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PTU-023 THE USE OF PROKINETICS IN SMALL-BOWEL CAPSULE ENDOSCOPY: A SYSTEMATIC REVIEW AND META-ANALYSIS

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Introduction Small-bowel capsule endoscopy (SBCE) is often limited by incomplete small-bowel transit. Although there are available meta-analysis data on the use of purgatives in SBCE, there is no similar data or consensus regarding the regular use of prokinetics for capsule ingestion. Our aim was to systematically review existing literature on the use of prokinetics in SBCE.

Methods Thorough and extensive, recursive search of PubMed/MEDLINE, Embase and Scopus databases for studies, published to the end of Nov 2012, was performed. No language, time or age limits were used. Abroad search strategy was employed, using the MeSH term "**capsule endoscopy**" connected with the following keywords by "AND": "**prokinetic**", "**promotility**", "**metoclopramide**", "**domperidone**", "**erythromycin**", "**antiemetic**", "**ondensetron**", "**completion**", "**gastric emptying**", "**transit**", "**ingestion**", "**preparation**", "**oral/liquid**", "**intramuscular**" & "**retention**". Additionally, the reference list of all the selected articles was manually checked for potentially suitable references that were not identified by the initial search. Studies were selected based on title and/or abstract. Eligible studies were included if the met **all** of the following criteria: (1)published as full articles of randomised control trials, (2) contained information on the type of the SBCE system used, (3)used prokinetics in (at least) one of the reported study arms/groups, (4) specified the type and dose of prokinetics used & (5)contained data on the rate of SBCE completion to caecum (CR). Data were extracted by the first author using a predifined Excel sheet. Primary end-point: the effect of prokinetics to SBCE CR.

Results A total of 13 studies (all prospective, randomised-controlled, single-centre; total of 1439 subjects) was selected for final review and analysis. In 11 of them, PillCam® (Given®Imaging Ltd) was used; 2 studies were performed with OMOM® (Chongqingjinshan Science & Tech Co, Ltd). 6 studies were designed to look at the value of metoclopramide vs control. In the remainder, other type of prokinetic factors (Erythromycin, Mosapride, Lubiprostone, Deikenchuto or chewing gum) was administered. Using random effects model analysis, the use of prokinetics seem to improve CR in SBCE (OR = 1.888, 95% C.I. = 1.178, 3.02; I^2 = 52.5%, P = 0.014). Moreover, in the sub-analysis for metoclopramide studies using fixed effect model, the results were similar (OR = 1.711 95% C.I. = 1.138, 2.573; I^2 = 42.3%, P = 0.123).

Conclusion Pooled data show that in comparison to no prokinetic, any type of administered prokinetic factor, before SBCE, improves the SBCE completion rate. Furthermore, most data to present are behind the use of Metoclopramide.

Disclosure of Interest None Declared

PTU-024 RELIABILITY OF ROCKALL SCORE CALCULATION AND ITS IMPACT ON GASTROSCOPY IN PATIENTS WITH ACUTE UPPER GASTROINTESTINAL BLEED (AUGIB)

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Introduction Documentation of Rockall score (RS) in patients with AUGIB should be accurate to prioritise patients for gastroscopy. We noticed that Rockall scores were being incorrectly calculated on electronic gastroscopy request forms and decided to analyse this further. We correlated RS with findings on gastroscopy

Methods Information was retrospectively collected on 100 patients who presented with AUGIB over a 2 month period between September and November 2012. Demographics, time to gastroscopy, Rockall score (RS) documented by requesting doctor, RS calculated by going through patient records (including A & E, paramedic entries) were recorded. We analysed patients whose RS was either under scored or over scored by the requesting doctor (as compared to the actual score as calculated by us) and correlated this with the electronic endoscopic records

Results 100 patients were included in the study with 60 males (60%) and 40 females (40%), age ranging from 17 to 92, (mean 65.2, median 69.5). Presenting symptoms were melaena in 57% of patients, haematemesis in 27%, coffee grounds vomiting in 12% and combined melaena and haematemesis in 4%. RS was calculated in 52% by Foundation Year 1 trainees (FY1), in 10% by FY2s, in 26% by Senior House officers (SHO), in 6% by Locum SHOs, in 5% by Registrars and in 1% by a consultant. 46 out of 100 Rockall scores were incorrectly scored. 28 patients (60.9%) were over scored, while 18(39.1%) were underscored

FY1s were responsible for incorrect scores in 27(58.7%) of patients, FY2 for 2 (4.3%), SHOs for 12(26%), locum SHOs for 3(6.5%) and registrars for 2(4.3%).

Mean time from electronic booking to endoscopy was days in patients Mean time to Gastroscopy was day in of under scored patients day in of over scored patients.

Of the 18 patients whose RS was under scored, 6 (33.3%) required endoscopic intervention with heater probe and Adrenalin injection. Of the 28 patients whose RS was over scored, only 3(10.7%) needed endoscopic intervention, while 5 of the 54 (9.2%) of the correctly scored patients needed endoscopic therapy.

Conclusion It is important to calculate the RS correctly at the time of first presentation rather than at the time when the admitting doctor sees the patient. Observations from A&E and ambulance records should be scrutinised to document the accurate RS thus helping endoscopy units to correctly prioritise patients for gastroscopy. Incorrect calculation of RS can have adverse impact on patient outcomes – under scored patients may be delayed while over scored patients may use up vital endoscopy slots.

Disclosure of Interest None Declared

PTU-025 DIAGNOSTIC YIELD OF A DEDICATED BARRETT'S SURVEILLANCE LIST USING TRIMODAL IMAGING

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Introduction A dedicated endoscopy list for Barrett's surveillance was introduced at our hospital from 2010. In this study we compared the rate of dysplasia detection and targeted biopsy of this approach with Barrett's surveillance on a general endoscopy list.

Methods In the dedicated list, all endoscopies were performed by a specific gastroenterologist who has an interest in Barrett's oesophagus using a combination of high resolution white light magnification,

Abstract PTU-025 Table 1

	2008–09	2010–11	Difference in rates	p
High grade dysplasia	1.325[95% CI 0.16 –4.785]	2.29 [95% CI 0.278 –8.304]	-0.9743 [95% CI –0.439 –2.445]	0.5766
Low grade dysplasia	3.974 [95%CI 1.458–8.649]	4.598 [95% CI 1.253 –11.772]	-0.6242 [95% CI –6.031–4.783]	0.8210
All dysplasia	6.04 [95% CI 2.762 –11.466]	8.046 [95% CI3.235–16.578]	-2.006 [95% CI –8.892–4.88]	0.5681
Targeted biopsy	0.6623 [95% CI 0.0168 –3.6898]	19.54 [95% CI 11.38–31.29]	-18.88 [95% CI –26.13- –11.62]	< 0.0001

auto fluorescence and narrow band imaging. This was in contrast to the practise of previous years where the endoscopies for Barrett's surveillance were done by a physician gastroenterologist, a surgeon, or a nurse endoscopist using conventional white light endoscopy alone. In this study, we compared the detection rate of high grade dysplasia, low grade dysplasia and targeted biopsy between patients who underwent endoscopy on a dedicated list and those who underwent surveillance on a general endoscopy list.

Results In group 1 were 151 endoscopies performed on a general list during the years 2008–2009, which were compared with 87 endoscopies performed on a dedicated list from 2010 to 2011. Only one targeted biopsy was taken in group 1 compared to 17 targeted biopsies in group2. The detection rate of high grade dysplasia, low grade dysplasia and all dysplasia were greater in group2 compared to group1. However we were not able to detect a statistically significant difference in rates between the two groups. On the other hand, the difference in the rates of targeted biopsies between the two groups was found to be statistically significant The difference in detection rates between the two groups [–18.88, 95% CI –26.13 – –11.62, p = < 0.0001]. Three of the four high grade dysplasia were detected on a targeted biopsy and two of them had a cancer in situ.

Conclusion In this retrospective comparative study we were able to demonstrate that a dedicated Barrett's surveillance endoscopy list is able to generate a significantly greater number of targeted biopsies compared to surveillance endoscopy performed on varied general lists. The detection rates of high grade dysplasia, low grade dysplasia and all dysplasia were greater on the dedicated list, although this did not reach statistical significance. We would therefore recommend a dedicated Barrett's surveillance endoscopy list

Disclosure of Interest None Declared

PTU-026 WITHDRAWN BY AUTHOR

PTU-027 PROPHYLAXIS OF POST ERCP PANCREATITIS IN THE UK. HAVE THE ESGE CREATED CONSENSUS?

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Introduction Post ERCP pancreatitis (PEP) occurs in 3.5% of unselected cases 10% of which are severe. PEP is significantly higher in certain patient groups, for example patients with Sphincter of Oddi dysfunction or with a pre-cut sphincterotomy. The 2010 European Society for Gastrointestinal Endoscopy (ESGE) guidelines on PEP prophylaxis recommend routine use of rectal NSAIDs and the insertion of pancreatic stents (PS) in high risk patients[1]. This study surveys UK practise of PEP prophylaxis in view of ESGE guidelines.

Methods 220 ERCPists were invited to complete an online survey concerning their awareness of ESGE guidelines, patient selection for PEP, and use of rectal NSAIDs and insertion of PS. 67 responses from 53 UK hospitals were received (response rate = 30.4%).

Results 79% of respondents were aware of ESGE guidelines, of which 47% had subsequently changed their practise. Only 9% of respondents used PEP for all patients as recommended by the ESGE. The majority (66%) used PEP in selected patients, whilst 25% never used PEP. Choice of PEP is demonstrated in the below table. Concerns relating to ESGE guidelines were expressed in a free text comments sections

Abstract PTU-027 Table

Form of PEP used by survey respondents	
Rectal NSAID	16.4%
Pancreatic Stent	23.8%
Both (NSAID/PS)	34.3%
Never use PEP	25.4%

Conclusion If this study is representative of wider practise it would suggest there is widespread variation in the administration of PEP in the UK. Only a minority of respondents were adherent to ESGE guidelines, although the majority had considered them. A significant number of departments were in the process of developing separate local guidelines. Stenting otherwise uncannulated pancreatic ducts and NSAID nephrotoxicity were commonly raised reasons for not adopting ESGE guidelines. Given there are currently no UK guidelines for PEP, this may be an opportunistic time for collaboration. A coordinated strategy of national guidelines or research may contribute to creating a consensus in practise across the UK and ultimately reduce the incidence of PEP.

Disclosure of Interest None Declared

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PTU-028 SYMPTOM ASSESSMENT OF PATIENTS IN THE CHESHIRE BOWEL CANCER SCREENING PROGRAMME WITH A FINDING OF CANCER

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Introduction When attending the bowel cancer screening (BSC) programme patients undergo pre-colonoscopy assessment of their symptoms. This is conducted by the specialist screening practitioner for the BCS programme. Following a diagnosis of bowel cancer at colonoscopy the questions were asked again, after a 3–6 month period. Comparison could then be made to assess the validity of the pre-assessment questionnaire. It would also allow us to look at whether patients reported all symptoms during pre-assessment.