

**Results** 195 patients (n=195, males 65%, mean age 58.6) underwent mediastinal EUS-FNA during the study period. Mean size of the lesions was 15.82 mm (range 3.9–43) in short axis and 28.23 mm (range 8–60) in long axis. Sub-carinal lymph nodes (LN) were the commonest (145/195, 70.3%) target lesions. Mean number of needle pass was 3.18 (range 1–6) and 22G (53.5%) was the commonest needle used. There were no procedure related complications or deaths. Of the 195 patients, FNAs were positive for malignancy in 61 (61/195, 31.2%), sarcoidosis in 40 (20.5%) and tuberculosis (TB) in 15 (7.6%) patients. Of the 64 (31.7%) cases where FNA was reported normal, 42 (65.6%) were accurate and 22 (34.3%) were inaccurate (final diagnosis: 8 cancer, 9 sarcoidosis and 5 TB). In 4 (2%) patients, FNA showed other diagnoses (3 anthracotic LNs, 1 sinus histiocytosis). Abstract PWE-221 table 1 Overall and condition specific results of mediastinal EUS-FNA.

Abstract PWE-221 Table 1

	EUS-FNA result (n)	Final clinical diagnosis (n)	Sensitivity (%), (95% CI)	Specificity (%), (95% CI)	PPV (%)	NPV (%)
Malignancy	61	74	82.4 (71.4 to 89.9)	100	100	90.2
Sarcoidosis	40	49	83.3 (69.2 to 92)	99.3 (95.7 to 99.9)	97.5	94.8
Tuberculosis	15	24	62.5 (40.7 to 80.4)	98.8 (95.3 to 99.7)	88.2	94.9
Other diagnosis	4	6	–	–	–	–
Overall	120	153	79.4 (71.8 to 85.5)	93.8 (82.1 to 98.4)	97.4	60.5

**Conclusion** Our large series on mediastinal EUS-FNA shows that it is an important and useful tool for the assessment of mediastinal lymphadenopathy of unknown aetiology and has overall high sensitivity ( $\approx 80\%$ ) and high specificity ( $\approx 94\%$ ). For sarcoidosis in particular, sensitivity ( $\approx 83\%$ ) and specificity ( $\approx 99\%$ ) of EUS-FNA is comparable to those for cancer.

**Competing interests** None declared.

#### PWE-222 AUDIT OF UPPER GI CANCER DIAGNOSIS BY ENDOSCOPY: ARE DIAGNOSES BEING MISSED?

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**Introduction** Gastric and oesophageal cancers have a high mortality rate, particularly if diagnosed at a late stage. We aimed to determine whether Upper Gastrointestinal (UGI) cancers are being missed either endoscopically or histologically in Leeds, and the reasons for any delays identified.

**Methods** As part of our rolling annual audit programme, histopathology records were gathered for all UGI cancers detected between September 2009 and August 2010 at Leeds Teaching Hospitals Trust. The endoscopy database was searched for endoscopies in the previous 3 years and the Trust Patient Pathway Manager reviewed for possible delays to diagnosis. Patients were classified into <1 month (m) from most recent endoscopy (delay not significant) and >1 m (possible significant delay). Previous biopsies were reviewed by a consultant histopathologist.

**Results** 211 cases of UGI cancers were detected (range 25–94 years, mean 70 years, 1.89:1 M:F) representing malignancy in 6.1% of 3460 endoscopies with gastric/oesophageal biopsy. Excluded from further study were: no endoscopy report (13); follow-up of previous diagnosis (38); not primary adenocarcinoma (12). 16/148 (10.8%) cases

had had endoscopy within the last 3 years, 6/16 (37.5%) had repeat endoscopy within 1m (mean delay 16.2 days). Reasons included: (2) suspicious endoscopy without histological confirmation of malignancy, (1) previous failed intubation, (1) follow-up of oesophageal ulcer. Of the 10 cases with previous endoscopy >1 m earlier, preventable delays were identified in six cases: Bleeding GU not biopsied at index endoscopy (42 days); failure to biopsy GOJ nodule due to triple anti-platelet therapy (91 days); a patient with known High Grade Dysplasia awaiting cardiology opinion before repeat under general anaesthetic (192 days); delayed surveillance interval for Barrett's Oesophagus (1035 days from previous endoscopy). Only in two cases was the cancer likely to have been missed on the first endoscopy: delayed follow-up after EMR, synchronous gastric carcinoma in separate site (180 days) and repeat endoscopy for symptomatic dysphagia (SCC in high oesophagus) (526 days). The other 4 cases had endoscopies unrelated to the subsequent diagnosis more than 2 years earlier and the delay was considered unavoidable. Review of previous biopsies, including further stains, showed that no malignant diagnosis had been missed.

**Conclusion** 6/148 (4.1%) patients had significant potentially avoidable delays to diagnosis of upper GI cancer. This is commensurate with audits in other centres. Most delays are systematic problems with bookings and appointments rather than endoscopic misses. We believe this simple rolling audit should be adopted as a mandatory Quality Assessment tool for MDTs and/or endoscopy units in order to improve delays in the diagnosis of UGI cancer in all hospitals.

**Competing interests** None declared.

#### PWE-223 GASTROENTEROLOGY INVESTIGATIONS FOR IRON DEFICIENCY ANAEMIA (IDA) IN PATIENTS WITH ACUTE CORONARY SYNDROME AWAITING CARDIAC INTERVENTIONS. HOW GOOD ARE OUR CARDIOLOGY COLLEAGUES?

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**Introduction** Anaemia is associated with increased risk of morbidity and mortality in patients with ischaemic heart disease (IHD) and heart failure. Incidental anaemia in patients awaiting coronary interventions is common particularly in our elderly populations. Currently there are no clear guidelines how to investigate these patients. The elderly patients have a higher RR of having occult GI malignancy and endoscopy is the gold standard to identify early disease. Majority of the physicians refer patients with anaemia to gastroenterologists routinely to exclude GI pathology. Endoscopic investigations are however not without complications and generally contraindicated during acute coronary syndrome.

**Methods** This is a retrospective analysis of patients with anaemia admitted with acute coronary syndrome to our hospital. Information was collected from patient records and endoscopy reporting database over a period of 2 years (January 2009–December 2010). We analysed all the investigations, outcomes/diagnosis of these patients. The data were analysed by Standard statistical methods.

**Results** A total of 230 patients were identified by the coding department with anaemia and IHD who were admitted over a period of 24 months. However, only 61 (26.5%) patients were investigated for anaemia. The mean age was 70±19 years with 77% (47/61) were more than 60 years of age. Serum Ferritin was checked in only 50% (31/61) of these patients before referral, out of which 71% (22/31) patients had low levels. Coeliac serology was done in only 5% (3/61) patients, which was normal. 75.5% (46/61) of the