

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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E Said,* E Lunn, A Mohamed, F Gohar, A Soliman, K Kapur, D P Hurlstone. *Gastroenterology, Barnsley District General Hospital, Barnsley, UK*

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.¹ It is therefore considered as low to medium risk upper GI bleeding compared to frank haematemesis and/or melena. 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 melena 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 be regarded as severe GI bleeding equivalent to haematemesis.

Competing interests None declared.

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

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¹E Scott,* ¹D Mole, ²A Miller, ¹R Ravindran, ³E Hidalgo, ¹M Duxbury. ¹Clinical Surgery, University and Royal Infirmary of Edinburgh, Edinburgh, UK; ²Endoscopy Unit, Royal Infirmary of Edinburgh, Edinburgh, UK; ³Department of Surgery, St James' University Hospital, Leeds, UK

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

may play a role, the cause of this association remains to be determined. The role of PEBD prior to PD warrants further evaluation in the context of a well-designed prospective clinical trial.

Competing interests None declared.

PMO-218 COLONOSCOPY IN PATIENTS PRESENTING WITH MELAENA AND A NORMAL UPPER GASTROINTESTINAL ENDOSCOPY: A RETROSPECTIVE REVIEW FROM A SINGLE UK CENTRE

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¹E Russo,* ¹L Hicks, ²J Hoare, ²H Thomas, ²J Teare, ²H Williams, ²T Orchard.
¹Imperial College London, London, UK; ²Imperial College Healthcare NHS Trust, London, UK

Introduction Colonoscopy is frequently performed in patients presenting with melaena who have a negative upper gastrointestinal endoscopy (UGIE). Published literature suggests a diagnostic yield of 8%–30%, the most common pathologies being colonic angiodysplasia and right-sided tumours. However these conditions often give rise to occult haemorrhage and a microcytic profile before patients present with overt bleeding. In patients presenting de novo with melaena a raised urea is known to be predictive of upper GI haemorrhage before any endoscopic assessment. Our aim was to examine the value of colonoscopy in the subgroup of patients with a negative UGIE, and to assess whether the absence of a raised blood urea and/or the presence of a microcytic erythrocyte profile at presentation are predictors of positive colonoscopy.

Methods Our reporting software was interrogated for the interval November 2007–October 2011. All cases of colonoscopy where melaena was the main indication, and which were preceded by a negative UGIE were analysed. In addition, we collected data on the admission blood urea and mean corpuscular volume (MCV). Patients for whom altered/fresh rectal bleeding were included in the indications in addition to melaena were excluded.

Results 724 patients had a total of 829 endoscopic evaluations of melaena, and of these 62 patients (53% female) with a median age of 69 year (range 27–91) met our inclusion criteria. 6 of 62 (9.6%) had a cause for the melaena identified on colonoscopy: cecal angiodysplasia in 2/6, right-sided malignancies in 2/6 and right-sided diverticular bleeds in 2/6. The admission urea was not significantly lower in patients with a positive colonoscopy (median 11.5 mmol/l, range 5.1–14.7) compared to those with a negative colonoscopy (median 7.2 mmol/l, range 1.4–33.6) ($p=0.43$). Admission MCV however was significantly lower in patients with a colonic haemorrhage (median 77 fL, range 64–89) compared to patients with a negative colonoscopy (median 90 fL, range 66–116) ($p=0.012$), with 3/6 (50%) having a low MCV compared to 5/56 (8.9%) of those with a negative colonoscopy (normal = 84–99 fL).

Conclusion The diagnostic yield of colonoscopy in patients with melaena and a non-contributory UGIE in our centre was low (9.6%). A normal/low blood urea on admission did not predict a positive diagnosis for the haemorrhage at colonoscopy in our cohort. However, patients with a colonic source of bleeding had a significantly lower MCV, suggesting a chronic natural history for such right sided colonic haemorrhages.

Competing interests None declared.

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PMO-219 HIGHER THAN EXPECTED FALSE NEGATIVE CLO TEST IN PATIENTS NOT TAKING PPI ASSOCIATED WITH REGULAR ALCOHOL INTAKE AND ABSENCE OF ENDOSCOPIC GASTRITIS

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F Tahir,* S Arshad, R C Evans, S Ashraf, H Elfaki, M Purcell-Jones. *Department of Gastroenterology, Llandudno General Hospital, Llandudno, UK*

Introduction *H pylori* has a prevalence of around 40%–50% in the UK.¹ Rapid urease test (CLO test) is commonly used in the endoscopy units around the UK to detect *H pylori*. False negative CLO test results are associated with early reading of the test and use of acid suppressing medication.² We assessed the reliability of CLO test and prevalence of false negative results.

Methods Retrospective data analysis was performed by auditing case notes of 85 patients with positive histology for *H pylori*. CLO test was performed by using Kimberly-Clarke CLO test kit and the reading time was between 12 and 24 h.

Results Male:Female ratio was 43:42. False negative CLO test was found in 37 patients (43.6%), out of which 21 (56.7%) were not taking PPI or stopped PPI for at least 2 weeks prior to the endoscopy. 16 (43.2%) patients in the false negative group were drinking alcohol regularly as compared to 11 (22.9%) in CLO positive group, while 28 (58.3%) in CLO positive group were non drinkers. Regular drinkers taking PPI before the test had a low percentage (3/12; 25%) of CLO positive results while non-drinkers not on PPI show a high percentage (28/36; 77.8%) for positive results [$p=0.013$]. Also, in patients who had false negative CLO test, approximately 45% of patients consume regular alcohol. Absence of gastritis was associated with a slightly higher rate of false negative CLO test result (27.1% vs 20.8% for CLO positive) [$p=NS$]. Use of PPI only showed to contribute to false negative CLO test in absence of gastritis endoscopically (70% in patients with no gastritis and taking PPI) [$p=NS$]. Smoking was not associated with false negative CLO test.

Conclusion High incidence of false negative CLO test result in our study suggests that CLO alone might not be a reliable test even in patients not taking acid suppressing medication. Regular alcohol use may contribute to false negative CLO test results. Gastric histology is better than CLO test in patients who are regular alcohol drinkers and taking PPI but in whom OGD does not show gastritis. Further studies need to be done to consider role of targeted gastric biopsies to increase the yield of CLO test.

Competing interests None declared.

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PMO-220 PATIENT ANTICIPATION OF SOME PAIN GOES ALONG WAY WHEN PREDICTING OVERALL SATISFACTION WITH A COLONOSCOPY PROCEDURE

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F-U-R Ali.* *Gastroenterology, Walsall Manor Hospital, Walsall, UK*

Introduction Providing a quality patient experience is a key facet of the Global Rating Score (GRS). Patient surveys are considered an integral means of assessing satisfaction. Meeting the patient's expectations is likely to influence their assessment of the procedure.