

**Results** Data published in the Bowel Screening Wales First Round Report dated 29 September 2011 shows that 6493 (82.2%) of SSP appointments were completed by telephone. 0.5% of participants required or requested a face to face assessment. 90% of participants assessed were fit for colonoscopy of which 89.4% attended a procedure. The 10% of participants found not fit were offered an alternative to colonoscopy such as CT colonography.

**Conclusion** The literature reviewed clearly shows that telephone assessment for Bowel Screening Wales participants following a positive FOBT is an effective and acceptable form of information gathering and provision. Good attendance rates for assessment appointments and colonoscopy procedures are evidenced by the Bowel Screening Wales first round report.

**Competing interests** None declared.

## REFERENCE

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## PTU-257 "TRIALS AND TRIBULATIONS OF SETTING UP AN ANAESTHETIST LED DAY-CASE ENDOSCOPY LIST"

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**Introduction** Endoscopy in UK is performed under conscious sedation in daycase (DC) endoscopy units. Patients intolerant of the procedure subsequently undergo the procedure under a general anaesthetic in operating theatres. However whether this service could be effectively offered in a "non-operating theatre room" setting through an anaesthetist-led sedation service (ALS) is not well established within the UK.

**Aim** To evaluate a new provision of an ALS in a day case endoscopy unit.

**Methods** Service evaluation audit (June–August 2011) of a new weekly dedicated ALS at the Royal Liverpool Hospital was performed. Administrative, anaesthetic and case records and satisfaction scores (1=unsatisfactory; 5=fully satisfied; patients, anaesthetists, endoscopists) and "patient journey" was evaluated.

**Results Administration:** Three cases were scheduled per listed. Waiting time was a median 9 weeks compared to a median 6 weeks for other lists. Of the 25 patients listed, only 20 (80%) had a procedure. DNA rate was 16% and cancellation rate 4%. **Patients and Indication:** Median age was 53 years (range 18–80 years), median ASA was 2 (range 1–3), 8 (42%) were female. 20 underwent propofol assisted endoscopy (7 colonoscopy, 8 HALO®, 3 ERCP, 1 OGD and 1 EUS). **Procedural details:** ALS was provided by a consultant anaesthetist assisted by operating theatre personnel and endoscopic procedures by a consultant gastroenterologist. All were successfully completed (mean duration of 33 min, range 20–70 min). Modification of anaesthetic equipment was required in all but one and additional equipment had to be borrowed in all. Adverse events were minor (rate 10%)—transient hypoxia (not required ventilation) and hypotension. All patients were discharged successfully as DC. 7-day readmissions and 30-day mortality was 0. The median satisfaction score was 5 (range 4–5) for patients, 5 (range 4–5) for anaesthetists and 5 (3–5) for endoscopists. The additional cost for provision of such a service included the services of the anaesthetist (one programmed activity) and OTP and for drugs (propofol).

**Conclusion** Deep sedation for selected endoscopic procedures can be safely and efficiently provided through a dedicated anaesthetist-led list in a remote endoscopy unit. However, waiting times were longer than other lists and a significant number of patients DNA'd/cancelled. We are now setting up pre-assessment clinics and increasing the number of lists to improve the service further.

**Competing interests** None declared.

## PTU-258 A UK NATIONAL COMPARATIVE AUDIT OF APPROPRIATENESS OF RED CELL TRANSFUSION IN MEDICAL PATIENTS

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**Introduction** The decrease in red cell usage (15%) that has been achieved in recent years has mainly been achieved through the use of blood conservation strategies adopted for surgical patients. Despite national guidelines for blood transfusion being available, agreed triggers for transfusion still need to be established in clinical practice, together with better decision-making in anaemia management to further reduce inappropriate transfusion of red cells in medical patients.

**Methods** The main aim of this audit was to observe the extent of inappropriate red cell transfusions, taking account of relevant clinical information and pretransfusion assessment. In autumn 2011, a total of 8759 red cell transfusions in medical units from almost all UK hospitals (>90%) were audited in 3 selected weeks. Through an algorithm based on clinical and diagnostic information provided, a panel of expert physicians estimated the appropriateness of the transfusion. Subgroup analysis was also undertaken to identify patients with a reversible cause of anaemia in whom timely diagnosis and treatment of the original condition would have almost certainly prevented the recourse to blood transfusion.

**Results** Preliminary analysis has revealed many cases of red cell transfusion when the pretreatment haemoglobin (Hb) was within acceptable limits. The findings show that 4.1% cases had a pretransfusion Hb higher than 10 g/dl (median 7.8, range 2.3–17.7) and 5.8% had a posttransfusion Hb of greater than 12 g/dl (median 9.9, range 4.2–19.3). Serum ferritin was measured in only 38% of cases and of these 9.3% of patients had a ferritin <15 µg/l. Of all the transfusion episodes, only 1748 were for blood loss, while 180 were for prophylaxis prior to a procedure. The vast majority were for anaemia, with the remaining 48 reports not having enough data. In blood loss, the commonest indication was haematemesis (1029 cases), while 423 were primarily for rectal bleeding.

**Conclusion** This national comparative audit shows: (i) there is substantial inappropriate red cell transfusion in medical patients; (ii) gastrointestinal bleeding is far and away the major reason for transfusion in the setting of blood loss among medical patients. The frequent use of red cell transfusion in the absence of clinical necessity seems to derive from the use of above-threshold triggers, and suboptimal management of anaemia with a reversible cause.

**Competing interests** None declared.