Abstract PTH-049 Table 1

Bowel preparation	Unsatisfactory	Sub-optimal	Satisfactory
Total number of colonoscopies (N = 2649 (%))	90 (3)	351 (12)	2208 (85)
Total number of procedures finding polyps (N = 1539 (%))	43 (48)	194 (55)	1302 (59)
% right	32.6	39.2	42.1
Mean number of polyps found for all procedures	1	1.2	1.5
Mean number of polyps found on the right side	0.32	0.48	0.62
Mean number of polyps found on the left side	0.66	0.75	0.85
Total polyps > 0.9cm (N = 525)	8	80	437
Average number of procedures find a polyp > 0.9cm	11.5	4.4	5.1
Completion rate overall %	85	99	98

Conclusion 15% of procedures in our surveillance population have sub-optimal or un-satisfactory bowel preparation, making the interpretation of the clinical guidelines difficult.

Patients who have sub-optimal or unsatisfactory preparation have a high proportion of further sub-optimal or unsatisfactory procedures. Endoscopy units should have a strategy for improving this.

In patients with sub-optimal or unsatisfactory bowel preparation there is a significant reduction in overall polyp detection which is particularly marked in the right colon. This does not appear to be the case with larger polyps.

In patients with sub-optimal or unsatisfactory preparation undergoing a complete colonoscopy, shorter surveillance intervals should be considered taking other patient related factors into account.

Disclosure of Interest None Declared.

PTH-050 WHAT DO ENDOSCOPISTS DO WHEN NO CANCER IS FOUND ON GASTROSCOPY DONE FOLLOWING AN UPPER GASTROINTESTINAL TWO WEEK-WAIT REFERRAL WITH WEIGHT LOSS?

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Introduction For patients referred with suspected upper gastrointestinal (UGI) cancer under the 2 week-wait (2WW), it has been shown that 10.5% will have endoscopic evidence of malignancy, whilst 6.5% of patients may harbour malignancy elsewhere.[1] For those patients with weight loss, a negative gastroscopy for cancer poses an important clinical question for the endoscopist. There are no consensus guidelines advising the most appropriate 'next-step' the endoscopist should make following patients referred with weight loss but have a negative endoscopy for malignancy.

Aim To evaluate local and national practise in endoscopist decisions when no UGI cancer is found on gastroscopy in 2WW referrals with weight loss.

Methods All 2WW referrals for suspected UGI cancer with weight loss were identified from the 2WW office over a 6 month period at a district general hospital. Endoscopy and imaging results were obtained from the respective computer software packages. Questionnaires were made available to British Society of Gastroenterologists members asking them to reveal their initial management preference at endoscopy in patients referred under the 2WW with weight loss where no upper GI cancer was found.

Results Of the 639 2WW referrals in 6 months, 140 (22%) had weight loss. 6/140 (4%) were found to have either oesophageal or gastric malignancy. 134/140 (96%) did not have cancer, whilst 91 (65%) revealed benign pathologies such as gastritis, duodenitis and hiatus herniae and 43 (31%) were normal. Of the 134 negative endoscopies, the endoscopist took the following actions; 16 (12%) had urgent CT abdomen/chest organised (1 lung malignancy identified), 61 (46%) referred to an urgent Outpatient clinic and 40 (30%) were discharged back to GP. 17 (12%) follow up was to be determined by the list consultant.

71% questionnaire responses received were from consultants. 46% of responders' preference was to follow up in clinic, 39% organised an urgent CT scan, 18% an ultrasound scan and the rest a brief history to ascertain their preference. 10% discharged the patient back to the GP. 100% of responders had no local guidelines at their trust with regards to this group of patients, whilst 54% felt formal guidelines were warranted.

Conclusion Our study shows a large variation in practise amongst endoscopists and hence the potential to over or under investigate and its consequences. Formal guidelines seem warranted.

Disclosure of Interest None Declared.

REFERENCE

1. Wireko MB, Subramanian V, Ragunath K. The two week WAIT (2WW) referral for upper gastrointestinal cancer: predictors and prevalence of non-upper gastrointestinal cancers in those with negative gastroscopy. Gut 2011; 60:A47

PTH-051 SAFETY AND EFFICACY OF COLONIC STENTS (SEMS) FOR LARGE BOWEL OBSTRUCTION FROM PROXIMAL COLORECTAL CANCER

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Introduction Colonic stenting of proximal Colorectal Cancers (CRC) (lesions at splenic flexure or beyond) is technically challenging and currently out-favour as surgical techniques allow safe primary anastomosis on unprepared dilated colon. Consequently, randomised trials (RCTs) have only compared colonic self-expandable metal stent (SEMS) with emergency surgery for acute left sided obstruction. However, emergency surgery is associated with substantial morbidity and mortality.

Aim: To assess the safety and effectiveness of colonic SEMS for obstruction caused by proximal CRC.

Methods Retrospective case series by 2 Consultant Gastroenterologists between 2005 to 2012 was audited. All procedures were performed using Through the Scope (TTS) technique and fluoroscopic guidance. End-points were technical success (correct SEMS placement confirmed radiologically at time of procedure), clinical success (resolution of patient symptoms within 48 hrs), re-intervention, patient discharge and mortality.

Results Demographics 31 patients (Male: Female ratio 2.1:1); median age 85.5 years (range 40–92), mean ASA score 2.5. **Indications:** 84% (n = 26) were palliative and 16% (n = 5) were bridge to surgery. 48% patients had subacute obstruction, 10% had total obstruction, and extent of obstruction was unknown in 42%. Lesions were located at Splenic flexure (n = 15), Distal Transverse (n = 7), Proximal Transverse (n = 3), Hepatic flexure (n = 4), Ascending (n = 1) & caecum (n = 1).

Procedural Success Technical success was 100%. Clinical Success was 81% (n = 25) with these patients being successfully discharged without requiring any further procedures during their hospital stay. Re-intervention was required in 5 patients (16%) due to SEMS dysfunction; managed by re-stenting in 1 and colostomy in 3 patients (Bridge group). The remaining was a colostomy for the only perforation in series (3%). Further surgery was only required in the 2 patients within the bridge group who went onto have uncomplicated elective surgery with primary anastomosis.

Mortality There was no procedure related mortality (0%). All cause 30 & 90 day mortality was 13% & 38% respectively, all of