

priority area for research and development to meet the clinical challenges posed by the scale of the infection in the UK. There has been a perceived lack of connection between clinicians and basic scientists working on HCV in the UK to address this problem. Aims: To create a multi-disciplinary consortium comprising clinicians and non-clinical scientists to encourage translational research. To establish a cohort of 10 000 patients with HCV infection across the UK, together with clinical database and biorepository—"HCV Research UK". To make this resource available to researchers, both academic/commercial, UK-based and abroad.

**Methods** Aims: Our objective has been to create a multi-disciplinary consortium comprising clinicians and non-clinical scientists to encourage translational research into the factors that determine outcome of infection, treatment response and disease progression. We aim to establish a cohort of 10 000 patients with HCV infection from across the UK that is supported by the necessary systems to make clinical data and specimens available to academic and commercial researchers, both in the UK and abroad.

**Results** Progress: HCV Research UK has been funded by the Medical Research Foundation (£1.92 million) to establish an infrastructure that connects 18 clinical centres who will recruit 10 000 HCV-infected patients. The key elements of the infrastructure are a bespoke clinical research database, which is linked to a biorepository of samples that will hold serum, PBMCs and DNA from patients. Access to data and samples is managed by a Tissue and Data Access Committee who have the authority to grant ethical approval for research using the resource. The study has been given CLRN portfolio status.

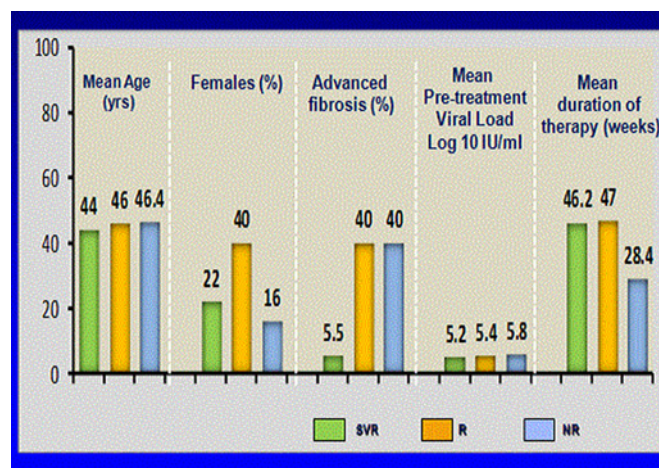
**Conclusion** Future plans: Recruitment of patients will begin in early 2012 and grant applications have been submitted to (1) Wellcome/ Department of Health Innovation Challenge fund (2) MRC call for Stratified Medicine (3) BLT Research call (4) NIHR Programme Development award schemes for research using the resource. It is hoped that portfolio support will provide a mechanism for new centres to join the consortium.

**Competing interests** None declared.

**Results** 63 patients were classified (number, mean age, females, advanced fibrosis) by treatment response as SVR (18, 44, 4, 1), R (20, 46, 8, 8) and NR (25, 46.4, 4, 10). Mean pre-treatment viral load was similar in the three groups (5.2, 5.4, 5.8 log<sub>10</sub> IU/ml) and mean duration of therapy shorter for NR (46.2, 47.2, 8.4 weeks) who often fulfilled an early stopping rule. The IL28B genotype was highly predictive of response (Abstract PMO-183 table 1). CC individuals have a much greater likelihood (p<0.002) of being in the SVR group than CT or TT individuals. Poorer response was also seen in patients with advanced fibrosis.

Abstract PMO-183 Table 1

	Total	CC	CT	TT
SVR	18	12	4	2
Relapse	20	9	10	1
Non-responder	25	2	16	7



Abstract PMO-183 Figure 1 Characteristics of study subjects

**Conclusion** The IL28B polymorphism is a useful and cheap assay allowing some prediction of response to antiviral therapy in patients with G1 chronic HCV infection.

**Competing interests** None declared.

**PMO-183** **ROLE OF IL28B POLYMORPHISM IN PREDICTION OF RESPONSE TO THERAPY IN PATIENTS WITH GENOTYPE 1 CHRONIC HEPATITIS C INFECTION**

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**Introduction** Patients with chronic hepatitis C virus (HCV) infection have a variable response to antiviral therapy with pegylated interferon and ribavirin. Influences include age, gender, viral genotype, viral load, severity of liver disease and coinfection. Around 45% of patients with viral genotype 1(G1) infection respond compared with 70%–80% with genotype 2/3. Recently a human IL28B polymorphism has been found to predict response in patients with G1 infection. There is little data on this from Europe and a study of IL28B polymorphisms in patients with G1 infection treated in Glasgow was conducted.

**Methods** Sequential Caucasian patients with G1 chronic HCV who had been treated with combination antiviral therapy were studied. Responses were classified as sustained viral response (SVR), relapse (R) or non-responder (NR). None had coinfection. Data on age, gender, viral load, duration of therapy and severity of liver disease (Ishak fibrosis stage <4 or ≥4) were collected. Individuals were genotyped for IL28B polymorphism rs12979860 using TaqMan<sup>®</sup>, Drug Metabolism Genotyping Assays and reported as CC, CT or TT.

**Endoscopy I**

**PMO-184** **COLONOSCOPIC TATTOOING OF COLORECTAL NEOPLASIA: A CHANGE IN PRACTICE**

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**Introduction** Quality Assurance Guidelines for colonoscopy in the Bowel Cancer Screening Programme recommend tattooing of all lesions that may require later surgical or endoscopic localisation, using local protocols as guidance.<sup>1</sup> The St. Mark's Hospital colonoscopic tattooing protocol stated that all suspicious lesions should be tattooed, with the exception of those in the caecum and within 20 cm of the anal verge. Three tattoos should be placed (120° apart, close to the lesion) and distal to lesions proximal to the splenic flexure (SpFlx). Left sided lesions should have tattoos placed proximal to the lesion. Our aim was to audit compliance with the tattooing protocol in patients undergoing surgery for colorectal neoplasia.

**Methods** We reviewed endoscopy reports of all patients who had surgery for colorectal neoplasia during a 12-month period. The report was deemed fully compliant if the following were clearly documented: location of the tattoos, correct location of the tattoos, the number of tattoos placed and a correct number of tattoos placed, hence, scoring 4/4. Non-compliance was defined if none of the parameters was mentioned and partial compliance was awarded to those scoring between one and three points.

**Results** 155 patients were identified, of which 114 had reports available. The overall compliance with the protocol was observed in 71 cases (62%) whereas 19 cases (17%) were partially compliant and 24 cases (21%) were non-compliant. Rates for full, partial and incomplete compliance were better for patients diagnosed through the BCSP (71% 26% and 3% respectively) when compared to those diagnosed through non-screening (58%, 13% and 29% respectively). Incomplete documentation (22 cases) and inability to place tattoos proximal to obstructing lesions (19 cases) were the major causes of reduced compliance.

**Conclusion** Educational intervention is necessary to address poor documentation. However, changes to our protocol are also required. We have therefore revised our protocol recommending that all tattoos should be placed distal to the lesion regardless of the anatomical position.

**Competing interests** None declared.

## REFERENCE

1. *Quality Assurance Guidelines for colonoscopy. NHS BCSP Publication No 6 February 2011.* <http://www.cancerscreening.nhs.uk/bowel/publications/nhsbcsp06.pdf>

## PMO-185 DUODENAL TAMPONADE: A CASE SERIES AND FOURTH MODALITY IN GASTROINTESTINAL BLEED CONTROL

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**Introduction** The mortality associated with gastrointestinal bleeding is around 10%, a figure which has remained roughly constant despite continuing innovation in therapy. The use of injection, thermocoagulation, and endo-clips is widely practiced in the context of bleeding duodenal ulcers. However a number of patients will re-bleed in spite of dual or even triple therapy. In cases where co-morbidity precludes surgical intervention further therapeutic options may be non-existent.

**Methods** We describe a case series of five patients with multiple co-morbidity who presented with upper gastrointestinal haemorrhage from duodenal lesions. A variety of therapeutic modalities were employed that is, injection with Adrenaline, thermocoagulation or endoclips. Unfortunately haemostasis was not achieved and surgical intervention deemed inappropriate. Our technique involves tamponade with a 18 mm CRE (constant radial expansion) balloon inflated in the duodenum. The gastroscope with the deflated balloon

is passed via the pylorus. The balloon is then inflated keeping the proximal portion of the balloon under direct vision at all times to ensure correct placement. Tamponade is maintained for up to 50 min.

**Results** This procedure achieved haemostasis in all five cases. The tamponade was maintained for a total of between 10 and 50 min.

**Conclusion** Duodenal tamponade to control Haemorrhage has been described previously only twice and has required either specialist equipment<sup>1</sup> or surgical intervention.<sup>2</sup> The CRE balloon is readily available within most endoscopy units and therefore no expenditure is required to use this new modality. In addition the technique is easily learnt and can be readily applied to lesions whose orientation makes targeted intervention difficult. Tamponade is a useful adjunct and may prove lifesaving in an otherwise hopeless situation.

**Competing interests** None declared.

## REFERENCES

1. **Rohatgi A**, Houghton PW. Duodenal tamponade in the treatment of an intractable peptic ulcer bleed. *Ann R Coll Surg Engl* 2001;**83**:335–6.
2. **Taylor TV**. Isolated duodenal tamponade for treatment of bleeding duodenal ulcer. *Lancet* 1988;**1**:911–12.

## PMO-186 COMPLICATION RATES OF COLONOSCOPIC REMOVAL OF LARGE COLORECTAL POLYPS IN A DISTRICT GENERAL HOSPITAL: A RETROSPECTIVE AUDIT

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**Introduction** Colonoscopic removal of large colorectal polyps, sessile or pedunculated, can pose a challenge. Techniques most commonly used are hot snare polypectomy or endoscopic mucosal resection using electrocautery snare. The bigger the size of the polyp greater the skill needed to avoid complications. The potential complications are bleeding and perforation. According to the British Society of Gastroenterology guidelines post polypectomy bleeding requiring transfusion should be <1:100 (for >1 cm polyps) and post polypectomy perforation rate should be <1:500.

**Methods** A retrospective audit was taken between the dates of October 2009 to October 2010 and included patients who had large polyps, defined as polyps equal to and >20 mm in size, removed from the colorectal region by various colonoscopists during their routine colonoscopy lists in a district general hospital. The size of the polyp was confirmed from both the colonoscopy and histology report.

**Results** In total 64 patients with large colorectal polyps were treated. Majorities were pedunculated (n=49) and the rest were sessile (n=15). In the group of patients who had pedunculated polyp, 29 were male and 20 were female with a mean age of 62.72 years. The average size of the polyp was 26.22 mm (range:

Abstract PMO-185 Table 1

Patient	Age	Co-morbidity	Initial endoscopic intervention	Tamponade in minutes	Outcome
1	77	Rheumatoid arthritis recurrent falls	Adrenaline injection thermocoagulation	50	Survived and discharged
2	88	Renal failure	Adrenaline endoclips three procedures in 4 days	10	Survived GI bleed but passed away from unrelated cause
3	89	Osteoarthritis, admitted with fractured neck of femur	Adrenaline injection thermocoagulation	10	Survived and discharged
4	79	Alcoholic liver disease type 2 diabetes	Awkwardly placed lesion at D1, injection with adrenaline only	10	Survived and discharged
5	88	Renal failure	Adrenaline injection	10	Survived and discharged