Abstract PTU-39 Table 1

Findings at Endoscopy	2WW	Urgent	Total
Normal	35	20	55
Benign pathology	92	26	118
Inflammatory pathology e.g. IBD	5	6	11
Low risk pre-malignant (e.g. low risk polyps)	25	12	37
High risk pre-malignant (e.g. advanced polyps)	8	6	14
Localised malignancy	18	8	26
Disseminated malignancy	7	0	7
Incomplete examination	2	0	2

[1]. The data were collected and analysed in May 2021 using Microsoft Excel.

Results 108 patients were already on 2WW at the start of this period and 204 patients were referred for 2WW endoscopy during this period. 119 patients were referred on an urgent pathway. Nearly a quarter of both groups did not have the procedure they were referred for (72/312 2WW, 28/108 Urgent). 1 patient on the 2WW pathway cancelled their procedure and was later found to have cancer. The mean and median wait times were 80 and 71 days, respectively.

Conclusions We detected cancers in 8% of the referrals, which is higher than historical national rates of between 3.1-4.1% [4]. This supports the conclusions from Rutter et al that patients did not seek diagnostic services during this time period [3]. Most of our patients were waiting nearly 3 months for their procedure. It is unclear what impact this will have for their further management, at this time. This period will likely be examined in the years to come to assess for the ultimate cost that patients may have borne as a result of the COVID-19 pandemic.

PTU-40 SURVEILLANCE ENDOSCOPY IN ELDERLY PATIENTS: AN AVENUE FOR COST-SAVING AND REDUCING SERVICE BURDEN

Shi Jie Looi*, Debabrata Majumdar. *Ashford and St. Peter's Hospitals NHS Foundation Trust, Chertsey, UK*

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Introduction In recent years, there has been increasing strain on endoscopy services with increasing activity and consequently, fewer services being able to meet waiting time targets¹. Disruption to services during the COVID-19 pandemic have also led to a significant increase in the backlog of patients, further exacerbating the problem². We attempt to reduce the burden of this issue at our organisation by reviewing the indication for surveillance of elderly patients against existing national guidelines^{3, 4, 5}.

Methods The list of patients due for surveillance endoscopy was obtained from the endoscopy department database. Inclusion criteria was simply age equal to 80 or above. One author scrutinised electronic case records, reviewing previous endoscopy reports and clinic letters to determine the indication for surveillance. If this was not consistent with national guidelines^{3, 4, 5}, the procedure would be cancelled after discussion and with patient consent.

Results The most common indication for surveillance gastroscopy and colonoscopy was Barrett's oesophagus (89%) and previous polypectomy (70%) respectively. From 168 patients reviewed, 75 colonoscopies, 1 flexible sigmoidoscopy and 1 gastroscopy were cancelled. This translates to a cost saving of between £35 159 - £44 461. The most common reasons for removal from surveillance were: indication not in keeping with current guidelines (90%), patient preference (4%) and frailty (4%).

Conclusions Our study highlights an easily transferable model to achieve cost savings and reduce unnecessary surveillance endoscopy whilst ensuring quality is maintained by adhering to current national guidelines. These savings could then be utilised to increase service capacity in order to help address the problem of increasing burden on endoscopy services.

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PTU-41 MAINTAINING ERCP CAPACITY AND HIGH QUALITY KEY PERFORMANCE QUALITY INDICATORS DURING THE CHALLENGE OF COVID-19

Ioannis Varbobitis*, Lewis Bulman, Dileep Lobo, Glen Irving, Steve Ryder, Guru Aithal, Suresh Venkatachalapathy, Adolfo Parra-Blanco, Martin James. *NIHR Nottingham Biomedical Research Centre, Nottingham University Hospitals NHS Trust and the University of Nottingham, Nottingham, UK*

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Introduction COVID-19 has negatively impacted on the delivery of endoscopy services worldwide. In the UK, national endoscopy database (NED) indicated activity was dramatically reduced by 80-95% during the first wave in 2020, due to redeployment of staff, challenges with personal protective equipment (PPE), room air-change cycle and patients' unwillingness to attend during lockdown restrictions. ERCP is a higher-risk procedure often performed in patients with an urgent indication such as cancer obstruction or gallstone-related biliary sepsis or pancreatitis. We aimed to define the impact of COVID-19 on our ERCP service delivery, clinical outcomes, patient safety and endoscopists' KPIs.

Methods We examined Nottingham ERCP outcomes during the COVID-19 pandemic in 2020 compared to those before in 2019 at a high-volume HPB endoscopy centre serving a local population of 750,000 and tertiary HPB MDT population of 2.3 million. Technical success, comfort rates and complications according to RCP JAG and ESGE quality standards, including 8- and 30-day readmission rates and deaths were recorded. We also assessed the incidence of Covid-19 infection among the population who underwent ERCP.

Results Pre-pandemic, during 2019, 686 ERCP procedures were performed. Of these, 433 (63.1%) were cases of first ever ERCP. In 2020, 614 ERCPs were performed including 390 (63.5%) cases of first ever ERCP. During the COVID-19 pandemic in 2020, compared to 2019, there was no significant reduction in any of: total number of ERCP procedures (619 vs. 686); virgin ERCP successful cannulation of the intended duct (91.3% vs. 89.6%; $p=0.8$); complete CBD stone clearance (80% vs. 81%; $p=0.9$); successful stent placement across extrahepatic stricture (91.9% vs. 97.3%; $p=0.6$); obtaining stricture cytology (85.6% vs. 84.4%; $p=0.9$). The sensitivity of biliary cytology for cancer (C5 or C4 with compatible imaging/tumour markers or clinical follow up) was 68% vs. 70%; $p=0.6$.

Patient comfort score was recorded as moderate/severe in 6% of cases in 2019 vs. 7.1% in 2020 ($p=0.4$). Following ERCP, the number of patients re-admitted within 8- and 30-days was 22 (3.2%) and 37 (5.4%) in 2019, versus 30 (4.9%) and 42 (6.8%) in 2020; $p=0.15$ and $p=0.3$, respectively. All-cause and procedure-related mortality within 30 days from ERCP was 1.6% and 0.14% in 2019 vs. 1.79% and 0.65% in 2020; $p=0.8$ and $p=0.15$, respectively.

In total, 25/9500 (0.26%) of all patients undergoing any endoscopy tested positive for COVID-19 within 14 days of endoscopy. However, none tested positive following ERCP.

Conclusions Our provision of clinically urgent ERCP during 2020 and the COVID-19 pandemic did not significantly fall due to combination of senior prioritisation of all referrals, accessing unused operating theatres and reducing training lists. Patients underwent ERCP in a safe environment, keeping comfort levels within accepted limits and post-operative Covid-19 infection levels to zero. The endoscopists' KPIs of successful outcome and adverse events were similar despite the challenges of PPE and staff anxieties or exhaustion.

PTU-42 SAFETY AND EFFICACY OF ERCP FOR REMOVAL OF CBD STONES IN THE NONAGENARIANS: RETROSPECTIVE STUDY

Amaan Khan*, Sijjad Ijaz Ijaz, Mohammed Gariballa, Mustafa Jalal, Yasser El-Sherif, Amer Al-Joudeh. *Sheffield Teaching Hospitals, Sheffield, UK*

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Introduction It is estimated that one in four persons in the UK will be >65 years old by 2050. Endoscopic retrograde cholangiopancreatography (ERCP) is the recommended therapy for removals of common bile duct (CBD) stones. There is a lack of UK data on the outcome of ERCP in the very elderly. We aimed to investigate the safety and efficacy of ERCP in the management of CBD stones in the elderly >90 years old compared with those aged 65-89 years old.

Methods We retrospectively analysed patients undergone ERCP between 2016-2020. Those with conditions other than suspected CBD stones were excluded. The following data was collected: general demographics, comorbidities, American Association of Anaesthesiology (ASA) grading, presence of dementia, anticoagulation therapy, endoscopic report on completed intention of treatment which is defined by either removal of stone and/or stent insertion. Also, post-procedure complications were collected including post-ERCP pancreatitis (PEP), bleeding, perforation, cholangitis, respiratory, and cardiovascular (CVS) events. Readmission within 7 days and death within

30 days were collected. Outcomes were reported as mean $\pm$ (SD) or n (%). Statistical significance was considered when $P < 0.05$

Results In total, 126 patients ≥ 90 years (group A) compared to 262 patients aged 65-89 years (group B). Group A had higher ASA grading $3 \pm (0.6)$ compared to group B $2 \pm (0.6)$, $p=0.03$. The total number of comorbidities was not different between the two groups, $p=0.5$. Group A had significantly higher rate of dementia, and anticoagulation therapy 22 (17.4%) vs 1 (0.4%) $p < 0.0001$ and 46 (36.5%) vs 47 (17.9%) $p < 0.0001$, respectively. Completed intention of treatment was achieved in group A in 114 (90.5%) compared to group B 233 (89.9%), $p=0.7$. PEP occurred in 1 patient (0.8%) in group A compared to 8 (3.1%) in group B, $p=0.3$. Respiratory complications were significantly higher in group A compared to group B, 7 (5.6%) vs 1 (0.4%), $p=0.001$. The overall complications rate was 17 (13.5%) in group A vs 25 (9.5%) in group B, $p=0.3$. None of group A were readmitted within 7 days, 0% vs 4 (5.3%), $p=0.008$. Four cases (3.2%) died within 30 days in group A compared to group B 5 (1.9%), $p=0.5$. Three deaths in groups A were caused by pneumonia including two deaths with COVID-19 pneumonia. There was no procedure-related death

Conclusions ERCP for removal of CBD stones in >90 years old is effective. Risk of post-ERCP pancreatitis and overall adverse events were not higher in the > 90 years compared to 65-89 years old. We report a 30-day mortality rate of 3.2%. The most common cause of death was pneumonia including COVID-19 pneumonia.

PTU-43 IMPACT OF THE COVID-19 PANDEMIC ON ENDOSCOPIC CANCER DETECTION AT A SINGLE-CENTRE IN THE UK

Rohan Sundramoorthi*, Anet Soubieres, Maria Bashyam, Lucy Hicks, Natalie Direkze. *Imperial College Healthcare NHS Trust, London, UK*

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Introduction Endoscopy services were paused during the first wave of the COVID-19 pandemic between March – April 2020. Endoscopy resumed in May 2020 at a reduced productivity alongside early clinical triage in an effort to use resources responsibly. We assessed whether our reduced service led to reductions in gastrointestinal (GI) cancer detection. We assessed differences in the choice of initial investigation, clinical triage and referral to endoscopy time among GI cancers diagnosed via the suspected GI cancer referral pathway.

Methods GI cancer diagnoses were reviewed retrospectively over a seven month period (Mar-Oct 2020). Inclusion criteria were patients coded with a new diagnosis of GI cancer. The volume of endoscopic procedures performed was assessed using our endoscopy reporting software. Results were compared to the equivalent time period in 2019. Differences in time to endoscopy (days) were evaluated with a two-sample unpaired t-test.

Results There was a 28.5% reduction in GI cancer diagnoses in 2020 (Mar-Oct) compared to 2019 (191 vs 267), with a 27.1% reduction in GI cancers diagnosed via endoscopic procedures (132 vs 181). There was a 42.7% reduction in endoscopic procedures in 2020 (Mar-Oct) compared to 2019 (6977 vs 12186). In terms of referrals for suspected GI cancers from GPs, there was a 30% reduction (3188 vs 4579).