indicated uncertainty about the correct techniques to use and 2.5% lacked confidence in managing immediate complications. Lack of formal training in endoscopic submucosal dissection was mentioned as a constraint to practise by 40% of responders. Overall 58% indicated they would welcome a national training scheme for complex polypectomy.

Conclusion Less than half of this self-selected group of experienced colonoscopists felt they had been formally trained in advanced polypectomy. Lack of confidence appears to limit practise. Some of this stems from uncertainties that could be addressed through guidelines and formal courses in advanced polypectomy. There is support for a national training programme in this area.

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PWE-046 EARLY CLINICAL EXPERIENCE OF ENDOCLOT™ IN THE TREATMENT OF ACUTE GASTRO-INTESTINAL BLEEDING

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Introduction EndoClot™ is a new novel haemostatic powder for the treatment of gastrointestinal bleeding. We report our initial experiences of EndoClot™ as an adjunct haemostatic therapy. This is the first UK report of its endoscopic use in gastrointestinal bleeding.

Methods EndoClot™ was used as an adjunct therapy in the treatment of continued bleeding following a therapeutic intervention, either for acute upper gastrointestinal bleeds, or after elective endoscopic mucosal resections. Up to 1g of AMP® (absorbable modified polymers) was applied in each patient using the EndoClot™ air compressor and applicator.

Results EndoClot™ was used in a total of 6 patients, (5 men, 1 woman; aged between 49 and 83 years, mean age 68 years). In 2 patients, EndoClot™ was applied following endoscopic mucosal resection of a rectal polyp after bleeding was not resolved with cautery. In a further 2 patients, EndoClot™ was applied over a duodenal ulcer with endoscopic stigmata of recent haemorrhage when there was residual bleeding despite adrenaline injection and gold probe cautery. In another patient, EndoClot™ was applied following clipping of a spurting vessel at the gastro-oesophageal junction (likely Mallory-Weiss tear). In these 5 patients, application of EndoClot™ resolved any continued bleeding. There was also no rebleeding within 14 days of the procedure, no mortality or major adverse events.

A sixth patient had EndoClot™ applied to what was first thought to be a duodenal ulcer with a probable vessel, when there was residual bleeding despite adrenaline injection and gold probe cautery. This patient was re-scoped the following day after further bleeding and subsequent investigations confirmed a carcinoma of the pancreatic head with duodenal infiltration.

Conclusion EndoClot™ appears to be a safe and effective adjunct to existing therapies in the treatment of gastrointestinal bleeding. Large prospective studies are required to establish its exact role alongside established methods of haemostasis.

Disclosure of Interest None Declared.

PWE-047 A PROSPECTIVE, COMPARATIVE AUDIT OF TWO COMMONLY USED, LOW VOLUME BOWEL PREPARATIONS FOR ROUTINE COLONOSCOPY: MOVIPREP VERSUS A SENNA AND CITRAMAG COMBINATION

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Introduction Colonoscopy is the principal therapeutic tool for colorectal cancer prevention. Adenoma removal has been shown to decrease the incidence of colorectal cancer in screened populations. Good visualisation of the entire colonic mucosa is essential for high rates of adenoma detection. The optimal preparation regimen for bowel preparation has not yet been defined.

Methods The aim was to assess the effectiveness of different regimens for bowel preparation, comparing low volume polyethylene glycol (Moviprep, Norgine, UK) with senna and magnesium citrate (Citramag, Sanochemia Diagnostics UK). Split dosing was used for afternoon appointments. All patients received instructions on dietary restrictions before the procedure.

Those undergoing colonoscopy in the first month of the trial were given senna and magnesium citrate; those in the following month were administered Moviprep unless there were contraindications to the intended bowel preparation. The quality of the bowel preparation was independently assessed using the validated 10-point Boston Bowel Preparation Scale (BBPS) by nurses trained in its use.

Results Patients who had undergone segmental colectomy were excluded. In total, 580 eligible procedures were performed. 251 patients received Moviprep; 326 were given senna and Citramag. Bowel cleansing with Moviprep was statistically superior in each assessed segment of the colon as well as overall (mean score 6.56, $p = 0.027$). Patients given Moviprep were more likely to have a perfect preparation score of 9 ($p < 0.001$). The reasons for failure in patients who were not fully imaged were recorded. 3 procedures were aborted due to poor bowel preparation; all of these patients received Moviprep ($p = 0.08$). The patient-assessed taste of Moviprep was significantly worse than senna and Citramag ($P < 0.001$). There was no significant difference between both groups with regards to age, sex or percentage of patients who finished the preparation ($p = 0.14$).

Abstract PWE-047 Table

	Moviprep	Senna/Citramag	p value
Left colon	2.22	2.12	0.036
Transverse colon	2.18	2.08	0.036
Right colon	2.10	2.01	0.05
TOTAL	6.56	6.20	0.027

Key: 3 = perfect preparation, 2 = minor amount of residual staining, 1 = portion of mucosa of the segment seen, 0 = unprepared segment

Conclusion These data – the largest in the literature comparing these two preparations – show that both produce acceptably high levels of bowel cleansing for colonoscopy. Moviprep appears to cleanse slightly better throughout the colon but was judged by patients to be less palatable.

Disclosure of Interest K. Patel Grant/Research Support from: Norgine provided the Moviprep gratis. No input into study design, data collection, analysis, or writing of the abstract., R. Fofaria: None Declared, S. Thomas-Gibson: None Declared, B. Saunders: None Declared

PWE-048 AN EVALUATION OF SCREENING COLONOSCOPISTS' PERFORMANCE AFTER A STRUCTURED ACCREDITATION PROCESS

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Introduction Colorectal cancer screening with colonoscopy has been shown to reduce mortality by removal of adenomatous polyps with potential for malignant change. Colonoscopists with higher adenoma detection rates have lower rates of interval cancer. The

Bowel Cancer Screening Programme offers colonoscopy to subjects aged 60–74 after a positive faecal occult blood test (FOBT). All colonoscopists have to be screening-accredited with a lifetime log of over 1000 colonoscopies with certain minimum key performance indicators and then undergo a formal structured assessment process during which they are observed performing 2 colonoscopies by trained assessors.

Methods The aim was to assess how performance varied in this highly selected group of colonoscopists in the 12 months after they commenced screening. 139,363 procedures were performed between June 2006 and March 2012 by 245 colonoscopists. Data were collected on caecal intubation rate (CIR), the adenoma detection rate (ADR), the mean number of adenomas detected per patient (MAP) and the number of procedures performed by each colonoscopist.

Results Colonoscopists were divided into quartiles by performance for CIR and ADR. The mean CIR in the top quartile was 98.6% compared to 91.4% in the lowest quartile. The mean number of procedures in the first year of screening was 141 and 123 respectively (t-test $p = 0.055$); there was a correlation between the number of procedures performed and CIR (Pearson's $r = 0.196$, $p = 0.002$). There was a significant difference in the number of procedures performed in the previous year before commencing screening (266 compared to 201, $p = 0.02$). There was no significant difference in the ADR ($p = 0.48$), pain caused, years of experience or number of lifetime procedures. There was no correlation between CIR and ADR ($r = 0.001$, $p = 0.982$). The mean ADR in the top quartile was 56.8% compared to 39.8% in the lowest quartile. There was no significant difference between these groups in the CIR, pain or any other measure from the lifetime procedure log. There was a significant difference in the MAP (1.64 compared to 0.77, $p < 0.01$). Overall there was a strong correlation between ADR and MAP ($r = 0.59$, $p < 0.001$).

Conclusion These data show that even in a stratified group of high-performing colonoscopists there is considerable variation in performance in CIR, ADR and MAP. There was no correlation between CIR and ADR but a significant association between CIR and the endoscopic activity the previous year. Colonoscopists performing more procedures in their first year screening patients did not have higher adenoma detection rates. Further studies are needed to ascertain the factors responsible for these differences to try to further improve performance and patient outcomes.

Disclosure of Interest None Declared.

PWE-049 FIVE YEAR RETROSPECTIVE MORBIDITY AND MORTALITY FIGURES FOR COLONOSCOPY IN A DISTRICT GENERAL HOSPITAL

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Introduction Between 1 July 2007 and 31 August 2012, 15284 colonoscopies were performed by Gastroenterologists, Colorectal Surgeons, Gastroenterology and Surgical trainees and Nurse Endoscopists. Over the 5 year period our unit has an average caecal intubation rate of 93.53% and polyp detection rate of 36.54% demonstrating colonoscopy performance that meets current national guidelines for performance indicators in endoscopy. The current JAG guidelines for complications of colonoscopy are perforation rate < 1:1000, post polypectomy bleeding requiring transfusion < 1:100 and post polypectomy perforation < 1:500.

Aim To determine the complication rate and 30 day mortality of colonoscopy performed in a district general hospital (DGH).

Methods Using the hospital IT system and a coding search, patients were identified if they had died within 30 days, were readmitted or went to theatre within 8 days of a colonoscopy. Case notes were then reviewed to assess if any event was directly related to the procedure or intervention undertaken.

Results In the 62 month period one death occurred from sepsis due to perforated diverticular disease (DD) (1/15284). In this time frame 4023 patients were diagnosed with DD giving a risk for perforation and death in DD of 1:4000.

Perforation: occurred in 13 patients (1:1175), the causes listed in table 1.

Abstract PWE-049 Table 1 Causes of perforation

Cause	Number	Rate for finding/intervention
DD	4	4/4023 DD - 1:1000
Polypectomy	6	6/5966 pts - 1:1000
APC	2	2/115 APC - 1:63
Retroflexion post APR	1	

One patient with Crohn's disease of the terminal ileum (TI) developed severe pain post procedure requring a laparotomy where the cause was found to be tearing of an adhesion to the TI, no perforation was seen 1/15284.

Bleeding Polyps were found in 5966 patients. Post polypectomy bleeding requiring admission occurred in 27 patients (1:220 patients). 18 were observed for 24–48 hours without any intervention. 9 required transfusion (1:663). Of these patients, one required a right hemicolectomy for haemostasis and one required angiogram and embolisation, the remaining managed conservatively. Post biopsy bleeding occurred in 4 patients out of 8702 who were biopsied (1:2175)

Post polypectomy syndrome occurred in 3 patients of 5966 patients with polyps (1:2000)

Pain post colonoscopy requiring admission occurred in 12 patients (1:1273). Pain was attributed to air insufflation with radiology excluding perforation.

Bowel preparation with Fleet resulted in one patient developing end stage renal failure due to phosphate nephropathy (1:4715), This preparation is no longer in use.

Conclusion Few papers are published on the complication rates of colonoscopy at DGHs. This data gives valuable long term insight into the rate of serious complications and demonstrates safe colonoscopy at this DGH within current JAG Guidelines.

Disclosure of Interest None Declared.

PWE-050 AN EVALUATION OF PATIENTS REFERRED TO GASTROENTEROLOGY ANAEMIA CLINIC

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Introduction Iron-deficiency anaemia in adults is a common cause of referral to gastroenterologists (4–13% of referrals). NICE guidelines, UK provides clear recommendations regarding upper and lower gastrointestinal investigations for such patients including coeliac and urine screening. The aim of this audit is to conduct a snapshot review of anaemic patients seen in gastroenterology anaemia clinic conducted by specialist nurses with consultant gastroenterologists input in a DGH to assess adherence to the NICE guidelines and to highlight changes in clinical practise that may be required, with implications for service development.

Methods Retrospective study involving 90 new patients referred predominantly from primary health care (92%) between July to September 2012.Of the 90 patients referred, 84 patients in the age range of 30–90 attended the clinic of which 53% were females.

Results The mean HB was 10.8 & 80% of the patients had ferritin level of less than 45. Of them 14 patients (16%), all referred from