Abstract PTU-50 Figure 1  Serial cholangiograms from one patient

discharged from A&E. 80% of these discharged patients had an Oakand 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 Oakand 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

Catherine Ebye*, Neil Harries, Richard Egan, David Robinson, Chris Brown, Wyn Lewis. 1Health Education And Improvement Wales, Cardiff, UK; 2Royal Glamorgan Hospital, Cardiff, UK; 3Monkton Hospital, Swansea, UK; 4Swansea University, Swansea, UK

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 endoscopic 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: 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.
Conclusions Short segment Barrett’s can be difficult to assess accurately. In our analysis, cases that did not meet the criteria for Barrett’s diagnosis on endoscopy, had segment < 1cm or an atypical Z line.

We have shown a potential 49% reduction in unnecessary gastroscopies, which could result in avoidance of unnecessary health and procedural anxiety for patients, and cut waiting lists and associated costs.

In addition, we suggest that patients with previous suspected Barrett’s should be evaluated on dedicated surveillance lists, by endoscopists with expertise in Barrett’s assessment.

**Abstract PTU-54 Table 1**

<table>
<thead>
<tr>
<th>Mean (Range)</th>
<th>Median (1SD)</th>
<th>Paired student t-test (2 tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experienced endoscopist results</td>
<td>39.1 (39-39.5)</td>
<td>39</td>
</tr>
<tr>
<td>Device Results</td>
<td>40 (37-46)</td>
<td>39 (2.5)</td>
</tr>
<tr>
<td>Experienced endoscopist results</td>
<td>39.1 (39-39.5)</td>
<td>39</td>
</tr>
<tr>
<td>Device Results</td>
<td>38 (34-43)</td>
<td>38 (2.6)</td>
</tr>
</tbody>
</table>

PTU-53 EFFICACY AND SAFETY OF ENDOSCOPIC AMPULLECTOMY IN THE UK
Sujith Sasidharan Nair*, Mohamed Abdelrahim, Lazaros Varytimiadis, Asma Al-Kandari, Patrick Goggin, Professor Pradeep Bhandari. Queen Alexandra Hospital, Portsmouth Hospital University Trust, Portsmouth, UK
10.1136/gutjnl-2021-BSG.126

Introduction Endoscopic ampullectomy is a minimally invasive technique of treating non-invasive lesions involving the ampulla of Vater and offers an alternative to major surgical intervention. In this study, we describe the safety and outcome of this procedure from a single large tertiary unit in the UK.

Methods Data were prospectively collected on an electronic database. Parameters related to ampullectomy outcome and complications were retrospectively analyzed.

10 to 20 mm snare sizes were used in these patients. ENDOCUT Q effect 2 was used. All patients were given indomethacin suppositories. Submucosal injection was performed only where the ampullary lesions spilled over to the duodenal mucosa.

Results A total of 48 cases were included in this analysis, between 2009 and 2021. The mean age was 62.4 years. Female represented 55.3% of patients. Mean duration of follow up was 118.29 weeks (27 months). 29 (60.4%) lesions were pure ampullary, and the remaining involved the duodenal wall as well. Lesions ranged from 5 to 80mm in size, with average size of 22.2 mm. 6 patients (12.5%) had familial adenomatous polyposis FAP. Pre resection histology confirmed HGD in one patient (2%), and neuro-endocrine tumor NET in one case (2%). Post resection histology showed focal adenocarcinoma in 2 patients (4%).

A total of 48 patients were included, with 31 cases (64.5%) in which tumour was < 1cm and 17 cases (35.4%) > 1cm. Out of these, 10 cases (21%) were pure ampullary and 18 cases (37.5%) had duplication of major papilla. All cases had submucosal injection. Clamps were used in 19 cases (40.3%) and endo clips in 29 cases (60.4%). The majority of cases were performed in the sitting position (89.6%). After resection, the average size of the ampulla was 22.2 mm.

Indomethacin was used as prophylactic in all cases. There were no significant differences in the measurements made by the device compared with either endoscopist. The device did not impede endoscopy in any way. The initial study guided improvements in the design and data processing to reduce variability.

Conclusions This early proof of concept feasibility study has encouraged us to develop a workable prototype device that we will test in a series of upper GI endoscopies in patients (ScopeMeasure Study IRAS Ref 20/SC/0387). This device will be compatible with any endoscope and will be reusable within a disposable sterile sleeve. We hope that automated