PTU-250 MANAGEMENT OF ANTICOAGULANT AND ANTIPLATELET THERAPY IN PATIENTS UNDERGOING ENDOSCOPIC PROCEDURES: COMPLIANCE WITH EXISTING GUIDELINES

doi:10.1136/gutjnl-2012-302514c.250

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Introduction It is not uncommon for patients on anticoagulants and antiplatelets to undergo endoscopic procedures. The main issue in such cases is balancing the risk of gastro-intestinal bleed and the need for anticoagulation. Recognising this, the British Society of Gastroenterology (BSG) issued in 2008 practice guidelines on the management of anticoagulants and antiplatelet therapy in patients undergoing endoscopic procedures. Aspirin, Clopidogrel and Warfarin are the most commonly used antiplatelets and anticoagulants in the UK. Aspirin is recommended to be continued for all endoscopic procedures while Clopidogrel and Warfarin should be tailored to the bleeding risk category of the procedure and the thrombotic risk of the patient's condition. Our clinical practice was retrospectively audited to assess adherence to the BSG guidelines.

Methods All patients on antiplatelets and anticoagulants undergoing endoscopic procedures except ERCP were included in the audit. Data were collected from case notes, endoscopy records and the Éclair pathology reporting system.

Results 48 patients were identified to have 52 procedures with 37 (64%) on Aspirin alone, 6 (10%) on Clopidogrel alone, 9 (16%) on Warfarin alone, 4 (7%) on Aspirin and Clopidogrel and 2 (3%) on Aspirin and Warfarin. 16/37 (43%) in Aspirin alone group had it stopped inappropriately for 3–7 days. 3/6 (50%) Clopidogrel alone patients had it stopped while having one high risk procedure and two low risk procedures. Warfarin was stopped inappropriately in 7/9 (78%) patients undergoing eight procedures.

Conclusion Endoscopic procedures have evolved over the years to include increasingly complex and invasive procedures carrying risk of serious complications including bleeding. Also significant proportions of patients are on multiple medications including anticoagulants and antiplatelets. It is therefore essential that appropriate management plan for the anticoagulant and antiplatelet therapy should be made to minimise the haemorrhagic and thromboembolic risk when requesting endoscopic procedures. The findings of this audit underline significant non-compliance to existing guidelines with potential serious implications for the standard of patient care. While endoscopy is performed by trained endoscopists, the procedures are requested by clinicians with variable knowledge and awareness of the existing BSG guidelines. This hurdle can be overcome using a combination of raising awareness through educational events and modification of the endoscopy requesting software by including a link to the anticoagulation management guideline flow chart making it accessible to the clinicians at the time of requesting. We hope these measures will result in improvement of service and make endoscopy safer in our hospital.

Competing interests None declared.

PTU-251 IMPACT OF APPLYING CURRENT BSG GUIDELINES ON COLORECTAL CANCER SCREENING AND SURVEILLANCE COLONOSCOPY PROCEDURES

doi:10.1136/gutjnl-2012-302514c.251

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Introduction The demand for colonoscopy is ever increasing, with greater pressures on endoscopy units. In order to provide a more

efficient and timely service we conducted a review of our practice. Our aim was to audit colorectal cancer screening and surveillance colonoscopy procedures and determine the impact of the updated BSG guidelines (2010) on service provision.¹

Methods The clinical letters, pathology reports and previous endoscopy reports were reviewed for all patients scheduled for surveillance colonoscopy over a period of 3 years (2010–2012). Data gathered included patient demographics, indication for procedure and outcome when audited against the current BSG guidelines. If the procedure did not meet the current guidelines with respect to indication or timing, the responsible clinician contacted both patient and GP, offering a clinic appointment to discuss further if needed.

Results A total of 354 colonoscopy requests were reviewed. Median age of the group was 62 years (range 22–98 years), male to female ratio 1.7:1. Indications included polyp surveillance 214 (60%), IBD surveillance 55 (15%), family history of colon cancer 50 (14%), high-risk disease and family groups 17 (5%), previous colon cancer 9 (3%) and other indications 9 (3%). 152 (43%) were appropriate when audited against the current guidelines with no changes made to their procedures. Of the remaining 202, 106 (52%) had the time to follow-up procedure extended (mean 3.25 years), 73 (37%) did not meet the criteria for a repeat procedure and 23 (11%) procedures were inappropriately delayed (mean 1.30 yrs). 125 colonoscopy requests were relevant to the updated guidelines for IBD surveillance, family history of colon cancer and high-risk disease and family groups. There were 57 IBD surveillance requests, of which 24 (42%) had the time to follow-up procedure extended (mean 1.75 yrs). Out of 51 requests with family history of colorectal cancer, 23 (45%) had the time to scheduled screening procedure extended (mean 8 yrs).

Conclusion Evaluating existing colonoscopy referrals against up to date BSG guidelines will contribute towards providing a more efficient colonoscopy service. In our practice a fifth of patients on the waiting list were inappropriate for further surveillance and a further third had the time to their procedure extended, therefore increasing capacity and efficiency to allow timely deliverance of procedures for those needing surveillance.

Competing interests None declared.

REFERENCE

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PTU-252 CA19.9—ARE WE USING IT APPROPRIATELY AND IS IT COST EFFECTIVE?

doi:10.1136/gutjnl-2012-302514c.252

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Introduction CA19.9 is frequently used in the assessment of patients with suspected pancreatic cancer or cholangiocarcinoma. Although specific guidelines are not available, data suggests that it should not be used for screening and only used in conjunction with appropriate imaging. The aim of this study was to investigate the clinical utility and cost effectiveness of using CA19.9 as a marker for pancreatic cancer and cholangiocarcinoma in a district general hospital.

Methods A retrospective analysis was undertaken of all patients with a CA19.9 measurement over a period of 12 months. Data on liver biochemistry and abdominal imaging were collected. The results were compared to identify those patients in whom; (i) a positive CA19.9 result was associated with the presence of biliary or pancreatic malignancy (ii) those patients in whom CA19.9 was inappropriately requested. A cost analysis was undertaken.

Results 492 CA19.9 assays were performed in 12 months. 245 were in patients who had not had abdominal imaging or LFTs measured. 247/492 had both imaging and LFTs and were included in the initial analysis. 102/247 had a positive CA19.9. A total of 45/247 were found to have a pancreatic or biliary malignancy 38/45 had a positive CA19.9. This was negative in 7/45. The overall clinical utility of CA19.9 was poor. From the 492 assays performed during the year a positive CA19.9 was associated with a new malignancy in just 7% (38/492). Overall 63% of patients with a positive CA19.9 did not have pancreatic cancer (PPV 37%). Conversely 5% of those with a negative result did (95% NPV). 22% of patients with pancreatic malignancy had normal LFTs at the time of diagnosis. In total 103/492 (20%) of assays were duplicates. Only 36/103 (35%) were in patients with confirmed malignancy. 67 assays were requested in patients with normal abdominal imaging or in the absence of imaging and LFTs. The total cost for all assays was £7380. £6165 was spent on inappropriate requests or where the diagnosis was not pancreatic malignancy.

Conclusion The clinical utility of CA19.9 is poor with only 7% of samples resulting in a new diagnosis of pancreatic malignancy. The assay is frequently requested inappropriately, often without abdominal imaging being available. LFTs should not be used to guide testing. CA19.9 measurement should only be undertaken in patients where imaging results are available and suggestive of pancreatic malignancy. There are significant cost savings from this approach.

Competing interests None declared.

PTU-253 LIFE WITHOUT A BLEEDING ROTA: RISK OF LATE ENDOSCOPY?

doi:10.1136/gutjnl-2012-302514c.253

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Introduction In the 2007 UK audit of acute upper gastrointestinal bleeding (AUGIB),¹ 44% of participant centres did not have facility for a dedicated bleeding rota. Gross measures of outcome, such as mortality, were found to be independent of the presence of a bleeding rota; however adherence to other aspects of guidance, such as time to endoscopy, in the absence of a bleeding rota, was not examined. We aimed to examine the performance in the absence of a dedicated bleeding rota, but with a "goodwill" out of hours service, against national guidelines and performance.

Methods Data were collected prospectively for all cases of AUGIB over a 2-month period from September 2010 to November 2010. Cases were identified from request forms in the endoscopy department. Data were collected for all endoscopies; repeat endoscopy on the same admission was recorded separately. Rockall score, if not included with the original endoscopy request was calculated retrospectively. Results were analysed in Excel. Statistics performed using Fischer's exact test.

Results There were 35 patients identified, referred for 40 procedures for AUGIB, 39 of which were carried out. Median age at presentation was 64 (35–92), 14 years younger than the national audit. The proportion of patients presenting with documented cirrhosis 23% (n=8) was significantly greater than in the national audit p=0.0026. Furthermore the proportion of patients with varices, although not necessarily responsible for the bleed, was greater 17% vs 8% p=NS. Rockall score was documented in 23% cases compared with 19% in the national audit. Rockall score was ≥ 3 in 73% compared with 51% in the national audit p=0.01. Time to endoscopy, regardless of Rockall score was <24 h in 72% and in patients with Rockall score ≥ 3 was 79% compared with 50% in both groups in the national audit. In the cases in our study for whom the Rockall score was

documented, all had a Rockall score ≥ 3 and proceeded to endoscopy within 24 h. Mortality in both our study and the national audit was 10%.

Conclusion Our patient group was younger than the national average with a higher proportion with pre-endoscopy Rockall score ≥ 3 . We demonstrate ongoing difficulties in encouraging documentation of risk assessment scores, however in our experience when the Rockall score was documented the endoscopy happened in a timely fashion. We demonstrate with data from our centre that early endoscopy is achievable in the majority of cases in the absence of a dedicated bleeding rota. This does not appear to affect overall mortality however risk assessment and early endoscopy are important as we strive to improve the service we offer our patients.

Competing interests None declared.

REFERENCE

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PTU-254 WHAT DO GENERAL PRACTITIONERS WANT FROM GASTROENTEROLOGY SERVICES IN SECONDARY CARE, AND WHAT ARE THEY HAPPY MANAGING IN PRIMARY CARE?

doi:10.1136/gutjnl-2012-302514c.254

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Introduction Recent changes in the NHS have focussed on moving more services into primary care. General Practitioners (GPs) are rarely consulted over planning of secondary care services, nor are they asked on their own comfort in managing gastroenterological conditions. The results of a GP survey of confidence and service development are presented.

Methods An online survey (created on Google Docs) was emailed to 102 GP practices. GPs were asked to rate their confidence in managing gastroenterological conditions as well as rate service developments using a 5-point Likert scale (1—very low, 5—very high). Free text boxes allowed GPs to provide additional comments for qualitative analysis. Responses (n=52) within 28 days were analysed in Microsoft Excel.

Table 1. GPs confidence in managing Gastroenterological conditions

Condition	Average	Median
Dysphagia	4.00	4
GERD and Dyspepsia	4.00	4
Iron Deficiency Anaemia	4.00	4
Gall Stone and Biliary Disease	3.93	4
Functional GI problems	3.87	4
Weight loss	3.78	4
Acute and Chronic Diarrhoea	3.75	4
Abdominal Pain	3.71	4
Gastrointestinal malignancies	3.58	4
Acutely Deranged LFTs	3.35	4
Patients on Immunosuppressants	3.33	4
Inflammatory Bowel Disease	3.33	4
Alcohol Dependency Syndrome	3.05	3
Malabsorption and Nutritional Problems	3.00	3
Chronically Deranged LFTs and Cirrhosis	2.79	2
Chronic Pancreatitis	2.26	2