

be risky. Balloon sphincteroplasty had prevented the further need for ERCP, and its associated cost and morbidity.

REFERENCE

Maydeo A, Bhandari S, et al., *Endoscopy* 2007; 39 (11)

Disclosure of Interest None Declared.

PTH-009 ERCP UNDER PROPOFOL: DO PATIENTS PREFER IT?

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Introduction Endoscopic retrograde cholangiopancreatography (ERCP) is an invasive procedure involving heavy sedation. Use of propofol as sedation in ERCP has been demonstrated to be safe, but is it preferred by patients?

Methods A prospectively collected dataset of patient satisfaction questionnaires post ERCP, using a Likert scale. Patients excluded were those who declined to do so, those unable to consent for themselves. After 30 days patients were contacted by an ERCP-trained nurse to discuss any problems and complications arising in that time.

Results 128 questionnaires have been completed and followed up at 30-days. 26 had the procedure under propofol +/- midazolam and fentanyl (administered by an anaesthetist) and 102 under a combination of midazolam and fentanyl as per standard unit practice administered by the ERCPist. 30-day FU: 93 of 103 agreed to contact, 16 of whom were uncontactable (based on 2-3 separate attempts to call them on the number provided), 4 of 23 uncontactable from propofol group. 5 propofol patients reported problems in the 30 day follow up (2 were serious), compared to 24 of the sedation group (4 of which were serious).

There was no difference in overall satisfaction between the groups, the propofol group reported less discomfort during the procedure ($p < 0.001$), less writhing ($p = 0.015$) and were more willing to have the procedure repeated ($p = 0.051$).

Using a score of 1 and 2 for satisfied and anyone reporting a score of 3-7 as less or not satisfied, the factors associated with less satisfaction were discomfort during the procedure ($=0.006$), overall discomfort ($p = 0.001$), overall rating of experience and unwillingness to repeat the procedure ($p < 0.001$). After adjusting for age, gender and number of interventions there was no association between propofol use and non satisfaction (adjusted OR 1.12 (95% CI: 0.28-4.45), $p = 0.868$).

Conclusion Patients do prefer ERCP under propofol, but not by much. They get less discomfort (where 0 was a scale of no discomfort and 7 of extreme pain) and therefore are more willing to have the procedure done again. Interestingly propofol procedures are not taking longer than normally-sedated procedures and there are not higher numbers of therapeutic interventions.

This may reflect the current bias in selecting a propofol list for a patient or form part of the learning curve of finding the role of propofol-ERCP in the therapeutic strategy.

Further data collection is required to see if ERCP under propofol reduces the number of repeat procedures and therefore can justify itself as cost-effective.

Disclosure of Interest None Declared.

PTH-010 THE SAFETY AND EFFICACY OF TRANSPANCREATIC SPHINCTEROTOMY FOR DIFFICULT CBD CANNULATION DURING ERCP: A DISTRICT GENERAL HOSPITAL'S EXPERIENCE

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Introduction Transpancreatic sphincterotomy (TPS) for difficult common bile duct cannulation during ERCP was first described by Goff in 1995. Since then its safety and efficacy has been debated with some concerns regarding high post ERCP pancreatitis rates (PEP). In published data from recent years PEP can range from 6-20% when TPS is carried out. The majority of TPS is carried out in tertiary referral centres but it is a technique that we have increasingly adopted in our district general hospital when common bile duct cannulation is proving difficult. We wished to review the safety and efficacy of this technique and compare our results to the literature

Methods We reviewed all procedure notes from ERCPs that had been carried out from October 2011 - October 2013. The reports were reviewed and any cases where transpancreatic sphincterotomy was performed were identified. We subsequently reviewed our radiology reporting system, the patients discharge letter and blood results as well as any subsequent hospital admissions to determine any complications. We noted any post ERCP pancreatitis, upper GI bleeding, perforation or death. Complications were classified using the system proposed by Cotton *et al.* We compared our complication rates to our departments overall complication rates

Results Out of 811 ERCPs carried out in the date range 31 patients were identified who had a transpancreatic sphincterotomy performed. 21 cases (68%) were performed by a consultant whilst 10 cases (32%) were performed by a senior registrar. Successful CBD cannulation was achieved in 25 patients (80%) and in the 6 that failed it was subsequently successful at a later date in 4 patients. Our complication rates are shown in the below table

Conclusion Our results show that transpancreatic sphincterotomy can be carried out at a district general hospital with similar levels of success and complications as reported in the literature from tertiary centres worldwide. In such a small data set a single patient death can bias the results and on reviewing the notes the patient died from a perforation due to a common bile duct stent

Abstract PTH-010 Table 1 Complication rates

complication	Standard complication rate	TPS complication rate and severity
Perforation	0.18%	3% (1 patient) - Fatal
Bleeding	0.33%	3% (1 patient) moderate
Post ERCP pancreatitis	0.42%	6% (2 patients) both moderate
Death	0.23%	3% (1 patient)