

PWE-217 IS "PUSH" AN EFFECTIVE AND SAFE METHOD FOR RELIEF OF OESOPHAGEAL FOOD BOLUS OBSTRUCTION ON ENDOSCOPY?

doi:10.1136/gutjnl-2012-302514d.217

V Mahesh,* M Schoeman. *Department of Gastroenterology, Royal Adelaide Hospital, Adelaide, Australia*

Introduction Food bolus obstruction of the oesophagus is not an uncommon acute presentation, but data on safe and effective endoscopic management is limited. Although "push" technique with the endoscope is commonly employed, no data on its safety and efficacy compared to other modalities is available.

Aim To evaluate the safety and efficacy of various endoscopic modalities for relief of acute oesophageal food bolus obstruction.

Methods Retrospective study of prospectively collected data. All patients presenting to the department of Gastroenterology at Royal Adelaide hospital, a tertiary centre in South Australia from January 1996 to November 2011 were included in the study. Detailed data on endoscopy, histopathology and complications were collected.

Results In total 288 patients presented with acute oesophageal food bolus obstruction. 70% male patients (202M:86 F); average age of 58.2 yrs±1.7 yrs at presentation. 150 (52%) patients had procedure with anaesthetic assist (± tracheal intubation), 135 (47%) with intravenous sedation (midazolam and fentanyl) and 3 (1%) with only topical anaesthesia. 44 (15%) patients had food bolus in the proximal, 59 (21%) in the mid and 146 (51%) in the distal oesophagus. In 39 (14%) food bolus had spontaneously cleared the oesophagus at endoscopy. The contributing aetiology for food bolus obstruction is described in Abstract PWE-217 table 1. Incomplete data on the type of food was available, but majority were documented to be meat bolus. Push technique was solely and successfully used in 167 (67%) compared to combination of techniques after failed "push" in 53 (21.2%) patients {forceps ± snare ± overtube ± basket} (p<0.01). Remnant 24 (9.6%) patients had one of the following: overtube/hood 5 (2%), forceps 8 (3.2%), snare 2 (1%), basket 5 (2%), suction 1 (0.4%) and wire guided dilatation 3 (1.2%). In five (2%) patients endoscopy was unsuccessful, one removed via rigid oesophagoscopy, four others passed food bolus spontaneously. Additional therapies like bougie and balloon dilatation was done in 64 (24.7%) patients at the index endoscopy. No complication/s attributable to endoscopy/technique was documented.

Abstract PWE-217 Table 1

Causes	n = 288	%
Normal	55	19
Web	5	2
Post Nissen's/surgical	9	3
Malignancy	21	7
Schatzki's ring	22	8
Benign stricture	30	10
Reflux related disease	55	19
Eosinophilic Oesophagitis	59	20
Others (including non-specific histology)	32	11

Conclusion This is the first study to clearly show the safety and efficacy of push technique in relief of oesophageal food bolus obstruction. Combination of manoeuvres is the next best option; tracheal intubation to protect airway must be considered. Limitations of the study include retrospective nature and incomplete data on the type of food bolus.

Competing interests None declared.

PWE-218 EXPERIENCE OF COLONIC STENTING IN A DISTRICT GENERAL HOSPITAL

doi:10.1136/gutjnl-2012-302514d.218

V Krishnan,* D Majumdar, D Dwarakanath. *Department of Gastroenterology, North Tees Hospital—NHS, Stockton on Tees, UK*

Introduction A significant number of colon cancer patients present with obstruction which is a surgical emergency. Emergency decompression surgery is associated with 25% mortality.¹ Self expandable metal stent (SEMS) provides a low-risk and successful option for managing them.² This study evaluates the outcome of the use of SEMS in malignant colonic obstruction (MCO) in a district general hospital (DGH).

Methods This retrospective study includes patients with MCO treated with SEMS over a period of 4 years. All the stentings were done by an experienced gastroenterologist. The Endoscopy reporting software (Unisoft), stent logbook, histology database and patient admitting system (PAS) were reviewed for data collection. Information regarding indication, site of the lesion, stent, procedure outcome, adverse events, discharge time and patient demographics were reviewed.

Results 52 patients had SEMS for MCO in the study period. 40 (76.9%) had elective and 12 (23.1%) had emergency stenting. The age range is from 48 to 93 years with a mean of 75.4 years. Majority of the patients were male (34, 65.4%). All patients with emergency stenting were admitted with total large bowel obstruction and 2 (16.6%) of them had post-stent curative surgery where as 6 (15%) of the elective group also had post-stent curative surgery. So in eight patients (15.4%) SEMS was used as bridge for surgery and in 44 (84.6%) it had a palliative role. Boston Scientific colonic stents (WallFlex) were used for all patients. The sites of the lesions were sigmoid 32 (61.5%), rectum 10 (19.3%), descending colon 7 (13.4%) and transverse colon 3 (5.8%). Extravasation of contrast occurred in 2 (3%), migration in 3 (5.8%) resulting in stent removal and blockage in 1 (1.9%) followed by Hartmann's procedure, giving a complication rate of 10.7%. The technical success rate is 100% (no procedural failure) and the clinical success rate is 89.3% (functional stent without complication). Average duration of post stenting hospital stay was 3.92 days.

Conclusion The key of our successful colonic stenting service (technical success—100%, clinical success—89.3% and successful bridging of 15.4% (n=8) to curative surgery) is the result of careful patient selection and delivery of the service by a single experienced operator. There was no procedure related mortality compared to emergency surgery of 25%. We feel all DGH with acute surgical intake should be equipped to provide this safe and useful service.

Competing interests None declared.

REFERENCES

1. Tekkis PP, Kinsman R, Thompson MR, *et al*. The Association of Colo-proctology of Great Britain and Ireland study of large bowel obstruction caused by colorectal cancer. *Ann Surg* 2004;**240**:76–81.
2. Aaron J, Coelho-Prabhu N, Baron TH, *et al*. Endoscopic placement of self-expandable metal stents for malignant colonic obstruction: long-term outcomes and complication factors. *Gastrointest Endosc* 2010;**71**:560–72.

PWE-219 FIRST REPORTED EXPERIENCE OF COLON CAPSULE ENDOSCOPY (CCE) IN ROUTINE CLINICAL PRACTICE

doi:10.1136/gutjnl-2012-302514d.219

V Sathyanarayana,* K Drew, S Hardcastle, A J Lobo, D Majumdar, R Sidhu, M E McAlindon. *Department of Gastroenterology, Sheffield Teaching Hospitals NHS Trust, Sheffield, UK*

Introduction The advantages of colon capsule endoscopy (CCE) over other imaging modalities include the absence of intubation, sedation