IS UNSEDATED COLONOSCOPY THE WAY FORWARD?

J Addley,* M Mitchell, S Johnston, I Mainie. Gastroenterology, Belfast City Hospital, Belfast, UK

Introduction Colonoscopy is a very common procedure however, unosed colonoscopy remains understated. 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 1.95 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 colonoscopy group. Complications in the sedated group were seen in 5: Vasovagal dated). There were no immediate complications in the unsedated colonoscopy group was 1.93 and 1.79 in the sedated group.

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.

REFERENCES
5. NCEPOD. Scoping our Practice—the 2004 Report of the National Confidential Enquiry into Patient Outcome and Death.

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

J Callaghan,* J Neale, Poger, P Patel. Gastroenterology, Southampton University Hospital, Southampton, UK

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:

Abstract PTU-211 Table 1

<table>
<thead>
<tr>
<th>Flex sig</th>
<th>PR bleeding only</th>
<th>PR bleed + another indication</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt;45 years</td>
<td>&gt;45 years</td>
</tr>
<tr>
<td>Normal*</td>
<td>127</td>
<td>213</td>
</tr>
<tr>
<td>Inflam+</td>
<td>17</td>
<td>104</td>
</tr>
<tr>
<td>Polyp</td>
<td>10</td>
<td>Left-10</td>
</tr>
<tr>
<td>Cancer</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Colon</td>
<td>Normal*</td>
<td>28</td>
</tr>
<tr>
<td>Inflam+</td>
<td>10</td>
<td>65</td>
</tr>
<tr>
<td>Polyp</td>
<td>7</td>
<td>Left-7</td>
</tr>
<tr>
<td>Cancer</td>
<td>0</td>
<td>7</td>
</tr>
</tbody>
</table>

*Normal/Haemorrhoids. Inflammation/Diverticular disease/Blood.

Competing interests None declared.
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** 195 (95%) 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 25% 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-213 SELF EXPANDABLE METAL STENTS (SEMS) FOR OBSTRUCTING COLORECTAL CANCER IN ENGLAND: LINKAGE ANALYSIS OF HOSPITAL EPISODE STATISTICS**

doi:10.1136/gutjnl-2012-302514c.213

1J Geraghty,* 1S Sarkar, 2M Shawihdi, 2E Thompson, 2M Pearson, 2,3K Bodger.
1Gastroenterology, Royal Liverpool University Hospital, Liverpool, UK; 2Andree Health Outcomes Partnership, University of Liverpool, Liverpool, UK; 3Gastroenterology, University Hospital Aintree, Liverpool, UK

**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 (10.5%) 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: 1–15 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 38.4%. Bridge procedures were coded in 48 (52%) 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...
PTU-211 Patient preparation prior to gastroscopy: a UK wide survey

J Callaghan, J Neale, P Boger and P Patel

Gut 2012 61: A271-A272
doi: 10.1136/gutjnl-2012-302514c.211

Updated information and services can be found at:
http://gut.bmj.com/content/61/Suppl_2/A271.3

These include:

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/