physiological variables such as the patient's temperature, blood pressure and pulse at diagnosis of CDAD were recorded as were any haematological and biochemical investigations taken within 24 h of diagnosis.

Results Hospital admissions between 14 and 30 days ($p=0.031$), increasing co-morbidities ($p=0.05$), systolic blood pressure <100 mm Hg ($p=0.048$) and heart rate greater than 100 beats per minute ($p=0.043$) were significantly associated with increased 30-day mortality. There was a clear trend of increased mortality for increasing length of stay (LOS) on the current admission before development of diarrhoea (If LOS greater than 7 days before onset, $p=0.07$), temperature $<35^{\circ}\text{C}$ ($p=0.07$), recent discharge from hospital within 30 days ($p=0.106$) and to a lesser degree, low albumin (albumin <30 g/l $p=0.221$) at the time of diagnosis, age >85 years ($p=0.947$) and current PPI use ($p=0.224$). From the data, a scoring system was derived whereby 1 point was given to the non-statistically significant trends and 2 points to the statistically significant trends. If there were 1 to 3 co-morbidities, this was scored as 1 and greater than 3 co-morbidities scored as 2. There was a maximum score of 14. On applying this retrospectively to the existing database, 39 patients were identified where all the parameters in the scoring system were available. Of these, a score of 4 or less was associated with low risk of 30-day mortality (0% mortality in 13 patients). A score of 5 to 7 was associated with moderate risk of 30-day mortality (33.3% mortality in 15 patients) and a score of 8 or more to be associated with a high risk of 30-day mortality (72.7% mortality in 11 patients).

Conclusion A simple scoring system holds promise for defining those patients at greatest risk of 30-day mortality from CDAD in our population. However a note of caution should be exercised. Applying a scoring system retrospectively to a dataset from which information has been used to derive the score does not validate it and a prospective study is planned to validate the York scoring system.

Competing interests None declared.

PWE-104 PREVALENCE AND SIGNIFICANCE OF SESSILE SERRATED LESIONS FROM A LARGE PROSPECTIVE UK SERIES IN THE SETTING OF BOWEL CANCER SCREENING PROGRAMME

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S Tholoor,* P Basford, P Bhandari. *Department of Gastroenterology, Portsmouth Hospitals NHS Trust, Portsmouth, UK*

Introduction Screening colonoscopy has not had a big impact in reducing right sided cancer mortality and it is believed that this could partly be due to sessile serrated lesions (SSLs) which are thought to be the precursors of microsatellite adenocarcinomas. In the UK, people from the age of 60 to 75 with positive faecal occult blood undergo screening colonoscopy. We aim to evaluate the prevalence and significance of SSLs in our screening population.

Methods All colonoscopies performed between 2007 and 2011 were prospectively recorded on a screening database along with the histology. Pathology was reported as per standards laid out by the National screening programme by accredited Pathologists.

Results We analysed 1948 polyps from a total of 1576 patients. 28/1948 polyps in 25/1576 patients were found to have sessile serrated lesions. This amounted to 1.4% of the total polyps found. Out of 25 patients, 13 patients were men. The prevalence of sessile serrated lesions in all patients with polyps was 1.7% 17/28 lesions. (60%) of the lesions were smaller than 10 mm. 17/28 (60%) were in the right colon. 14/28 (50%) had no dysplasia. 14/28 (50%) had low grade dysplasia. None had high grade dysplasia or cancer. No interval cancer was found in a mean follow-up of 12 months. All 25 patients

with sessile serrated lesions were also found to have conventional adenomas. 1–2 adenomas were found in 6/25 patients, 3–4 adenomas in 6/25 patients and 13/25 patients had at least 5 adenomas.

Prevalance of dysplasia: SSLs with dysplasia: 14/28 (50%)

—Low grade dysplasia: 14/14, High grade dysplasia/cancer: 0/14
SSLs with NO dysplasia: 14/28 (50%).

Conclusion (1) Our study shows a low prevalence of 1.7% of sessile serrated lesions accounting to $<1.5\%$ of the total number of polyps found in the setting of bowel cancer screening programme. (2) We did not find any high grade dysplasia or cancer in these patients. No interval cancer or synchronous cancers were found. (3) All patients with SSLs had conventional adenomas and the presence of SSLs had no effect on their surveillance plans. (4) Our study does not show any clinical impact of the sessile serrated lesions on patient outcomes. This questions the clinical relevance of SSLs.

Abstract PWE-104 Table 1

Site	No of lesions
Right colon	17 (60%)
Left colon	11 (40%)
Upto 10 mm	17 (60%)
>10 mm	11 (40%)

Competing interests None declared.

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PWE-105 CLINICAL EFFICACY OF THE COMBINATION OF PROPOFOL AND KETAMINE (KETOFOL) FOR DEEP SEDATION FOR COLONOSCOPY

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S Amornyotin,* W Chalayonnawin, S Kongphlay. *Department of Anesthesiology, Faculty of Medicine Siriraj Hospital, Mahidol University, Bangkok, Thailand*

Introduction A combination of propofol and ketamine is usually used to achieve sedation and analgesia during colonoscopy. Few studies have compared their efficacy. The aim of this study was to compare and evaluate the clinical efficacy of the combination of propofol and ketamine (ketofol) vs propofol alone when each regimen is used as sedative agents for colonoscopy.

Methods 194 patients who underwent colonoscopy in 2 years, were randomly assigned to PN and PK groups. 97 patients in group PN received propofol and normal saline and 97 patients in group PK received propofol and ketamine for intravenous sedation (IVS). All patients were premedicated with 0.02–0.03 mg/kg of midazolam. The primary outcome variable was the successfully completed colonoscopic procedure. The secondary outcome variables were patient tolerance, discomfort during insertion, patient and endoscopist satisfaction, haemodynamic responses, as well as complications during and immediately after procedure. Immediately after the procedure, the endoscopist was asked to rate tolerability for the patient, discomfort during insertion and satisfaction. As well, a blinded member of the research team evaluated the patient satisfaction, procedural pain, recovery time and recovery score.

Results All endoscopies were completely successfully. Mean total dose of propofol in group PK and PN was 6.98 (2.90) mg/kg/h and 7.73 (3.45) mg/kg/h, respectively ($p=0.413$). Mean total dose of