

(5.4%) of TNE biopsies did not permit a definite diagnosis, but when standard biopsies were later taken, also failed to confirm diagnosis.

**Conclusion** TNE is equal to SOGD in image quality, endoscope handling and length of procedure. It is superior to SOGD in the ability to perform a panendoscopy and in terms of comfort and patient acceptance. Importantly it induced significantly less stress to the heart, thus should be considered as the endoscopic diagnostic method of choice in patients with significant cardio-respiratory problems.

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## OC-046 GUIDELINES ON THE ENDOSCOPIC ASSESSMENT OF GASTRIC POLYPS: IS THE WORKLOAD JUSTIFIED?

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**Introduction** British Society of Gastroenterology guidelines on the management of gastric polyps<sup>1</sup> recommend increased intensity of evaluation compared with traditional practice, including biopsy of ALL polyps, biopsy of intervening gastric mucosa (hyperplastic/adenomatous polyps) and 1 year follow-up of dysplasia; a considerable increase in endoscopic and histological workload. The purpose is to reduce risk, and increase early detection of gastric carcinoma. It would therefore be expected that in clinical practice there would be an association between gastric polyp detection and subsequent carcinoma, and that application of the guidelines would improve patient outcomes. The purpose of this study was to evaluate whether this association exists in a DGH setting where traditional polyp assessment and surveillance was followed.

**Methods** Our database was searched for gastroscopies where polyps were found over 5 years. These records were cross-referenced against the local cancer database for those 5 years plus 1 year of follow-up. Any cases where polyps were found along with subsequent cancers were audited.

**Results** Details of 15 489 gastroscopies in 11 938 patients over 5 years (2006–2010) were analysed. 670 patients (756 gastroscopies) were found to have gastric polyps (5.6%—in line with larger studies).<sup>2</sup> In 2006–2011, 1328 upper GI cancers were recorded on the local register. Cross reference of these revealed 57 patients with polyps at gastroscopy who had a co-existent record on the local cancer register. Cases were excluded where cancer was diagnosed at the index endoscopy [45 patients with polypoid tumours or co-existent polyps where the guidelines would not have influenced outcome]. Seven of the remainder had non-gastric neoplasia. Of the remaining 5, 3 had a small neuroendocrine tumour on follow-up endoscopy, with no specific treatment. The other two were an 80 year old with a dysplastic polyp, followed up at 3 and 6 months when carcinoma was identified (the patient was not fit for radical treatment); and a patient with a large suspicious polyp— inflammatory on initial biopsies with dysplasia identified following intensive follow-up (leading to resection). Neither would have benefited from application of the guidance.

**Conclusion** This retrospective analysis reveals no patients where an initial suspicion of simple fundic polyps was followed by a subsequent diagnosis of significant neoplasia, or where follow-up of hyperplastic polyps would prevent progression. On the basis of these results, the upper 95% confidence limit for patient benefit from the proposed algorithm is ≈0.5%. These guidelines should therefore be more thoroughly assessed for cost effectiveness.

**Competing interests** None declared.

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## OC-047 A PROSPECTIVE, BACK-TO-BACK, COMPARATIVE STUDY OF MANUAL SPIRAL ENTEROSCOPY AND DOUBLE-BALLOON ENTEROSCOPY

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**Introduction** By facilitating examination and therapy of the deep small bowel (SB) without recourse to surgery, double-balloon enteroscopy (DBE) has revolutionised SB endoscopy and is now considered to have become the “gold-standard” device assisted enteroscopy (DAE) technology. The more recently developed manual spiral enteroscopy (SE) shows promise to facilitate faster DAE, although whether these two technologies enable similar SB insertion depths remains uncertain.

**Methods** We performed a prospective, back-to-back comparative study of SE and DBE performed during the same session (under general anaesthesia) in 15 patients (10 women, 5 men; mean age ±SD, 51.4±15.4 years). The aim was to compare SB insertion depths by SE and DBE procedures performed in tandem, in the same cohort, using the same method of SB insertion depth estimation. Comparisons of duration, procedure difficulty (PD) (endoscopists' VAS score) and diagnostic yield (DY) were also performed. SE procedures were performed first and a tattoo was placed to mark the most distal point of SB insertion.

**Results** In 14 cases, the tattoo placed at SE was reached and passed by DBE; median (95% CI) insertion depths for DBE vs SE were 265 (227 to 324) vs 175 (132 to 212) cm respectively, p=0.004. In one patient, the tattoo placed during SE could not be reached by DBE at an estimated final SB insertion depth of 160 cm. Conversely, the median time taken to achieve deepest insertion was significantly shorter for SE as compared with DBE (median (95% CI) times for SE vs DBE: 24 (20 to 28) min vs 45 (35 to 53) min respectively, p=0.0005). Median procedure duration was also shorter for SE (median (95% CI) duration: SE vs DBE was 28 (27 to 36) min vs 54 (45 to 62) min respectively, p=0.0002. In the 14 patients where comparison was possible, median time taken by SE to reach maximal insertion was not significantly different to the time taken by DBE to reach the tattoo placed at SE (median (95% CI) times for SE vs DBE were 24 (20 to 28) min vs 19 (14 to 26) min respectively, p=0.28). Mean VAS PD scores were similar (mean VAS±SD (95% CI) PD score: SE vs DBE, 5.3±2.3 (4.0 to 6.6) vs 5.2±2.4 (3.9 to 6.5) respectively, p=0.86). Overall DY was similar for both (DY: SE vs DBE, 46.7% vs 53.3% respectively, p=0.4). However, in one case, deeper SB insertion at DBE (median SB insertion at DBE vs SE, 270 cm vs 150 cm respectively) led to the identification of the suspect SB lesion (SB lipoma) which had not been reached by SE. Mild SE-related mucosal trauma was observed in 60% of cases; no other complications were observed in the study.

**Conclusion** Our experience suggests that although SE may enable faster DAE procedure times, DBE allows for significantly deeper SB insertion.

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