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.

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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

Serial cholangiograms from one patient

Abstract PTU-50 Figure 1 Serial cholangiograms from one patient

discharged from A&E. 80% of these discharged patients had an Oakland Score >8 . 21 (17.2%) of admitted patients received an inpatient lower GI endoscopy; 19% of which received endoscopic therapy. The most commonly identified cause of LGIB was diverticulosis (23.8%). Overall, 82.8% of admitted patients received no inpatient lower GI endoscopy and were managed conservatively. Comparing those who underwent LGI endoscopy versus a watch and wait approach, there was no difference in inpatient mortality (0% vs 4%, $p=1.0$) or 30-day re-admission rate (9.5% vs 22.8%, $p=0.24$). However, undergoing inpatient LGI endoscopy was associated with greater median length of stay (8 days vs 3 days, $p=0.0002$).

Conclusions Age and co-morbidities complicate risk stratification in the elderly as many will score highly regardless of bleed severity, limiting the role of the Oakland Score. Endoscopic assessment of all elderly patients presenting with LGIB is not performed in real world practice, may not be necessary or even appropriate. Although not in keeping with current guidelines, this watch and wait approach does not appear to be associated with adverse outcomes in the elderly.

PTU-51 PROSPECTIVE OBSERVATIONAL COHORT VALIDITY STUDY VIRTUAL REALITY ENDOSCOPIC SIMULATION

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Introduction The benefit of simulated endoscopy training is inversely proportional to trainee experience. The aim of this study was to determine the face validity of the EndoSim high-fidelity virtual reality simulator (Surgical Science, Gothenburg, Sweden). and establish benchmark metric values to inform research into endoscopy skill acquisition, learning curve trajectory, and curriculum development.

Methods A pilot cohort of four experts rated simulated exercises by Likert-scale (1-5). Following iterative development, 10 experts completed a 13-exercise simulator-based curriculum, with 35 individual amounting to 858 total metric values. Statistical analysis for non-parametric data was used: where multiple comparisons were made, Bonferroni calculation was performed which altered the standard significance of $p<0.05$ to $p<0.0014$.

Results There was no significant difference in expert performance in any metric across all exercises ($p>0.0014$). Face validity was determined by expert Likert score ratings (1-5 [1:

very poor, 5: very good]) and varied between exercises (median Likert-scale score 4 [3-5]). Lower GI exercises: Loop Management and Intubation Case 3, had worse face validity (median Likert-scores 3: [IQR 1-3, and 2-3 respectively]) compared to basic handling exercises: Scope Handling, Visualise Colon 1 and 2 (median scores 4.5: [IQR 3-5, 4-5 and 4-5 respectively]).

Conclusions Overall, experts felt the EndoSim curriculum had good face validity for basic scope handling skill acquisition: the next focus will be in establishing translation of these skills into clinical practice and as such, its' future role in Endoscopy training.

PTU-52 SURVEILLANCE ENDOSCOPY FOR BARRETT'S OESOPHAGUS

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Introduction Correct endoscopic evaluation of a possible Barrett's segment is essential for correct diagnosis and avoidance of unnecessary, sometimes lifelong surveillance procedures.

The British society of Gastroenterology guidelines define Barrett's oesophagus as:

'an oesophagus in which any portion of the normal distal squamous epithelial lining has been replaced by metaplastic columnar epithelium, which is clearly visible endoscopically (≥ 1 cm) above the GOJ and confirmed histopathologically from oesophageal biopsies' Histopathological confirmation is based on the presence of intestinal metaplasia.

In cases of short segment Barrett's (<3 cm) accurate endoscopic assessment can be difficult.

Our project aimed to determine what proportion of patients with short segment Barrett's oesophagus at Imperial College Healthcare NHS Trust, were correctly endoscopically diagnosed, and thus, what proportion may be undergoing unnecessary surveillance procedures.

Methods A retrospective cohort study was performed, identifying cases of short segment Barrett's (<3 cm) at Imperial NHS Trust between 2017 and 2020. Imaging was reviewed by an independent consultant endoscopist to determine whether endoscopic evaluation criteria had been met.

Results 261 cases of short segment Barrett's were identified. 25 had no available imaging and 10 patients were under surveillance following HALO/EMR or surgery for oesophageal cancer.

Of the remaining 226 cases, 97 had been booked for surveillance, 37 were discharged and 92 were neither discharged nor booked for surveillance.

Of the 97 already booked, 43 (44%) were felt not to meet endoscopic criteria. Of the 92 not yet booked, 49 (53%) did not meet the criteria.

Of the 37 patient discharged, 4 were felt to meet endoscopic criteria and had intestinal metaplasia on histology. Of these, 2 were over the age of 80, 1 moved out of area and 1 was lost to follow up.

Removing cases which did not meet endoscopic criteria for surveillance, would give a 44% reduction in unnecessary gastroscopies for patients who had already been booked. Including those who had not yet been booked, this would give a 49% reduction overall.