condition. The instant generated clinic letters have been a particular success with both patients and GPs.

Results The dashboard facility gives an instant overview of our local IBD cohort, revealing 2571 (as of Jan 2014), 1280 with UC, 934 with Crohn's, 77 with IBD unclassified and 59 with microscopic colitis. It takes 4–5 min to upload the basic details in clinic, although complex histories take longer. There were 1072 telephone and virtual clinic contacts recorded between Jan-Nov 2013. The time spent on the IBD phone line was 943 min, with a further 940 min spent dealing with these issues. This work saved 149 clinic visits. Data reports sent to our CCG provided evidence of this service and enabled an income generation not previously claimed for. The IBD-R/PMS identified 913 clinic visits and 173 inpatient reviews. Experience using the worklist functions now allow us to better monitor colonoscopy surveillance, schedule MDT patients and regulate azathioprine reviews.

Conclusion The IBD-R/PMS has been a huge success, with relatively little effort on our behalf. It would be difficult now to go back to paper based reporting. There are still benefits yet to be fully appreciated. The service reports have been easy to generate and strongly assisted in our bid to fund 2 additional IBD nurses. Further integration is expected to reduce duplication with our own IBD-SSHAMP project, IBD-GRS and the Biologics Audit.

Disclosure of Interest. None Declared.

PTH-053 | OPEN ACCESS TO COLONOSCOPY: ONE YEAR OF EXPERIENCE IN A DISTRICT GENERAL HOSPITAL

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Introduction Open access endoscopy allows non-gastroenterologists to schedule elective endoscopies without prior consultation with a specialist and is widely used for upper gastrointestinal endoscopy. Our hospital has provided an open access service for colonoscopy (OAC) since May 2011. We analyse our initial data to determine the appropriateness of referral and proportion of clinically significant diagnoses found.

Methods We retrospectively reviewed endoscopy reports from all open access colonoscopies between 01/05/2011 and 30/04/2012 performed in a local district general hospital. Patient demographic data was collected alongside indication for examination, completion rates and final diagnosis. Further information from all colonoscopies performed during this period was retrieved from our endoscopy database system for comparison. Appropriateness of

open access colonoscopy was graded using the European Panel on the Appropriateness of Gastrointestinal Endoscopy criteria (EPAGE II). Primary endpoint: appropriateness of colonoscopy. Secondary endpoint: clinically significant diagnosis.

Results 2895 colonoscopies were performed in total during the study period of which OAC accounted for 14% (407). 57% (231) patients were female, age range 24–89 years (median 56 years). Caecal intubation was achieved in 96% (389 patients). OAC had the lowest diagnostic yield for all outpatient referrals to colonoscopy compared to bowel cancer screening (86%), medical outpatients (61%) and surgical outpatients (57%). The indication was designated appropriate in 69% (279 patients), inappropriate in 6% (25 patients) and uncertain in 25% (103 patients) based on the EPAGE II criteria. Patients with appropriate or uncertain indications had more relevant endoscopic findings than those with inappropriate indications (45.8 vs 19.0% p = 0.005). Sensitivity and negative predictive value of the EPAGE II criteria for detecting clinically significant pathology were 97.7 and 83.3% respectively. The most common diagnosis was diverticular disease, followed by polyps and haemorrhoids (Table 1). Colorectal cancer was found in 0.5% (2 patients), both in the appropriate/uncertain EPAGE group based on indication.

Conclusion Open access to colonoscopy is useful to avoid delay in investigation of symptomatic patients but is associated with a low proportion of clinically significant findings compared to standard referral routes. Inclusion of the EPAGE II criteria in the referral form may help to avoid unnecessary examinations.

Disclosure of Interest None Declared.

PTH-054 | IS TIME ALLOCATED FOR COLONOSCOPIC ENDOSCOPIC MUCOSAL RESECTION ENOUGH?

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Introduction Colorectal cancer is the third commonest cancer in the United Kingdom with 35000 patients newly diagnosed per annum Evidence has shown that resection of adenomatous colonic polyps decreases the occurrence of malignancy by upto 90%. Endoscopic mucosal resection of polyps has been very effective in removing polyps.

Methods A retrospective case study of lower GI EMR procedures done by a single endoscopist (colonoscopy/ sigmoidoscopy) at a district general hospital from September 2012 and January 2013 was performed. The data was extracted from endobase reporting system.

Data collected included size, location and morphology of polyp. Procedural data collected included type of EMR and procedural time.

Results 95 EMRs were included in the study. 1 unit time point was assumed to be 15 min. Procedures were allocated between 2 and 4 units.

All the procedures were performed by a consultant gastroenterologist with experience in EMRS. The mean time for 95 procedures was 52 min, whilst the mean allocated time was 43 min. There was a significant correlation between the time taken to complete EMR polypectomy and age (mean age = 66.6 years, p = 0.02 and polyp size (mean diameter = 25.3 mm) p < 0.0001.

Morphology of the polyps did not cause significant variation in time taken (sessile/flat-elevated Vs semi-pedunculated/pedunculated: mean duration = 51 mins vs. 54 mins mean time difference = 3 mins p = 0.28.

Abstract PTH-053 Table 1

EPAGE referral status	Appropriate/Uncertain	Inappropriate
Diagnosis		
Diverticular Disease	77	1
Polyp (s)	53	-
Haemorrhoids	19	2
Inflammatory Bowel Disease	13	1
Anal fissure	2	-
Colorectal cancer	2	-
Angiodysplasia	1	-