

High case volume and prior sigmoidoscopy experience are associated with a CIR > 90%. The potential of both these factors to influence the attainment of competency should be exploited within endoscopy training programmes.

**Disclosure of Interest** None Declared.

**PTH-059 UPPER GASTROINTESTINAL MALIGNANCIES: 6976 ENDOSCOPY REVIEW IN A MULTINATIONAL STUDY**

doi:10.1136/gutjnl-2013-304907.546

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**Introduction** To compare the prevalence of upper gastrointestinal (UGI) malignant and premalignant conditions in three separate populations; British, Japanese and Arabian.

**Methods** 6976 Upper Gastrointestinal (UGI) endoscopies were retrospectively reviewed in a multinational comparative study. This involved three population groups: Group A- British & others (n = 2158); Group B- Japanese (n = 2628); Group C- Arabians (Saudi Arabians & others (n = 2190)).

The majority of the patients fell in the above 16 age group.

The patients presented with UGI symptoms and were selected at random. The data was collected between 1986 and 2012.

The study involved patients from Barnsley District General Hospital (Barnsley), Darent Valley Hospital (Dartford) & Queen Mary's Hospital (Sidcup) in UK - Group A; Showa University Fujigaoka Hospital & Niigata Cancer Centre Hospital (Japan)- Group B; Jubail Hospitals (Saudi Arabia) – Group C.

**Results** A comparison was made for the malignant and premalignant diseases. It revealed a very high incidence of UGI malignancies amongst Japanese (Group B). There is significant number of malignant diseases amongst non-Arabians, but such malignancies amongst Arabians are rare.

The incidence of gastric ulcers and gastric polyps are very high amongst Japanese compared to the other population groups in the study.

It is found that the prevalence of Barrett's Oesophagus has increased significantly in the last ten years.

The results are summarised as below:

UGI malignancies recorded:

Group A: British population: 37 (1.71% with 95% CI: 1.17 to 2.26)

Group B: Japanese population: 148 (5.63% with 95% CI: 4.75 to 6.51)

Group C: Arabian population: 16 (1.17% with 95% CI: 1.17 to 2.26)

Ulcers in the upper GI tract recorded:

Group A: British population: 366 (16.96%, 95% CI: 15.38 to 18.54)

Group B: Japanese population: 498 (18.95% 95% CI: 17.45 to 20.45)

Group C: Saudi population: 506 (23.11%, 95% CI = 21.34 to 24.87).

**Conclusion** It can be concluded that Arabians (Saudis) suffer rarely from UGI malignancies and it may be related to social, environmental, geographical, genetic and dietary habits. Dietary habits in Japan are very different from the British and Saudi population.

Alcohol consumption amongst Saudis is very little. In comparison, Japanese and UK populations drink alcohol significantly more.

Prevalence of Barrett's has increased significantly in the last 10 years. It is likely due to effective Helicobacter Pylori eradication and due to increasing awareness of Barrett's amongst endoscopists.

**Disclosure of Interest** None Declared.

**PTH-060 ACUTE UPPER GASTROINTESTINAL BLEEDING TO BE ENDOSCOPED WITHIN 24 HOURS OF ADMISSION - ARE WE MEETING BSG AND NICE GUIDELINES? THE EXPERIENCE OF A DISTRICT GENERAL HOSPITAL**

doi:10.1136/gutjnl-2013-304907.547

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**Introduction** BSG and NICE guidelines recommend that all patients with a suspected GI bleed have an endoscopy within 24 hours of admission. The Queen Elizabeth Hospital (QEH), Gateshead (a District General Hospital serving a population of approximately 200,000) provides an urgent out of hours GI bleed service. Additionally there is an 8.30am slot in endoscopy from Monday to Friday allocated to patients who have symptoms of an upper GI bleed. We audited our compliance to the 24 hour guideline.

**Methods** The electronic reporting system 'Endosoft' was searched using the terms: *Upper GI bleed; Malaena; or Haematemesis*, for all referrals for gastroscopy between January 1<sup>st</sup> 2011 and December 31<sup>st</sup> 2011. The date, time of endoscopy, findings and interventions were noted. Time of admission, theatre use and In-patient and 4 week mortality were also noted.

**Results** 162 patients were admitted with acute GI bleeding over the 12 month period. Overall 126 (78%) were endoscoped within 24 hours. 35 of the 36 patients endoscoped in theatre had their procedure within 24 hours of admission. 16 (44%) of the 36 patients outside the 24 hour window were admitted on a Friday evening or Saturday. Of the 36 patients that suffered a delay to endoscopy: 5 had oesophageal varices; 1 a gastric varix; 6 peptic ulcer disease (4 high risk stigmata and 2 low risk); 2 Mallory Weiss tear, and 22 were normal. Of the 36 patients who went straight to theatre, 34 (94%) had an endoscopic cause for bleeding identified. 20 (56%) had variceal bleeds, 12 had peptic ulcer disease (10 high risk stigmata and 2 low risk). Overall in-patient mortality of those found to have an upper GI cause for bleeding was 16% (15 of 91) and 4 week mortality was 18% (17 of 91). Five (29%) of those that died were cirrhotic patients and 8 (47%) had peptic ulcer disease with high risk stigmata. 3 of the 17 deaths occurred in the patients who were delayed prior to endoscopy, one of whom came in at a time when there was no allocated 8.30am slot the following morning. All 3 of the mortalities who waited over 24 hours for their procedure had endoscopic intervention. There was however no significant difference (chi-square test) between mortality of the delayed patients and those scoped within 24hrs (8% compared to 11%).

**Conclusion** During 2011 the QEH appropriately identified sick patients suitable for the out of hours GI bleed service, with 94% of theatre cases requiring endoscopic intervention. The NICE and BSG guidelines of endoscoping patients referred for a GI bleed within 24 hours of admission was met in 78% of cases. Allocated 8.30am endoscopy slots on Saturday and Sunday would improve these figures, but it is currently unclear if this would affect the patient outcome.

**Disclosure of Interest** None Declared.

**PTH-061 TO EVALUATE THE SAFETY AND OUTCOMES OF ESD AND HYBRID ESD FOR LARGE SESSILE COLORECTAL POLYPS INCLUDING PROCEDURAL COMPLICATIONS AND RECURRENCE RATE**

doi:10.1136/gutjnl-2013-304907.548

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**Introduction** The purpose of ESD and Hybrid ESD (circumferential excision and snaring) is to obtain en bloc specimen. Margins are checked for residual tissue and APC applied if appropriate