

unit. 357 cases were performed prior to regular GA list introduction and 356 cases after. There were 28 cases performed under GA in the BGA group and 81 in the AGA group ($p < 0.01$). There was no statistical difference in patient age or gender ratio.

Following the introduction of regular GA ERCP lists, the overall procedural success rate increased from 94.7% to 98.3% ($p < 0.01$). Procedural failure did not occur in any of the 109 cases performed under GA. Reasons for failure at ERCP were multiple, with sedation failure directly quoted in 3 of the 25 cases. Use of sedation reversal agents was lower in the AGA group (8 vs 1 cases, $p < 0.05$).

Conclusion The introduction of a weekly general anaesthetic ERCP list has improved desired duct cannulation and drainage success within our endoscopy unit. This advantage of anaesthetist-led sedation has not been previously demonstrated. The mechanism of improved success is likely to be multi-factorial in origin. Although agitation and sedation failure were cited in only a minority of procedural failures, we believe the increased control and safety afforded allows the endoscopist to successfully perform more challenging interventions. These data may support the wider introduction of anaesthetist-led sedation/general anaesthesia for ERCP.

Disclosure of Interest None Declared.

REFERENCES

1. Bo LL *et al.* Propofol vs traditional sedative agents for endoscopic retrograde cholangiopancreatography: a meta-analysis. *World J Gastroenterol.* 2011 Aug 14; 17(30):3538–43.
2. Garewal D *et al.* Sedative techniques for endoscopic retrograde cholangiopancreatography. *Cochrane Database Syst Rev.* 2012 Jun 13; 6:CD007274.

PWE-036 CLINICAL PRESENTATION, CAUSES AND OUTCOME OF ULCERS IN ILEO-CECAL REGION: A PROSPECTIVE STUDY FROM A TROPICAL COUNTRY

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Introduction Ulcerations in the ileo-cecal (IC) region may have various causes and outcome, depending on the geographical region of the patients. Such data is scarce from tropical countries.

Methods To evaluate the clinical, endoscopic and histologic characteristics of ileocecal ulcers in a tropical country. Prospective study of consecutive patients undergoing colonoscopy, and diagnosed to have ulcerations in the IC region presenting at an tertiary care centre. All patients underwent endoscopic documentation. Biopsy was obtained and their clinical presentation and outcome were recorded.

Results Out of 1632 colonoscopies performed in our hospital from May 2010 to October 2011, 104 patients had ulcerations in the IC region. This population represents the study group. The median age was 44.5 years (range 18–85) and 59% were male. The predominant presentation was lower GI bleed (55.5%), pain abdomen +/-diarrhoea (36.3%), diarrhoea alone (9.9%), or miscellaneous (4.4%). Associated fever was present in 32 (31%) patients. On colonoscopy, terminal ileum could be entered in 96 (92%) cases. The distribution of ulcers was as follows: Ileum alone 40% (38/96), cecum alone 33% (32/96), and both ileum plus cecum 27% (26/96). In the 8 patients in whom ileum could not be entered ulcerations were present in the cecum and the IC valve. The ulcers were multiple in 98% and in 34% there were additional ulcers elsewhere in colon. Based on clinical presentation and investigations, the aetiology of ulcers was classified into infective causes (43%), non-infective causes (29%), and non-specific ulcers (28%) (Table). With infective cause, fever was significantly more common (47% vs 19%; $p < 0.01$) and cecum was preferentially involved (82% vs 45%; $p < 0.01$). Three patients (3%) died (all had presented with bleed and had non-specific ulcers), and 8 patients (8%) required surgical treatment. The remaining 93 patients (89%) had an uneventful recovery.

Conclusion Unlike in Western countries the most common (> 40%) cause of ulcerations of the IC region in the tropics is infections. Cecal involvement and fever are important clues to infective cause. These causes must be kept in mind while treating IC ulcers in patients from the tropics.

Disclosure of Interest None Declared.

PWE-037 "BEAR-CLAW" OR OVER-THE-SCOPE -CLIP SYSTEM (OTSC); A BREAKTHROUGH, SURGERY SAVING, ENDOSCOPIC DEVICE

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Introduction The "bear-claw" or over-the-scope clip system, OTSC (Ovesco Endoscopy, Tübingen, Germany) is a new clipping device developed for closure of large luminal gastrointestinal (GI) defects.

Methods To evaluate the clinical outcomes of patients treated with the OTSC a prospective, single-arm, pilot study was conducted in a regional hospital with tertiary care endoscopy. This study involved 11 clip applications in 10 patients (median age 76.2 years [range 52–89 years], 5 women) with GI defects from fistulas and anastomotic dehiscence and peptic ulcer bleeding.

Results Bleeding posterior duodenal wall ulcers ($n = 4$), bleeding gastric ulcer ($n = 2$), three fistulas or anastomotic dehiscences ($n = 4$) were treated using the OTSC-system. In addition a self-expanding metal stent was anchored securely in place with an OTSC-system. The diameter of ulcers and/or leaks ranged between 12 and 20 mm. A complete sealing of leaks was achieved in 3/4 patients. There were no clip complications. However, during introduction of the loaded clip on the tip of the endoscope, the hood tended to migrate over the scope, i.e. retracting, thus diminishing the exposed hood. This leads to diminished tissue suction and closure. Thus we modified the technique by tightly taping the hood on the tip of the scope. This trick may explain why all our cases were successful.

Conclusion The OTSC system is a useful device in a variety of clinical scenarios including the management of larger GI leaks, GI bleeding and stent anchoring, even in very old and frail patients.

Disclosure of Interest None Declared.

PWE-038 PATIENT CONTROLLED PROPOFOL – DO WE NEED AN ANAESTHETIST?

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Introduction Propofol is widely used during endoscopy but there remains controversy around its safety, if administered by non-anaesthetists. In a review of endoscopist-administered Propofol of 600 000 patients, only four deaths were reported. Patient-controlled Propofol sedation (PCPS) has been used during ERCP with lower sedation scores reported. We therefore piloted the use of PCPS in an unselected population attending for ERCP.

Methods PCPS was used in eleven patients undergoing ERCP. Propofol 8mg/ml and Remifentanyl 10mcg/ml was administered via a patient controlled pump, under the guidance of trained anaesthetic staff. Outcomes included completion and safety. Adverse events were defined as saturations < 90% or systolic < 90mmHg. Recovery was measured using the Aldrete score.

Results There was no difference between baseline demographics between the groups. In those undergoing PCPS, mean procedure