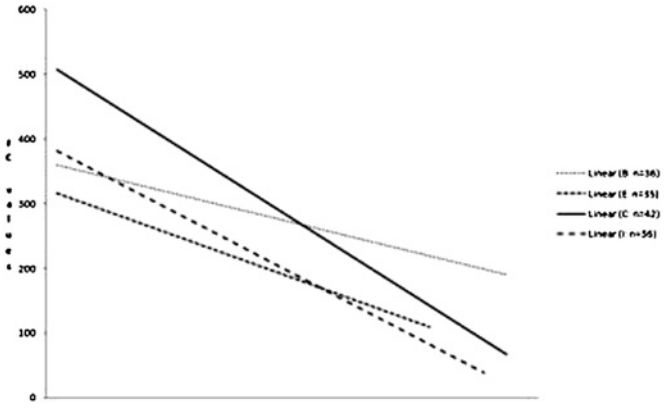
Eurospital ["E"]) and two monoclonal (Buhlmann ["B"], Immunodiagnostik ["I"]). "C" is a manual assay, rest are automated. Automation eases testing. Monoclonal assays are reportedly more accurate. Head-to-head comparison of all four assays is unexplored to the best of our knowledge.

Aim Pilot study to compare the four assays to help us select one (preferably automated) that best meets our clinical needs: reliably exclude GI inflammation (new patients) and quantify inflammation (known IBD).

Methods 42 stool samples collected from January to March 2011 were tested. Patients: 18 new (mainly for diarrhoea), 24 follow-up IBD (in remission/chronic active disease/flare). Assay (n): "C" (42), "B" (36), "I" (36), "E" (35). All four assays: 29/42 (sample insufficient in rest to do all 4). Analysis: Blinded to assay details, a single investigator (MS) mapped FC values to inflammation grade (0=nil, 1=mild/possible, 2=severe/definite) based on conventional markers (CRP/imaging/endoscopy/histology) and final diagnosis. Linearity characteristics of each assay was assessed by Excel trendlines. Restricting analysis to the 29 samples tested by all four assays (giving six pairings), inter-assay concordance was determined for each inflammation grade by Kendall co-efficient. p Value <0.02 (Fisher ratio) was deemed significant.

Results All four assays showed linear characteristics with different gradients, minimum and maximum values (Abstract PTU-243 figure 1). "C" had maximum gradient and highest values while "I" had the lowest levels detectable. Assays "B" and "E" had characteristics in between. Inter-assay concordance (Abstract PTU-243 table 1) was statistically significant in absence of inflammation for all pairings. The highest assay concordance across all grades of inflammation was between monoclonal "I" and polyclonal "C".



Abstract PTU-243 Figure 1

Abstract PTU-243 Table 1

Assay pairing (n=29)	Grade of inflammation: inter-assay concordance			
	All grades (n=29)	0 (n=12)	1 (n=11)	2 (n=6)
B/C	0.9284*	0.9788*	0.7346	0.8000
E/C	0.9611*	0.9767*	0.8941*	0.9058*
I/C	0.9863*	0.9797*	0.9682*	0.9143*
B/E	0.9440*	0.9875*	0.7671	0.8061
B/I	0.9484*	0.9930*	0.7847	0.8000
E/I	0.9650*	0.9813*	0.9487	0.7609

*p Value <0.02 by Fisher ratio.

Conclusion In this pilot, assays "I" and "C" had the most favourable characteristics/concordance. If this trend is confirmed by larger numbers, we will adopt the monoclonal assay "I" as it is automated.

Competing interests None declared.

PTU-244 AUDIT OF 30-DAY MORTALITY POST ENDOSCOPY—A TERTIARY CENTRE EXPERIENCE

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Introduction Post endoscopy mortality is a quality standard for all endoscopy units. Despite the BSG guidelines on endoscopy related mortality in 2006 there has been little published data available for individual trusts. To review all deaths occurring 30 days post Endoscopy performed within the UHL Trust and establish if they are related to the procedure. We also determined an all cause mortality and procedure related mortality for our Trust.

Methods Deaths that occurred both in hospital and community within 30 days post endoscopy were captured through our local CASE team for a period of 6 months (January—June 2009) and information was obtained on certified cause of death. All patients' case records were critically reviewed. Data were collected on demographics, principal diagnosis, indication for procedure, nature and type of procedure, immediate complications and cause of death. We made an observation and established if the death was related to endoscopic procedure. Results are analysed using MS excel 2007 and SPSS V.13.

Results In total 6783 endoscopy procedures were performed during this 6-month period. Of these, 3342 were Gastroscopies, 1645 Flexible Sigmoidoscopies, 1441 Colonoscopies and 355 ERCPs. A total of 87 patients died within 30 days of their Endoscopy procedure, a high proportion of which were inpatients. 56 died during their inpatient stay. 117 (72 OGD, 24 ERCP, 18 FOS, 2 Colons and 1 EUS) procedures completed on these 87 patients were reviewed. Of these, 54 were therapeutic procedures. 53 were male and 34 were female with a median age 74 years. Of these 6 (5%) patients had three or more procedures, 26 (22%) patients had two procedures and 55 (73%) had single procedures. None required reversing agents nor had sedation related complications. One immediate complication of duodenal perforation following ERCP was recorded. Overall four deaths were identified to be causally related to Endoscopy, all of who had therapeutic procedures (One OGD with oesophageal dilatation and three therapeutic ERCP (one of who died following a myocardial infarct)). 14 cardiovascular deaths occurred within 30 days post endoscopy, eight of which were within 8 days. Underlying malignancy was the commonest recorded cause of death in 30. Individual mortality rates 30 days post OGD, FOS, Colonoscopy and ERCP of 1.7%, 0.61%, 0.14% and 7.8% respectively were noted giving an overall mortality rate of 1.3% (1:78). Individual procedure related mortality figures for OGD and ERCP are 0.03% and 0.56% respectively.

Conclusion Post endoscopy mortality is a safety and quality standard for all units. Our audit serves as a reminder of the appreciable risk associated with therapeutic endoscopy and that cardiovascular complications still account for a significant proportion of endoscopy related morbidity and mortality.

Competing interests None declared.

PTU-245 COMMUNITY BASED SPECIALIST GASTROENTEROLOGY CLINIC IN SHEFFIELD, UK—COMPARING PRIMARY CARE AND SECONDARY CARE BASED CLINICS 2010—2011

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Introduction Community based clinics may improve patients' access to healthcare and improve communication between primary and

secondary care.[1] A community gastroenterology clinic was established in Sheffield in 2011 to deliver out-patient care closer to patients' homes while retaining access to specialist expertise. This study reports results from the first 8 months of the community clinic and compares with secondary care gastroenterology clinics.

Methods A single, weekly, consultant-delivered new patient community clinic (CC), designed as a "one touch", single consultation, was established in primary care for a Consortium of 27 General Practices. Data for the study period, March 2011–October 2011, was retrieved for the CC from referral proformas, letters and primary care records. This was compared to secondary care clinics for patients' referred from the same consortium during the study period and for the same time period the year prior to the CC (March 2010 to October 2010).

Results In March–October 2010, 579 patients from the consortium were seen in secondary care gastroenterology clinics. During March–October 2011, 896 patients were seen in gastroenterology clinics: 741 (82%) in secondary care and 155 (18%) in the newly established CC. Mean age was lower in the CC (50 vs 57.8 years, $p<0.001$), with 42/155 (27%) aged over 65 in the CC compared to 310/741 (42%) in the secondary care clinic ($p<0.01$). 67/741 (9.0%) patients did not attend appointments at the secondary care clinic compared to 9/155 (5.8%; $p=0.15$) in the CC. Median waits for CC appointments was 21 days at month 1 rising to 47.5 days in month 8. Presenting features were altered bowel habit (n=59 (38%)), abdominal pain (n=23 (15%)), reflux type dyspepsia (n=18 (12%)) and iron deficiency anaemia (n=16 (10%)). 144 patients (93%) attending the CC had had the specified pre-clinic investigations. 118/146 (81%) patients attending the CC were discharged back to the GP after one visit: of whom 111 (94%) had further tests recommended (33 blood tests, 56 gastroscopy, 53 colonoscopy, 16 ultrasound abdomen). In the 2010 period prior to the CC, 35/579 (6%) patients seen were discharged from their initial secondary care clinic review ($p<0.0001$).

Conclusion The new primary care gastroenterology clinic is associated with higher initial discharge rates, moving co-ordination of ongoing out-patient management to primary care. However, this was not associated with a reduction in patients seen in secondary care and attracted a younger cohort of patients. Additional follow-up is required to assess effects on overall healthcare resource utilisation.

Competing interests None declared.

REFERENCE

1. **Powell J**. Systematic review of outreach clinics in primary care in the UK. *J Health Serv Res Policy* 2002;**7**:177–83.

PTU-246 NHS BOWEL CANCER SCREENING PROGRAMME

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Introduction Background: The NHS Bowel Cancer Screening Programme (BCSP) in England was established following successful pilot screening programmes in England and Scotland.[1] The BCSPcommenced in 2006 with a 3-year phased implementation offering screening to men and women aged 60–69. The programme also enabled people aged 70 and over to self-refer into the screening programme.

Objectives:

–reduce mortality from bowel cancer by up to 16%.[2]

–offer men and women aged 60–69 a guaiac-based FOBt every 2 years.

–enable those over 70 to be screened on request.

–offer those with an abnormal screening result a colonoscopy as the investigation of choice.

–refer for treatment if cancer is found at screening colonoscopy.

–transfer to colonoscopic surveillance within BCSP where intermediate/high risk polyps are found.

Methods The programme comprises five regional programme hubs responsible for call and recall, laboratory processing of test kits and booking clinic appointments for participants with abnormal FOBt results. Participants with an abnormal FOBt result are referred to a local screening centre to discuss colonoscopy with a specialist screening practitioner (SSP) within 2 weeks and offered a screening colonoscopy within a further 2 weeks. General practitioners are not directly involved in the screening process, but do receive information to support their patients to make an informed choice.

Results All 58 screening centres have completed their prevalent round of screening, and the entire eligible population has received at least one invitation. The screening invitation age range is being extended to 75th birthday from 2010 in response to the government's Cancer Reform Strategy.

Conclusion Over twelve million invitations have been despatched. Data shows that uptake has increased from 47.73% in prevalent round to 87.41% in incident round and positivity has decreased from 2.19% in prevalent to 1.99% in incident round. Of these patients, prevalent round data showed 9.90% had a confirmed cancer diagnosis and in incident round this has reduced to 6.05%. Over 143 000 diagnostic tests have been carried out, of which 130 402 were screening colonoscopies. Episode outcomes also show a reduction in incident rounds of high risk polyps (10.21% to 7.65%) and intermediate risk polyps (17.95% to 14.33%). There has been an increase in low risk polyps (15.81% to 21.13%) and abnormal findings, not polyps (19.73% to 26.38%).

Competing interests None declared.

REFERENCES

1. **Alexander F**, Weller D. *Evaluation of the UK Colorectal Cancer Screening Pilot*. Final Report, February 2003, revised May 2003. Report to The UK CRC Screening Pilot Evaluation Team.
2. **Cancer Research UK**. *UK Bowel Cancer Statistics*. http://info.cancerresearchuk.org/cancerstats

PTU-247 ERCP—CAN A SMALL VOLUME UNIT PROVIDE A SATISFACTORY SERVICE?

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Introduction In recent years, systems grading ERCP technical difficulty have been introduced in UK clinical practice. According to these, small volume units are advised to refer complex cases to specialised centres. Conversely, in the US the American Society for Gastrointestinal Endoscopy (ASGE) has announced favourable results of community based hospitals ERCP success rates compared to university hospitals. Recommended competence rates are: 90% successful bile duct cannulation, 85% for bile duct stone removal and 90% for bile duct drainage of a blocked duct.[1] In the UK, the J.R. B. Green and the UK ERCP stakeholders working party and Joint Advisory Group (JAG) suggest an overall 80% success rate.[2] This study compares ERCP success rates in Nobles Hospital, a geographically isolated District General Hospital, to the competence rates of ASGE and JAG in order to assess whether ERCP can be performed successfully in district general hospitals in the UK.