

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

Lesion site	22G		25G		Fischer's exact test
	Adequate sample	Inadequate sample	Adequate sample	Inadequate sample	
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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¹A Sugumaran, ²P Macleod, ¹L Thomas. ¹Department of Gastroenterology, Singleton Hospital, Swansea, UK; ²Singleton Hospital, Swansea, UK

Introduction British Society of Gastroenterology (BSG) released guidelines for management of gastric polyps in 2010¹ 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 histo-

logical 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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B R Disney,* B Johnson, M Anderson. *Gastroenterology, Sandwell and West Birmingham Hospitals NHS Trust, Birmingham, UK*

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

quality of bowel preparation or caecal visualisation/intubated rates ($p=0.93$).

Conclusion Moviprep® was tolerated much better when compared to Klean-prep® in terms of side effects and the willingness to take the preparation again. Having a preparation that is well tolerated may help with patient compliance and improve colonoscopic examination.

Competing interests None Declared.

PMO-202 USE OF THE BLATCHFORD SCORE TO IDENTIFY LOW-RISK UPPER GASTROINTESTINAL BLEEDS

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B R Disney,* ²R Watson, ²A Blann, ²G Lip, ³C Tselepis, ¹M Anderson. ¹Gastroenterology, Sandwell and West Birmingham Hospitals NHS Trust, Birmingham, UK; ²Cardiology, Sandwell and West Birmingham Hospitals NHS Trust, Birmingham, UK; ³Cancer Sciences, University of Birmingham, Birmingham, UK

Introduction Acute upper gastrointestinal bleeding is a medical emergency associated with a significant health burden and risk of mortality. A significant proportion of patients are admitted to hospital unnecessarily for endoscopy following presentation with acute upper gastrointestinal bleeding. The Blatchford score can be used to identify patients with low-risk gastrointestinal bleeds suitable for discharge and outpatient endoscopy. However, some debate remains regarding what level of Blatchford score can be considered low-risk. The aim of this study was to assess the need for intervention in patients presenting with upper gastrointestinal bleeding based upon the admission Blatchford score.

Methods All patients admitted with acute upper gastrointestinal bleeding to Sandwell and West Birmingham Hospitals NHS Trust from 1 January 2009 to 31 December 2009 were included in the study.

Results Overall, 470 patients with acute upper gastrointestinal bleeding were admitted during the study period. Of these 67.2% were male and 32.8% female. The mean age of patients was 64.0 ± 18.8 years. The most common diagnosis was peptic ulcer disease, which was found in 34.5% of patients. A Blatchford score of 0 accounted for 6.0% of patients ($n=28$) and 14.7% ($n=69$) had a Blatchford score ≤ 2 . Of the patients admitted with a Blatchford score ≤ 2 none required intervention (transfusion, endoscopic therapy or surgery) and there were no deaths. These patients were significantly younger than patients with a Blatchford score >2 (mean age 44.1 ± 17.5 years for a Blatchford score ≤ 2 vs 67.4 ± 18.8 years for a Blatchford score >2).

Conclusion Patients with acute upper gastrointestinal bleeding with a Blatchford score ≤ 2 did not require inpatient intervention and can be considered for early discharge from hospital with outpatient endoscopy. This strategy identified 14.7% of patients in our population that were unnecessarily admitted. Using a Blatchford score of ≤ 2 may help to significantly reduce hospital admissions.

Competing interests None Declared.

PMO-203 DIRECT GASTRIC PUNCTURE AND GASTROPEXY (FREKA® PEXACT) INSERTION TECHNIQUE FOR PERCUTANEOUS ENDOSCOPIC GASTROSTOMY REDUCES PERISTOMAL INFECTION RATES COMPARED WITH STANDARD PULL-THROUGH INSERTION IN PATIENTS WITH HEAD AND NECK CANCER

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B R Disney,* M Nizamuddin, A Tanajura, M Anderson, M Lewis. Gastroenterology, Sandwell and West Birmingham Hospitals NHS Trust, Birmingham, UK

Introduction Patients with head and neck cancer often have a percutaneous endoscopic gastrostomy (PEG) inserted to provide

nutritional support while undergoing treatment. The standard pull-through PEG technique is associated with a high incidence of peristomal infection. This is thought to be a result of pulling the PEG through the oral cavity which may be colonised with bacteria. In addition there is the risk of tumour seeding at the PEG site with this method. In our institution, such patients now have an endoscopic controlled introducer PEG (Freka® Pexact) with dual gastropexy inserted which avoids passage of the bumper through the oral cavity. We aimed to compare peristomal infection rates between the two methods of PEG insertion.

Methods We carried out a retrospective audit of PEG insertions in patients with head and neck cancer. Patients were identified using the ADAM® medical documentation system (Fujinon Europe GmbH, Willich, Germany) and the Nutrition team logs. Complications, peristomal infection and 30-day mortality were documented after review of case notes and liaison with Community Nutrition Nurses.

Results A standard pull-through PEG (16F Corflo®, Merck, UK) was inserted in 13 patients and 30 patients had a Freka® Pexact 15F (Fresenius Kabi, Germany) inserted. Of the Pexact group 76.7% were male ($n=23$); 84.6% ($n=11$) of the standard group were male. The mean age of patients was 58 years (range 35–81) in the Pexact group and 61 years (range 35–78) in the standard PEG group. Prophylactic antibiotics were prescribed to 83.3% ($n=25$) in the Pexact group compared with 100% ($n=13$) of the standard pull-through PEG group. In the standard PEG group 69.2% ($n=9$) developed peristomal infection compared with 36.7% ($n=11$) in the Pexact group. Immediate complications occurred in 15.4% ($n=2$) in the standard group and in none of those in the Pexact group. There were no deaths in either group at 30 days.

Conclusion The introduction of the direct gastric puncture and gastropexy technique led to a significant reduction of peristomal infections in patient with head and neck cancer. This new technique is well tolerated by patients.

Competing interests None declared.

PMO-204 ASSESSING RISK OF ADVERSE OUTCOME IN ACUTE LOWER GASTROINTESTINAL BLEEDING: ARTIFICIAL NEURAL NETWORK VS SIGN GUIDELINES AND BLEED SCORE

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¹C H Choi,* ²J Swingland, ¹A Ali, ²S Bose, ¹L Ayaru. ¹Department of Gastroenterology, Charing Cross and Hammersmith Hospitals, Imperial College Healthcare NHS Trust, London, UK; ²PET Methodology Group, MRC Clinical Science Centre, Imperial College London, London, UK

Introduction The majority of patients with acute lower gastrointestinal bleeding (ALGIB) have a low risk of requiring intervention, rebleeding or death. Nevertheless in routine clinical practice most are admitted to hospital for observation and endoscopy increasing cost of care. There are no risk scores routinely used in clinical practice which differentiate high risk patients who should be admitted to hospital from those who could be managed as outpatients. British Society of Gastroenterology/Scottish intercollegiate guidelines network (SIGN) have published expert opinion based criteria for non-admission but the accuracy of these is unclear.

Methods The aim of this study was to compare an artificial neural network's (ANN) performance in distinguishing high-risk from low-risk patients with ALGIB to SIGN guidelines (six clinical variables) and BLEED score (five clinical variables). Data were collected retrospectively from patients with ALGIB who were admitted to the emergency department of a teaching hospital between 2007 and 2010 ($n=174$). A multi-layered perceptron ANN model using back propagation and logistic activation function with hidden nodes to