Eurospital ["E"]) and two monoclonal (Buhlmann ["B"], Immuno-diagnostik ["I"]). "C" is a manual assay, rest are automated. Automation eases testing. Monoclonal assays are reportedly more accurate. Head-to-head comparison of all four assays is unexplored to the best of our knowledge.

Aim Pilot study to compare the four assays to help us select one (preferably automated) that best meets our clinical needs: reliably exclude GI inflammation (new patients) and quantify inflammation (known IBD).

Methods 42 stool samples collected from January to March 2011 were tested. Patients: 18 new (mainly for diarrhoea), 24 follow-up IBD (in remission/chronic active disease/flare). Assay (n): "C" (42), "B" (36), "I" (36), "E" (35). All four assays: 29/42 (sample insufficient in rest to do all 4). Analysis: Blinded to assay details, a single investigator (MS) mapped FC values to inflammation grade (0=nil, 1=mild/possible, 2=severe/definite) based on conventional markers (CRP/imaging/endoscopy/histology) and final diagnosis. Linearity characteristics of each assay was assessed by Excel trendlines. Restricting analysis to the 29 samples tested by all four assays (giving six pairings), inter-assay concordance was determined for each inflammation grade by Kendall co-efficient. p Value <0.02 (Fisher ratio) was deemed significant.

Results All four assays showed linear characteristics with different gradients, minimum and maximum values (Abstract PTU-243 figure 1). "C" had maximum gradient and highest values while "I" had the lowest levels detectable. Assays "B" and "E" had characteristics in between. Inter-assay concordance (Abstract PTU-243 table 1) was statistically significant in absence of inflammation for all pairings. The highest assay concordance across all grades of inflammation was between monoclonal "I" and polyclonal "C".

Abstract PTU-243 Figure 1

Abstract PTU-243 Table 1

Assay pairing (n = 29)	Grade of inflammation: inter-assay concordance			
	All grades (n = 29)	0 (n = 12)	1 (n = 11)	2 (n = 6)
B/C	0.9284*	0.9788*	0.7346	0.8000
E/C	0.9611*	0.9767*	0.8941*	0.9058*
I/C	0.9863*	0.9797*	0.9682*	0.9143*
B/E	0.9440*	0.9875*	0.7671	0.8061
B/I	0.9484*	0.9930*	0.7847	0.8000
E/I	0.9650*	0.9813*	0.9487	0.7609

*p Value <0.02 by Fisher ratio.

Conclusion In this pilot, assays "I" and "C" had the most favourable characteristics/concordance. If this trend is confirmed by larger numbers, we will adopt the monoclonal assay "I" as it is automated.

Competing interests None declared.

PTU-244 AUDIT OF 30-DAY MORTALITY POST ENDOSCOPY—A TERTIARY CENTRE EXPERIENCE

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Introduction Post endoscopy mortality is a quality standard for all endoscopy units. Despite the BSG guidelines on endoscopy related mortality in 2006 there has been little published data available for individual trusts. To review all deaths occurring 30 days post Endoscopy performed within the UHL Trust and establish if they are related to the procedure. We also determined an all cause mortality and procedure related mortality for our Trust.

Methods Deaths that occurred both in hospital and community within 30 days post endoscopy were captured through our local CASE team for a period of 6 months (January–June 2009) and information was obtained on certified cause of death. All patients' case records were critically reviewed. Data were collected on demographics, principal diagnosis, indication for procedure, nature and type of procedure, immediate complications and cause of death. We made an observation and established if the death was related to endoscopic procedure. Results are analysed using MS excel 2007 and SPSS V.13.

Results In total 6783 endoscopy procedures were performed during this 6-month period. Of these, 3342 were Gastroscopies, 1645 Flexible Sigmoidoscopies, 1441 Colonoscopies and 355 ERCPs. A total of 87 patients died within 30 days of their Endoscopy procedure, a high proportion of which were inpatients. 56 died during their inpatient stay. 117 (72 OGD, 24 ERCP, 18 FOS, 2 Colons and 1 EUS) procedures completed on these 87 patients were reviewed. Of these, 54 were therapeutic procedures. 53 were male and 34 were female with a median age 74 years. Of these 6 (5%) patients had three or more procedures, 26 (22%) patients had two procedures and 55 (73%) had single procedures. None required reversing agents nor had sedation related complications. One immediate complication of duodenal perforation following ERCP was recorded. Overall four deaths were identified to be causally related to Endoscopy, all of who had therapeutic procedures (One OGD with oesophageal dilatation and three therapeutic ERCP (one of who died following a myocardial infarct)). 14 cardiovascular deaths occurred within 30 days post endoscopy, eight of which were within 8 days. Underlying malignancy was the commonest recorded cause of death in 30. Individual mortality rates 30 days post OGD, FOS, Colonoscopy and ERCP of 1.7%, 0.61%, 0.14% and 7.8% respectively were noted giving an overall mortality rate of 1.3% (1:78). Individual procedure related mortality figures for OGD and ERCP are 0.03% and 0.56% respectively.

Conclusion Post endoscopy mortality is a safety and quality standard for all units. Our audit serves as a reminder of the appreciable risk associated with therapeutic endoscopy and that cardiovascular complications still account for a significant proportion of endoscopy related morbidity and mortality.

Competing interests None declared.

PTU-245 COMMUNITY BASED SPECIALIST GASTROENTEROLOGY CLINIC IN SHEFFIELD, UK—COMPARING PRIMARY CARE AND SECONDARY CARE BASED CLINICS 2010–2011

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Introduction Community based clinics may improve patients' access to healthcare and improve communication between primary and