

Methods To assess the clinical and cost effectiveness and potential risks of RFA for malignant biliary obstruction.

MEDLINE, EMBASE, Cochrane Library, Scopus, CINAHL, HTA and DARE, 3 websites and 7 trial registers were searched from 2008 to 2021. Study inclusion criteria were: malignant biliary obstruction; intervention as endoscopic RFA, either to fit a stent (primary RFA) or to clear a blocked stent (secondary RFA); primary outcomes were survival, quality of life or procedure-related adverse events. Risk of bias was assessed using the RoB 2.0 and ROBINS-I tools. Primary analysis was meta-analysis of the hazard ratio of mortality.

Results 68 studies (1742 patients) were identified but only 2 randomised trials, 1 retrospective case control study and 3 retrospective cohort studies reported a hazard ratio of death for primary RFA compared to stent-only control. The pooled hazard ratio of mortality for primary RFA compared to stent-only was 0.34 (95% confidence interval (CI) 0.21 to 0.55). There was moderate heterogeneity (I^2 = 53%) however the studies were consistently in favour of primary RFA. There was insufficient evidence available to analyse effectiveness in secondary RFA. No evidence about the impact on quality of life was found. There was no evidence of increased risk of cholangitis (risk ratio 1.15, 95% CI 0.63 to 2.12) or pancreatitis (risk ratio 1.34, 95% CI 0.55 to 3.25), but there was an increase in cholecystitis (risk ratio 11.47, 95% CI 2.28 to 57.66). Inconsistencies in standard reporting and study design were noted e.g. adverse outcomes and lack of standardised comparator groups. RFA was estimated to cost £2,659 and produced 0.18 QALYs more than no RFA on average. With an ICER of £14,392/QALY, RFA was likely to be cost-effective at a threshold of £20,000/QALY. The source of the vast majority of decision uncertainty lay in the effect of RFA on stent patency.

Conclusions Primary RFA is associated with increased survival and appears cost-effective. The evidence for the impact of secondary RFA on survival and of quality of life is limited. There was no increase in the risk of post-ERCP cholangitis or pancreatitis but increased risk of cholecystitis. High quality RCTs to investigate primary and secondary RFA are needed with accurate documentation of quality of life, adverse event rates and survival.

PTU-36 GASTROINTESTINAL BLEEDING EVENTS IN PATIENTS WITH A LEFT VENTRICULAR ASSIST DEVICE: A 10 YEAR EXPERIENCE

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Introduction The advent of left ventricular assist devices (LVAD) has improved the survival and quality of life in patients with end stage heart failure however gastrointestinal bleeding remains one of the limitations. Little is known regarding important endoscopic findings and therapy rates.

Patients and methods A retrospective analysis of the LVAD database was conducted over the period 2009 - 2019. Data was collected on demographics, date of LVAD implantation, underlying cardiac diagnosis, history of anaemia, duration of implantation and survival. Each LVAD patient was cross checked on the endoscopy recording software for whether they had had any procedures, when, what type and findings. Univariate and multivariable analysis was performed.

Results 235 patients were included (median age 61.1 years, 203 males) with a median time of implantation of 465 days. Overall 56/235 (23.8%) had undergone gastroscopy mainly for bleeding symptoms, of which 8/235 (3.4%) were therapeutic. Multivariable analysis showed that undergoing gastroscopy was associated with a history of anaemia (adj OR 64.2, 95% CI 22.5 - 182.9, p<0.0001), female sex (adj OR 6.84, 95% CI 1.82 - 25.7, p<0.0001) and aetiology of ischaemic heart disease (adj OR 3.05, 95% CI 1.16 - 8.00, p=0.0235). Therapeutic endoscopy was associated with increasing age (adj OR 1.09, 95% CI 0.99 - 1.19, p=0.055) and aetiology of congenital heart disease (adj OR 12.9, 95% CI 1.44 - 116.7, p=0.022). Need for gastroscopy was not associated with survival however cumulative frequency plotting showed that 50% of gastroscopies occurred within 6 months of device implantation.

Conclusions Gastrointestinal bleeding symptoms are common in patients with LVAD however significant yield at gastroscopy is low. Highest yield is found in older patients and those with congenital heart disease as the aetiology.

PTU-37 TO SCOPE OR NOT TO SCOPE: OUTCOMES OF ENDOSCOPY SURVEILLANCE IN OLDER ADULTS

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Introduction Updated guidance from the British Society of Gastroenterology (BSG) no longer recommends endoscopic surveillance after colorectal cancer resection or polypectomy in patients over 75 years. We aimed to evaluate the outcomes of surveillance in older adults in our local population, which is considered one of the most elderly in the country.

Methods A retrospective analysis of patient records was conducted for patients over 70 years, who had undergone colorectal cancer surgery with curative intent, between 2014 and 2016 at our district general hospital. We identified patients that had surveillance and those that did not. In the surveillance group, endoscopic findings were noted, including the presence of high-risk findings according to the BSG criteria, as well as complications following endoscopy. Parameters of interest for both groups were age, sex, ASA grade, Charlson comorbidity index (CCI), original tumour site, resection margin, TNM stage, CEA level, whether the patient received neoadjuvant or adjuvant therapy, overall survival and cause of death. Statistical analysis was performed using SPSS v27.

Results 207 patients were included in the study. 199 patients had major resection and 8 had endoscopic mucosal excision for their primary cancer. Median age was 77 years. Further demographics are shown in table 1. 108 patients had at least one surveillance endoscopy, of which 41 (38%) identified polyps, including 11 (10%) with high risk findings. No major complications were reported. Overall survival was greater in the surveillance group at 38 months, compared to 21.5 months in the non-surveillance group (p<0.01). Mortality due to colorectal cancer was lower in the surveillance group (8 patients vs 29 patients) including mortality due to local recurrence (1 patient vs 7 patients). Parameters that were significantly lower in the surveillance group were age, ASA grade, CCI, M stage and CEA. There was no significant difference in sex, tumour site, resection margin, T stage, N stage and