3 oesophageal ulcers). 12% (6 of 50) had oesophageal cancer. A further 10 had hiatus hernia, 1 had a motility disorder and 1 had oesophageal diverticulum.
Conclusion From this study, 68% of patients endoscoped for odynophagia have a positive endoscopic mucosal abnormality. Odynophagia as a symptom has a high sensitivity for abnormal endoscopy. 12% of patients endoscoped for odynophagia had oesophageal cancer. This prevalence is similar to the diagnosis of cancer in patients referred on the 'two week wait upper GI cancer referral form'. We recommend the symptom of odynophagia be classified as an alarm symptom and those presenting with odynophagia all undergo upper GI endoscopy to define the exact mucosal abnormality and exclude oesophageal cancer.
Disclosure of Interest None Declared.

PTU-052 DOES USE OF SEDATION AFFECT THE SPEED AT WHICH ENDOSCOPY IS PERFORMED AND NUMBER OF BIOPSIES OBTAINED IN BARRETT'S OESOPHAGUS?

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Introduction Guidelines for Barrett's oesophagus (BE) screening recommend 2 yearly endoscopies with 4 quadrant biopsies every 2cm for BE without dysplasia. There is increasing evidence that longer inspection time of BE segment is associated with increased detection of high-grade dysplasia and oesophageal cancer. In our experience, BE surveillance endoscopies have been undertaken both with and without sedation as no formal guidelines recommend use of one method over the other. Endoscopic procedures may be quicker in the unsedated patient and therefore these are likely to have lower Barrett's inspection time (BIT) and also fewer biopsies than in sedated patients. The aim of our study was to assess the prevalence of sedation use in BE surveillance endoscopy and to determine if this affected the time taken for the procedure and the number of biopsies obtained.
Methods A retrospective analysis of all patients who underwent surveillance endoscopy for BE over a 5 year period (2009–2013) in a large district general hospital in North London were identified using the audit tool on Unisoft Endoscopy reporting software. Data collection was done by endoscopy unit nursing staff. From each report, use of sedation, length of BE and number of biopsies taken from BE segment were recorded. The time taken for each BE endoscopy was also obtained from procedure logbooks. The mean length of time (LOT) per procedure was compared between sedated and unsedated endoscopies using a t test. A multiple linear regression fit was performed on the data using regressors sedation values, length of BE and number of biopsies taken.
Results 181 endoscopies for BE surveillance were performed over 5 years. 37 were excluded as insufficient data was available. Of the 144 endoscopies remaining, 73 were unsedated and 71 with sedation. The mean LOT for sedated compared with unsedated endoscopies was 12.47 min and 10.36 min respectively ($p = 0.05$, confidence interval= –4.23, 0.01). The average number of biopsies in sedated patients was 3.87 and 3.85 in the unsedated ($p = 0.47$). The regression was a poor fit (R^2 adjusted = –0.00033) and the overall relationship not significant: $F(2, 141) = 0.976$, $p = 0.38$. P values for sedation ($p = 0.96$) and length of BO ($p = 0.16$) did not achieve significance either.
Conclusion In our study of patients undergoing endoscopy for BE surveillance, the LOT of endoscopic procedure was greater in patients receiving sedation than unsedated patients. The length of BE or the use of sedation did not have a significant effect on the number of biopsies taken. Sedation use did not affect number of biopsies obtained and therefore may not increase dysplasia detection. We conclude that surveillance for BE patients can be performed without sedation.
Disclosure of Interest None Declared.

PTU-053 IS IT WORTH REPEATING PREVIOUS UNREMARKABLE SB2 CAPSULES WITH THE NEW SB3?

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Introduction Small bowel capsule endoscopy (SBCE) has become a valuable tool for investigating the small bowel and technology is rapidly advancing. One of the most recent devices available for capsule endoscopy (Pillcam® SB3, Given Imaging) has improved image resolution and a variable frame rate. The aim of this work is to address whether these innovations lead to increased mucosal visualisation and diagnostic yield in clinical practice and therefore whether a repeat SB3 capsule should be considered in those patients with an equivocal SB2 result.
Methods A review was undertaken of the last 100 Pillcam® SB2 capsules and the first 55 Pillcam® SB3 capsules to be performed at South Tyneside District Hospital (14/01/13–12/12/13). Visualisation of the ampulla was used as a surrogate marker of mucosal visualisation and diagnostic yield was assessed by reviewing the reports. Statistical significance was calculated using Fisher's exact test.
Results Results are summarised in Table 1 below. The ampulla was visualised in 14% of SB2 capsules and 18% of SB3 capsules ($p > 0.05$). 44% of SB2 capsules were abnormal and SB3 capsules were abnormal in 62% of cases ($p < 0.05$).
Conclusion It is recognised that the views obtained by SBCE can be compromised in the duodenum due to "rapid transit" and previous studies have suggested that due to this the ampulla of Vater is not often seen.[1] Variable frame rates aim to address this by capturing more images when the capsule is moving quicker. We showed no statistically significant difference between ampullary visualisation of the SB2 and SB3 capsules, although the trend was to a higher percentage visualisation with the SB3 capsule. The overall yield of pathology from SB3 capsules was significantly higher than that in SB2 capsules. Given the overall increased yield of pathology it may be beneficial to repeat an SB3 capsule in someone with a previously equivocal SB2 result.

Abstract PTU-053 Table 1

Capsule type	Number	Ampulla seen (%)	Pathology found (%)
SB2	100	14 (14%)	44 (44%)
SB3	55	10 (18%)	34 (62%)
p value		0.495	0.044

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1 Koulaouzidis A, Rondonotti E, Karargyris A. Small-bowel capsule endoscopy: A ten-point contemporary review. *World Journal of Gastroenterology* 2013;19 (24):3726–2840

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