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PTU-037 IMPROVING ACUTE UPPER GI BLEEDING SERVICES IN A DISTRICT GENERAL HOSPITAL

doi:10.1136/gutjnl-2013-304907.129

¹D R Moffat, ¹I Gooding, ¹A Sundaralingam, ¹M T Wong, ¹K Shaw. ¹*Gastroenterology, Colchester Hospital, Essex, UK*

Introduction Colchester General Hospital (CGH) serves a population of 360,000. Approximately 300–350 patients present with acute upper gastrointestinal bleeding (UGIB) per annum. NICE guidelines recommend gastroscopy (OGD) within 24 hours of presentation. In 2009, there was no dedicated provision for OGD for UGIB cases. Only 15% of patients at CGH met the 24 hour target.

To improve performance, we introduced a new Early Morning Bleeding (EMB) OGD list. The EMB list provides protected endoscopy slots between 08:00 to 09:00. This 5 days week service was introduced in July 2009. To further improve our performance we extended this to an EMB list 7 days a week in November 2011. Data was collected for 2011 and 2012 to assess the outcomes of our performance.

Methods Data was collected for all UGIB cases over the same three-month period (March– May) in 2009, 2011 and 2012. Cases were identified from investigation request forms. Inclusion for the analysis was the OGD indication being either for haematemesis, melaena or unexplained haemoglobin drop.

For each case we obtained the admission date and time, OGD date and time and the length of hospital stay (LOS) from hospital databases. The endoscopy diagnosis and treatment information was also collected.

Patient s admitted for UGIB were separated from patients developing bleeding after admission, by the use of electronic discharge summaries and patient records. Wait from admission to OGD and LOS were calculated for patients admitted for UGIB. Surgical theatre logbooks were consulted to identify emergency out-of-hour OGDs for the period 2007–2012.

Wilcoxon rank sum tests were used to compare wait times to OGD and LOS.

Results**Abstract PTU-037 Table**

	AB2009 (no EMB)	AB2011 (5 day EMB)	AB2012 (7 day EMB)
Total Cases	72	85	81
Admission with UGIB	54	52	40
OGD < 24 hr (%)	14.8	40.4	75.0
Median wait for OGD (hr)	51.7	27.5*	20.5*§
Median LOS (days)	6	3*	3*
Emergency OGD per yr	11.5	7.1*	2.8*

* p < 0.05 vs 2009

§ p < 0.05 vs 2011

Conclusion Providing an EMB list 7-days is an effective method to improve services. Compliance with 24hr target guidelines improved from 14.8% to 75%. LOS was reduced by 50%. Providing a 5-day

service resulted in substantial improvements but did not achieve adequate compliance. Whilst our study is too small to assess any impact on mortality, the reduction in emergency out-of-hours procedures with a 7-day service indicates an improvement in patient safety.

The EMB system is relatively cheap: during the week no new resources are required. We had only to staff new lists at weekends. The system ensures that most procedures are performed by consultant gastroenterologists experienced in endoscopic therapy for UGIB. The marked reduction in emergency cases suggests that any further improvements in outcomes from providing a (much more expensive) 24/7 service are unlikely to be cost effective.

Disclosure of Interest None Declared

PTU-038 SHOULD A PLASTIC OR A FULLY COVERED METAL STENT BE PLACED AT INDEX ERCP WHEN A PATIENT PRESENTS WITH JAUNDICE DUE TO A MALIGNANT DISTAL BILIARY STRICTURE?

doi:10.1136/gutjnl-2013-304907.130

¹D McClements, ¹S Mahmood, ²P Whelan, ³E-E Psarelli, ¹H L Smart, ⁴J Evans, ¹M Lombard, ¹S Sarkar. ¹*Gastroenterology; ²Hepatobiliary, Royal Liverpool University Hospital; ³Medical Statistics, Cancer Research UK; ⁴Radiology, Royal Liverpool University Hospital, Liverpool, UK*

Introduction Traditionally plastic stents (PS) are inserted at the index ERCP to treat obstructive jaundice from malignant distal biliary strictures. However, with the development of fully covered metal stents (C-SEMS), this approach is now debated and practise at the Royal Liverpool Hospital (RLH) has now changed towards preference for C-SEMS in this clinical scenario. This of course has cost implications as C-SEMS are 15–20 times more expensive than plastic stents. The aim of this study is to determine the benefit of C-SEMS over PS placement, to answer the question which stent should be inserted at the index ERCP if a patient presents with malignant obstructive jaundice

Methods A retrospective audit was performed of patients undergoing ERCP with placement of plastic or SEMS for obstructive jaundice due to malignant distal biliary strictures at the RLH between March 2007 and December 2012. Clinical history, course and outcomes from MDT documents, electronic patient records and the endoscopy database were recorded on a standardised proforma. Only PS and C-SEMS insertion at the index ERCP were included.

Results Of 147 patients identified, 72 were excluded (bare metal stents or partially covered metal stents placed). This left 43 in PS group and 32 in C-SEMS group. 21 patients underwent surgical resection; 17 within PS and 4 within C-SEMS. Of these no patient with C-SEMS but 3 (18%) patients with plastic stents required re-intervention prior to surgery due to stent dysfunction. In the remaining palliative patients (PS: n = 26 and C-SEMS: n = 28), 19 with plastic stents (73%) and 3 patients with SEMS (7%) required endoscopic re-intervention due to stent dysfunction (p < 0.001). Median time to re-intervention was 32 days (range 5–58) for PS and 25 days (range 25–38.5) for C-SEMS (p = 0.394). Overall, PS at the index ERCP only offered definitive stenting in only 53% (23/43) compared to 91% (29/32) by C-SEMS (p = 0.001).

Conclusion Placement of a fully covered SEMS (C-SEMS) at index ERCP offered a definitive procedure in majority of patients compared to plastic stent (PS) which was just over half. Whilst C-SEMS significant more expensive than PS, this increased cost may be potentially be offset by the reduction in the need for repeat ERCP intervention and subsequent stent insertions. A full cost analysis is currently being undertaken.

Disclosure of Interest None Declared