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PTU-026 WITHDRAWN BY AUTHOR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.