Abstract PTU-48 Table 1 Summary of OGD findings. Those highlighted with (*) are findings which could explain a patient's anaemia

OGD findings	Number (%)
Varices*	3 (2.0)
Angiodysplasia*	4 (2.7)
Ulcer (gastric, duodenal)*	9 (6.1)
GAVE*	2 (1.3)
Malignancy*	4 (2.7)
Oesophagitis $\geq$ grade 3*	3 (2.0)
Normal	47 (32.0)
Gastritis/Duodenitis/Oesophagitis $\leq$ grade 2	58 (39.5)
Hiatus hernia	7 (4.8)
Oesophageal candidiasis	6 (4.1)
Barrett's	1 (0.6)
GIST	2 (1.3)
Other	5 (3.4%)

inpatient management is rarely altered by performing the OGD, suggesting that many of these examinations could be done in the outpatient setting or postponed until management of the main clinical condition has finished. No independent predictors of positive OGD findings were identified in this study, which may again support a drive to investigate IDA as an outpatient. We hope to conduct a further, larger scale study to examine this further.

BIBLIOGRAPHY

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PTU-49 WHAT'S IN A NAME? THE GLOBAL BURDEN OF POSTCOLONOSCOPY COLORECTAL CANCER USING WEO TERMINOLOGY

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Introduction Population-based screening and surveillance with colonoscopic removal of premalignant lesions reduces colorectal cancer (CRC) incidence and mortality. However, up to 9% of patients presented with symptomatic cancers despite undergoing negative colonoscopies in the three years preceding diagnosis and before the next recommended examination. 'Postcolonoscopy' CRCs (PCCRCs) are devastating for patients, providers, and healthcare systems, and have been proposed as a key performance metric for colonoscopy quality assurance programs. Previously there was no standardised definition for PCCRC and reported rates varied depending on terminology and calculation methods used. The World Endoscopy Organisation (WEO) recently suggested a standardised PCCRC definition and rate calculation methods.

Our aim was to assess PCCRC burden using WEO methods and update prevalence estimates reported in a previous meta-analysis. We explored causes of heterogeneity and reviewed changes in prevalence over time.

Methods A systematic literature search identified population-based studies reporting PCCRC prevalence. We estimated

pooled prevalence compared with detected CRCs and investigated between-study sources of heterogeneity using subgroup and sensitivity analyses.

Results Six population-based studies reporting on 23,018 PCCRCs were included. Pooled prevalence was 8.2% (95% CI = 7.3-9.0%) - a twofold increase compared to the previously published pooled prevalence (Am J Gastroenterol 2014; 109:1375). Considerable heterogeneity was observed.

In subgroup analyses, proximal PCCRC prevalence was higher than distal PCCRC (10.2%, 95% CI=8.7-11.7%; vs. 6.3%, 95% CI=5.6-6.9%, respectively). This partially accounted for observed heterogeneity ($p<0.01$). Geography did not contribute to differences in PCCRC.

Using WEO methodology pooled PCCRC prevalence was 8.2% (95% CI=6.9-9.4%) and heterogeneity remained high.

Six studies reported PCCRC rates over time. Three showed a decrease in PCCRC prevalence, while three showed no significant temporal changes.

Conclusions Overall PCCRC pooled prevalence was 8.2%; however, significant heterogeneity existed between studies. Time trend analyses within individual studies showed decreased or unchanged rates. Proximal PCCRC prevalence was significantly greater than distal PCCRC. Despite application of WEO methodology, comparing PCCRC rates between populations may be challenging at present due to heterogeneity related to patient selection criteria and endoscopist factors e.g. including higher risk patients (e.g. inflammatory bowel disease), endoscopist experience, or the presence of a CRC screening programme. Standardisation of such factors as well as PCCRC terminology may facilitate comparison of endoscopy service performance between centres.

PTU-50 WATCH AND WAIT, A RATIONAL MANAGEMENT FOR LOWER GASTROINTESTINAL BLEEDING IN THE ELDERLY?

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Introduction Many patients presenting to hospital with lower gastrointestinal bleeding (LGIB) are elderly and co-morbid. British Society of Gastroenterology (BSG) guidelines recommend LGI endoscopy for all patients admitted with LGIB. As the majority of LGIB ceases spontaneously and risks of endoscopy increase with patient age, a 'watch and wait' management approach may be appropriate for older patients.

Methods Patients aged ≥ 75 years presenting with LGIB to seven hospital trusts from June 1st– September 1st 2019 were included. Data on presentation, management and outcomes were recorded, then compared to current BSG guidelines.

Results 127 patients were included. 47% were male with a mean age 84 (range 75-96), 73.2% of patients had ≥ 2 listed co-morbidities. Mean Shock Index (SI) on presentation was 0.69, with a SI >1 being rare (7.0%) and reduced to 2.4% following resuscitation. Of stable patients (SI <1), 94.3% were classified as having a major bleed (Oakland Score >8). 96.1% of presenting patients were admitted, while 3.9% were