

Abstract PTH-047 Table 1

	Pre-Bundle Population	Post-Bundle Population	Total
Good Visualisation	24	30	54
Moderate/Poor Visualisation	29	7	36
Total	53	37	

P-value = 0.0008; two-tailed Fisher's exact test.

Conclusion Our study - the first looking at the effect of a bowel cleansing care bundle on inpatients - shows that its implementation conferred significantly better visualisation scores at colonoscopy with a dramatic reduction in poor visualisation.

Disclosure of Interest None Declared.

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PTH-048 BENCHMARKING IN UPPER ENDOSCOPY - BEST PRACTICE MARKERS

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Introduction UK practise in diagnostic oesophago-gastric-duodenoscopy (OGD) has changed little over the last 10–20 years. Currently the only quality measure relates to ability to reach the second part of the duodenum. Evidence-based quality indicators in colonoscopy pertain to the quality of views, the amount of time spent examining the mucosa and expected levels of lesion detection, in addition to completion rates. Their adoption, in combination with robust clinical governance has undoubtedly improved the detection of colorectal diseases, patient safety and patient experience. The equivalent evidence base for diagnostic OGD does not exist and this has limited development.

Benchmarking is a process measuring the practise of one organisation against its peers and may provide a basis for developing quality standards for upper GI practise. This study measures routine OGD practise in the UK and practise in a Japanese centre of excellence for endoscopy and oesophago-gastric cancers.

Methods Two experienced endoscopists recorded OGD practise in the National Cancer Centre Hospital in Tokyo. The following were recorded: net procedural time spent screening the oesophagus, stomach, and duodenum; lens cleaning, mucosa cleaning, presence of residual food; use of dye spray and narrow band imaging; picture numbers and biopsies; patient age and sex.

One experienced endoscopist recorded OGD practise during routine diagnostic lists at 3 hospitals.

Results 134 procedures were recorded, 67 in each country. The average age in the UK was 58.5 yrs (60% male) and 68.2 yrs in Japan (57% male). The average screening time in Japan was 6:51 mins, and 5:49 mins in the UK. The Japanese use advanced imaging techniques 73% of the time. They were never used in routine UK practise.

Japanese endoscopists met weekly reviewing all pathology detected and discussing therapeutic cases. All images were reviewed closely and were an essential part of decision making and education in the unit.

	Japan	UK
Overall Screening time (mins)	00:05:51	00:05:49
% of cases where the lens was cleaned pre-procedurally	46.3	1.9
% of procedures where stomach/oesophagus was washed	100	13.2
% of cases with a stomach clear of food	92.5	96.2
% of cases using advanced imaging	73.1	0
% of cases using NBI	37.3	0
% of cases using iodine	13.4	0
% of cases using indigo carmine	49.3	0
% of cases using zoom	1.5	0
Average pictures taken	45.7	2.4
Average biopsies taken	0.6	2.8
% of cases with extra pathology found	22.4	15.1

Abstract PTH-048 Figure 1

Conclusion Comparison of the 'cultures of practise' are interesting, revealing significant differences of approach in UGI examination.

In the Japanese cohort a 48% higher yield of pathological findings was achieved despite the average screening time being only one minute longer per case.

Although there are differing disease prevalence's in the background populations, it seems likely that better cleaning of the upper GI tract, use of mucosal enhancement techniques, care in image capture, and better awareness of upper GI pathology will have significantly contributed to increased detection.

Further investigation is needed into which factors can be used as independent measures of quality in UGI examination, including time taken to examine the upper GI tract and measures of endoscopists' lesion recognition skills (not currently assessed as part of endoscopy training).

Disclosure of Interest None Declared.

PTH-049 SUB-OPTIMAL BOWEL PREPARATION IN THE SURVEILLANCE POPULATION - WHAT DOES IT MEAN?

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Introduction Modern colonoscopic surveillance follows clear evidence based guidelines, and clinical decisions appear straight forward. However, the guidelines do not define what should be done in cases with sub-optimal preparation.

Methods We retrospectively reviewed all adenoma and post carcinoma surveillance colonoscopies over 5 years (2006–2011) with a further year follow up looking for incident cancers.

Polyp site, number, size, and colonoscopy completion rates were recorded.

Two cleaning regimes were used: standard - Fleet; second line and in older patients/renal failure - KleanPrep, picolax and senna. Preparation was graded by the performing colonoscopist as satisfactory, sub-optimal or unsatisfactory.

Results 2176 patients underwent 2649 surveillance colonoscopies. Average patient age was 68.8 years. Mean follow up was 3.4 years.

3758 polyps were identified in 1539 procedures; 525 polyps were 1cm or larger. There was a marked trend towards lower polyp detection with worsening bowel preparation ($p = 0.056$ Chi²) with a marked reduction in mean number of polyps particularly on the right side with worsening preparation.

12 colorectal cancers were detected in this population. The overall cancer rate in this high risk population was 1 in 181 patients (95% C.I. 103 – 350).

73 patients with sub-optimal or unsatisfactory preparation had a repeat colonoscopy. In 64% the preparation was satisfactory, 28% were sub-optimal, and 8% had an un-satisfactory examination.