the 25F needle. Indications for EUS and FNA were pancreatic lesions 43%, lymph node enlargement 28%, biliary tract lesions 16%, submucosal lesion 8% and adrenal mass 1% and others 4%. Overall sample adequacy was 83.03% Adequacy per needle was 86.7% (22G) vs 79.2% (25G), $p=0.22$ Fischer's Exact test. The number of passes used in successful FNA was higher with use of the 25G needle compared with the 22G needle. (2.42 ± 0.11 SEM vs 1.962 ± 0.15 SEM, $p=0.015$, t-test). In particular the use of a 25G needle had a higher number of passes in pancreatic lesions compared with the 22G needle (2.58 ± 0.16 SEM vs 1.94 ± 0.14 , $p=0.004$, t-test). There was no difference in adequacy between the needle sizes for each type of lesion sampled (Abstract PMO-199 table 1). Two needle exchanges (25G to a 22G) occurred. One complication of local site bleeding occurred (22G) that settled during the test.

Abstract PMO-199 Table 1

Lesion site	22G		25G		Fischer's exact test
	Adequate sample	Inadequate sample	Adequate sample	Inadequate sample	
Lymph node	19	4	20	3	NS
Biliary tract lesion	9	2	11	4	NS
Pancreatic lesion	33	3	33	2	NS
Submucosal lesion	4	2	2	5	NS

Conclusion We show no difference in sample adequacy between the two needle sizes. Use of a 25G results is associated with a higher number of passes in pancreatic FNA. Both needle sizes appear safe. Operator choice and ease of passage of needle into anatomical location may also influence choice of needle.

Competing interests None declared.

PMO-200 BEST PRACTICE FOR MANAGEMENT OF GASTRIC POLYPS

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Introduction British Society of Gastroenterology (BSG) released guidelines for management of gastric polyps in 2010¹ and main recommendations are to biopsy all polyps, complete adenoma removal and follow-up, test and treat *H Pylori* (if suspicious of hyperplastic or adenomatous). Though polyps are noted in 1%–2% of any gastroscopy, studies have reported adenomas in up to 6.6% of all polyps.² While colorectal polyps have rigorous management pathways, there is huge disparity in assessment and treatment of gastric polyps that also follow the adenoma-carcinoma sequence. Our study aimed to compare our current practice with BSG recommendations and possibly devise a standard local Proforma to ensure best practice.

Methods A retrospective audit was conducted in a teaching hospital on all gastric polyps noted during upper GI endoscopy performed between January 2009 and October 2011. Data identified by "Endoscribe" software was compared with BSG guidelines. Demographics including the size of polyp, whether biopsy taken, histological and endoscopic diagnosis as mentioned in the report, documented usage of proton pump inhibitors and urease test result (if done) are collected.

Results Out of 161 patients reported to have gastric polyps, only 61% (98) had at least one biopsy taken. Endoscopic diagnosis of polyp types were mentioned in the report only in 17/160 procedures (16 fundic gland and 1 hyperplastic) and it correlated with histo-

logical diagnosis in 64.3%. The distribution of various polyp types by histology is shown in Abstract PMO-200 table 1 and adenomas comprised only 3.06% of total number of polyps biopsied. 33 polyps were >5 mm but of varied pathology. Proton pump inhibitors usage was documented in 23 patients and was associated with fundic gland polyps in 71.4%. 28 patients had urease test done but only one was positive (Histology of polyp showed chronic gastritis).

Abstract PMO-200 Table 1 Histological distribution of gastric polyps

Fundic gland polyps	41.8%
Hyperplastic/inflammatory polyps	21.4%
Chronic gastritis	19.3%
Normal gastric tissue	7.1%
No result	5.1%
Adenomatous polyps	3.06%
Xanthoma	1.02%
Barrett's changes	1.02%

Conclusion There is poor compliance with BSG recommendations, especially with regards to taking biopsies from gastric polyps. There is evidence for gross under-reporting of polyps which can miss early cancers. We have now designed a local hospital pathway for management of gastric polyps adapted from the guideline and will complete the audit cycle with the new protocol.

Competing interests None declared.

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PMO-201 BOWEL PREPARATION: MOVIPREP® VS KLEAN-PREP®, REAL LIFE EXPERIENCE IN UNSELECTED PATIENTS

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Introduction The numbers of colonoscopies being performed has increased since the introduction of the Bowel Cancer Screening Programme. Bowel preparation is essential for a successful colonoscopy. However, bowel preparation is a major deterrent for patients undergoing screening colonoscopy. Having a bowel preparation that is more acceptable to patients may improve acceptance of bowel preparations, promote compliance and increase the likelihood of a successful procedure. The aim of this study was to assess patient tolerability of a newer bowel preparation, Moviprep®, to the current preparation used, Klean-prep®.

Methods Patients received either Moviprep® or Klean-prep® prior to colonoscopy. Each patient was asked to complete a questionnaire assessing various side effects and tolerability.

Results In total 50 patients received Moviprep® of which 42 (84%) completed the questionnaire. Eighty-eight patients who received Klean-prep® completed the questionnaire. The patients who received Moviprep® suffered from fewer side effects such as, bloating ($p=0.002$), abdominal pain ($p=0.02$) and anal irritation ($p=0.04$). No significant differences were seen in the incidence of nausea, vomiting or abdominal cramps between the two preparations. Patients found the taste of Moviprep® more acceptable and as a result were more likely to take all of the preparation as compared with Klean-prep® ($p=0.002$). No difference was observed in the