therapy has failed, yet there is little outcome data. We describe our experience of outcome following endoscopic therapy where both radiological and surgical interventions are readily available.

Methods A retrospective observational study of all patients undergoing therapeutic endoscopy as primary treatment for NV-UGIB at the John Radcliffe Hospital, Oxford, was performed. All 180 patients eligible over a 2-year period (January 2009 to December 2010) were included. The main outcome measures were failure of primary endoscopy, defined as continuing bleeding or rebleeding requiring further intervention or causing death, and definitive haemostasis rate after all intervention (repeat endoscopy, radiological embolisation or surgery).

Results 180 patients underwent therapeutic endoscopy; median age 75 years, 114 male (63.3%). 128 (71.1%) had peptic ulcer disease. Haemostasis was achieved at endoscopy in 165 (91.7%). In four patients endoscopic therapy was not attempted due to inaccessibility of the lesion. There was failure of primary therapeutic endoscopy in 40 (22.2%), with continuing bleeding in 13 and rebleeding in 27. A second intervention was undertaken in 37; embolisation in 21, repeat endoscopy in 14 and surgery in 2. 13 required three or more interventions Definitive haemostasis was achieved in 18/25 (72%) of patients undergoing embolisation and 8/8 (100%) of patients undergoing surgery. All cause mortality was 20% in the embolisation group, with one patient dying from ischaemic complications. There were no deaths in the surgical group. Overall, definitive haemostasis was achieved in 174 patients (96.7%) with all cause 30-day mortality 10% and bleeding-related mortality 3.3%. Failure of primary endoscopy was associated with an increased risk in all cause mortality (RR 2.80, CI 1.18 to 6.62, p=0.02).

Conclusion The failure rate of therapeutic endoscopy for NV-UGIB was comparable with the published literature. The combination of endoscopic, radiological and surgical therapy achieved definitive haemostasis in a high proportion (96.7%). When endoscopic therapy failed, interventional radiology was an effective salvage modality in the majority of cases, avoiding the need for surgery. Failure of primary endoscopic therapy was associated with all cause mortality.

Competing interests None declared.

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PWE-213 COMPARISON OF COLONOSCOPY QUALITY INDICATORS BETWEEN SURGEONS, PHYSICIANS AND NURSE ENDOSCOPISTS IN THE NHS BOWEL CANCER SCREENING PROGRAMME: ANALYSIS OF THE NATIONAL DATABASE

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Introduction Screening colonoscopists in the NHS Bowel Cancer Screening Programme (BCSP) are predominantly surgeons, physicians or nurse endoscopists. There are a small number from other backgrounds such as general practice. All are required to be screening-accredited, attain the same standards prior to commencing colonoscopy in the programme (including performance of at least 1000 colonoscopies) and undergo the same performance audits. This study examines whether there are any differences in colonoscopy quality indicators (CQI) among colonoscopists from these different backgrounds.

Methods The following CQI were calculated for all colonoscopists in the BCSP based on all index screening colonoscopies performed between August 2006 and August 2009: adenoma detection rate (ADR), polyp detection rate (PDR), mean number of adenomas per patient (MAP), mean negative complete colonoscopy withdrawal time (nc-CWT), caecal intubation rate (CIR), rectal retroversion rate (RRR), polyp retrieval rate (PRR), percentage of patients with no, minimal or mild discomfort and percentage of procedures performed with no intravenous sedation. Colonoscopists were classified according their background. As only one colonoscopist was from a general practice background, this group was not included from subsequent analyses. ANOVA was used to compare the mean values for each of the CQI for each speciality.

Results Of 148 colonoscopists, 114 were physicians, 24 were surgeons and 10 were nurse endoscopists. In the study period, 36 460 colonoscopies were performed. The mean ADR for surgeons, physicians and nurse endoscopists were 46.7%, 46.6% and 44.2% respectively. The mean CIR rates were 95.3%, 95.3% and 94.7% respectively. These values were not significantly different (p=0.570, p=0.839). Similarly, no significant differences were seen in comparison of any of the other CQI or performance indicators (PDR, MAP, nc-CWT, RRR, PRR or patient comfort). The proportion of procedures performed without sedation by surgeons, physicians and nurse endoscopists were 10.4%, 13.8% and 27.5% respectively (p=0.002).

Conclusion This study demonstrates that standards of colonoscopy as assessed by eight colonoscopy quality indicators and measures of performance are similar for surgeons, physicians and nurse endoscopists. The difference in percentage of procedures performed without sedation may reflect differing attitudes to sedation and warrants further investigation. These data support the accreditation process for screening colonoscopists by demonstrating that all accredited colonoscopists perform to a high standard irrespective of speciality.

Competing interests None declared.

PWE-214 ENDOSCOPIC MUCOSAL RESECTION FOR EARLY NEOPLASIA IN BARRETT'S EPITHELIUM IN PATIENTS ON ANTICOAGULATION USING WARFARIN: IS IT SAFE?

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Introduction Endoscopic mucosal resection (EMR) has become an established treatment modality in the managment of patients with high grade dysplastic lesions and intramucosal cancer in Barrett oesophagus. The mucosal defect caused by the endoscopic resection usually takes several weeks to heal. There is no data whether this procedure is also safe for patients requiring anticoagulation. The aim of the study was to investigate the risk of acute and delayed bleeding in patients on anticoagulation undergoing EMR for treatment of early neoplasia in Barrett oesophagus. We compared the complication rate of EMR in patients taking warfarin as anticoagulants with that of a control group.

Methods Warfarin was stopped 5 days before the planned EMR and restarted on the evening of the procedure day. Patients with high risk conditions such as recent pulmonary thromboemboli received bridging with low molecular weight heparin. All EMRs were performed when the INR was <1.5.