

Abstract PTU-013 Table 1

	Lobo et al, 2001	Current study		
		Pre teaching (n = 56)	Post teaching (n = 36)	p value
Not confident in prescribing	14%	25%	6%	p = 0.02
Unsatisfactory or poor teaching in Medical school	34%	34%	-	-
Not given guidelines at induction	67%	48%	-	-
Fluid balance charts not checked regularly	3%	18%	22%	p = 0.6
Correct sodium content of normal saline	34%	10%	64%	p < 0.0001
> 2 litres normal saline prescribed	32%	9%	5%	p = 0.7

chart review with seniors or other relevant teaching sessions, their main source of knowledge was postulated to be from our teaching. More attention should be given to this subject in medical schools and guidance should be given at Trust inductions.

Disclosure of Interest None Declared

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PTU-014 IMPACT OF PRIMARY CARE EDUCATION ON THE TWO WEEK WAIT REFERRAL PROCESS FOR GI CANCERS

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Introduction The two week wait referral process was introduced in 2000 to improve cancer prognosis in the UK with an anticipated 20% reduction in cancer-related deaths. The cancer yield has in fact been reported as 9–16%. Referrals should be made on the basis of NICE guidance. Previous studies have highlighted that as few as 53% of referrals from Primary Care have been within NICE guidance. The Government's nine-week "Be clear on cancer" campaign launched in January 2012 via online, TV and radio adverts to increase public awareness of bowel cancer symptoms impacted our service. The proportion of colonoscopies done for the two-week wait service increased from 27% to 48% in the month after the campaign. It is clearly important that referrals made are appropriate to justify this service requirement. This study compares referrals and outcomes before and after a GP education session.

Methods Two week wait GI Referrals to the Horton General Hospital between December 2011 and February 2012 were assessed. A presentation was given to Primary Care Practitioners in May highlighting NICE guidance and referrals were re-audited in June 2012.

Results 100% of referrals met the two week wait target (to clinic, CT scan or endoscopy) and the mean time to first test was 9 days. The results are summarised below. 24% of Upper GI referrals did not meet NICE guidance, mostly patients referred with anaemia above the referral threshold or for dyspepsia without concerning features. The cancer pick-up was 8.6% (2 oesophageal, 2 gastric and 4 pancreatico-biliary). 26% of Lower GI referrals were non-compliant with guidance (mostly due to rectal bleeding or change in bowel habit shorter than the required time). Cancer pick-up was 5.1%. All but one GI cancer was detected in appropriately referred patients.

In June 2012 compliance improved to 81% of upper GI and 79% of lower GI referrals. Reasons for referral outside NICE guidance

were similar to the previous cohort. Cancer detection rose to 12.9% for Upper GI and 8.6% for Lower GI cancers. All cancers in the second audit were in appropriately referred patients.

Abstract PTU-014 Table

	Dec 2011-Feb 2012		June 2012	
	Upper GI	Lower GI	Upper GI	Lower GI
Mean age	71 years	61 years	70 years	68 years
Gender	46% male	43% male	38% male	43% male
% compliance with NICE guidance	76%	74%	81%	79%
Cancer pick up	8.6%	5.1%	12.9%	8.6%

Conclusion The study highlights the importance of communication with Primary Care Practitioners who are responsible for referrals for GI cancer exclusion. There have been previous education sessions but despite this there remains an advantage in re-stating the message and keeping regular contact. The cancer detection rate improved with better compliance with NICE guidance and may indicate the value of adhering to this guidance. Larger studies are required to validate this.

Disclosure of Interest None Declared

PTU-015 TRAINEE ENDOSCOPIC PROCEDURES BY DEANERY AND YEAR OF TRAINING IN THE UNITED KINGDOM: AUGUST 2011 TO JULY 2012. ARE WE DOING ENOUGH?

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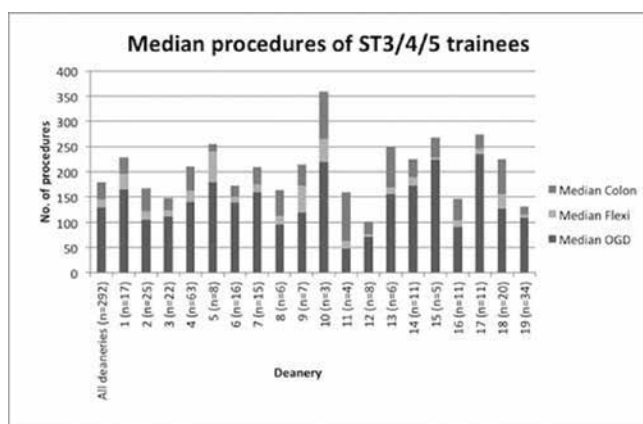
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Introduction The burden of acute medicine on specialty trainee registrars (StR) is rising. Anecdotal evidence suggests that fewer endoscopic procedures are being performed by gastroenterology (GI) StR's and that trainees although competent at the time of being awarded their CCT may have less confidence in their endoscopic skills when compared to a historical cohort. The annual review of competency progression (ARCP) decision aid includes indicative numbers of procedures which should be undertaken annually. Since September 2010 all endoscopic procedures undertaken by UK GI trainees have been recorded on a national electronic record (the Joint Advisory Group Endoscopy Training System (JETS)).

Methods We obtained anonymised records from the JETS database for the period 3 August 2011 – 31 July 2012. We analysed the data by trainee grade (ST3–7, locum appointment for training (LAT's)), deanery, numbers and type of procedure, and annual numbers of endoscopy lists (dedicated training, ad-hoc training, and service). Duplicate entries & blank entries were removed.

Results A total of 721 records were obtained from the 19 UK deaneries. 183 blank records were deleted leaving 538 for analysis. 49 (9.1%) were ST3 trainees, 101 (18.8%) ST4, 142 (26.4%) ST5, 120 (22.3%) ST6, 102 (18.9%) ST7, and 24 (4.5%) LAT. Significant

variation was seen between trainees both within individual deaneries and between deaneries. The median exposure to endoscopic units (OGD/flexi = 1 unit; colon = 2 units) increased from ST3-ST6 (112–218–275–304) before tailing off at ST7 (227). LAT trainees performed fewer endoscopic units (median 97 units). This pattern was also seen for median number of procedures. Numbers of colonoscopies were generally low across all deaneries. 8 deaneries outperformed the ARCP targets for overall procedures performed at ST3 level and this was accounted for largely by OGDs. Few deaneries met the published targets at ST4-ST7 level. Trainees performed an average of 31 training lists each year (range 0–134; median 29) and 12 service lists (range 0–210) the latter of which were largely, but not entirely, restricted to senior trainees in this dataset.



Abstract PTU-015 Figure

Conclusion Trainees are performing fewer procedures than recommended in the ARCP guidelines. The variation in endoscopy numbers both between and within trainee grade and deanery suggest factors which can be explored to optimise future opportunities. This analysis should be undertaken regularly to inform The Training Committee of future trends in endoscopic training.

Disclosure of Interest None Declared

Endoscopy

PTU-016 ENTONOX VS SEDATION IN COLONOSCOPY: A PROSPECTIVE COHORT STUDY

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Abstract PTU-016 Table

Parameter	Entonox n = 143	Sedation n = 145	P-value
Time to caecum (mins)	8.9 (SD 3.6)	8.9 (SD 4.4)	NS
Completion to caecum (%)	135 (94%)	137 (94%)	NS
Endoscopist score for patient comfort (Score out of 10, higher scores imply improved comfort)	7.3 (SD 2.20)	6.9 (SD 2.33)	NS
Reduction in blood pressure post-procedure (Systolic BP)	10.2 (SD 18.08)	14.8 (SD 17.22)	0.05
Pain (score out of 10, higher scores imply worse pain)	4.8 (SD 2.63)	4.5 (SD 2.80)	NS
Bloating (score out of 10, higher scores imply worse bloating)	4.3 (SD 2.68)	4.0 (SD 3.08)	NS
Recommend chosen parameter for future (Score out of 10, higher scores imply recommendation for future)	6.4 (SD 3.57)	6.1 (SD 3.64)	NS

Introduction Intravenous sedation for colonoscopy is associated with cardiorespiratory risk and delayed recovery. There is also the perception that patients tolerate the procedure better with sedation. Moreover some studies suggest that colonoscopy performance is compromised if patients do not tolerate the procedure well. This study aimed to compare inhaled nitrous oxide (entonox) with intravenous sedation during colonoscopy in terms of completions rates, patient comfort and changes in physiological status.

Methods 288 patients undergoing elective colonoscopy were included performed by a single endoscopist. Carbon dioxide was used for insufflation. Patients were offered a choice to have intravenous sedation or entonox. Vital signs were recorded before, during and after the procedure. Following the colonoscopy, patients completed a satisfaction survey questionnaire charting symptoms of pain and bloating (modified 10mm Visual analogue score tool) and the endoscopist scored patient comfort.

Results Out of the 288 participants, 143 (48 women and 95 men) chose entonox and 145 (66 women and 79 men) opted for sedation. Of those who received entonox initially, 25 were converted to sedation during their procedure (results not reported). For those who had sedation, the mean dose of Midazolam was 2.4 mg (SD 0.6) and Pethidine was 28.5 mg (SD 9.0). The most common indications for colonoscopy in both groups were altered bowel habit, chronic diarrhoea and inflammatory bowel disease surveillance.

Conclusion

1. Entonox is as effective as intravenous sedation in relieving pain and bloating during colonoscopy without compromising performance.
2. Entonox had less effect on systolic blood pressure suggesting it may be more appropriate in the elderly or those with cardio-pulmonary compromise.

Disclosure of Interest None Declared

PTU-017 SYSTEMATIC REVIEW OF ENDOSCOPIC FULL THICKNESS RESECTION (EFTR) TECHNIQUES FOR COLONIC LESIONS

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Introduction Introduction of the English Bowel Cancer Screening Program has resulted in increase in the number of patients diagnosed with endoscopically irresectable colonic polyps. A significant proportion of these patients undergo hemicolectomy associated with a significant risk of death, anastomotic leakage and general