In 2020 (Mar-Oct), among cancers diagnosed via endoscopic procedures on the suspected GI cancer pathway, 40 of 68 (58.8%) patients had imaging as their first investigation (n=5 Barium swallow, n=13 CT abdomen, n=22 CT colonography) compared to 21 of 81 (25.9%) patients in 2019 (n=11 CT abdomen, n=9 CT colonography). Following the start of clinical triage (May-Oct 2020), 36 of 54 (67%) patients were triaged as 'very urgent'. 17 of 54 (31%) patients were triaged as 'urgent'. 1 patient was not prioritised as their barium swallow suggested a diagnosis of achalasia which was later found to be an oesophageal malignancy (referral to endoscopy 95 days). There was no significant difference in referral to endoscopy time in 2020 (Mar-Oct) [mean 45 days, SD 40.2] compared to 2019 [mean 41.6 days, SD 26.7] (mean difference 3.4 days $p=0.55$).

Conclusions The COVID-19 pandemic has led to a 28.5% reduction in GI cancer diagnoses. This worrying reduction in cancer detection will need to be ameliorated by an increase in endoscopy capacity. Radiological investigations were utilised more during this period to assess suspected GI cancer referrals. 98% of cancer patients were appropriately prioritised as very urgent or urgent based on clinical triage, and radiological investigations aided in triage. There was no significant difference in referral to endoscopy time. We highlight that achalasia diagnosed on barium swallow should always be visualised directly, even with curtailed endoscopy capacity.

PTU-44 COLONOSCOPY AND THE ELDERLY: SHOULD WE UTILISE CT COLONOSCOPY AS A FIRST-LINE TEST?

Carmel Bergbaum*, Benjamin Norton, Samuel Baskind, Alexander Hung, Kalpesh Besherdas. *Royal Free London NHS Foundation Trust, Barnet and Chase Farm Hospitals, London, UK*

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Introduction Colonoscopy is the gold-standard for investigation of lower gastrointestinal symptoms. However, in very elderly patients it may not be appropriate due to patient choice, sub-optimal fitness or increased peri-procedural risk. Computed tomographic colonography (CTC) poses an excellent alternative to colonoscopy with similar sensitivity for detection of colorectal cancer (CRC) and large polyps, which could prevent unnecessary colonoscopy. We analysed a very elderly patient cohort undergoing colonoscopy to determine the diagnostic yield and potential role for CTC.

Methods We conducted a retrospective analysis of 122 very elderly symptomatic patients (≥ 85 years old) undergoing diagnostic colonoscopy in 2020 at Chase Farm Hospital, London. Patient demographics, indication, diagnosis, key performance indicators and subsequent management were determined from our endoscopy database.

Results Among 122 patients undergoing colonoscopy, average age was 87 years (85-100) and 50% had >2 major co-morbidities. Main indications for colonoscopy were an abnormal CT (27.0%), anaemia (26.2%) and altered bowel habit (20.5%). Findings were CRC (22;18.0%), polyps (49;40.2%), diverticulosis (62;50.8%), haemorrhoids (26;21.3%), normal (20;16.4%), other (8;6.6%), colitis (5; 4.1%), and two abandoned cases. Bowel preparation was inadequate in 11.5% and adjusted caecal intubation rate was 82.5%. Among those diagnosed with CRC eight underwent curative surgery, three declined, three had chemo/radiotherapy and eight received

best supportive care. All cause one-year mortality, or at data completion, was 7.4%.

Conclusion Incidence of CRC and large polyps (≥ 10 mm) among very elderly symptomatic patients was 18.0% and 19.7%, respectively. This high diagnostic yield warrants endoscopic assessment. However, few patients were fit enough to undergo curative treatment and some patients declined. CTC represents a safer, better tolerated alternative to prevent unnecessary colonoscopy and provide prognostication among those amenable to further treatment. In our cohort, we would have prevented 57 colonoscopies with CTC screening if colonoscopy was performed for polyps ≥ 6 mm. Smaller polyps are unlikely to develop into significant pathology in this cohorts lifetime. This approach would enable detection of extra-colonic lesions to increase identification of explanatory pathology and help inform patient choice. On the contrary, CTC screening can miss mucosal lesions (e.g. colitis/telangiectasia in our cohort) and the best strategy to deal with extra-colonic findings is unclear. This is a major barrier to its cost-effectiveness. Ultimately, due to the high volume of CTs leading to, or being completed after, colonoscopy, CTC screening should be considered in very elderly patients to prevent unnecessary colonoscopy.

PTU-45 ERCP OUTCOMES DURING COVID PANDEMIC IN COMPARISON TO PRE-COVID TIMES

Kwee Yen Goh*, Muhammad Asim Hamza, Sister Jill Sibbald, Abubaker YM Ahmed. *Manchester University Foundation Trust, Manchester, UK*

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Background The British Society of Gastroenterology (BSG) published a guidance document to aid triaging during the COVID-19 outbreak. The document sets out the essential endoscopic procedures than can be carried out during the accelerated phase of the outbreak. This guidance was adopted in endoscopic retrograde cholangio-pancreatography (ERCP) practice in Manchester University Foundation Trust (MFT) from March 23 to June 7, 2020. ERCPs were only performed on patients presenting with acute biliary obstruction with jaundice, cholangitis or blocked biliary stent replacement.

Aim This study is to examine the impact of COVID-19 outbreak and introduction of BSG guidance on the key performance indicator outcomes of ERCPs, compared with non-COVID time in MFT.

Method A retrospective data analysis of all ERCP outcomes and key performance indicators during March 23 to June 7, 2020 was done and compared with the same time period in 2019.

Results All patients were tested for COVID-19 with nasopharyngeal swab. Patients who were COVID-19 positive had their ERCPs in theatre and those who were COVID-19 negative were done in endoscopy with full personal protective equipment.

A total of 130 ERCPs were done from 23rd March to 7th June 2019. Only 51 patients whose ERCP were performed with similar indications during the COVID-19 period were included in this study. We have also included patients who required ERCP acutely for management of bile leak post cholecystectomy.

A table comparing the data collected from 2019 and 2020 are shown below:

Abstract PTU-45 Table 1

	COVID-19 period (2020)	Pre-COVID-19 period (2019)
Number of patients	51	51
Female/Male	63%/ 37%	45%/ 55%
Mean age (years)	63.4 (21 – 87)	64.8 (29 – 86)
ASA grades		
1	37% (19)	41% (21)
2	33% (17)	31% (16)
3	16% (8)	12% (4)
4		
Presenting complain		
Abdo pain	43% (22)	55% (28)
Jaundice		
Blood test		
Bilirubin (umol/L)	107 (6 – 493)	108 (3 – 669)
CRP (mg/L)	66 (1 – 206)	64 (1 – 342)
Indications for ERCP		
Obstructed CBD	92% (47)	82% (42)
Blocked biliary stent	4% (2)	10% (5)
Biliary leak	4% (2)	8% (4)
Waiting time for ERCP (days)	2.5 (0 – 9)	4.6 (0 – 27)
Length of hospital stay (days)	20.6 (8 – 31)	21.5 (0 – 175)
COVID-19 +ve	7.1 (1 – 43)	
COVID-19 -ve		
30-day mortality		
COVID-19 +ve	50% (2/4)	8% (4/51)
COVID-19 -ve	6% (3/47)	
ERCP success rate		
Cannulation rate	90% (46)	86% (44)
Technical failure	6% (3)	16% (8)
Complete stone extractions	80% (16/20)	94% (16/17)
Extrahepatic strictures stented	88% (21/24)	85% (17/20)
ERCP complications		
Nil	98% (47)	88% (45)
Post ERCP pancreatitis	4% (2)	10% (5)
Mucosal tear/Bleeding	-	2% (1)
Biliary sepsis	-	2% (1)
Desaturation post sedation	-	-

In the COVID-19 positive cohort, two patients passed away due to worsening COVID pneumonitis. One of the patients had COVID-19 prior to ERCP, while the other contracted COVID-19 post-ERCP. Patients who were negative for COVID-19 passed away due to metastatic adenocarcinoma of bile duct, bilateral pleural effusions and atelectasis post cholecystectomy and pulmonary embolism.

In comparison to 2020, the mean length of hospital stays and waiting time for ERCP were slightly longer, at 21.5 days (range, 0-175) and 4.6 days (range, 0-27) respectively.

Conclusion Patients undergoing ERCP who were infected with COVID-19 had longer hospital stay, and higher 30-day mortality compared to those who did not have COVID-19. However, length of hospital stay was shorter in COVID time. There was no statistically significance in the KPI between COVID-time and normal times.

PTU-46

SAFETY AND EFFICACY OF FULLY COVERED METALLIC STENT PLACEMENT FOR PATIENTS WITH PRIMARY SCLEROSING CHOLANGITIS

^{1,2}Leonardo Henry Eusebi*, ³Laura Cristoferi, ⁴Richard Sturges, ¹Jonathan Potts, ⁴Laura Dwyer, ⁵Giulia Bonato, ²Sinan Sadalla, ³Pietro Invernizzi, ⁵Massimiliano Mutignani, ¹Douglas Thorburn. ¹Royal Free Hospital, Sheila Sherlock Liver Centre and UCL Institute for Liver and Digestive Health, Royal Free Hospital, London, UK; ²Gastroenterology and Endoscopy Unit, IRCCS Azienda Ospedaliero-Universitaria di Bologna, Bologna, Italy; ³Department of Medicine and Surgery, University of Milano-Bicocca, Monza, Italy; ⁴Aintree Digestive Diseases Unit, Aintree University Hospital, Liverpool, UK; ⁵Digestive Endoscopy Unit, ASST Niguarda, Milan, Italy

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Introduction Endoscopic retrograde cholangiopancreatography (ERCP) is the gold standard for the treatment of dominant stricture (DS) in primary sclerosing cholangitis (PSC). Multiple therapeutic options, including dilation and stenting, are available, each with their own benefits and drawbacks. Generally, balloon dilatation is preferred due to lower rates of complications compared to temporary plastic stenting. Anecdotal experience of using fully-covered self-expandable metallic stents (FC-SEMS) in this setting is unfavourable, but larger series are lacking. The aim of this study is to assess safety and efficacy of FC-SEMS in PSC patients with DS.

Methods The endoscopic databases of three European referral centres (London, Liverpool, Milan/Monza) were searched to identify and extract data on patients with PSC diagnosis who underwent ERCP with FC-SEMS placement. Patients with biliary malignancy diagnosed during ERCP or follow-up were excluded.

Results A total of 23 patients were identified from 2010 to 2020. 78% were males, median age was 52.9 years (range 32-82). Indication for FC-SEMS placement were: imaging evidence of DS (43%), worsening of biochemical cholestasis and jaundice (43%), acute cholangitis (13%). Median stricture length was 25mm (range 10-70). The length of FC-SEMS deployed were 80mm in 8 patients, 60mm in 7, 40mm in 7 and 100mm in one patient. In four patients, balloon dilatation was performed before stent placement. In all cases the stent was successfully deployed as planned.

Adverse events (AEs) were observed in 48%(11/23) of patients, of which 64% were early (<30 days) (5 acute pancreatitis, 1 biliary bleeding, 1 gallbladder perforation) and 36% delayed (1 cholangitis and 3 stent migrations).

FC-SEMS were removed/migrated in 18 patients after a median time of 66 days (range 7-462) and 61% had a DS resolution, while 7 of them required further endoscopic treatment. Three patients died or underwent liver transplant during follow-up.

Conclusions In a multicentre observational study of patients with PSC and DS, FC-SEMS placement while technically successful and resulting in a >50% efficacy in DS resolution, was associated with a high rate of treatment-related AEs. We conclude that the use of FC-SEMS in PSC with DS is inadvisable.