

that traditionally quoted (1). The true complication rate of flexible sigmoidoscopy is of particular importance as the UK is introducing the Bowel Cancer Screening Programme (BCSP) by which all citizens will be offered the procedure at age 55.

Methods The aim of this study was to identify the morbidity and related healthcare costs of unexpected hospital attendance following outpatient flexible sigmoidoscopy. An observational study of A&E attendances and admissions occurring within 14 days of all outpatient flexible sigmoidoscopies which took place in 2011 was conducted. All procedures took place at West Middlesex University Hospital, London. Data was collected using the hospital's electronic records system, enterpriseCAMIS®. Cases were analysed to assess whether reattendance could be attributed to the procedure, and healthcare costs were determined.

Results Of the 1137 outpatient flexible sigmoidoscopies performed, 18 patients (1.58%) presented to A&E within 14 days. Only 2 of these attendances were thought to be related to the procedure (0.18%). 1 case resulted in a 5 day admission due to bleeding post polypectomy. The second A&E attendance was also due to bleeding. The cost of the above admission was £4,682. Including the related A&E attendance, the total financial burden of related reattendance following flexible sigmoidoscopy was approximately £4,827 in 2011. This equates to an additional cost of £4.25 per procedure.

Cost of hospital attendance within 14 days of outpatient flexible sigmoidoscopy (WUMH 2011, n = 1137):

Abstract PWE-033 Table

	Total A&E Attendances	A&E Attendances Related to procedure	Admissions Related to procedure	All episodes related to procedure
Number	18	1	1	2
Average Cost Per Attendance	£145	£145	£4,682	£2,413.50
Total Cost	£2,610	£145	£4,682	£4,827

Conclusion This study suggests outpatient sigmoidoscopy is relatively safe, with complications necessitating reattendance occurring following 0.18% procedures. The financial burden of hospital reattendance within our UK based study population was minimal, supporting the cost effectiveness of extending services for National bowel cancer screening programmes.

Disclosure of Interest None Declared.

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PWE-034 DIAGNOSTIC YIELD AND SAFETY OF 'BITE ON BITE' TUNNELED BIOPSY FOR SAMPLING OF UPPER GASTRO-INTESTINAL SUBMUCOSAL LESIONS

doi:10.1136/gutjnl-2013-304907.323

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Introduction Submucosal lesions are detected incidentally in a small proportion of diagnostic upper gastro-intestinal endoscopies. Endoscopic ultrasound guided fine needle aspiration (EUS-FNA) and endoscopic submucosal resection (ESMR) are useful diagnostic investigations for the assessment of such submucosal lesions with studies reporting diagnostic yields of 42% - 92% and 87% respectively.^{1,2,3} However, access to these techniques is usually limited to

specialist centres and they can have complications, with bleeding rates for ESMR ranging from 0–24%.³ The diagnostic yield with standard sized biopsy forceps is recognised as very low when assessing submucosal lesions.³ However, there is some evidence that this diagnostic yield might be increased to 17–38% by using a repeated “bite on bite” technique with larger capacity forceps.³

Methods We evaluated the diagnostic yield and safety of “bite on bite” tunnelled biopsy in diagnosing submucosal lesions found on upper gastro-intestinal endoscopy.

Data from 30 patients who underwent tunnelled biopsy was prospectively collected over an 18 month period. The acquisition of tissue required repeated biopsies consisting of 6 bites from the same point using a biopsy forceps with an open jaw diameter of 7mm (Radial jaw 4 large capacity, Boston Scientific).

Results 30 patients were included; (18 male, median age 60 years: range 31–79). The diagnostic yield on tunnelled biopsy was 7/30 (23.33%). Positive sample sites were: 4/12 oesophageal (1 mycobacterium tuberculosis, 3 leiomyomas), 0/13 gastric, 3/5 duodenal (1 pancreatic tissue, 2 endocrine carcinomas). No sampling led to bleeding requiring additional therapy to gain haemostasis. No patient required readmission with complications related to tunnelled biopsy within 30 days of their procedure.

Conclusion The tunnelled ‘bite on bite’ biopsy technique produced a low positive diagnostic yield of 23.33% when compared to EUS-FNA and ESMR. However, there were no complications with this method. Despite its low yield, tunnelled biopsy could still be considered as an initial diagnostic method for investigating incidental submucosal lesions as it is inexpensive to perform, safe and universally available.

Disclosure of Interest None Declared.

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PWE-035 THE INTRODUCTION OF A WEEKLY GENERAL ANAESTHETIC ERCP LIST IMPROVES DESIRED DUCT CANNULATION AND DUCT DRAINAGE RATES

doi:10.1136/gutjnl-2013-304907.324

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Introduction ERCP remains a key, but potentially complex endoscopic modality. ERCP procedures can be prolonged and consequently require higher dose and longer duration of conscious sedation. The use of anaesthetist-led deep sedation or general anaesthesia (GA) has been clearly demonstrated as a safe alternative to the use of conscious sedation^{1,2}. However, the effect of general anaesthesia on the success of ERCP has not been well studied. The aim of this study was to examine the impact of the introduction of a weekly anaesthetist-led GA ERCP list on the successful completion of ERCP.

Methods The data for all ERCP procedures performed within our unit was retrieved from the local endoscopic database covering the period one year before (BGA) and one year after (AGA) introduction of a weekly GA ERCP list in January 2012. Data regarding selective cannulation rates, patient and endoscopist demographics and complications were analysed. Success at ERCP was defined as selective deep cannulation of the targeted duct and the successful drainage of obstructed systems when required.

Results A total of 713 ERCP cases were examined. ERCPs were performed by 3 experienced endoscopists within a single endoscopy