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

1. Goddard A *et al.* Guidelines for the management of iron deficiency anaemia. GUT 2010; 60: 1309–1316.

PTH-171 COLONOSCOPY PERFORMANCE IN EXTENDED THREE SESSION WORKING DAYS

doi:10.1136/gutjnl-2013-304907.658

[1,*]S Subramanian, [1]N Haslam, [1]P Collins, [1]S Sarkar. *[1]Gastroenterology, Royal Liverpool University Hospital, Liverpool, UK*

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

doi:10.1136/gutjnl-2013-304907.659

[1]N K Bhangu, [1,*]S C Shieh, [1]T Cacciattolo, [1]S Millman, [1]R Geary, [1]M W Johnson. *[1]Gastroenterology, Luton & Dunstable University Hospital, Luton, UK*

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

doi:10.1136/gutjnl-2013-304907.660

[1,*]S Vinnamala, [1]B Disney, [1]I Mohammed, [1]W Chapman, [1]E Fogden. *[1]Gastroenterology Department, Sandwell & West Birmingham Hospitals NHS Trust, Birmingham, UK*

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.

This checklist was modified and used for all endoscopic procedures performed in our trust.

The Aim of the survey was to gather opinions from endoscopy staff about the recently introduced team debrief and the modified WHO checklist for endoscopy in our trust. We aimed to assess the staff's perception of the impact of the checklists (positive or negative) on patient safety, communication and team behaviour, staff satisfaction and their general effectiveness. We also aimed to assess the need for training on the use of the checklists and their potential to drive improvement with an additional section for their comments. Responses were obtained from the different grades of staff including nurses, health care assistants, trainees and consultants.

Methods We designed a questionnaire according to the LIKERT[2] scale, where the respondent could choose between five options including one neutral stance and the other four with varying degrees of agreement or disagreement with sixteen questions covering the above mentioned key categories. Participation in the survey was anonymous and voluntary.

Results 78 staff across two hospitals of the trust responded to the survey, of which two were incomplete and hence excluded from analysis. Respondents included consultants (20), Specialist Registrars (8), nurses (29), health care assistants (12) and unknown (7).

81% perceived an improvement in patient safety and 75% in team communication. 75% were satisfied with the checklists. 80% believed that the checklists have the potential to drive improvement with 96% of them wanting to continue using these. The only negative aspect from the survey was that almost a half of the respondents (48%) felt that their feedback was not acted upon. 100% agreed that all staff needed to participate actively in the checklist and team briefs.

Conclusion Our results suggest that the introduction of the adapted WHO checklist has been a positive experience based on this staff survey, enhancing patient safety and staff communication. This adapted checklist will continue to evolve based on staff feedback. We suggest that all endoscopy units should introduce an adapted WHO checklist and we understand that the BSG is developing one currently.

Disclosure of Interest None Declared.

REFERENCES

1. Safe Surgery Save Lives - WHO/IER/PSP/2008.07
2. Public Opinion and the Individual. Gardner Murphy and Rensis Likert. New York: Harper & Brothers, 1938

PTH-174 DEVELOPMENT OF A NETWORK MULTIDISCIPLINARY TEAM AND NATIONAL REFERRAL CENTRE FOR TREATMENT OF COMPLEX BENIGN COLORECTAL POLYPS

doi:10.1136/gutjnl-2013-304907.661

[1,*]S Dolwani, [1]H Heard M Davies, N Williams, G Tudor, M Morgan, R Davies, A Maw, C Lewis. [1]*Bowel Screening UK, Llantrisant, UK*

Introduction Large flat or sessile lesions are not uncommon on a screening colonoscopy list and endoscopic removal is often technically challenging. The assessment process for screening colonoscopists in Wales does not assess therapeutic skill and variation in rates of referral to surgery suggest that clinician skill level may influence management decisions. A Network Multi Disciplinary Team (NMDT) and National Referral Centre (NRC) pilot was established to offer the opportunity for expert opinion and discussion of therapeutic options for participants of the welsh bowel screening programme.

Methods The six month pilot began in October 2011 by taking referrals from Screening Colonoscopists and local MDT's. The aim was to provide a service that would reduce variation of practise with potential value for education on lesion recognition, EMR technique and decision making.

Expressions of interest were invited and expert advisors appointed for Colonoscopy, Pathology, Radiology and Surgery. Specialist Screening Practitioners and management staff were appointed and the NMDT established as a virtual group to meet biweekly.

Referral criteria were agreed based on a composite of size, morphology and accessibility of lesion. Participants with lesions satisfying the criteria were referred to the NMDT electronically. Local Assessment Centres were provided with image capture devices and staff trained to record and edit video clips which were subsequently saved on a share drive, reviewed by expert advisors and discussed at NMDT meetings.

Expertise in complex polypectomy is often limited to few centres and the NRC was designated in a unit accessible to colonoscopists with appropriate skills. It was established in Cardiff at University Hospital Llandough via an agreement with Public Health Wales. Depending on outcomes of NMDT discussions participants were given the option of accessing local surgery or travelling to the NRC for therapeutic endoscopy where appropriate.

Results During the initial pilot phase 13 meetings were held. No meeting was cancelled due to availability of advisors, 1 was cancelled on a bank holiday and 1 because of technical difficulties. Thirty eight cases were referred for discussion and 15 of them referred to the NRC for therapeutic procedures.

Challenges including image quality, video transmission and interface with local MDT's were discussed at a multidisciplinary workshop and solutions identified for future development. Evaluation of the pilot indicates that the service has been well received by participants, NMDT members and local teams.

Conclusion This development has been logistically feasible, safe and successful in providing an equitable service for participants of the bowel screening programme in Wales and has contributed to a reduction in referrals for surgery for benign lesions.

Disclosure of Interest None Declared.

PTH-175 NATIONAL ANALYSIS OF EMERGENCY ADMISSIONS FOR ALCOHOL-RELATED CONDITIONS BY HOSPITAL SPECIALTY

doi:10.1136/gutjnl-2013-304907.662

[1,*]V P K Lekharaju, [2]E Thompson, [1]S V Hood, [2]M Pearson, [3]K Bodger. [1]*Digestive Diseases Unit, Aintree University Hospital;* [2]*Aintree Health Outcomes Partnership;* [3]*Gastroenterology Department, University of Liverpool, Liverpool, UK*

Introduction Harmful alcohol use is associated with substantial health and economic burden.[1] Patients with alcohol-related conditions (ARCs) present acutely to hospital with a wide spectrum of disorders, impacting a range of medical & surgical specialties - a major challenge to the organisation and delivery of effective care within a hospital. Public health metrics derived from hospital (coding) data provide useful top-level indicators but do not provide clinically-relevant information for hospital teams. Gastroenterologists are seen increasingly as potential leaders in alcohol services. The aim of this project is to develop clinically-meaningful analyses and metrics that allow clinicians to better-understand alcohol-related emergency admission data to help in service planning.

Methods We analysed a 2-year download of HES data (~24M. care episodes) for acute NHS Trusts in England in IBM-SPSS stats package. Emergency admissions containing any alcohol code were extracted, all recorded diagnoses were tabulated and reviewed by clinical steering group. Logical baskets of conditions were generated, reflecting common clinical presentations and allocated to specialties. The resulting coding rules and hierarchies were applied to the national data to label each admission and summary data generated.

Results Of 7,440,546 emergency admissions to 150 trusts, ARCs accounted for 228,994 (3%). 12 diagnostic-specialty categories of admission were defined, of which Hepatology (alcoholic liver disease) and Gastroenterology (other GI conditions) ranked 1st and 3rd for admissions (17.4% and 13.8%) with alcohol withdrawal/intoxication