

with the main referral indication being Crohn's disease (in 46%) and GI bleeding in only 30% of cases. The overall rate of positive findings is lower than in the literature at 37% and may be due to the different referral indications as well as the small number of procedures performed so far.

Competing interests None declared.

REFERENCE

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PMO-209 INCIDENCE OF STROKE FOLLOWING ENDOSCOPY IN A DISTRICT GENERAL HOSPITAL

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Introduction There has been a sustained increase in demand for gastrointestinal (GI) endoscopy. 1.4%–1.6% of the population undergo upper GI endoscopy per annum, 0.8 % flexible sigmoidoscopy (FS) and 0.6% colonoscopy.¹ Complications occur due to the risk of the procedure or sedation. With the advent of the bowel cancer screening programme there has been increasing scrutiny of the safety of endoscopy and strict quality assurance. Both transient ischaemic attacks (TIAs) and strokes (cerebrovascular accidents (CVAs)) are recognised to occur both during and following endoscopic procedures,^{1,2} however data regarding prevalence are lacking. Our objective was to establish the frequency of stroke after endoscopy in our hospital.

Methods We performed a retrospective audit of stroke occurrence after endoscopy. Hospital episode statistics were cross referenced with endoscopy reporting system from November 2009 to November 2011. Patients admitted with a stroke within 28 days of an endoscopic procedure (OGD, colonoscopy or FS) were identified. The notes were then examined to ascertain further information about demographics, procedure type, comorbidities, complications, haemodynamic changes, time period between procedure and symptoms, length of stay and survival.

Results 8790 procedures were performed: colonoscopy 1953, OGD 4084, FS 2753. Seven strokes were identified; 5 OGD, 1 FS and 1 colonoscopy. 6 of 7 (86%) of the strokes occurred within 10 days, 4 (57%) within 4 days of procedure. Four patients died. Five strokes were cerebral infarcts, two intracerebral haemorrhages. There were no cardiovascular changes or hypoxia during any procedures. 86% of the patients were aged over 75 years. Data from 2 UK audits of OGD and colonoscopy have found the rate of stroke to be 0.04%.^{1,2} Our rates of stroke following endoscopy are similar for colonoscopy at 0.05% but are 3 times higher for OGD at 0.12%. This suggests post endoscopy stroke is a more common occurrence than is previously documented. Although the relatively small numbers make bias likely, an alternative reason could be the under reporting of strokes occurring in the 28 days following endoscopy.

Abstract PMO-210 Table 1

Abnormal imaging modalities	Normal imaging modalities	Pathology suggested by imaging/VCE	Symptoms only	Result of DBE	Histology
VCE	BaFT	SB inflammation	No	Normal	None
VCE	BaFT	SB ulceration	No	Normal	None
Nil	CE, BaFT	Normal	Yes	Normal	Normal
Nil	CE, BaFT	Normal	Yes	Normal	Normal
Nil	CT, CE BaFT	Normal	Yes	Normal	Normal
CT	Nil	SB ulceration/thickening	No	SB ulceration	Inconclusive
MRE	Nil	SB thickening	No	Crohn's stricture	Crohn's
CE	MRE	SB ulcers	No	SB ulceration	Inconclusive

Conclusion Endoscopy is a safe procedure but it does have risks, we are performing more procedures and have an aging population. Stroke is a serious event with high mortality and long hospital stay. Quality assurance of endoscopy is an important factor in all procedures and our data would suggest that stroke should be specifically looked for following endoscopy. We need to consider if there is any alternative ways of monitoring patients to be able to predict those who are at risk of stroke following endoscopy.

Competing interests None declared.

REFERENCES

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2. **Quine MA, et al.** Prospective audit of upper gastrointestinal endoscopy in two regions of England. *Gut* 1995;**36**:462–7.

PMO-210 DOUBLE BALLOON ENTEROSCOPY: HOW USEFUL IS IT TO CONFIRM CROHN'S DISEASE?

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Introduction Double Balloon Enteroscopy (DBE) is widely used in clinical practice worldwide. A DBE service at South Tyneside District Hospital was commenced in January 2010 to complement the existing capsule endoscopy (CE) service. We present the results of an audit of prior investigation before DBE.

Methods Clinical records were examined for patients referred for DBE with a diagnosis of suspected Crohn's disease. Information was gathered regarding: place of referral, previous imaging and endoscopy, findings and histology.

Results 28/37 (77%) of referrals were from outside our hospital. 15/37 referred for investigation of Crohn's disease, 75% of these were from outside our hospital. Seven patients with known Crohn's were referred for investigation of recurrent symptoms or for possible stricturing disease. Eight patients were referred with possible Crohn's based on clinical symptoms and signs. All patients had been previously investigated with multiple endoscopic or imaging modalities. Most common method of prior imaging for patients being investigated for Crohn's disease was Barium follow through (BaFT) 42%, followed by CE 33%, CT 12.5%, MRE 12.5%. 87% had a colonoscopy prior to referral. 11/15 had abnormal imaging, 5 (33.3%) having inflammatory changes seen on CE. Of these histology was taken in three and found: Crohn's (1), non-specific inflammation (1), normal (1). 3/5 cases were normal at DBE. 4/15 had entirely normal previous investigations. Of the eight patients with suspected Crohn's, two patients with abnormal radiology had DBE findings consistent with Crohn's. Of the three patients with SB ulceration on CE only one had an abnormal DBE and histology obtained was inconclusive. See Abstract PMO-210 table 1.