

At 5 years, 20% had died or developed malignancy and 80% were alive and well.

With the exception of diabetes, OR 0.24 (95%CI 0.1–0.8, $p = 0.02$), no other factors were found to be a significant risk factor for poor prognosis when the two groups were compared, including age, gender, haemoglobin level at presentation, persistent anaemia at 3 months, or other co-morbidities.

Only 3 patients developed colonic malignancy; in all 3 patients the anaemia had resolved at 3 months. Two patients had diverticular disease only at initial barium enema but presented 4 years later with colorectal cancer. One patient declined lower GI investigation and presented with metastatic colon cancer on CT scanning at 1 year.

No other GI cancers were diagnosed at 5 year follow up.

Conclusion This study demonstrates that this nurse led, protocol driven pathway is a highly effective and safe system for the exclusion of GI cancer with 5 years follow up and we would recommend implementation throughout the NHS.

Disclosure of Interest None Declared.

REFERENCE

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PTH-171 COLONOSCOPY PERFORMANCE IN EXTENDED THREE SESSION WORKING DAYS

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Introduction Three session working days were introduced in our endoscopy unit to accommodate the increasing demand for endoscopic procedures. There is evidence to suggest that caecal intubation rate (CIR) and polyp detection rate (PDR) declines as the day progresses in a standard two session working day. There is currently no literature on CIR and PDR for an extended 3-session working day. The aim of this study was to characterise the impact of endoscopist fatigue on quality of colonoscopy performance by comparing outcomes based on time of day and chronological procedure order for an extended working day.

Methods We conducted a retrospective audit of all colonoscopies undertaken in our unit between January and December 2011. In order to assess the effect of repetitive fatigue, endoscopy lists with < 3 colonoscopies were excluded. Time of colonoscopy was stratified into three categories by the starting time of the scheduled list – morning (AM), afternoon (PM), and evening (PM). Queue position was defined as the order that the colonoscopy was performed on the same list i.e. 1st, 2nd and so on. Data on potential confounders including age, sex, quality of bowel preparation (recorded on a three point rating scale of good, satisfactory and poor) were recorded. To evaluate the effect of endoscopist fatigue on colonoscopy performance, we analysed CIR and PDR according to time of day and queue position.

Results A total of 2520 colonoscopies were included, of which 1299 (51.5%) were male and 1221 (48.5%) female. The median age was 63 (interquartile range, IQR, 51–70). 1062 (42.2%) were performed in AM lists, 984 PM (39.1%) and 470 EVE (18.7%). CIR did not vary according to time of day (89.8, 90 and 89.5% for AM, PM and EVE lists respectively, $p = NS$). In multivariate analysis, CIR was adversely affected by age > 70, female gender, poor bowel preparation (all $p < 0.01$) but not queue position. PDR was not influenced by time of day or queue position. PDR was higher in men in multivariate analyses ($p < 0.01$).

Conclusion Colonoscopy quality is not dependent on time of day or queue position in an extended 3 session day. Our findings support

the provision of 3 session days to meet the increasing demand for colonoscopy.

Disclosure of Interest S. Subramanian Speaker bureau with: Shire, Dr Falk, Abbott, Conflict with: Advisory board for Abbott, Vifor Pharma, N. Haslam: None Declared, P. Collins: None Declared, S. Sarkar: None Declared

PTH-172 OUTCOME ASSESSMENT OF THE FIRST TWO YEARS OF A NEW OESOPHAGEAL HIGH RESOLUTION MANOMETRY UNIT WITHIN A DISTRICT GENERAL HOSPITAL

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Introduction Oesophageal high resolution manometry (OHRM) is a fast developing area of medicine. Whilst seemingly being at the “cutting edge” of technological advancement, it is a relatively simple procedure to perform and interpret. Its ability to demonstrate functional as well as anatomical abnormalities, has led to a range of new diagnoses and shed light on areas of previous clinical and management dilemma. Despite this, few hospitals outside of the large central teaching hospitals, have embraced this new technology.

Objective To assess the demand for OHRM within a district general hospital (DGH). To assess the reasons for referral and the general outcomes from the procedure.

Methods The Luton & Dunstable Hospital set up a new OHRM service in July 2009. Prospective procedure related information was stored on a HRM database. This database was analysed to assess total number of procedures performed, the reasons for referral and the diagnostic outcome of those procedures.

Results Over the course of the first 2 years, a total of 162 procedures were performed. Patients were referred in with a range of symptoms, often in combinations. Of these 162 patient 9 suffered dental problems, 31 had globus, 32 had persistent sore throat, 27 had chronic cough, 13 had nocturnal cough, 118 had endoscopic negative reflux-like symptoms, 40 had endoscopy negative dysphagia, 30 had atypical chest pains, 1 had persistent nausea, 24 had dysphonia and 2 were for reflux assessment. A wide range of diagnoses were made often in combination, including: - 52 with reduced LOS pressures, 18 with a small LOS, 58 with a hiatus hernia, 52 with acid reflux, 40 with non-acid reflux, 75 with oesophageal dysmotility, 23 with oesophageal spasm, 6 with hypertonic contractions, 19 with hypotonic dysmotility, 5 with achalasia type 2, 4 with achalasia type 3, 15 with a wide transition zone, 17 with transient LOS relaxation, 3 with poor pharyngeal co-ordination, 1 with food bolus, and 20 who were normal.

Conclusion OHRM is relatively simple procedure to perform and interpret. With its ability to diagnose both functional and anatomic abnormalities it has become an invaluable part of our DGH gastroenterology unit. Given the clear benefits over standard manometry, we believe that all patients throughout UK should have access to an OHRM service.

Disclosure of Interest None Declared.

PTH-173 INTRODUCTION OF THE TEAM BRIEF AND WHO SAFETY CHECKLIST IN ENDOSCOPY

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Introduction The World Health Organization (WHO) launched the Global Patient Safety Challenge, ‘Safe Surgery Saves Lives’¹, in 2008 with the aim of reducing the number of deaths and adverse events resulting from surgical procedures. Central to this initiative is the WHO checklist that covers the various phases of a procedure.