acute alcohol withdrawal; enable continued monitoring of vulnerable patients in a controlled OP environment. There is a need for a paradigm shift of offering AD in AC setting rather than IP treatment. Further patients are beibng recruited into an ongoing study.

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Disclosure of Interest None Declared.

OC-059 LOW DOSE AZATHIOPRINE AND ALLOPURINOL IN AZATHIOPRINE INTOLERANT PATIENTS: IS IT TOLERATED AND IS IT EFFECTIVE IN IBD?

HE Johnson*, SA Weaver, SD McLaughlin. *Gastroenterology, Royal Bournemouth Hospital, Bournemouth, UK*

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Introduction Despite the advancement and introduction of new biological therapies, thiopurines remain effective treatment options for the maintenance of remission for both ulcerative colitis (UC) and Crohn's disease (CD). Once tolerated and therapeutic, thiopurines have many advantages over biologics for long-term maintenance therapy. However, it has been documented that intolerance and adverse events are common. We have previously published our 36 month follow-up data reporting that 56.5% of our patients stop thiopurines due to side effects, abnormal liver function tests (LFTs) or therapeutic failure.

Low dose azathioprine and allopurinol (LDAA) co-therapy is a well proven treatment option for patients who develop side effects or hepatotoxicity with standard dose azathioprine. LDAA has been used at our institution since 2010.

Aim to report the safety, tolerability and therapeutic outcome at 12 months, for LDAA in patients who have failed standard dose azathioprine.

Methods We maintain a prospective IBD data-base. After starting LDAA we monitor full blood count and LFTs weekly for 8 weeks. 6-Thioguanine (6-TGN) and 6-Methyl-mercaptopurine (6 MMPN) nucleotide levels are checked at 4–6 weeks. We searched our database for patients who started LDAA and had a minimum of 12 months follow-up. We recorded the indications for therapy, metabolite levels, and blood monitoring and clinical outcomes.

Results 62 patients were started on LDAA. 25 (40%) were male. Mean age was 47 (range 16 – 77). Disease type was UC, 21; CD, 35; IBD(U), 6. Reasons intolerant to standard dose azathioprine were: drug side effects (nausea and arthralgia) 24; hepatitis (ALT 2x upper limit normal) 20; Hypermethylation (TGN: MMPN ratio >11), 12. Gout 4; High TPMT 2.

At 12 months 44 (70%) remained on LDAA and were in clinical remission (HBI <1 for CD), (stool frequency <4 and no bleeding for UC) with therapeutic 6TGN levels on LDAA, of these 7 (11%) required additional treatment with biologic therapy.

Of the remaining 18 (29%) patients, 3 (5%) were lost to follow up and 1 (2%) chose to stop LDAA. 1 patient (UC) required a colectomy. 3 (5%) stopped LDAA to conceive.

10/62 (16%) remained intolerant and treatment was stopped.

One patient developed myelosuppression WCC <3 and stopped therapy. No patients developed abnormal LFTs on LDAA.

Conclusion LDAA is well tolerated and effective in patients who failed standard dose azathioprine due to drug side effects and hepatotoxicity. This therapy results in resolution of hepatotoxicity and will allow more IBD patients to achieve clinical remission.

Disclosure of Interest None Declared.

Endoscopy section research symposium

OC-060 PERFORMANCE CHARACTERISTICS OF UNSEDATED ULTRATHIN VIDEO ENDOSCOPY IN THE ASSESSMENT OF THE UPPER GASTROINTESTINAL (GI) TRACT: SYSTEMATIC REVIEW AND META-ANALYSIS

[1]SS Sami*, [2]V Subramanian, [1]J Ortiz-Fernández-Sordo, [1]A-H Saeed, [3]S Singh, [3]PG Iyer, [1]K Ragunath. *[1]Digestive Diseases Centre and NIHR Biomedical Research Unit, University of Nottingham, Nottingham, UK; [2]Institute of Biomedical and Clinical Sciences, University of Leeds, Leeds, UK; [3]Gastroenterology and Hepatology, Mayo Clinic, Rochester, MN, USA*

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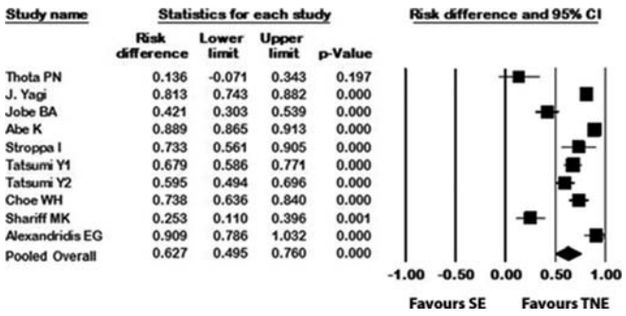
Introduction Unsedated ultrathin endoscopy has been proposed as a cost-effective and accurate alternative to standard endoscopy (SE) in screening for oesophageal varices, Barrett's oesophagus and upper GI neoplasia. However, reports on performance of this technique (both via the transnasal [TNE] and transoral [TOE] routes) are conflicting. We aimed to estimate the technical success rate, tolerability, acceptability and patients' preference for TNE and TOE alone and in comparison to SE.

Methods A systematic review and meta-analysis was performed of all primary studies reporting the outcomes of interest. Electronic databases (Cochrane library, MEDLINE, EMBASE) were searched from 1980 to September 1st 2013. Articles not published in English language were excluded.

Detailed data on study characteristics and endoscopic procedures was extracted. Study quality was assessed using the Cochrane Collaboration's tool for assessing risk of bias. Sources of heterogeneity were investigated using meta-regression and subgroup analysis.

Results 34 studies met the inclusion criteria with 6,659 patients in total. The pooled proportion of technical success rate was slightly lower for TNE (0.94; 95% confidence interval [CI]: 0.92, 0.96; 30 studies) compared to TOE (0.98; 95% CI: 0.96, 0.99; 16 studies). The difference in proportion of success for TNE compared to SE was -0.03 (95% CI: -0.13, -0.48; 18 studies), however, there was no significant difference in success rate between TNE <6 mm in diameter and SE (-0.14; 95% CI: -0.32, 0.05; 9 studies). Similarly, There was no significant difference between TOE and SE (0.03; 95% CI: -0.12, 0.17; 10 studies).

The standardised difference in mean tolerability scores was not significant for both TNE vs. SE (0.036; 95% CI: -0.435, 0.508; 11 studies) and TOE vs. SE (0.004; 95% CI: -0.417, 0.424; 7 studies). Proportion of patients willing to undergo the procedure again in future (acceptability) was high for both TNE and TOE (0.85; 95% CI: 0.79, 0.90; 16 studies and 0.89; 95% CI: 0.82, 0.93; 10 studies, respectively). The pooled difference in proportion of patients who preferred TNE over SE was 0.63 (95% CI:



Abstract OC-060 Figure 1

0.50, 0.80; 10 studies) (figure below), while 0.38 preferred TOE over SE (95% CI: -0.04, 0.80; 3 studies).

Conclusion There is no difference between TOE and SE in terms of technical success rate and preference. Success rate of TNE <6 mm in diameter is equivalent to SE, but majority of patients prefer the former over the latter. Hence, TNE (<6 mm in diameter) should be the procedure of choice for screening. Modern disposable and portable TNE devices might be useful for screening in the community.

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Joint endoscopy and bowel cancer screening symposium

OC-061 RATES OF POST COLONOSCOPY COLORECTAL CANCER (PCCRC) ARE SIGNIFICANTLY AFFECTED BY METHODOLOGY, BUT ARE NEVERTHELESS DECLINING IN THE NHS

[1]R Valori*, [2]E Morris, [2]J Thomas, [3]M Rutter. [1]*Gloucestershire Hospitals, Gloucester, UK;* [2]*Leeds Univ, Leeds, UK;* [3]*Univ Hospital of North Tees, Stockton, UK*

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Introduction It is recognised that post-colonoscopy colorectal cancer (PCCRC) can be due to missed cancer, or cancer arising from missed or incompletely removed polyps. Thus the rate of post-colonoscopy colorectal cancer (PCCRC) should become a key quality indicator of colonoscopy. A quality indicator should be relevant to patients, clearly defined, standardised, and measurable over time and have a target to aim for. This study compares methods for defining PCCRC rates, proposes a method that best meets these criteria and explores rates over time.

Methods Information on all individuals with a primary colorectal cancer and prior colonoscopic investigations in England between 2001 and 2010 was extracted from the National Cancer Data Repository. Previously published methods (Bressler, Cooper, Singh and leClerc) for deriving PCCRC rates were applied to these data to investigate the effect on the rate. A new method, based on the year of the colonoscopy, not CRC diagnosis, is proposed.

Results Of 297,956 individuals diagnosed with colorectal cancer in the study period a total of 94,648 underwent a colonoscopy in the 3 years prior to their diagnosis. The table illustrates how application of the published methods and exclusion criteria to the dataset produces significantly different PCCRC rates from 2.4 to 7.8%:

Abstract OC-061 Table 1

	Method			
Exclusion criteria	Bressler	Cooper	Singh	le Clerc
Bressler	3.6	4.7	3.9	4.4
Cooper	6.3	7.8	7.0	7.6
Singh	6.1	7.5	6.8	7.4
le Clerc	6.3	2.4	2.4	2.4

The PCCRC rate of 6.8% produced by the Singh method best fulfils the proposed criteria for a quality indicator but it is not suitable for annual reporting: the rate reflects colonoscopy performance in the years preceding the year of reporting. Amending this method to look forward from the time of colonoscopy, rather than backward from the time of diagnosis of cancer, provides a rate relating to the year the procedure was actually performed. This new method demonstrates that PCCRC rates within 3 years of colonoscopy (without exclusions) decreased in the English NHS over 7 years by 29%: from 10.2 to 7.2% for colonoscopies performed in 2001 and 2007 respectively. 25% (37/148 hospitals) achieved a PCCRC for the period of 4.0% or less.

Conclusion PCCRC rates in England are improving over time and comparable to those in other countries. The method used to determine rates significantly affects findings, thus international benchmarking requires an agreed method for defining PCCRC. The Singh and suggested new method provide a PCCRC rate most relevant to patients. It is proposed that on the basis of current evidence, and improvements evident over time in this study, a reasonable target for a national rate of PCCRC up to 3 years following a colonoscopy should be less than 4%.

Disclosure of Interest None Declared.

OC-062 A MULTI-CENTRE PRAGMATIC STUDY OF AN EDUCATIONAL INTERVENTION TO IMPROVE ADENOMA DETECTION AT COLONOSCOPY

[1]PT Rajasekhar*, [2]CJ Rees, [3]MD Rutter, [4]BP Saunders, [5]MG Bramble, [6]P Hungin, [6]DW Wilson, [7]JE East on behalf of The QIC study group. [1]*Gastroenterology, Freeman Hospital, Newcastle, UK;* [2]*South Tyneside District Hospital, South Shields, UK;* [3]*Gastroenterology, University Hospital North Tees, Stockton-on-Tees, UK;* [4]*St Marks Hospital, London, UK;* [5]*Durham University, Stockton-on-Tees, UK;* [6]*School of Medicine, Pharmacy and Health, Durham University, Stockton-on-Tees, UK;* [7]*Gastroenterology, John Radcliffe Hospital, Oxford, UK*

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Introduction High quality colonoscopy prevents colorectal cancers. Low adenoma detection rates (ADR) are linked to subsequent high interval cancer rates. Variability in ADR exists between practitioners. Withdrawal time of >6 min, Buscopan use, position change and rectal retroflexion have some evidence to improve lesion detection. Implementation of evidence based 'bundles' of care has shown to be effective in improving outcomes in other clincal settings [1].

Methods We aimed to evaluate the feasibility of implementing a 'bundle' comprising the above measures into routine practice and effect on ADR. Twelve English endoscopy units participated. All nominated a lead endoscopist and nurse. A model combining central training, locally led implementation, feedback and ongoing study team support was used. Colonoscopist's ADRs were measured for 3 months prior to implementation and for a 9 month period following. Colonoscopists performing