weekends. Hospitals with no current method for prioritising OGDs for bleeding should consider using this system.

Competing interests None declared.

PM0-197 ENDOSCOPIC FINDINGS IN COLLAGENOUS COLITIS; NOT ALWAYS MICROSCOPIC

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Introduction CC is classically associated with normal or unremarkable colonoscopy. In the last few years, reports have been published revealing findings that are thought to be characteristic or even pathognomonic of CC, such as alteration of the vascular mucosal pattern, mucosal nodularity and a sequence of mucosal changes from defects/lacerations to cicatricial lesions. The aim of this study was to evaluate the frequency and type of endoscopic findings in patients diagnosed with CC in our centre.

Methods *Setting:* Tertiary hospital, outpatients. *Design:* Retrospective study. The database of Pathology Department was searched for patients who have been diagnosed with CC between May 2008 and August 2011. Endoscopy reports and endoscopic images were retrieved and reviewed.

Results 155 patients were diagnosed with CC in the study period. The indications for colonoscopy were altered bowel habit (acute or chronic diarrhoea) in 126/133; 33 patients reported associated weight loss. The reports from 123 patients (96F/27M; median age 68.7 yrs, range 37–91 yrs) were eventually retrieved and further reviewed. The colonoscopies had been carried out by consultant (medical/surgeons): 47%, nurse endoscopist: 20%, associate specialist: 13% and fellow or registrar: 10%. Of the above cohort, 67 (54.4%) patients had no endoscopic findings and 44 (35.7%) had irrelevant to CC findings such as diverticulosis, polyps or telangiectasias. Twelve (n=12; 9.75%) had findings previously described as consistent with CC. In particular: 7 (5.7%) had mucosal erythema or oedema (patchy, mild granularity or congestion), 4 (3.25%) had lacerations (cat-scratch mucosa or bigger mucosal breaks) and 1 of them had a few mucosal scars. The sigmoid and the descending colon were the main colonic parts affected (in 7/12 cases) and the rest were found in the caecum-ascending colon area (4/12) while there was only one patient in which the entire large bowel was affected.

Conclusion A significant minority of patients with CC (almost 10%) presented endoscopic findings indicative of CC. Furthermore, 4% had findings that are considered pathognomonic for CC. Although still the subject of isolated cases reports, the endoscopic appearances of CC are becoming more familiar among the endoscopic community.

Competing interests None declared.

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PM0-198 POST-OPERATIVE ENDOSCOPY IN BARIATRIC SURGERY PATIENTS

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Introduction Bariatric surgical patients may require endoscopy in the post-operative phase. The current study analyses the indications and findings of upper GI endoscopy (OGD) in post-operative bariatric surgery patients.

Methods A retrospective analysis of all bariatric surgery patients referred for oesophagogastroduodenoscopies (OGDs) at Charing Cross Hospital from 1 January 2009 to 30 October 2011. The Endoscopy units' electronic database of OGDs performed was analysed to determine how many bariatric surgery patients had OGDs post-operatively. Further sub-analysis was done for each operation type.

Results During this time period 1093 bariatric surgeries were performed. These included 542 laparoscopic gastric bypasses, 220 laparoscopic gastric bands, 223 laparoscopic sleeve gastrectomies and 108 revisional bariatric procedures. 147 OGDs were performed on a total of 116 Bariatric surgical patients, with 23 patients having had more than one OGD. Of these 147, 103 were done post-operatively; 58 (56.3%) post-roux-en-y gastric bypass, 34 (33%) post-gastric band insertion, 6 (5.8%) post-gastric sleeve gastrectomy and 5 (4.9%) post- bariatric revisional surgery. Indications for OGDs were abdominal pain (44.7%), vomiting (15.5%), haematemesis/malaena (9.7%), failure of weight loss (7.8%), follow-up for previous scopes/imaging (6.8%), reflux symptoms (3.9%), dysphagia (3.9%), interventional purposes (3 naso-jejunal tube insertions and 1 stricture dilatation) (3.9%), suspected abnormal positioning/band erosion (2.9%) and microcytic anaemia (0.9%). Of the 34 gastric band OGDs done 13 were normal and 21 showed abnormalities including 7 gastric band erosions, 6 with mucosal inflammation, 2 with insufficient band compression, 2 with abnormal band position and 2 hiatal hernias. Of the 58 post-bypass endoscopies done 33 were normal, 15 showed anastomotic/pouch ulceration/inflammation/erosion, 4 showed signs of recent haemorrhage and 3 oesophageal irritation. Out of 6 post-sleeve OGDs 2 were normal, 1 was done for an interventional stricture dilatation, 1 showed a gastric stricture, 1 oesophageal candidiasis and 1 a hiatal hernia. Four OGDs out of 5 done post-revisional surgery were normal. Of all OGDs referred for post-operative abdominal pain, 50% yielded abnormal findings.

Conclusion Endoscopy units need to be familiar with and prepared for bariatric surgery patients as post-operatively a substantial number will need endoscopic postoperative assessments. In our study 9.4% of all postoperative bariatric surgery patients underwent endoscopy, the commonest referral reason was abdominal pain and the commonest finding was normal.

Competing interests None declared.

PM0-199 COMPARATIVE STUDY OF SAMPLE ADEQUACY OF 25G VS 22G NEEDLE IN ENDOSCOPIC ULTRASOUND (EUS) GUIDED FINE NEEDLE ASPIRATE (FNA) OF SOLID LESIONS

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Introduction Optimal needle size in achieving greatest diagnostic yield from EUS- guided FNA remains unclear.

Aim We prospectively compared sample adequacy and safety of FNA of solid lesions between 25G and 22G (Cook^{TM}) needle at two tertiary centres.

Methods Prospective data from two sites was collected between November 2008 and November 2011. A single operator alternated on a case-by-case basis between a 25G and 22G needle. A cytopathologist was present to assess adequacy of sample. The operator could switch needle size if required.

Results 152 patients undergoing 165 FNA were analysed (42M/30F, mean age 59). 76 patients had FNA with a 22 F needle and 76 with

the 25F needle. Indications for EUS and FNA were pancreatic lesions 43%, lymph node enlargement 28%, biliary tract lesions 16%, submucosal lesion 8% and adrenal mass 1% and others 4%. Overall sample adequacy was 83.03% Adequacy per needle was 86.7% (22G) vs 79.2% (25G), p=0.22 Fischer's Exact test. The number of passes used in successful FNA was higher with use of the 25G needle compared with the 22G needle. (2.42±0.11 SEM vs 1.962±0.15 SEM, p=0.015, t-test). In particular the use of a 25G needle had a higher number of passes in pancreatic lesions compared with the 22G needle (2.58±0.16 SEM vs 1.94±0.14, p=0.004, t-test). There was no difference in adequacy between the needle sizes for each type of lesion sampled (Abstract PMO-199 table 1). Two needle exchanges (25G to a 22G) occurred. One complication of local site bleeding occurred (22G) that settled during the test.

Abstract PMO-199 Table 1

	22G		25G		
Lesion site	Adequate sample	Inadequate sample	Adequate sample	Inadequate sample	Fischer's exact test
Lymph node	19	4	20	3	NS
Biliary tract lesion	9	2	11	4	NS
Pancreatic lesion	33	3	33	2	NS
Submucosal lesion	4	2	2	5	NS

Conclusion We show no difference in sample adequacy between the two needle sizes. Use of a 25G results is associated with a higher number of passes in pancreatic FNA. Both needle sizes appear safe. Operator choice and ease of passage of needle into anatomical location may also influence choice of needle.

Competing interests None declared.

PMO-200 BEST PRACTICE FOR MANAGEMENT OF GASTRIC POLYPS

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Introduction British Society of Gastroenterology (BSG) released guidelines for management of gastric polyps in 2010[1] and main recommendations are to biopsy all polyps, complete adenoma removal and follow-up, test and treat *H Pylori* (if suspicious of hyperplastic or adenomatous). Though polyps are noted in 1%–2% of any gastroscopy, studies have reported adenomas in up to 6.6% of all polyps.[2] While colorectal polyps have rigorous management pathways, there is huge disparity in assessment and treatment of gastric polyps that also follow the adenoma-carcinoma sequence. Our study aimed to compare our current practice with BSG recommendations and possibly devise a standard local Proforma to ensure best practice.

Methods A retrospective audit was conducted in a teaching hospital on all gastric polyps noted during upper GI endoscopy performed between January 2009 and October 2011. Data identified by "Endoscribe" software was compared with BSG guidelines. Demographics including the size of polyp, whether biopsy taken, histological and endoscopic diagnosis as mentioned in the report, documented usage of proton pump inhibitors and urease test result (if done) are collected.

Results Out of 161 patients reported to have gastric polyps, only 61% (98) had at least one biopsy taken. Endoscopic diagnosis of polyp types were mentioned in the report only in 17/160 procedures (16 fundic gland and 1 hyperplastic) and it correlated with histological diagnosis in 64.3%. The distribution of various polyp types by histology is shown in Abstract PMO-200 table 1 and adenomas comprised only 3.06% of total number of polyps biopsied. 33 polyps were >5 mm but of varied pathology. Proton pump inhibitors usage was documented in 23 patients and was associated with fundic gland polyps in 71.4%. 28 patients had urease test done but only one was positive (Histology of polyp showed chronic gastritis).

Abstract PMO-200 Table 1 Histological distribution of gastric polyps

Fundic gland polyps	41.8%
Hyperplastic/inflammatory polyps	21.4%
Chronic gastritis	19.3%
Normal gastric tissue	7.1%
No result	5.1%
Adenomatous polyps	3.06%
Xanthoma	1.02%
Barrett's changes	1.02%

Conclusion There is poor compliance with BSG recommendations, especially with regards to taking biopsies from gastric polyps. There is evidence for gross under-reporting of polyps which can miss early cancers. We have now designed a local hospital pathway for management of gastric polyps adapted from the guideline and will complete the audit cycle with the new protocol.

Competing interests None declared.

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PMO-201 BOWEL PREPARATION: MOVIPREP® VS KLEAN-PREP®, REAL LIFE EXPERIENCE IN UNSELECTED PATIENTS

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Introduction The numbers of colonoscopies being performed has increased since the introduction of the Bowel Cancer Screening Programme. Bowel preparation is essential for a successful colonoscopy. However, bowel preparation is a major deterrent for patients undergoing screening colonoscopy. Having a bowel preparation that is more acceptable to patients may improve acceptance of bowel preparations, promote compliance and increase the likelihood of a successful procedure. The aim of this study was to assess patient tolerability of a newer bowel preparation, Moviprep®, to the current preparation used, Klean-prep®.

Methods Patients received either Moviprep® or Klean-prep® prior to colonoscopy. Each patient was asked to complete a questionnaire assessing various side effects and tolerability.

Results In total 50 patients received Moviprep® of which 42 (84%) completed the questionnaire. Eighty-eight patients who received Klean-prep® completed the questionnaire. The patients who received Moviprep® suffered from fewer side effects such as, bloating (p=0.002), abdominal pain (p=0.02) and anal irritation (p=0.04). No significant differences were seen in the incidence of nausea, vomiting or abdominal cramps between the two preparations. Patients found the taste of Moviprep® more acceptable and as a result were more likely to take all of the preparation as compared with Klean-prep® (p=0.002). No difference was observed in the