abdominal x-ray was requested at 6 weeks post-ERCP to assess expulsion of the stent. Complications were recorded.

Results Of the 24 participants 16 were female. Abdominal x-rays were obtained in all patients at a median of 6 weeks (5—12 weeks) post-ERCP. Stents were retained in 2 (8.3%) patients. Spontaneous stent self-expulsion rate was therefore 91.7%. There were no other compliations. Hyperamylaseaemia occurred in 2 (8.3%) patients—unrelated to stent retention. Prior to routine stent insertion pancreatitis occurred in seven patients (46%), thus we have shown a reduction in ERCP-induced pancreatitis (p=0.003).

Conclusion In the absence of pancreatic and biliary disease stents will self-expel by 12 weeks. We have also shown that the deployment of small pancreatic stents is safe and well tolerated. Comparison with ERCP performed prior to routine stent placement has shown a significant reduction in the rate of pancreatitis. Both retained stents were removed without complication by a standard OGD.

Competing interests None declared.

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PTU-207 DETECTION OF DYSPLASIA ARISING IN BARRETT'S OESOPHAGUS IS ASSOCIATED WITH BETTER QUALITY ENDOSCOPIC TECHNIQUE

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Introduction Barrett's columnar lined oesophagus (CLO) is the pre-malignant lesion to oesophageal adenocarcinoma (OAC). The presence of dysplasia, when diagnosed in surveillance programmes, is an important marker of risk of progression and an indication for endoscopic therapy. Barrett's surveillance should be undertaken with a minimum of four quadrant biopsies every 2 cm, with documentation of length of BE segment by Prague C/M criteria, yet adherence to this is variable. We aimed to assess the quality of Barrett's surveillance and effect on dysplasia detection.

Methods Prospective database of patients undergoing Barrett's surveillance over 3 year period at tertiary referral upper GI centre. Patients with a previous diagnosis of dysplasia/OAC were excluded. Endoscopists were separated into two groups; Group A—endoscopist has newly diagnosed patient with dysplasia over study period; Group B—endoscopist has not diagnosed patient with dysplasia at any time point. Analysis was by independent t-tests for continuous variables and chi-squared tests for categorical variables.

Results 395 patients with Barrett's CLO underwent endoscopy between 2007 and 2010. Of these 23/395 were diagnosed with dysplasia/OAC by group A endoscopists (n=14) vs none in Group B (n=32). Results are shown in Abstract PTU-207 table 1. There was no significant difference in patient's age, sex or length of Barrett's mucosa between the two groups. There was a significant difference in adherence to Seattle protocol four quadrant biopsies every 2 cm between the two groups. The detection rate of Specialised Intestinal Metaplasia (SIM) and documentation of length of Barrett's mucosa by Prague criteria were significantly higher in group A than group B. The use of High Resolution Endoscopy was similar between both groups.

Abstract PTU-207 Table 1 Study outcomes

	Group A (n=232)	Group B (n=163)	p Value
Age (±SD)	60.7 years (±13.8)	61.3 years (±15.1)	0.65
Sex (Male)	78% (181)	73% (119)	0.28
Length (±SEM)	3.3 cm (±0.17)	3.5 cm (±0.23)	0.38
Mean number biopsies per 2 cm	2.88 (±0.11)	2.32 (±0.13)	0.001
SIM detection	70% (163)	60% (97)	0.035
Prague documentation	12% (28)	4% (7)	0.007

Conclusion This study demonstrates that endoscopists who detect dysplasia arising in Barrett's CLO are more likely to undertake high quality Barrett's surveillance as evidenced by higher rates of SIM, adherence to Seattle protocol biopsy and documentation of length of Barrett's mucosa by Prague classification. This lends support to the argument that Barrett's surveillance should be centralised and undertaken on dedicated lists by trained endoscopists with a specialist interest, in order to maximise dysplasia detection rates. A prospective study is warranted.

Competing interests None declared.

PTU-208 LAPAROSCOPIC ASSISTED ENDOSCOPIC MUCOSAL RESECTION (LAP-EMR)

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Introduction Successful colonic endoscopic mucosal resection (EMR) may be limited by several factors such as lesion size, position, access and complexity. We present a series of cases performed by Lap-EMR, which has the potential to overcome these difficulties, safely extending the application of EMR.

Methods Cases were identified from a prospectively held database recording patient demographics, polyp details, procedural complications and follow-up outcomes.

Results 13 patients (62% male) underwent Lap-EMR between September 2008 and 2011. Median patient age 64 years old. Median polyp size 35 mm (range 12—60 mm). 85% of lesions were located within the right colon and 31% at either the hepatic or splenic flexures. Three patients required laparoscopic resection either due to lesion extension into the appendix (n=2) or failure to lift with submucosal injection (n=1), where histology revealed a focus of adenocarcinoma. One patient underwent a laparoscopic right hemicolectomy due to post-polypectomy haemorrhage. No other peri-operative complications occured. The median post-operative hospital stay was 2 days (range 1—19 days). Small residual adenoma was identified in 3 out of 6 patients that have undergone 3-month follow-up to date, successfully treated with argon photocoagulation. No adenoma was identifed in these patients at follow-up 1 year later.

Conclusion Lap-EMR is safe and effective in treating lesions that would otherwise require segmental colonic resection. It provides the option of localised laparoscopic resection, which is of particular benefit for lesions visible at the appendiceal orifice where suitability for resection can be difficult to assess at diagnostic colonoscopy.

Competing interests None declared.