assess the nature of such lesions using endoscopic ultrasound (EUS) prior to a biopsy.

Methods A total of 22 consecutive patients with portal hypertension who underwent an EUS evaluation between June 2008 and November 2011 for upper GI polypoid lesions found on endoscopy were included in the study. Procedure and pathology reports, obtained from patients' electronic records, were reviewed.

Results Of the 22 patients (16 men, 6 women, median age 66) who underwent upper GI endoscopy, 11 had lesions in the proximal stomach (gastro-oesophageal junction, fundus, gastric body) while eight had lesions in the distal stomach (antrum, pylorus) and three in the duodenum. Six (27.3%) proved to be varices and 4 (18.2%) polypoid lesions over varices (2 benign, 2 malignant). Whereas, 7 (31.8%) patients had true polyps. The remaining lesions found on EUS included 1 (4.5%) case of gastric fold, 1 gastric antral vascular ectasia (GAVE), one ulcer, 1 case of external compression and one patient had a normal EUS with no lesion seen. Of the 10 cases of varices and varices underlying polypoid lesions, 8 (80%) were in the proximal stomach. Histology of non-vascular lesions under EUS were available in 11 patients, which showed 5 (45.5%) inflammatory polyps, 2 (18.2%) adenocarcinoma, 2 (18.2%) adenoma, 1 (9.1%) normal and one was reported as insufficient sample.

Conclusion Indeterminate upper GI lesions encountered during routine endoscopy in patients with portal hypertension are commonly either varices or may develop around varices. We recommend EUS evaluation prior to biopsying such lesions in order to avoid potential serious complications such as iatrogenic variceal bleed.

Competing interests None declared.

PMO-195 IS THERE OPTIMUM PERIOD OF OBSERVATION POST DAYCASE ERCP? 12 MONTH EXPERIENCE IN A LARGE NON-TERTIARY CENTRE

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[1]A Singhal,* [2]A Jayachandran, [1]R Faizallah. *[1]Gastroenterolgy, Wirral NHS Teaching Hospitals, Wirral, UK; [2]Acute Medicine, Wirral NHS Teaching Hospitals, Wirral, UK*

Introduction Daycase ERCP is practised in approximately 50% centres in UK. Even in these centres there is no uniform policy for post ERCP observation or duration of hospital stay. We established daycase ERCP service in January 2010 on the Wirral, catering to 360 000 population and hereby present our experience over a 12-month period.

Methods Data from Unisoft, GI Endoscopy reporting tool, was analysed to identify all the daycase ERCPs performed from 1 January to 31 December 2010. All the patients who for any reason stayed overnight after ERCP or re-attended hospital within 7 days, were identified from day ward registry and patient administrative system. Medical notes of all these patients were reviewed. All patients were closely monitored post ERCP in medical day ward for 4 h and were then allowed to eat and drink if there were no concerns. All patients were seen by the ERCPist prior to discharge.

Results Total of 395 ERCPs were performed by three endoscopists in this period of which 195 (48%) were as daycases. Difficulty level in all cases was Level 1–2 as per cotton *et al*. Indication of ERCP was pancreato biliary malignancy in 29 (15%), stone disease in 160 (82%) and previous bile leak 6 (3%) patients. All procedures in our unit are done with therapeutic intent. 137 (72%) patients underwent sphincterotomy and/or stent insertion. Previously placed stents were removed in the rest along with balloon trawl/stone extraction as needed. In all 32 (16.4%) patients were admitted overnight. Of these, 13 (6.6%) were elective admissions due to patient choice such as those who were elderly and lived alone. There were 7 (3.5%) complications including 3 mild cholangits, 1 moderate cholangitis, 1 mild and 1 severe pancreatitis and 1 death as per accepted guidelines by Cotton *et al*. One patient who died, chose to stay back electively but died 12 h later with pulmonary embolism. Rest 13 (6.6%) cases were advised to stay overnight because of suspected adverse event (commonest being post ERCP pain in 10 cases) but this was not substantiated on further investigations. Only one out of 195 patients (0.5%), presented within 7 days with procedure related complication, namely mild cholangitis. Overall there were 8 (4%) complications in 195 daycase ERCPs. Out of these 8, only 2 (25%) presented within 0–2 h, 4 (50%) in 2–6 h and rest 2 (25%) after 12 h of the procedure.

Conclusion Daycase ERCP is a safe service. We propose that patients should be kept nil by mouth for 4 h post procedure and observed upto 6 h on the daycase unit. It is good practise for patients to be seen by the ERCPist prior to discharge. This would pick up majority of procedure related complications and enhances patient satisfaction.

Competing interests None declared.

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PMO-196 REDUCING TIME TO GASTROSCOPY IN UPPER GASTROINTESTINAL BLEEDING

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[1]M T Wong, [1]A Sundaralingam,* [1]S Bains, [1]K Shaw, [2]S Afghan, [2]S A Filson, [1]I Gooding. *[1]Colchester General Hospital, Colchester, UK; [2]Barts and The London Medical School, London, UK*

Introduction Approximately 300–350 patients present to Colchester General Hospital with an upper Gastrointestinal (GI) bleed per year. Guidelines advise endoscopy within 24 h of presentation. To improve our performance, we introduced a new system for prioritising these requests and monitored the results with repeated audits.

Methods An audit of all upper GI bleed cases was conducted over the same 3-month period (March–May) in 2009, 2010 and 2011. For each case we obtained the times of admission, Oesophagogastroduodenoscopy (OGD) request, procedure and discharge. The discharge summary, and where necessary the notes, were consulted to separate cases admitted for bleeding from those where bleeding occurred after admission for another reason. The main theatre logs were consulted for numbers of emergency out-of-hours OGDs. In an effort to tackle to poor waiting times, the Early Morning Bleeder (EMB) system was introduced in July 2009. Two slots are allocated daily (excluding weekends) for gastroscopy for cases of upper GI bleeding at the beginning of the working day. Requests are collected in a box in the Medical Assessment Unit daily at 0730. The Rockall Score is used for prioritisation. These three audits thus compare the situation before and after introducing the EMB system.

Results

		2009	2010	2011
Total cases		72	80	85
Bleeder admissions		54	59	53
Wait from	0	3.7%	11.9%	15.1%
admission to	1	29.6%	35.6%	49.1%
OGD (days)	≥2	68.5%	52.5%	35.8%
Mean wait for OGD (days)		3.26	1.95*	1.66*
Median length of stay (days)		6	4	3*

*$p<0.05$ compared to 2009.
Waits were significantly longer for cases admitted on Friday or Saturday.
Numbers of out of hours OGDs for bleeding were 12 (2007) and 11 (2008) before the EMB and 7 (2010) and 6 (2011) afterwards.

Conclusion The EMB system has reduced waits from presentation to OGD and length of hospital stay for patients presenting with upper GI bleeds. Patients are probably safer as the number of out of hours OGDs has fallen. There are plans to extend the service to include