Abstract PTH-047 Table 1

	Pre-Bundle Population	Post-Bundle Population	Total
Good Visualisation	24	30	54
Moderate/Poor Visualisation	29	7	36
Total	53	37	

P-value = 0.0008; two-tailed Fisher's exact test.

Conclusion Our study - the first looking at the effect of a bowel cleansing care bundle on inpatients - shows that its implementation conferred significantly better visualisation scores at colonoscopy with a dramatic reduction in poor visualisation.

Disclosure of Interest None Declared.

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PTH-048 BENCHMARKING IN UPPER ENDOSCOPY - BEST PRACTICE MARKERS

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Introduction UK practise in diagnostic oesophago-gastric-duodenoscopy (OGD) has changed little over the last 10–20 years. Currently the only quality measure relates to ability to reach the second part of the duodenum. Evidence-based quality indicators in colonoscopy pertain to the quality of views, the amount of time spent examining the mucosa and expected levels of lesion detection, in addition to completion rates. Their adoption, in combination with robust clinical governance has undoubtedly improved the detection of colorectal diseases, patient safety and patient experience. The equivalent evidence base for diagnostic OGD does not exist and this has limited development.

Benchmarking is a process measuring the practise of one organisation against its peers and may provide a basis for developing quality standards for upper GI practise. This study measures routine OGD practise in the UK and practise in a Japanese centre of excellence for endoscopy and oesophago-gastric cancers.

Methods Two experienced endoscopists recorded OGD practise in the National Cancer Centre Hospital in Tokyo. The following were recorded: net procedural time spent screening the oesophagus, stomach, and duodenum; lens cleaning, mucosa cleaning, presence of residual food; use of dye spray and narrow band imaging; picture numbers and biopsies; patient age and sex.

One experienced endoscopist recorded OGD practise during routine diagnostic lists at 3 hospitals.

Results 134 procedures were recorded, 67 in each country. The average age in the UK was 58.5 yrs (60% male) and 68.2 yrs in Japan (57% male). The average screening time in Japan was 6:51 mins, and 5:49 mins in the UK. The Japanese use advanced imaging techniques 73% of the time. They were never used in routine UK practise.

Japanese endoscopists met weekly reviewing all pathology detected and discussing therapeutic cases. All images were reviewed closely and were an essential part of decision making and education in the unit.

	Japan	UK
Overall Screening time (mins)	00:05:51	00:05:49
% of cases where the lens was cleaned pre-procedurally	46.3	1.9
% of procedures where stomach/oesophagus was washed	100	13.2
% of cases with a stomach clear of food	92.5	96.2
% of cases using advanced imaging	73.1	0
% of cases using NBI	37.3	0
% of cases using iodine	13.4	0
% of cases using indigo carmine	49.3	0
% of cases using zoom	1.5	0
Average pictures taken	45.7	2.4
Average biopsies taken	0.6	2.8
% of cases with extra pathology found	22.4	15.1

Abstract PTH-048 Figure 1

Conclusion Comparison of the 'cultures of practise' are interesting, revealing significant differences of approach in UGI examination.

In the Japanese cohort a 48% higher yield of pathological findings was achieved despite the average screening time being only one minute longer per case.

Although there are differing disease prevalence's in the background populations, it seems likely that better cleaning of the upper GI tract, use of mucosal enhancement techniques, care in image capture, and better awareness of upper GI pathology will have significantly contributed to increased detection.

Further investigation is needed into which factors can be used as independent measures of quality in UGI examination, including time taken to examine the upper GI tract and measures of endoscopists' lesion recognition skills (not currently assessed as part of endoscopy training).

Disclosure of Interest None Declared.

PTH-049 SUB-OPTIMAL BOWEL PREPARATION IN THE SURVEILLANCE POPULATION - WHAT DOES IT MEAN?

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Introduction Modern colonoscopic surveillance follows clear evidence based guidelines, and clinical decisions appear straight forward. However, the guidelines do not define what should be done in cases with sub-optimal preparation.

Methods We retrospectively reviewed all adenoma and post carcinoma surveillance colonoscopies over 5 years (2006–2011) with a further year follow up looking for incident cancers.

Polyp site, number, size, and colonoscopy completion rates were recorded.

Two cleaning regimes were used: standard - Fleet; second line and in older patients/renal failure - KleanPrep, picolax and senna. Preparation was graded by the performing colonoscopist as satisfactory, sub-optimal or unsatisfactory.

Results 2176 patients underwent 2649 surveillance colonoscopies. Average patient age was 68.8 years. Mean follow up was 3.4 years.

3758 polyps were identified in 1539 procedures; 525 polyps were 1cm or larger. There was a marked trend towards lower polyp detection with worsening bowel preparation ($p = 0.056$ Chi²) with a marked reduction in mean number of polyps particularly on the right side with worsening preparation.

12 colorectal cancers were detected in this population. The overall cancer rate in this high risk population was 1 in 181 patients (95% C.I. 103 – 350).

73 patients with sub-optimal or unsatisfactory preparation had a repeat colonoscopy. In 64% the preparation was satisfactory, 28% were sub-optimal, and 8% had an un-satisfactory examination.

Abstract PTH-049 Table 1

Bowel preparation	Unsatisfactory	Sub-optimal	Satisfactory
Total number of colonoscopies (N = 2649 (%))	90 (3)	351 (12)	2208 (85)
Total number of procedures finding polyps (N = 1539 (%))	43 (48)	194 (55)	1302 (59)
% right	32.6	39.2	42.1
Mean number of polyps found for all procedures	1	1.2	1.5
Mean number of polyps found on the right side	0.32	0.48	0.62
Mean number of polyps found on the left side	0.66	0.75	0.85
Total polyps > 0.9cm (N = 525)	8	80	437
Average number of procedures find a polyp > 0.9cm	11.5	4.4	5.1
Completion rate overall %	85	99	98

Conclusion 15% of procedures in our surveillance population have sub-optimal or unsatisfactory bowel preparation, making the interpretation of the clinical guidelines difficult.

Patients who have sub-optimal or unsatisfactory preparation have a high proportion of further sub-optimal or unsatisfactory procedures. Endoscopy units should have a strategy for improving this.

In patients with sub-optimal or unsatisfactory bowel preparation there is a significant reduction in overall polyp detection which is particularly marked in the right colon. This does not appear to be the case with large polyps.

In patients with sub-optimal or unsatisfactory preparation undergoing a complete colonoscopy, shorter surveillance intervals should be considered taking other patient related factors into account.

Disclosure of Interest None Declared.

PTH-050 WHAT DO ENDOSCOPISTS DO WHEN NO CANCER IS FOUND ON GASTROSCOPY DONE FOLLOWING AN UPPER GASTROINTESTINAL TWO WEEK-WAIT REFERRAL WITH WEIGHT LOSS?

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Introduction For patients referred with suspected upper gastrointestinal (UGI) cancer under the 2 week-wait (2WW), it has been shown that 10.5% will have endoscopic evidence of malignancy, whilst 6.5% of patients may harbour malignancy elsewhere.¹ For those patients with weight loss, a negative gastroscopy for cancer poses an important clinical question for the endoscopist. There are no consensus guidelines advising the most appropriate 'next-step' the endoscopist should make following patients referred with weight loss but have a negative endoscopy for malignancy.

Aim To evaluate local and national practise in endoscopist decisions when no UGI cancer is found on gastroscopy in 2WW referrals with weight loss.

Methods All 2WW referrals for suspected UGI cancer with weight loss were identified from the 2WW office over a 6 month period at a district general hospital. Endoscopy and imaging results were obtained from the respective computer software packages. Questionnaires were made available to British Society of Gastroenterologists members asking them to reveal their initial management preference at endoscopy in patients referred under the 2WW with weight loss where no upper GI cancer was found.

Results Of the 639 2WW referrals in 6 months, 140 (22%) had weight loss. 6/140 (4%) were found to have either oesophageal or gastric malignancy. 134/140 (96%) did not have cancer, whilst 91 (65%) revealed

benign pathologies such as gastritis, duodenitis and hiatus herniae and 43 (31%) were normal. Of the 134 negative endoscopies, the endoscopist took the following actions; 16 (12%) had urgent CT abdomen/chest organised (1 lung malignancy identified), 61 (46%) referred to an urgent Outpatient clinic and 40 (30%) were discharged back to GP. 17 (12%) follow up was to be determined by the list consultant.

71% questionnaire responses received were from consultants. 46% of responders' preference was to follow up in clinic, 39% organised an urgent CT scan, 18% an ultrasound scan and the rest a brief history to ascertain their preference. 10% discharged the patient back to the GP. 100% of responders had no local guidelines at their trust with regards to this group of patients, whilst 54% felt formal guidelines were warranted.

Conclusion Our study shows a large variation in practise amongst endoscopists and hence the potential to over or under investigate and its consequences. Formal guidelines seem warranted.

Disclosure of Interest None Declared.

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PTH-051 SAFETY AND EFFICACY OF COLONIC STENTS (SEMS) FOR LARGE BOWEL OBSTRUCTION FROM PROXIMAL COLORECTAL CANCER

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Introduction Colonic stenting of proximal Colorectal Cancers (CRC) (lesions at splenic flexure or beyond) is technically challenging and currently out-favour as surgical techniques allow safe primary anastomosis on unprepared dilated colon. Consequently, randomised trials (RCTs) have only compared colonic self-expandable metal stent (SEMS) with emergency surgery for acute left sided obstruction. However, emergency surgery is associated with substantial morbidity and mortality.

Aim: To assess the safety and effectiveness of colonic SEMS for obstruction caused by proximal CRC.

Methods Retrospective case series by 2 Consultant Gastroenterologists between 2005 to 2012 was audited. All procedures were performed using Through the Scope (TTS) technique and fluoroscopic guidance. End-points were technical success (correct SEMS placement confirmed radiologically at time of procedure), clinical success (resolution of patient symptoms within 48 hrs), re-intervention, patient discharge and mortality.

Results Demographics 31 patients (Male: Female ratio 2.1:1); median age 85.5 years (range 40–92), mean ASA score 2.5. **Indications:** 84% (n = 26) were palliative and 16% (n = 5) were bridge to surgery. 48% patients had subacute obstruction, 10% had total obstruction, and extent of obstruction was unknown in 42%. Lesions were located at Splenic flexure (n = 15), Distal Transverse (n = 7), Proximal Transverse (n = 3), Hepatic flexure (n = 4), Ascending (n = 1) & caecum (n = 1).

Procedural Success Technical success was 100%. Clinical Success was 81% (n = 25) with these patients being successfully discharged without requiring any further procedures during their hospital stay. Re-intervention was required in 5 patients (16%) due to SEMS dysfunction; managed by re-stenting in 1 and colostomy in 3 patients (Bridge group). The remaining was a colostomy for the only perforation in series (3%). Further surgery was only required in the 2 patients within the bridge group who went onto have uncomplicated elective surgery with primary anastomosis.

Mortality There was no procedure related mortality (0%). All cause 30 & 90 day mortality was 13% & 38% respectively, all of