procedure related or associated deaths being rare. GI cancers are twice as likely to be associated than non-GI cancers.

Disclosure of Interest None Declared.

PWE-057 STENT PLACEMENT IN PALLIATIVE OESOPHAGO-GASTRIC CANCER: CHANGED PRACTICE WITH IMPROVED OUTCOMES

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Introduction Oesophageal cancer is often diagnosed late in its pathological process and as a consequence management is often focussed on palliation of symptoms. The insertion of oesophageal stents tend to occur in small numbers and as such any individual endoscopist will perform only a few in a given time period. In this study we aim to establish whether by limiting this procedure to a few operators we can improve outcomes by increasing operator experience.

Methods This is a retrospective review of palliative stenting in patients with advanced oesophageal and oesophagogastric cancers across East and North Hertfordshire NHS Trust in the 15 month period from 1st April 2011 – 31st July 2012. We audited endoscopy reports and our prospectively maintained Upper Gastrointestinal Cancer database for any reported post procedural complications and calculated 7, 14 and 30 day mortality rate for these cohort patients. We also re-audited complications following stent insertion from March 2010–2011 where stents were performed by the first available gastroenterologists. Results were analysed according to BSG Quality indicators and compared with National Oesophagogastric cancer Audit 2010.

Results 20 patients had palliative stents with in this time period. The median age was 74 and male to female ratio is 3:2. 70% of cases were adenocarcinoma and 20% were Squamous cell carcinoma. The combination of pharyngeal anaesthesia and sedation were used only in 10% (n = 2) compared to 21% last year. Procedures carried under fluoroscopy guidance were 100% compared to 36% nationally. Boston Scientific Ultraflex covered metal stents were used in 95% of patients. All the stents were deployed successfully. No reported complications of stent migration (compared to 12% migration rates last year), perforation and haemorrhage post procedure. This was achieved with two gastroenterologists with special interest performing the procedure compared to five consultants last year. Our 7, 14 and 30 day mortality are as shown in the graph below.

Conclusion We use laser therapy first line where appropriate. This usually achieves a better dysphagia grade than stenting initially. This means that our patients have been palliated for several months before stents are inserted. Despite this patient selection seems to be appropriate as most survived more than 30 days. No complications were noted with insertion and post stent, this was a major improvement from last year's audit. From this study we have demonstrated that by treating oesophageal stent insertion as a specialist procedure, with dedicated operators we are able to minimise complication rates.

Disclosure of Interest None Declared.

PWE-058 TISSUE ACQUISITION FROM SOLID PANCREATIC LESIONS – ENDOSCOPY OR SURGERY

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Introduction The accurate diagnosis of solid pancreatic masses is important in directing appropriate management of patients. The methods commonly used are percutaneous, laparoscopic and EUS guided biopsy of these lesions. Laparoscopic guided biopsy consumes theatre time and space and can be more expensive than the alternatives. In our unit; laparoscopic guided biopsy is reserved for patients who have an inconclusive result from an EUS guided biopsy or are considered for trial resection. The aim of this study was to look at the diagnostic performance of endoscopic ultrasound (EUS) guided biopsy (fine needle aspiration (FNA) or pro-core biopsy) and laparoscopic (lap) guided biopsy of solid pancreatic masses in a large HPB referral centre.

Methods Retrospective review of patients undergoing EUS or laparoscopic guided biopsy for solid lesions between January 2011 and March 2012. Data was obtained from a dedicated prospectively maintained database in the histopathology department. Final diagnosis was based on positive histology/cytology of pancreatic adenocarcinoma. Benign cases were followed up for a period of at least six months.

Results 464 specimens from the pancreas (histology + cytology including pancreatic resections) were received by the histopathology department during this period. Of these 275/464 (59%) patients had tissue biopsy of solid lesions.

These included: EUS guided biopsy = 253 and Laparoscopic guided biopsy = 22.

In the latter group; 10/22(45%) had a previous EUS of which 8/10 had an accurate diagnosis. 12/22(54%) patients went straight for laparoscopic guided biopsy. For the purposes of this study; highly suspicious and malignant samples were categorised as malignant. The accuracy, sensitivity and negative predictive value for EUS guided biopsy and laparoscopic guided biopsy were 92%/96%; 90%/94% and 74%/89% respectively. The inadequate aspirate rate was 5% and 0% respectively. There was no significant difference between the two groups. The cost of performing these procedures in our trust were: EUS guided biopsy £1094 and lap guided biopsy £ 2164.

Conclusion In our unit;EUS guided biopsy of solid pancreaticobiliary lesions provides high diagnostic accuracy with a low inadequate aspirate rate. Our data supports the role of EUS guided FNA as the first modality of tissue acquisition from the pancreas. Though this data also shows the cost effectiveness of EUS guided biopsy over lap guide biopsy; in units with lower diagnostic accuracy of EUS guided biopsy the cost benefit may not be realised.

Disclosure of Interest None Declared.

PWE-059 SINGLE DOSE ENDOSCOPIC THROMBIN INJECTION FOR ACUTE VARICEAL BLEEDING

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Introduction Endoscopic Human Thrombin injection appears a technically simple yet efficacious alternative to cyanoacrylate for gastric varices with fewer complications from studies to date, but data remains limited. We evaluated the outcomes of patients following single thrombin injection treatment for acute bleeding from oesophageal and gastric varices.

Methods Retrospective review of patients receiving endoscopic human thrombin injection (Tisseel Baxter Intl Inc.) for active bleeding from varices at a UK centre 2011–2012.

Results 15 patients (67% male, mean age 56 (SD 10)), received human thrombin injection for actively bleeding varices. Mechanism of portal hypertension was alcoholic cirrhosis in 12 patients (80%), extra-hepatic in 3 (20%). Extrahepatic portal hypertension was due to cancer, portal vein thrombosis and splenic vein thrombosis respectively. Mean MELD was 15 (SD 6). Childs grade was A, B, C in 6%, 47% and 47% respectively. Bleeding varices were identified as gastric in 13 patients (87%), oesophageal in 2 (13%). These 2 cases were not amenable to further banding due to band-induced fibrosis.

Gastric varices were classified as: GOV1 4 (31%), GOV2 6 (46%), IGV1 3(31%). There were co-existing oesophageal varices in 9 of 13 (69%), of which 3 were banded in addition but not actively bleeding. Mean thrombin dose used was 1125IU (range 500–2000). Immediate haemostasis was achieved in all 15 cases. Propanolol was commenced post endoscopy in 14 (93%) patients and maintained at a mean dose of 80mg/day (SD 35, range 20–160).

Median follow up time was 129 days (range 9–753). No patient received TIPSS or liver transplantation. Rebleeding occurred in 3 (20%) patients, at 14, 43 and 299 days respectively. All 3 patients died following rebleeding (2 declined treatment, 1 pre-hospital arrest). There were 7 deaths in total during the study period, the remainder due to liver failure (2), pneumonia (1), metastatic cancer (1). Cumulative survival at 1, 3, 6, 12 months was 73%, 59%, 59%, and 50% respectively.

Conclusion Single dose thrombin injection in our series appears to be a safe, easily administered and effective endoscopic therapy for acutely bleeding oesophagogastric varices. Mortality however remains high due to their underlying liver disease.

Disclosure of Interest None Declared.

PWE-060 THE HOSPITAL ANXIETY AND DEPRESSION SCALE (HADS) PREDICTS PAIN AND DISTRESS AT ENDOSCOPY

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Introduction Tolerability of endoscopy is variable, with pain and distress influencing overall experience. Currently, there is a paucity of work evaluating distress, with no reliable tools established as predictors of endoscopic tolerability. A recent study found higher levels of discomfort during colonoscopy in patients scoring 11 or more (out of a maximum of 21) on the anxiety portion of the HADS questionnaire evaluated post-procedure.[1] Our study evaluates the pre-endoscopic use of HADS and its value in predicting procedural pain and distress.

Methods Consecutive patients attending for clinically indicated OGD or colonoscopy were prospectively recruited between September 2011 and June 2012 at a University hospital. Prior to endoscopy, patients completed the HADS questionnaire and were familiarised with the 10-point numeric rating scale used to assess expected pain and distress and post-procedural pain and distress. Patients with high HADS anxiety scores (HADS≥11) were then compared with those with low scores (HADS≤10), with the cut off value of 11 defined in accordance with the original HADS paper.[2] Data was analysed using SPSS version 20, with a Mann Whitney U test used to determine differences between procedural pain and distress scores.

Results 610 patients were prospectively recruited (280 male patients, median age 56 years, range 17–90 years, 306 OGD's), with 21% (128/610) having HADS anxiety scores > 11. Of these individuals, 51% (65/128) had elevated procedural pain, with 53% (68/128) having elevated procedural distress. By comparison in patients with HADS anxiety scores < 10, only 32% (154/482) had elevated procedural pain and 37% (176/482) had elevated distress. Comparisons between the two groups (HADS≥11 and those with HADS ≤10) demonstrated significant differences ($p = 0.001$ for pain and $p < 0.001$ for distress). Median scores for the two groups are highlighted in Table 1.

Abstract PWE-060 Table 1 Median procedural pain and distress scores

	HADS anxiety score of 11+	
	Less than 10	11 or more
Median Procedural pain Score	3	5
Median Procedural distress Score	2	5

Conclusion This is the first study demonstrating how the HADS could be used to predict endoscopic tolerability, with HADS anxiety scores ≥11 associated with over a 50% chance of having procedural pain and distress. Adopting HADS into pre-endoscopy assessments could help identify patients likely to poorly tolerate endoscopy, leading to earlier consideration of sedation, analgesia and other endoscopic measures to minimise pain and distress.

Disclosure of Interest None Declared.

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PWE-061 ERCP PRACTICE IN A UK DISTRICT HOSPITAL– ARE WE MEETING THE STANDARDS?

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Introduction The 2004 NCEPOD report "Scoping our Practice"[1] had been highly critical of certain aspects of ERCP practise in UK, raising specific concerns about case selection and sedation practise. We analysed our own ERCP practise in a medium sized district hospital with a moderate case workload and a growing proportion of elderly population.

Methods Retrospective data was collected from 263 ERCPs performed between 2009–2011. Comprehensive information regarding demographics, indications, success and complication rates was recorded from ERCP reports and case notes and our practise was compared to NCEPOD recommendations.

Results 263 (n) ERCPs were included in this study. Median age was 72 (range = 16–98), 63% were females. 55% of patients were ASA grade 3–4. 84% of ERCPs were of grade 1 difficulty. All ERCP referrals were reviewed and authorised by a consultant gastroenterologist. Indications for ERCP were choledocholithiasis (63%), pancreatic or biliary malignancy with obstructive jaundice (18%), stent removal/replacement (10%), dilatation of biliary ducts with abnormal liver function tests (10%) and others (4%). > 90% of ERCPs were performed with a therapeutic intent and success was achieved in 86% of ERCPs at first attempt. Our successful cannulation rate was of 92%. Only 9.1% of cases were referred to tertiary centres for further management. Prophylactic oral ciprofloxacin was used in 60% of patients. Patients received a combination of midazolam and pethidine with a mean dose (±SD) of 3.2 mg (± 2.03) and 44.3 mg (±16.05) respectively. Reversal with flumazenil or naloxone was not required in any of the patients included in this study. Biliary sphincterotomy was performed in 60%(156), pre-cut sphincterotomy in 2.6%(7), stricture dilatation in 9.5%(25), biliary stenting 30.4%(80), balloon sphincteroplasty 3%(8), balloon trawl 67%(177) and mechanical lithotripsy 8.7%(23). 78.7% of malignant strictures were successfully stented (37). Overall complication rate was 5.7% - moderate haemorrhage requiring blood transfusion in 1.5%(4), post ERCP pancreatitis in 2%(6), sepsis 1.9%(5), duodenal perforation 0.7%(1) and respiratory arrest in 0.7%(1). 30 day mortality rate was 0.76%(2).

Conclusion In contrast to NCEPOD report, our audit demonstrates that ERCP practise is effective, safe and of high quality in a district general hospital setting. Complication and mortality rates are minimal and comparable to national standards, even in the elderly population. Post ERCP very low sepsis rate is most likely due to use of prophylactic antibiotics (Ciprofloxacin).

Disclosure of Interest None Declared.