

**Results** The cost of bowel preparation based on 220 procedures a year was calculated. Picolax cost £824.00 and Moviprep cost £1336.00 a year. Therefore the additional cost to the Health Board of using Moviprep each year would appear to be £512. However, the audit identified five participants that had been prescribed Picolax who needed repeat procedures at a cost of £3690.00, while in the Moviprep group only one participant needed a repeat colonoscopy due to unsatisfactory bowel preparation at a cost of £738.00. Moviprep allowed for greater examination of the right side of the colon and could, therefore, potentially incur a higher detection rate of polyps with the improved standards of preparation.

**Conclusion** Moviprep proved to be statistically more effective as bowel preparation for screening colonoscopy. Of the participants prescribed Moviprep 82% had a good standard of bowel preparation, whilst only 26% of participants prescribed Picolax had a good standard of bowel preparation. Following this audit Moviprep is now the first choice bowel preparation for screening colonoscopy within the Health Board, providing clinical and cost effective bowel preparation for screening participants.

**Competing interests** None declared.

Abstract PMO-215 Table 1

Standard	Picolax (%)	Moviprep (%)
Good	26	82
Adequate	70.5	16.4
Unsatisfactory	3.5	1.6

**PMO-216** IS COFFEE GROUND VOMITING "HEMODYNAMICALLY" SIGNIFICANT?

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**Introduction** Coffee ground vomiting is defined as the passage of black material which is assumed to be blood. Its presence implies that bleeding has ceased or has been relatively modest.<sup>1</sup> It is therefore considered as low to medium risk upper GI bleeding compared to frank haematemesis and/or malena. Sign guidelines recommend admission and early endoscopy with Rockall score for patients above 60 years who present only with witnessed haematemesis or suspected continued bleeding.

**Methods** Aim: evaluate the outcome of coffee ground vomiting in patients above the age of 60 in our hospital. Retrospective analysis of all OGD's performed in our hospital over the last 3 years (December 2007–December 2011) using the endoscopy register (Endosoft). Patients with the indication of coffee ground vomiting, excluding associated haematemesis and/or malena were identified. Hb urea level and intervention at the time of the procedure were recorded.

**Results** Overall, 93 patients were identified. 73 patients were more than 60 years old, 46 females (64%) and 27 males (36%), 24 had ulcer or evidence of bleeding (32%), the causes of bleeding includes: gastric ulcers 6, duodenal ulcers 4, oesophageal ulcers 4, severe gastritis/oesophagitis 5, others 5. Endoscopic Interventions includes: adrenalin injection, banding, heat probe and endoclips. 11 patients (42%) had more than 1 gm drop in Hb while 17 patients (65%) had raised urea. On the other hand, 20 patients were 60 years old or less, three patients had ulcers or evidence of bleeding (15%), four females (20%)

and 16 males (80%), the cause of bleeding in all cases were gastric ulcers, two of them treated endoscopically with adrenalin and heat probe. Only one patient had more than one gm drop in Hb and raised urea.

**Conclusion** Increase age is an independent risk factor in the assessment of bleeding and is part of the Rockall score. In this small cohort, Patients above 60 years old presenting with coffee ground vomiting were predominantly females with around third had a major cause for upper GI bleeding requiring endoscopic intervention. Raised urea appear to be more significant parameter than drop in Hb. Coffee ground vomiting in this age group should regarded as severe GI bleeding equivalent to haematemesis.

**Competing interests** None declared.

**REFERENCE**

1. **Scottish Intercollegiate Guidelines Network.** Management of Acute Upper and Lower Gastrointestinal Bleeding, 2008.

**PMO-217** PREOPERATIVE ENDOSCOPIC BILIARY DRAINAGE AND SHORT-TERM CLINICAL OUTCOME FOLLOWING PANCREATICODUODENECTOMY FOR PANCREATIC ADENOCARCINOMA: SITE-SPECIFIC FACTORS

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**Introduction** The role of preoperative endoscopic biliary drainage (PEBD) prior to pancreaticoduodenectomy (PD) remains controversial. We sought to determine the effects of PEBD on the short-term outcome of initially jaundiced patients undergoing PD for pancreatic adenocarcinoma in a regional Hepatopancreaticobiliary (HPB) Surgery unit.

**Methods** 100 consecutive initially jaundiced patients undergoing PD for histologically-confirmed pancreatic adenocarcinoma at our institution between 2006 and 2009 were identified from a prospectively maintained database. Patient demographics, perioperative serum bilirubin levels, surgical complications (Clavien classification), length of inpatient stay and in-hospital mortality were assessed. The use of PEBD, the location in which PEBD was performed, and time from PEBD to PD were ascertained. Three patient groups were defined: 1. No PEBD, 2. PEBD in HPB surgery unit (PEBD-HPB) and 3. PEBD in non-HPB surgery unit (PEBD-nHPB). Patients undergoing preoperative percutaneous biliary intervention were excluded from the study.

**Results** Mean patient age was 66 years (SD=11.9), M:F=56:44. 74/100 patients underwent PEBD prior to PD, of whom 53 (72%) patients underwent PEBD-HPB and 21 (28%) underwent PEBD-nHPB. In-hospital mortality did not significantly differ between the three patient groups. Mean preoperative serum bilirubin was significantly higher in No PEBD group (p<0.01). Mean length of inpatient stay and occurrence of documented infective wound complications were significantly higher in the PEBD-nHPB group vs PEBD-HPB and No PEBD groups (p=0.035). Mean time from PEBD to PD was significantly higher in the PEBD-nHPB vs the PEBD-HPB group (p=0.045).

**Conclusion** In this albeit small sample of patients, PEBD prior to PD did not significantly affect indicators of short-term perioperative morbidity and mortality. PEBD may be detrimental when performed in non-HPB surgical units. While increased time from PEBD to PD