Abstract PTU-37 Table 1

Demographics	n (%)
Age	139
70-79	(67%)
>=80	68
	(33%)
Sex	
Male	114
	(55%)
Female	93
	(45%)
ASA Grade	12 (6%)
1	
2	122
	(59%)
3	64
	(31%)
4	2 (1%)
Unknown	7 (3%)

whether the patient received neoadjuvant or adjuvant therapy between the two groups.

Conclusions Patients in our local population are known to have far greater life expectancy and associated quality of life compared to the rest of the country. Older patients selected for surveillance have certain favourable prognostic factors and better survival. The detection of significant pathology in older adults considered fit for endoscopy supports ongoing surveillance in this group and should be considered on an individual basis for the older population in our area.

PTU-38 MISSED UPPER GASTROINTESTINAL CANCERS: PREDISPOSING FACTORS IN A DISTRICT GENERAL HOSPITAL POPULATION OVER 7 YEARS

Craig Jordan Tilley*, Arash Vaziri, Anna Cavazza, Roderick Rawiradiradja, Evangelos Chalatsis, Julie Deacon, James Evans, Danielle Morris. *East And North Hertfordshire Nhs Trust, Hertford, UK*

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Introduction Missed upper gastrointestinal (GI) cancers are associated with poorer survival outcomes. Missed cancer is defined as having had a negative upper GI endoscopy within three years of confirmatory diagnosis. The aims of this study are to quantify cases of missed upper GI cancer at endoscopy from a district general hospital and identify potential predisposing factors to improve future outcomes.

Methods In this project, retrospective patient records were obtained from MDT meetings run between 2019 and 2020. For data comparison, similar records from previous cohorts were reviewed. The endoscopy records of these patients were extracted from the CIPTS endoscopy recording system and analysed to see if any patient had an endoscopy within the three years prior to diagnosis of their upper GI cancer. Previous endoscopies were scrutinised for the following factors: indication, visible abnormality, biopsy, endoscopist grade, sedation, presentation type, histology and follow up.

Abstract PTU-38 Table 1

Year	2013-14	2014-15	2016-17	2019-20	Total
Missed cancers	6	5	4	5	20
Total cancers	65	71	66	78	280
Percentage	9.2%	7.0%	6.1%	6.4%	7.1%

Results Of the 280 patients in total, 20 (7.1%) had a negative endoscopy in three years prior to diagnosis. Subgroup analysis of 2019-20 patients showed identified 78 cases of upper GI cancer. We identified five formal cases of missed upper GI cancer in this subgroup. In the 2019-20 cohort the average age in the missed cancer group and non-missed cancer group were 83.8 and 73.2 years, respectively. Factors identified in missed cancer groups from earlier cohorts included emergency bleeding, visible abnormality not biopsied, administrative delay in rescope and lack of recognition of pathology.

Conclusions The incidence of missed upper GI cancer diagnosis within this centre is similar to that of recent studies from other centres. Our study has highlighted that advanced age, accurate recognition and biopsy, and timely re-biopsy may be factors influencing missed upper GI cancers. This evidence has highlighted the importance of endoscopy training in the recognition and biopsy of pre neoplastic lesions. Furthermore, we intend to analyse data for the year 2020-21 to monitor the impact of COVID-19 on missed upper GI cancer diagnosis.

PTU-39 OUTCOMES OF URGENT ENDOSCOPY DELAYS DURING UK-WIDE LOCKDOWN AT A TEACHING HOSPITAL

Andrew Baxter, Andrew Baxter*, Stephen Hearing. *Royal Derby Hospital, Derby, UK*

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Introduction The COVID-19 pandemic had far reaching consequences for patients beyond those who suffered with the disease. The British Society of Gastroenterology (BSG) advised cessation of all non-emergency endoscopy on 25/03/2020 [1]. A 2 month delay in diagnostics was modelled to result in between 6.4-12.5% reduction in 10 year survival depending on age and gastrointestinal cancer site [2]. Real world endoscopy data suggests that 37.1%, 52.3% and 72% of oesophageal, gastric and colorectal cancers, respectively, were not diagnosed in comparison to historical data [3]. However, the true data is currently unknown as patients may have received diagnosis through alternative means such as imaging studies. As we come out of restrictive measures, we will need to answer what happened to these patients, whose diagnoses may have been delayed.

All endoscopy referrals in our centre were vetted by senior clinicians and were streamlined into pathways such as telephone clinics, referral for imaging or deferred until endoscopy services resumed. This abstract analyses the consequences of the emergency measures taken and the impact on our patient cohort.

Methods Patients on either an upper GI or Colorectal two week wait pathway (2WW), were identified prospectively throughout the period of emergency throughout 26/3-4/5/2020