Table 2: Results of NLP and ICD Codes Used to Identify Dysphagia Indications for Index and Repeat EGDS in the US Veteran Population (2010-2014).

<table>
<thead>
<tr>
<th>Index EGDS with Dysphagia Indication (2010-2012)</th>
<th>NLP (n)</th>
<th>ICD (n)</th>
<th>Difference between NLP and ICD (n, %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repeated EGDS Performed in Patients who had Index EGD for Dysphagia (2010-2014)</td>
<td>9,251</td>
<td>7,548</td>
<td>1,703 (18.4%)</td>
</tr>
<tr>
<td>Repeated EGDS with Dysphagia Indication</td>
<td>4,802</td>
<td>3,365</td>
<td>1,437 (29.9%)</td>
</tr>
<tr>
<td>Repeated EGDS without Dysphagia Indication</td>
<td>4,449</td>
<td>4,183</td>
<td>266 (6%)</td>
</tr>
</tbody>
</table>

Tu1003

CAN WE TRUST THE DATA AT GASTROENTEROLOGY CONFERENCES? LESSONS LEARNED ACROSS THE POND

Raj Shah, Jame Varghese, Mahahu Indaram, Samaa Asif, Cody Braun, Usman Hasnie, Ahmed Elbermawy, Annapoorna Singh, Mir Fahad Faisal, Joseph D. Feuerstein

Introduction: Abstracts at conferences serve as an important avenue to inform physicians. We aimed to determine rate of and factors for successful publication of hepatobiliary abstracts from February 2017 presented at the 2010 American conferences (USA) including Digestive Diseases Week (DDW), American Association for the Study of Liver Disease (AASLD), and American College of Gastroenterology (ACG) and compare these to European conferences (EUR) including United European Gastroenterology (UEG) and European Association for the Study of Liver (EASL). Method: We reviewed the online 2010 AASLD, DDW, ACG, UEG, and EASL, abstracts using the search term "Liver." We used validated methodology to determine successful publication and abstracted gender of authors and study design. We assessed whether studies that were published as manuscripts had different conclusions, results or number of study participants compared to the abstracts. Results: A total of 3670 abstracts were reviewed with 568 (15%) from USA, 1415 (39%) from EUR and 1487 (41%) from AASLD. We found that 70% of studies were published as manuscripts, with statistically significant differences noted in age, sex, race/ethnicity, and polyp detection rate.

Weekly Number of Unresolved Positive FITs

Tu1005

WILLINGNESS TO STOP PROTON PUMP INHIBITORS IN PATIENTS WITH GASTROESOPHAGEAL REFUX DISEASE: RESULTS OF A PATIENT SURVEY

Jennifer K. Kennedy, Samer Sani, Jacob E. Kurlander

Introduction. Increasing evidence has linked long-term proton pump inhibitor (PPI) use to multiple adverse effects (AEs), including chronic kidney disease, bone fracture, and enteric infection. These concerns have motivated efforts to minimize unnecessary long-term PPI use, such as the Choosing Wisely Campaign. Aims: To assess patients’ willingness to stop or reduce PPIs using different deprescribing strategies. Methods. We administered an online survey in July 2017 to adults taking PPIs for gastroesophageal reflux disease (GERD), as identified by a commercial survey firm. We assessed participants’ willingness to stop PPIs under varying conditions, including type of provider recommending stopping (primary care provider vs. gastroenterologist vs. pharmacist), and different deprescribing strategies (tapering PPI vs. substituting H2 blocker vs. providing reassurance about ability to resume PPI if needed). For analysis, responses to questions about willingness to stop PPI were dichotomized as somewhat/very unwilling vs. somewhat/very willing. Chi-square analysis was used to compare responses across conditions. Results. Among 755 survey participants, mean age was 49 years (SD 16), 71% were female, and 91% were Caucasian. A majority (62%) used PPIs at least daily. There was a significant difference in participants’ willingness to stop PPIs based on the provider recommending discontinuation, with 77% willing to stop PPIs if recommended by a gastroenterologist vs. 71% if recommended by a PCP and 59% if recommended by a pharmacist (χ²=61.1, p<0.001). Rates of willingness to stop PPIs increased with additive deprescribing strategies. While 71% were willing to stop a PPI in general, this number increased to 83% if they could stop by tapering the PPI dose, 88% if they could stop with the option to resume a PPI if needed, and 79% if they could stop by switching to a H2 blocker (χ²=38.8, p<0.001). Conclusion. Our results provide practical guidance for health systems and individual physicians attempting to deprescribe unnecessary PPIs for patients with GERD. Most patients are willing to stop PPIs if recommended by a gastroenterologist or primary care physician. However, patients are less willing to follow a recommendation to stop from a pharmacist, a group that would otherwise be well positioned to contribute to large scale deprescribing efforts. Patients are more willing to stop if given the option of additive deprescribing strategies, such as a PPI taper, H2 blocker substitution, or reassurance about the possibility of resuming PPI if needed.

Tu1006

IMPROVEMENT IN COLONOSCOPY QUALITY METRICS IN CLINICAL PRACTICE FROM 2000 TO 2014

Simon Mathews, Jennifer L. Holub, David A. Lieberman

Background: Quality and safety are essential components of providing excellent care to patients in all settings including endoscopy. The landscape and literature on quality with respect to colonoscopy in particular have grown and matured greatly over the last 15 years. Guidelines since 2002 have promoted measurement of quality metrics in practice. We aimed to determine whether quality has improved over time in patients undergoing screening colonoscopy during the periods 2000-2004; 2005-2009; 2010-2014. Methods: Colonoscopy data were collected prospectively at 84 gastrointestinal practice sites from 2000 to 2014, using an endoscopic report generator, from 390,741 average-risk adults who underwent colonoscopy for screening. Data were collected using the PSQI, a validated tool that assesses 8 quality measures: overall quality, completeness, patient satisfaction, quality of patient refusal documentation, and documented refusal of colonoscopies for patients with unresolved FITs.