

PTU-209 IS UNSEDATED COLONOSCOPY THE WAY FORWARD?

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Introduction Colonoscopy is a very common procedure however, unsedated colonoscopy remains underused. The use of sedation increases adverse events, prolongs recovery, affects ability to recall information relating to procedure outcome, and can impact on the efficiency of an endoscopy unit.

Methods A retrospective analysis was carried out on patients attending a large teaching hospital for outpatient colonoscopy from September 1st 2009 to December 31st 2010. A proforma was completed with details relating to demographics, seniority of endoscopist, presence of a trainee, reason for referral, sedation use, outcome of procedure, interventions required, subsequent complications and comfort scores.

Results 244 patients had unsedated colonoscopies (68 female and 176 male) with a median age of 60.6 years. These were matched with 244 randomly selected colonoscopies during that time period. The completion rate was 96% in the unsedated group and 91% in the sedated group ($p < 0.041$). The mean comfort score in the unsedated colonoscopy group was 1.93 and 1.79 in the sedated group. Mean procedure time was 23.6 min (sedated) and 22 min (unsedated). There were no immediate complications in the unsedated group. Complications in the sedated group were seen in 5: Vasovagal episode ($n=1$), respiratory depression ($n=2$), bleeding post polypectomy ($n=1$).

Conclusion An increasing number of unsedated colonoscopies are being performed successfully in our unit with high completion rates, shorter procedure time and similar comfort scores between sedated and unsedated groups. A heightened awareness of the availability of unsedated colonoscopy is required and it should be offered to all suitable patients.

Competing interests None declared.

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PTU-210 YOUNG PATIENTS WITH PR BLEEDING: FLEXIBLE SIGMOIDOSCOPY OR COLONOSCOPY?

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Introduction PR bleeding is a common indication for endoscopy. Other risk factors for sinister pathology include increasing age, anaemia, change in bowel habit and family history of colorectal cancer. In our centre there is debate about whether a flexible sigmoidoscopy, vs colonoscopy, is sufficient for young patients with

PR bleeding alone. If sigmoidoscopy is sufficient it would reduce the risk patients are exposed to by full colonoscopy and the workload on the endoscopy unit. We ultimately aim to design a protocol for how to investigate PR bleeding.

Methods Retrospective review of all lower GI endoscopies done for either PR bleeding alone or in combination with another indication in 2008–2010. We reviewed patient age, indications and findings. Age groups were divided into <45 years or ≥ 45 years. Indications were divided into PR bleeding alone or plus another indication.

Results 1492 procedures were done in this period. 15 were abandoned. 17 of 199 (8.5%) procedures performed in people under 45 years for PR bleeding alone found polyps. The histology showed 10 metaplastic polyps, 1×15 mm rectal low grade villous adenoma, 1×12 mm sigmoid low grade tubulovillous adenoma, 1×2 mm sigmoid low grade tubular adenoma, 1 prolapsed haemorrhoid, 1 polypoid ganglioneuroma, 1×3 mm splenic polyp (not retrieved for histology) and 1×2 mm sigmoid polyp not removed given current GI bleed.

Conclusion No patients in the low risk group had cancer. Only two patients (1%) had large (>10 mm) polyps (low grade dysplasia, completely excised), both within reach of a flexible sigmoidoscope. No patients in the younger age group with PR bleeding as the sole indication would have had significant pathology (large polyp or cancer) missed due to having a flexible sigmoidoscopy rather than colonoscopy. This suggests that a protocol for this group could be implemented to prevent unnecessary tests with the associated incumbent risks. Further review of a larger cohort is required to ensure that this strategy does not expose patients to an unacceptable risk of missing significant pathology.

Abstract PTU-210 Table 1

	PR bleeding only		PR bleed + another indication	
	<45 years (n=199)	≥45 years (n=581)	<45 years (n=186)	≥45 years (n=511)
Flex sig				
Normal*	127	213	50	64
Inflam†	17	104	14	28
Polyp	10	Left-10 48	3	24
Cancer	0	9 Left-9	0	11 Left-11
Colon				
Normal*	28	59	78	143
Inflam†	10	65	34	108
Polyp	7	Left-7 76	7	116
Cancer	0	7 Left-6, Right-1	0	17 Left-14, Right-3

*Normal/Haemorrhoids.

†Inflammation/Diverticular disease/Blood.

Competing interests None declared.

PTU-211 PATIENT PREPARATION PRIOR TO GASTROSCOPY: A UK WIDE SURVEY

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Introduction Background: Optimal patient preparation for colonoscopy is shown to improve polyp detection in the colon. In Japan, it is widely accepted practice to administer a mucolytic agent prior to gastroscopy to improve visualisation of the upper gastrointestinal tract. There is a paucity of robust UK studies which describe optimal methods of preparation prior to gastroscopy. The current variations in UK practice have not been quantified. **Aims:**

To investigate current practice in patient preparation prior to gastroscopy across the UK.

Methods A list of all Hospitals in the UK was obtained from the JAG website (391). Hospitals that did not perform endoscopy were excluded (14), as were Children's Hospitals (5) and private hospitals (165). The number of hospitals included was 207. A structured telephone survey was conducted with each endoscopy unit. The method of preparation prior to gastroscopy was established.

Results 193 (93%) endoscopy units responded to the survey. 11 (5%) endoscopy units declined to participate in the survey and 3 (2%) of endoscopy units did not respond. Preparation prior to gastroscopy (%) included:

1. 6 h nil by mouth (NBM) to food or clear fluids (38%)
2. 6 h NBM to food and NBM to clear fluids for 2 h (26%)
3. NBM to food and clear fluids from midnight for morning lists with 6 h NBM for afternoon lists (13%)
4. Nine different methods of preparation accounted for the remaining 23% of hospitals.

No hospital used a mucolytic drink for routine gastroscopy cases.

Conclusion Current gastroscopy preparation regimes vary across the UK. Future studies should evaluate which preparation regime provides the best possible visualisation of the upper gastrointestinal tract.

Competing interests None declared.

PTU-212 TO ANALYSE THE RISK OF STENT MIGRATION WITH THE NITI-S COVERED FLARED BILIARY STENT

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Introduction Stent migration occurs in 6%–12% of patients undergoing biliary stenting¹ The Niti-S fully covered metal stent (Taewoong Medical, Seoul) has a flared end which acts as anti-migration.² Few studies have evaluated the efficacy of these stents and are contradictory.^{3 4} The aim of our study is to compare their migration rates, investigate contributory factors and patient outcomes.

Methods This was a retrospective cohort study. 32 Niti-S flared stents were placed between January 2010 and July 2011. Each of the patients' records were analysed. The indication for stent, size and whether there had been any previous endoscopic therapy was recorded. The cholangiograms were then re-reviewed by an experienced radiologist to assess stricture length and position of the stent proximal to the stricture.

Results 10 out of 32 stents (31%) had migrated. Nine were placed for benign strictures and one for a malignant stricture. There was no significant difference between the stents that did and did not migrate comparing the length of stricture (mean 11.8 mm vs 12.4 mm), or where the stent was placed (mean proportion of stent above the proximal end of the stricture 16 mm vs 17.5 mm). There also appeared to be no association with previous endoscopic therapy: in 6 (60%) of the procedures where the stents had migrated there had been previous therapy, compared to 14 of the remaining 22 procedures (64%). 4 of the 9 (44%) patients with migrated stents were subsequently admitted to hospital with cholangitis, compared to 1 patient who did not have a migrated stent.

Conclusion The flared end covered metal stents significantly migrate despite the theories behind the design. Direct cost implications of this should be sought. There appears to be no association between aetiology, length of stricture, previous endoscopic therapy or where the stent was placed and subsequent migration.

Competing interests None declared.

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PTU-213 SELF EXPANDABLE METAL STENTS (SEMS) FOR OBSTRUCTING COLORECTAL CANCER IN ENGLAND: LINKAGE ANALYSIS OF HOSPITAL EPISODE STATISTICS

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Introduction Colorectal cancer (CRC) is the 4th commonest cancer worldwide. Hospital admission with large bowel obstruction occurs in 15% and requires urgent decompression. SEMS can provide palliative treatment in advanced disease (avoiding surgical defunctioning) or preoperative bridging to elective surgery for operable disease. We aimed to describe a national profile for incidence (activity) of SEMS, volumes per Trust, length of stay and rates of readmission, reintervention and mortality for CRC in England.

Methods We developed techniques within the SPSS software package to identify a 1-year cohort of incident cases of CRC, starting with a merged file of raw HES data for all care episodes in English hospitals for 2006/7 and 2007/8. We selected only patients with first coding of CRC in the middle 12 months (October–September), then extracted all their admissions within 6 months (before and after) of first cancer coding, ordering them chronologically and then screening to identify admissions for SEMS and surgical procedures. Linkage to death registry provided date of death. Patients with SEMS and no subsequent surgical resection were flagged as palliative patients and those with a subsequent resection as bridge patients.

Results Overall: 517 patients were identified nationally as having SEMS placement for obstructing CRC (mean age: 72.6 yrs [SD: 12.0]; 62.5% male), with mean LOS of 7.9 [SD 11.3] days and overall mortality at 30 d (10.3%) and 90 d (18.0%). The 30 d emergency readmission rate was 15.1%. SEMS were code by 122 (81.3%) of acute Trusts in England, with volumes ranging from 1 to 24 per institution. **Palliative group:** (n=421, 81.4% of cases), mean LOS for index admission 9.2 [SD: 14.6] days and mortality at 30 d (12.1%) and 90 d (21.2%). Emergency readmission within 30 d (17.8%). Subsequent surgical colostomy coded in 9.5%. Palliative procedures were recorded in 122 Trusts (Volumes: 1–13 per institution), **Bridge group:** (n=96, 18.6% of cases), mean LOS for index admission 9.5 [SD: 10.4] days and mortality at 30 d (2.1%) and 90 d (4.2%). Emergency 30 d readmission (8.7%). Colostomy coded as part of surgery in 33.4%. Bridge procedures were coded in 48 (32%) acute Trusts (Volumes: 1–12).

Conclusion Analysis of HES data suggests SEMS insertion in English hospitals is predominantly for palliative purposes and most cases selected for this intervention survive beyond 30 days and avoid operative decompression. The use of SEMS as a bridge to surgery