the UK. Most series have however included smaller polyps (1 cms or less) and there is paucity of data on EMRs limited to large polyps. We report the outcomes on a series with large polyps (>2 cms) from a bowel cancer screening centre in the UK.

Methods A total of 5190 polypectomies were performed within the region from January 2008 to December 2011 on the Bowel Screening Programme. Data were collected from three hospitals on all large polyp EMR greater than 2 cm in size. Data were analysed using the SPSS V.20.

Results A total of 61 patients with polyps 2cm or greater were identified. The mean age was 69 years, 75% (n=46) of which were male. The mean size of the polyps resected was 35 mm (range 20–60 mm). The majority of the polyps were sessile (n=40) and located in the left colon (n=43). Tattooing was performed in 46% (n=28) and Argon-beam photocoagulation (APC) therapy was applied in 41% of cases (n=25). In 97%, the resections were complete (n=59). Histopathology results were obtainable in 57 patients of whom 12% (n=7/57) showed high grade dysplasia and 5% (n=3/57) were confirmed as adenocarcinoma. The overall major complication rate was 3% (n=2). Both complications were bleeding post-EMR. Surveillance data were available for 43 patients up-to 12 months post EMR. Six recurrences (10%) were seen at the EMR site at 3 months, five of these in left colon. On reviewing their initial EMR, the polyps had a median size of 25±6 mm; 50% (n=3/6) had APC therapy and 5/6 the excision was endoscopically complete on initial EMR. Histology confirmed low grade dysplasia (LGD) in all cases. Recurrence was endoscopically treated successfully in all cases. Recurrence rate was not influenced by the size or site of the polyp or APC therapy. Sessile polyp EMR were more likely to show recurrence (n=5/6). At 12 months, eight patients had recurrence. Six of these patients had endoscopically complete excision on initial EMR. On reviewing their initial EMR, the polyps had a median size of 35±5 mm; 50% had APC therapy. Recurrence was treated successfully in all cases.

Conclusion Endoscopic mucosal resection for large colorectal polyps is safe with relatively low complication rates compared to laproscopic surgery. Recurrence rate is low at 3 months but can still occur upto 12 months in lesions felt to be completely excised.

Competing interests None declared.

PWE-191 THE ROLE OF ERCP IN THE MANAGEMENT OF POST CHOLECYSTECTOMY BILIARY LEAKS

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Introduction Bile duct injury causing a biliary leak after cholecystectomy is an important and well recognised surgical complication. It has a significant impact on the post operative recovery and is often managed endoscopically with the insertion of a biliary stent.

Objectives To assess the clinical course of patients who had a biliary stent placed for a post operative bile duct leak.

Methods All patients who underwent ERCP and biliary stent insertion for a biliary leak between 1 November 2009 and 30 November 2011 at our NHS trust were identified. Demographic data, endoscopic procedure details and outcomes were recorded.

Results 25 patients had endoscopic (Endoscopic Retrograde Cholangio Pancreatography-ERCP) management of a biliary leak by stent insertion. 72% of the cohort were females. Age range was between 19 and 80 years with a mean of 52.6 years. 16/25 (64%) of patients had two ERCPs for the insertion and subsequent removal of a plastic stent (size between 7 and 10 Fr). Nine patients (36%) had >2 ERCPs due to a persistent leak. 10/16 patients (62.5%) had the 2nd ERCP within 7 weeks and all had no persistent leak during that examination. The remaining 6 (37.5%) had the 2nd ERCP later than 7 weeks, and found to have no further biliary leak. The mean time between the two ERCPs was 9.3 weeks. Three Patients with a persistent biliary leak (33%) had an ERCP as early as 3 days. Others had between 1 and 4 weeks. None of the patients had any complications secondary to ERCP. The majority of the biliary leaks originated from the cystic duct stump (64%) or gall bladder bed (20%). Out of the total 25, four patients (16%) had retained stones within the common bile duct identified at the second ERCP and all were successfully extracted. 22 (88%) of the cohort did not have a persistent leak or stricture during their final ERCP. Three patients (12%) developed a stricture at the common bile duct or common hepatic duct.

Conclusion Within a district general hospital setting, the majority of patients with a post-cholecystectomy biliary leak can be managed effectively with the insertion of plastic biliary stents. A minority of patients will develop a subsequent biliary stricture.

Competing interests None declared.

PWE-192 EFFICACY AND SAFETY OF EXTENSIVE ENDOMUCOSAL RESECTION FOR COMPLETE BARRETT'S ERADICATION IN EARLY BARRETT'S NEOPLASIA: A META-ANALYSIS

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Introduction The efficacy of complete Barrett's eradication by extensive endomucosal resection (E-EMR) of Barrett's oesophagus with early cancer ranges from 60% to 100% with a post-resection stricture rate of up to 88% in a recent RCT.[1] The primary aim of this meta-analysis was to determine the long-term efficacy and safety of E-EMR for complete Barrett's eradication in patients with early Barrett's cancer.

Methods MEDLINE, EMBASE and PubMed databases were searched using keywords, "Barrett's oesophagus," "oesophageal cancer," "endomucosal resection," "circumferential endomucosal resection," Barrett's high-grade dysplasia and Barrett's intra-mucosal carcinoma from January 1965 to December 2011. Articles were selected/reviewed and data collected based on pre-defined inclusion criteria, independently by two authors (RK and TT). Meta-analysis using random effects model was done.

Results Thirteen studies (N=691) were included in the final analysis. (586 males, average age, 65.9 range 65–67). 116 patients in six studies had long-segment Barrett's. The average Barrett's length was 3.78 cm (range 2–4.9 cm). Visible lesions were seen in 371/586 (63.3%) patients. At an average of 2 (range 1.5–2.5) EMR sessions, four resections (range 3–8) were done per session Complete Barrett's eradication was achieved in 71.9% (95% CI 68.1% to 75.4%) and eradication of early Barrett's cancer in 96% (95% CI 91% to 99%) of patients. At an average follow-up of 20.5 months (range 9–31.6) Barrett's/dysplasia recurrence was seen in 13% (95% CI 10.7%>15.9%). Total number of resections (p=0.026) and age (p=0.037) were significant confounders for complete Barrett's eradication. The overall stricture rate was 39% (95% CI 35%>43%). Procedure related perforations occurred in 12/691 (1.3%) and bleeding in 9.9% (95% CI 5.1%>13.5%) of patients. On meta-regression analysis there were no significant confounders for stricture formation.

Conclusion Complete long-term complete Barrett's eradication in patients harbouring early cancer is effective in only 71.9% of patients with age and total endoscopic resections being significant confounders. The procedure appears safe but has a stricture rate of 39%.

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Competing interests R Krishnamoorthy: None declared, K Abrams: None declared, K Ragunath Conflict with: Member of the shortlisting panel for the Endoscopy section of the BSG., T Thomas: None declared.

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PWE-193 OUT OF HOURS GI BLEEDER SERVICE: THE LEICESTER EXPERIENCE

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Introduction The incidence of upper gastrointestinal bleeds is 50–150 cases per 100 000.[1] The introduction of the CROMES: "Scope for improvement" toolkit[2] has focused on the need for provision of a comprehensive GI bleed service. The RR-adjusted mortality in hospitals without an out of hours rota is 1.21 compared to those with a rota.[1] Despite this only 52% of hospitals have a formal out of hours (OOH) endoscopy rota.[1] The University Hospitals of Leicester (UHL) established a rota in 2006 which now provides 24/7 cover. We examined procedures performed since the rota was commenced.

Methods The audit period covered August to January for each of the five consecutive years. We analysed procedures carried out on weekdays (17:00–9:00) and weekends and Bank holidays (24 h). Data were gathered from OOH books where all endoscopies are recorded and from formal endoscopy reports (Unisoft). In each case we considered the indication for endoscopy; appropriateness for an "urgent" procedure; findings at index endoscopy and the need for therapeutic intervention.

Results The bulk of OOH work was performed on weekend mornings with weekdays accounting for much less; 6% in 2010–2011. Since commencement an increasing proportion of endoscopies were performed for "inappropriate" indications, as judged by UHL criteria (see Abstract PWE-193 table 1). There was an increase from 17% to 27% in the number of endoscopies where no pathology was found. Interestingly the proportion of patients with varices or variceal bleeds remained static at 9% throughout. Findings of peptic ulcer disease and gastritis/duodenitis have fallen by 16% over the period. The need for therapeutic intervention has almost halved. However, of those requiring intervention use of variceal banding and adrenaline injection significantly increased. Short-term outcomes were very good with over 90% of patients each year having their bleeding controlled and being returned to their ward. Longer-term outcomes were difficult to ascertain due to difficulties obtaining data.

Abstract PWE-193 Table 1

Appropriate indications	Inappropriate indications
Haematemesis	Dysphagia
Haematemesis + melaena	Nausea + vomiting
Melaena	Weight loss
Liver disease + evidence of bleed	Diarrhoea
Liver disease + drop in Hb	Campylobacter infection
Dysphagia + haematemesis	Anaemia
Intermittent rectal bleeding	Abdominal pain
Overt rectal bleeding	Constipation
	Previous peptic ulcer
	IBD assessment

Conclusion The data shows trends towards an increasing number of procedures with fewer positive findings and less need for therapeutic intervention. While this is likely to be multi-factorial, one likely contributing factor is the ever-present shortage of acute medical beds leading to more routine work in order to expedite discharges. This does not necessarily constitute a misuse of the service, as early specialist endoscopic input is likely to improve patients' management. However, these factors need consideration before offering such a service.

Competing interests None declared.

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PWE-194 WE'VE GOT TO THE CAECUM…NOW WHAT WILL WE DO WITH THE POLYPS?

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Introduction Recent work, especially in the national Bowel Cancer Screening Programme (BCSP) has focussed on adenoma detection and removal as a marker of quality of colonoscopy. It is vital that this quality assurance is applied to all patients undergoing colonoscopy and that we move away from caecal intubation rate (CIR) as the main marker of a successful colonoscopy. We aimed to review practice in terms of adenoma detection and removal technique among all NHS colonoscopist in a busy district general hospital.

Methods Procedural data were retrospectively collected from Endosoft reporting software for all colonoscopies performed in a 6-month period. BSCP lists were excluded. The reports were reviewed and data collected including operator, size of list, extent of procedure, and details of polyps found—size, location, description, whether removed or biopsied, method of removal and if tattoo used. In addition, the completeness of the report was recorded. Where polyps were removed, the histology result was also recorded.

Results 472 procedures were performed by 18 operators—three trainees, two nurse endoscopists, and 13 consultants (eight gastroenterology, five surgical). 159 procedures identified polyps (246 polyps in total), with a unit polyp detection rate of 33.7%. Individual polyp detection rates varied between 14.7% and 58.8%. Histology showed a unit adenoma detection rate (ADR) of 21%. Eight cancers and one polyp cancer were detected. Documentation of polyp location was good (240/246) but size and description were less well documented (171 and 185 out of 246 respectively). 211 polyps were removed, 31 left in situ, and unclear in 4. 26 polyps removed were ≥10 mm, of which nine with a snare and 16 by EMR (one unknown.) Smaller polyps were removed by a variety of methods (Abstract PWE-194 table 1).

Conclusion ADR in this unit is comparable to elsewhere in the UK, but not as high as within the BCSP, although this represents a different patient population. Documentation of these polyps varied greatly, and could be improved. Detection rate and removal methods varied widely between endoscopists. This prompted the creation of an "aide memoir" poster (see Abstract PWE-194 figure 1) to be displayed in the endoscopy room, advising on documentation and highlighting the current guidance for management of polyps. Teaching was also undertaken at dedicated "polypectomy afternoons," with a view to re-assessing polyp management at a later date, using ADR as quality marker.

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