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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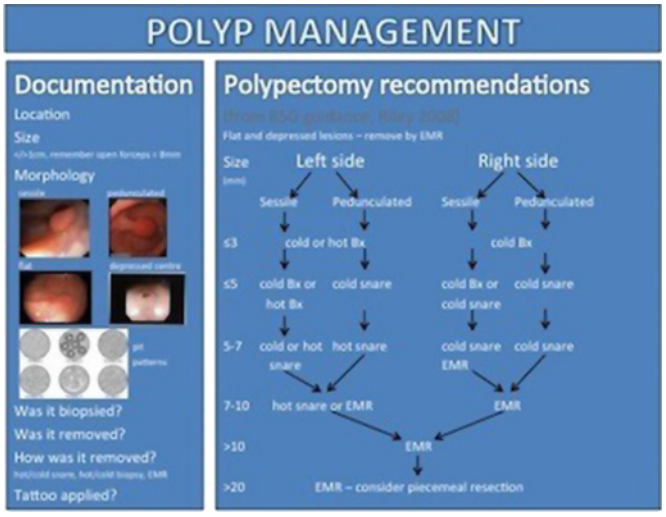
Introduction Recent work, especially in the national Bowel Cancer Screening Programme (BCSP) has focussed on adenoma detection and removal as a marker of quality of colonoscopy. It is vital that this quality assurance is applied to all patients undergoing colonoscopy and that we move away from caecal 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.



Abstract PWE-194 Figure 1

Abstract PWE-194 Table 1 Polypectomy methods

Polyp size	Cold biopsy	Hot biopsy	Snare	EMR	Not removed	Unknown
≤3 mm	10	0	23	14	6	0
4–5 mm	2	3	18	18	3	1
6–9 mm	0	2	18	7	1	2

Competing interests None declared.

PWE-195 NON-NEOPLASTIC DIAGNOSES WITHIN THE NHS BOWEL CANCER SCREENING PROGRAMME

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Introduction The aim of the NHS Bowel Cancer Screening Programme (BCSP) is to diagnose colorectal cancer. Small studies have demonstrated a yield of diagnoses other than cancer or adenomas (non-neoplastic diagnoses (NND)) ranging from 11% to 25%. NND may account for false positive FOB test (FOBt) results and may generate a significant workload outside the BCSP. The aim of this study was to evaluate the burden of NND generated by the BCSP.

Methods Data were obtained from the BCSP national database for all patients with a positive FOBt who subsequently underwent investigation from August 2006 to November 2011. These data included patient demographic data, smoking status, clinical outcome and NND made. Data were analysed using SPSS.

Results 121 728 patient episodes in the BCSP were included in the analysis. 60.2% of patients were male and the mean age was 65.7 years. In this period 10 836 cancers were detected (8.9%). One or more NND were made in 26 251 patients (21.6%). Patients with a diagnosis of neoplasia (cancer or adenomas) were less likely to have a NND than those without neoplasia (19.8% vs 24.4%, p<0.001). Older age and male gender were, but smoking status was not, associated with a greater likelihood of an NND being made (NND in males 21.8% vs 21.2% in females, p=0.01; NND in those <65 years 20.6% vs 22.3% in those ≥65 years, p<0.001; NND in smokers 21.4% vs 21.7% in non-smokers, p=0.34). After adjustment for confounding using multivariable analysis, older age and male gender were still associated with a small but statistically significant increased risk of a NND.

Conclusion The BCSP generates a significant volume of Non-Neoplastic Diagnoses. Inflammatory bowel disease is an important and common diagnosis and may have important implications for the management of the patient. Large numbers of patients had diverticulosis and haemorrhoids diagnosed however reporting of these findings may vary. Patients undergoing bowel cancer screening should be aware that a diagnosis other than cancer or polyps may be made. The burden of NND generated by the BCSP nationally has not been investigated and the impact of this on primary and secondary care is not known.

Abstract PWE-195 Table 1 Frequency of non-neoplastic diagnoses

	Frequency (%)
Inflammatory bowel disease	2152 (1.8)
Angiodysplasia	902 (0.7)
Diverticulosis	18 875 (15.5)
Haemorrhoids	7011 (5.8)
Radiation enteritis	374 (0.3)
Solitary rectal ulcer syndrome	228 (0.2)
Other diagnoses (including: lymphoma, ischaemic colitis, pseudomembranous colitis)	1362 (1.1)

Competing interests None declared.

PWE-196 ENDOSCOPIC MUCOSAL RESECTION OF FLAT AND SESSILE POLYPS IN THE COLON: SAFETY, EFFICACY AND CLINICAL OUTCOMES FROM A LARGE DATA BASE IN THE UK TERTIARY REFERRAL CENTRE

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Introduction Endoscopic Mucosal Resection (EMR) is now well established as the procedure of choice for removing flat and sessile polyps in the colon. It stems from large scale studies in Japan that is increasingly practised in the UK, thus potentially avoiding surgery for benign polyps. Our aim was to assess the safety, efficacy and clinical outcomes of EMR procedures at Nottingham University Hospitals NHS Trust.

Methods We searched our prospectively collected database for all sessile and flat colonic polyps >10 mm (Paris0–Is, 0–II) removed by injection and snare EMR technique in our centre over a 7-year period (2004–2011). Follow-up examinations were done as per BSG guidelines. Parameters analysed included patient's demographics; type of resection; completeness of resection; endoscopic success rate; as well as recurrence and complication rates.

Results All procedures were done by endoscopists trained in EMR. 338 EMRs were done in 325 patients, age range 20–90 yrs, male 55% (180). 77% (261) had sedation and one patient had GA for the procedure. 53% (180) had en bloc resection, 39% (132) had piecemeal while 4.7% (16) had incomplete or partial resection. 2.9% (10) were unable to resect. Endoscopic success at 1st attempt was achieved in 82% (278) and over all endoscopic cure was 92% (310). 4.4% (15) were referred for surgery. A follow-up procedure was performed in 77% (242) within 12 months Recurrence rate for enbloc resection was 5.7% (9/156), for piecemeal resection it was 18% (16/86). Overall recurrence rate was 10.3% (25/242). Adenocarcinoma was