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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**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 melena, 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 melena 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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**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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**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.