unit. 357 cases were performed prior to regular GA list introduction and 356 cases after. There were 28 cases performed under GA in the BGA group and 81 in the AGA group ($p < 0.01$). There was no statistical difference in patient age or gender ratio.

Following the introduction of regular GA ERCP lists, the overall procedural success rate increased from 94.7% to 98.3% ($p < 0.01$). Procedural failure did not occur in any of the 109 cases performed under GA. Reasons for failure at ERCP were multiple, with sedation failure directly quoted in 3 of the 25 cases. Use of sedation reversal agents was lower in the AGA group (8 vs 1 cases, $p < 0.05$).

Conclusion The introduction of a weekly general anaesthetic ERCP list has improved desired duct cannulation and drainage success within our endoscopy unit. This advantage of anaesthetist-led sedation has not been previously demonstrated. The mechanism of improved success is likely to be multi-factorial in origin. Although agitation and sedation failure were cited in only a minority of procedural failures, we believe the increased control and safety afforded allows the endoscopist to successfully perform more challenging interventions. These data may support the wider introduction of anaesthetist-led sedation/general anaesthesia for ERCP.

Disclosure of Interest None Declared.

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PWE-036 CLINICAL PRESENTATION, CAUSES AND OUTCOME OF ULCERS IN ILEO-CECAL REGION: A PROSPECTIVE STUDY FROM A TROPICAL COUNTRY

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Introduction Ulcerations in the ileo-cecal (IC) region may have various causes and outcome, depending on the geographical region of the patients. Such data is scarce from tropical countries.

Methods To evaluate the clinical, endoscopic and histologic characteristics of ileocecal ulcers in a tropical country. Prospective study of consecutive patients undergoing colonoscopy, and diagnosed to have ulcerations in the IC region presenting at an tertiary care centre. All patients underwent endoscopic documentation. Biopsy was obtained and their clinical presentation and outcome were recorded.

Results Out of 1632 colonoscopies performed in our hospital from May 2010 to October 2011, 104 patients had ulcerations in the IC region. This population represents the study group. The median age was 44.5 years (range 18–85) and 59% were male. The predominant presentation was lower GI bleed (55.5%), pain abdomen +/-diarrhoea (36.3%), diarrhoea alone (9.9%), or miscellaneous (4.4%). Associated fever was present in 32 (31%) patients. On colonoscopy, terminal ileum could be entered in 96 (92%) cases. The distribution of ulcers was as follows: Ileum alone 40% (38/96), cecum alone 33% (32/96), and both ileum plus cecum 27% (26/96). In the 8 patients in whom ileum could not be entered ulcerations were present in the cecum and the IC valve. The ulcers were multiple in 98% and in 34% there were additional ulcers elsewhere in colon. Based on clinical presentation and investigations, the aetiology of ulcers was classified into infective causes (43%), non-infective causes (29%), and non-specific ulcers (28%) (Table). With infective cause, fever was significantly more common (47% vs 19%; $p < 0.01$) and cecum was preferentially involved (82% vs 45%; $p < 0.01$). Three patients (3%) died (all had presented with bleed and had non-specific ulcers), and 8 patients (8%) required surgical treatment. The remaining 93 patients (89%) had an uneventful recovery.

Conclusion Unlike in Western countries the most common (> 40%) cause of ulcerations of the IC region in the tropics is infections. Cecal involvement and fever are important clues to infective cause. These causes must be kept in mind while treating IC ulcers in patients from the tropics.

Disclosure of Interest None Declared.

PWE-037 "BEAR-CLAW" OR OVER-THE-SCOPE -CLIP SYSTEM (OTSC); A BREAKTHROUGH, SURGERY SPARING, ENDOSCOPIC DEVICE

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Introduction The "bear-claw" or over-the-scope clip system, OTSC (Ovesco Endoscopy, Tübingen, Germany) is a new clipping device developed for closure of large luminal gastrointestinal (GI) defects.

Methods To evaluate the clinical outcomes of patients treated with the OTSC a prospective, single-arm, pilot study was conducted in a regional hospital with tertiary care endoscopy. This study involved 11 clip applications in 10 patients (median age 76.2 years [range 52–89 years], 5 women) with GI defects from fistulas and anastomotic dehiscence and peptic ulcer bleeding.

Results Bleeding posterior duodenal wall ulcers ($n = 4$), bleeding gastric ulcer ($n = 2$), three fistulas or anastomotic dehiscences ($n = 4$) were treated using the OTSC-system. In addition a self-expanding metal stent was anchored securely in place with an OTSC-system. The diameter of ulcers and/or leaks ranged between 12 and 20 mm. A complete sealing of leaks was achieved in 3/4 patients. There were no clip complications. However, during introduction of the loaded clip on the tip of the endoscope, the hood tended to migrate over the scope, i.e. retracting, thus diminishing the exposed hood. This leads to diminished tissue suction and closure. Thus we modified the technique by tightly taping the hood on the tip of the scope. This trick may explain why all our cases were successful.

Conclusion The OTSC system is a useful device in a variety of clinical scenarios including the management of larger GI leaks, GI bleeding and stent anchoring, even in very old and frail patients.

Disclosure of Interest None Declared.

PWE-038 PATIENT CONTROLLED PROPOFOL – DO WE NEED AN ANAESTHETIST?

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Introduction Propofol is widely used during endoscopy but there remains controversy around its safety, if administered by non-anaesthetists. In a review of endoscopist-administered Propofol of 600 000 patients, only four deaths were reported. Patient-controlled Propofol sedation (PCPS) has been used during ERCP with lower sedation scores reported. We therefore piloted the use of PCPS in an unselected population attending for ERCP.

Methods PCPS was used in eleven patients undergoing ERCP. Propofol 8mg/ml and Remifentanyl 10mcg/ml was administered via a patient controlled pump, under the guidance of trained anaesthetic staff. Outcomes included completion and safety. Adverse events were defined as saturations < 90% or systolic < 90mmHg. Recovery was measured using the Aldrete score.

Results There was no difference between baseline demographics between the groups. In those undergoing PCPS, mean procedure

time was significantly longer (24mins vs 40 mins, $p = 0.04$), although this group tended to have more unwell patients (ASA grade) and a higher difficulty grade of ERCP ($p = 0.06$ and 0.05 respectively). There were no significant differences in frequency of adverse events between PCPS and standard sedation ($p = 0.87$). Also, there were no significant differences in recovery time, although Aldrete scores tended to be higher in the PCPS group. Endoscopist rating of how sedation was tolerated was significantly higher in the PCPS group ($p = 0.04$). 2 cases that had failed under standard sedation were subsequently completed using PCPS.

Conclusion PCPS is an effective method of sedation for ERCP. This small UK based study shows that PCPS is at least as safe as standard sedation techniques, even when used in complex procedures in severely unwell patients. In the future, with appropriate training and governance, PCPS might be utilised without anaesthetic support.

Disclosure of Interest None Declared.

PWE-039 INFORMING PATIENTS AND THE MULTI DISCIPLINARY TEAM OF A DIAGNOSIS OF GASTRO-INTESTINAL MALIGNANCY

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Introduction The management of gastro-intestinal (GI) malignancy is largely determined by multi-disciplinary team (MDT) discussion, where members have not met the patient. The quality of information given to the patient immediately following endoscopy, and subsequently to the MDT, is variable.

Methods A 3 month retrospective audit of all outpatient endoscopic diagnoses of upper and lower GI malignancies at Derriford Hospital, Plymouth. The endoscopy report (Endosoft), endoscopy care pathway and medical notes were reviewed. Information provided regarding the description of pathology; post endoscopic patient discussion; GI Cancer Nurse Specialist (CNS) involvement and request for staging imaging was interrogated. Inpatients were excluded.

Results There were 65 patients with GI malignancy (oesophago-gastric cancer [OGC] $n = 24$; colorectal cancer [CRC] $n = 41$). For patients with confirmed OGC the report recorded suspected malignancy in 19/24 (79%). Post endoscopy patient discussion was recorded on the report in 7/19 (37%); patient informed & recorded only in the nurse's care pathway in 5/19 (26%); no evidence of discussion with patient in 7/19 (37%). GI CNS involvement was documented on the report in 5/19 (26%); the report documented requesting of staging imaging by the endoscopist in 10/19 (53%). For patients with confirmed CRC the report recorded suspected malignancy in 33/41 (80%). Post endoscopy discussion was recorded on the report in 10/33 (30%); patient informed & recorded only in the nurse's care pathway in 13/33 (39%); no evidence of discussion with patient in 10/33 (30%). GI CNS involvement was documented in 15/33 (45%). The report documented requesting of staging imaging by the endoscopist in 22/33 (67%).

Conclusion The MDT relies upon patients being informed of their suspected diagnosis, and accurate endoscopic documentation in order to make informed decisions and to allow direct referral to Surgical and Oncological specialities. However, a significant proportion of patients with upper and lower GI cancer leave the endoscopy department without a diagnosis of suspected cancer being made, and even when it is suspected, are frequently not informed by the endoscopist.

Disclosure of Interest None Declared.

PWE-040 PREVALENT ROUND STAGE SHIFT IN THE NATIONAL BOWEL CANCER SCREENING PROGRAMME IN WALES; DATA FROM THE FIRST 3 YEARS AT A SINGLE SCREENING CENTRE

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Introduction Colorectal cancer screening is based on early detection of cancers and removal of premalignant polyps though this adenoma to carcinoma sequence is thought to progress over several years. The Bowel Screening Programme in Wales based on guaiac FOBt and colonoscopy for individuals resting positive began roll-out in October 2008, with the aim of reducing mortality through cancer detection at an early stage. The aim of this study was to investigate whether screen detected cancers in Cardiff and the Vale of Glamorgan demonstrated any shift in the stage of cancer during the first three years of screening (initial prevalent round).

Methods Data was collected prospectively to compare the staging of colorectal cancer diagnosed in the BCSP with cancers diagnosed in the non-screening population in the same geographical region from 1st October 2008 to 31st December 2011. All information was cross checked with Cancer Registry data.

Results Screen detected cancer was found in 69 individuals (44 male, 25 female), with a positive predictive value of colonoscopy (after positive FOB testing) of 8.7%. Complete clinical staging was available for all 69 individuals; two patients did not undergo surgical resection due to the presence of metastases after radiological staging. There were 696 non-screening detected cancers during the same time period. For the purposes of this analysis, polyp cancers (cancer that was removed by endoscopic means at the time of colonoscopy/flexible sigmoidoscopy) were included in Duke's stage A, except for one polyp cancer that required subsequent surgical resection and was staged as Duke's C1. The results are shown in table 1. Three-quarters of cancers diagnosed in the BCSP were Dukes A or B, compared to 44.1% in the non-screening population. Of Duke's D cancers, only 2.8% were diagnosed through screening, with 27% diagnosed in the non screening population ($p < 0.0001$).

Abstract PWE-040 Table 1 Stage of cancer diagnosed with comparable data from non-screening population

Stage	BCSP	Non-screening population	p Value
Duke's A	35 (50%)	115 (16%)	$p < 0.0001$
Duke's B	14 (25%)	192 (28%)	$p = 0.67$
Duke's C1	11 (16%)	120 (17%)	$p = 0.87$
Duke's C2	4 (6%)	27 (4%)	$p = 0.35$
Duke's D	2 (3%)	192 (28%)	$p < 0.0001$
Dukes unknown	-	49 (7%)	

Conclusion This data strongly supports significant stage shift of colorectal cancer even within the initial prevalent round in this single Bowel Cancer Screening centre in Wales that the benefits of screening may be demonstrable in outcomes at a relatively early stage of the programme.

Disclosure of Interest None Declared.

PWE-041 HISTOPATHOLOGICAL UNCERTAINTIES IN THE MANAGEMENT OF EARLY COLORECTAL CANCERS RESECTED THROUGH ENDOSCOPIC THERAPY

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