To investigate current practice in patient preparation prior to gastroscopy across the UK.

Methods A list of all Hospitals in the UK was obtained from the JAG website (391). Hospitals that did not perform endoscopy were excluded (14), as were Children's Hospitals (5) and private hospitals (165). The number of hospitals included was 207. A structured telephone survey was conducted with each endoscopy unit. The method of preparation prior to gastroscopy was established.

Results 193 (93%) endoscopy units responded to the survey. 11 (5%) endoscopy units declined to participate in the survey and 3 (2%) of endoscopy units did not respond. Preparation prior to gastroscopy (%) included:

1. 6 h nil by mouth (NBM) to food or clear fluids (38%)
2. 6 h NBM to food and NBM to clear fluids for 2 h (26%)
3. NBM to food and clear fluids from midnight for morning lists with 6 h NBM for afternoon lists (13%)
4. Nine different methods of preparation accounted for the remaining 23% of hospitals.

No hospital used a mucolytic drink for routine gastroscopy cases.

Conclusion Current gastroscopy preparation regimes vary across the UK. Future studies should evaluate which preparation regime provides the best possible visualisation of the upper gastrointestinal tract.

Competing interests None declared.

PTU-212 TO ANALYSE THE RISK OF STENT MIGRATION WITH THE NITI-S COVERED FLARED BILIARY STENT

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¹J K Moore,* ¹M Davies, ²M Sheridan. ¹Hepatology, St James University Hospital, Leeds, UK; ²Radiology, St James University Hospital, Leeds, UK

Introduction Stent migration occurs in 6%–12% of patients undergoing biliary stenting¹ The Niti-S fully covered metal stent (Taewoong Medical, Seoul) has a flared end which acts as anti-migration.² Few studies have evaluated the efficacy of these stents and are contradictory.^{3 4} The aim of our study is to compare their migration rates, investigate contributory factors and patient outcomes.

Methods This was a retrospective cohort study. 32 Niti-S flared stents were placed between January 2010 and July 2011. Each of the patients' records were analysed. The indication for stent, size and whether there had been any previous endoscopic therapy was recorded. The cholangiograms were then re-reviewed by an experienced radiologist to assess stricture length and position of the stent proximal to the stricture.

Results 10 out of 32 stents (31%) had migrated. Nine were placed for benign strictures and one for a malignant stricture. There was no significant difference between the stents that did and did not migrate comparing the length of stricture (mean 11.8 mm vs 12.4 mm), or where the stent was placed (mean proportion of stent above the proximal end of the stricture 16 mm vs 17.5 mm). There also appeared to be no association with previous endoscopic therapy: in 6 (60%) of the procedures where the stents had migrated there had been previous therapy, compared to 14 of the remaining 22 procedures (64%). 4 of the 9 (44%) patients with migrated stents were subsequently admitted to hospital with cholangitis, compared to 1 patient who did not have a migrated stent.

Conclusion The flared end covered metal stents significantly migrate despite the theories behind the design. Direct cost implications of this should be sought. There appears to be no association between aetiology, length of stricture, previous endoscopic therapy or where the stent was placed and subsequent migration.

Competing interests None declared.

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PTU-213 SELF EXPANDABLE METAL STENTS (SEMS) FOR OBSTRUCTING COLORECTAL CANCER IN ENGLAND: LINKAGE ANALYSIS OF HOSPITAL EPISODE STATISTICS

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¹J Geraghty,* ¹S Sarkar, ²M Shawihi, ²E Thompson, ²M Pearson, ^{2,3}K Bodger. ¹Gastroenterology, Royal Liverpool University Hospital, Liverpool, UK; ²Aintree Health Outcomes Partnership, University of Liverpool, Liverpool, UK; ³Gastroenterology, University Hospital Aintree, Liverpool, UK

Introduction Colorectal cancer (CRC) is the 4th commonest cancer worldwide. Hospital admission with large bowel obstruction occurs in 15% and requires urgent decompression. SEMS can provide palliative treatment in advanced disease (avoiding surgical defunctioning) or preoperative bridging to elective surgery for operable disease. We aimed to describe a national profile for incidence (activity) of SEMS, volumes per Trust, length of stay and rates of readmission, reintervention and mortality for CRC in England.

Methods We developed techniques within the SPSS software package to identify a 1-year cohort of incident cases of CRC, starting with a merged file of raw HES data for all care episodes in English hospitals for 2006/7 and 2007/8. We selected only patients with first coding of CRC in the middle 12 months (October–September), then extracted all their admissions within 6 months (before and after) of first cancer coding, ordering them chronologically and then screening to identify admissions for SEMS and surgical procedures. Linkage to death registry provided date of death. Patients with SEMS and no subsequent surgical resection were flagged as palliative patients and those with a subsequent resection as bridge patients.

Results Overall: 517 patients were identified nationally as having SEMS placement for obstructing CRC (mean age: 72.6 yrs [SD: 12.0]; 62.5% male), with mean LOS of 7.9 [SD 11.3] days and overall mortality at 30 d (10.3%) and 90 d (18.0%). The 30 d emergency readmission rate was 15.1%. SEMS were code by 122 (81.3%) of acute Trusts in England, with volumes ranging from 1 to 24 per institution. **Palliative group:** (n=421, 81.4% of cases), mean LOS for index admission 9.2 [SD: 14.6] days and mortality at 30 d (12.1%) and 90 d (21.2%). Emergency readmission within 30 d (17.8%). Subsequent surgical colostomy coded in 9.5%. Palliative procedures were recorded in 122 Trusts (Volumes: 1–13 per institution), **Bridge group:** (n=96, 18.6% of cases), mean LOS for index admission 9.5 [SD: 10.4] days and mortality at 30 d (2.1%) and 90 d (4.2%). Emergency 30 d readmission (8.7%). Colostomy coded as part of surgery in 33.4%. Bridge procedures were coded in 48 (32%) acute Trusts (Volumes: 1–12).

Conclusion Analysis of HES data suggests SEMS insertion in English hospitals is predominantly for palliative purposes and most cases selected for this intervention survive beyond 30 days and avoid operative decompression. The use of SEMS as a bridge to surgery