is important; particularly in IBD patients on surveillance. It is important to retroflex in rectum to inspect the anal verge. Left sided cancers comprised the major part of missed cancers.

Competing interests None declared.

REFERENCES

1. **Bressler B**, *et al.* Rates of new or missed colorectal cancers after colonoscopy and their risk factors. *Gastroenterology* 2000.
2. **Shah HA**, *et al.* Factors associated with incomplete colonoscopy. *Gastroenterology* 2007.
3. **Aslinia F**, *et al.* Quality assessment of colonoscopic cecal intubation: an analysis of 6 years of continuous practice at a university hospital. *Am J Gastroenterology* 2006.
4. **Lakoff J**, *et al.* Risk of developing proximal versus distal colorectal cancer after a negative colonoscopy. *Clin GastroenterolHepatol* 2008.
5. **Rex DK**, *et al.* Relative sensitivity of colonoscopy and barium enema for detection of colorectal cancer. *Gastroenterology* 1997.
6. **Winawer SJ**, *et al.* Prevention of colorectal cancer by colonoscopic polypectomy.The National Polyp Study. *N Engl J Med* 1993.

PMO-207 CHANGING TRENDS IN UPPER AND LOWER GASTROINTESTINAL BLEEDING OVER A 13-YEARS PERIOD

doi:10.1136/gutjnl-2012-302514b.207

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Introduction Acute gastrointestinal (GI) bleeding is a common medical emergency associated with significant mortality and morbidity. Recent studies suggest that the incidence of upper GI bleeding (UGIB) has decreased mainly due to reduction in peptic ulcer disease. Trends for lower GI bleeding (LGIB) are less well defined and therefore the burden on health services is unknown. The aim of this study was to examine the trends in all types of GI bleeding presenting to our bleeding unit over a 13-year period.

Methods Our Gastrointestinal Bleeding Unit opened in October 1991 and serves a population of around 600 000. The unit admits patients with both upper (UGIB) and lower (LGIB) bleeding and maintains a prospective database of all admissions. The database was analysed for yearly admissions over the period 1991–2004 with respect to total number of admissions and then stratified by bleeding source, age, gender and diagnosis. Age, gender, bleeding source and disease specific rates were calculated.

Results 12 572 patients (median age 66, 7028 males) were admitted to the unit over the period October 1991–October 2004. 9544 presented with symptoms of UGIB and 2508 with symptoms of LGIB with 520 patients being unclassified due to a mixture of symptoms. Overall numbers of admissions increased from 728 in the first year to 1003 in year six then reached a plateau thereafter around 950 per year. Overall 30-day mortality was 9.7% (8.7–10.8) for UGIB and 11.4% (9.2–14.1) for LGIB and there was no change in rebleeding rates. Median age increased significantly from 64 years to 68 years ($p<0.001$) over this period mirrored by increasing age in UGIB (63 to 65 years, $p<0.001$) but no significant difference in LGIB. Patients presenting with LGIB were significantly older than those presenting with UGIB (70 vs 64, $p<0.001$) and were more likely to be female (OR 1.64, 95% CI 1.5 to 1.8, $p<0.001$). With respect to UGIB, there was a non significant increase in admissions overall but there was a rise in variceal bleeding (OR 2.5, 95% CI 1.5 to 4.4, $p=0.005$) but a reduction in bleeding peptic ulcers (OR 0.65, 95% CI 0.49 to 0.87, $p=0.039$) particularly in males age <40 years. There was a significant increase in the numbers of admission due to LGIB ($p<0.001$) predominantly due to inflammatory bowel disease ($p=0.04$), haemorrhoidal bleeding ($p=0.001$) and ischaemic colitis ($p=0.0016$).

Conclusion There has been an increase in numbers of patients admitted with GI bleeding and this population is significantly older over time. There has been a decline in peptic ulcer bleeding but a rise in variceal cases. Admissions overall for GI bleeding have increased mainly due to a significant rise in LGIB mainly accounted for by IBD, haemorrhoids and ischaemic colitis.

Competing interests None declared.

PMO-208 DOUBLE BALLOON ENTEROSCOPY IN A DISTRICT GENERAL HOSPITAL: THE EXPERIENCE SO FAR

doi:10.1136/gutjnl-2012-302514b.208

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Introduction Double Balloon Enteroscopy (DBE) is widely used in clinical practice worldwide and can be used to explore the small bowel in an antegrade or retrograde approach. A DBE service at South Tyneside District Hospital was commenced in January 2010 to complement the existing capsule endoscopy service.

Methods Patient records were examined retrospectively for all DBE's performed at South Tyneside District Hospital between January 2010 and January 2012. Information recorded included: indication for procedure, route of procedure, average depth of insertion, findings of procedure, therapy performed, sedation used and complications.

Results A total of 37 procedures (17 (46%) in first 12 months, 20 (54%) in 2nd) were performed: 17 anal, 1 via ileostomy, 19 oral. 81% were done under sedation using a combination of midazolam and pethidine (average doses 4.7 mg midazolam, 62 μg pethidine), 19% were performed under GA. Average depth of insertion for all procedures was 197 cm for oral DBE and 81 cm for anal DBE. Average depth for year 1: 204 cm oral, 69 cm anal. Average depth of insertion for year 2: 190 cm oral, 93 cm anal. Indications: Suspected mid GI bleeding 30%, definite or suspected Crohns 46%, neoplasia, 10.5%, abnormal imaging 10.5%, symptoms/signs only 3%. See Abstract PMO-208 table 1. DBE Findings: Diagnostic yield: 30% for occult GI bleeding, 46% for suspected or definite Crohns with an overall change in management (or can explain symptoms) in 37%. See Abstract PMO-208 table 2. Overall biopsies were taken in 43% (37.5% year 1, 47% year 2). Therapy was performed in 9% (1 Crohn's stricture dilatation, 2 Peutz Jegher polypectomies.). There have been no complications.

Conclusion Our DBE service appears safe. In the second 12 months there were deeper depths of insertion for the anal approach suggesting the "learning curve" is greatest for this approach. Increasing amounts of therapy and tattoos are being performed as experience is increasing. A recently published systematic review of DBE[1] found the main indication for referral for DBE to be GI bleeding (60.2%), interestingly our results show a different picture

Abstract PMO-208 Table 1

DBE indication	%
GI bleeding	30
Crohn's disease	46
Neoplasia	10.5
Abnormal imaging	10.5
Symptoms/signs	3

Abstract PMO-208 Table 2

DBE findings	%
Inflammatory	27
Vascular	2
Neoplastic	9
Normal	62