Abstract PTU-025 Table 1

	2008–09	2010–11	Difference in rates	p
High grade dysplasia	1.325 [95% CI 0.16–4.785]	2.29 [95% CI 0.278–8.304]	-0.9743 [95% CI -0.439–2.445]	0.5766
Low grade dysplasia	3.974 [95% CI 1.458–8.649]	4.598 [95% CI 1.253–11.772]	-0.6242 [95% CI -6.031–4.783]	0.8210
All dysplasia	6.04 [95% CI 2.762–11.466]	8.046 [95% CI 3.235–16.578]	-2.006 [95% CI -8.892–4.88]	0.5681
Targeted biopsy	0.6623 [95% CI 0.0168–3.6898]	19.54 [95% CI 11.38–31.29]	-18.88 [95% CI -26.13–-11.62]	< 0.0001

auto fluorescence and narrow band imaging. This was in contrast to the practise of previous years where the endoscopies for Barrett's surveillance were done by a physician gastroenterologist, a surgeon, or a nurse endoscopist using conventional white light endoscopy alone. In this study, we compared the detection rate of high grade dysplasia, low grade dysplasia and targeted biopsy between patients who underwent endoscopy on a dedicated list and those who underwent surveillance on a general endoscopy list.

Results In group 1 were 151 endoscopies performed on a general list during the years 2008–2009, which were compared with 87 endoscopies performed on a dedicated list from 2010 to 2011. Only one targeted biopsy was taken in group 1 compared to 17 targeted biopsies in group2. The detection rate of high grade dysplasia, low grade dysplasia and all dysplasia were greater in group2 compared to group1. However we were not able to detect a statistically significant difference in rates between the two groups. On the other hand, the difference in the rates of targeted biopsies between the two groups was found to be statistically significant. The difference in detection rates between the two groups [-18.88, 95% CI -26.13 – -11.62, $p = < 0.0001$]. Three of the four high grade dysplasia were detected on a targeted biopsy and two of them had a cancer in situ.

Conclusion In this retrospective comparative study we were able to demonstrate that a dedicated Barrett's surveillance endoscopy list is able to generate a significantly greater number of targeted biopsies compared to surveillance endoscopy performed on varied general lists. The detection rates of high grade dysplasia, low grade dysplasia and all dysplasia were greater on the dedicated list, although this did not reach statistical significance. We would therefore recommend a dedicated Barrett's surveillance endoscopy list.

Disclosure of Interest None Declared

PTU-026 WITHDRAWN BY AUTHOR

PTU-027 PROPHYLAXIS OF POST ERCP PANCREATITIS IN THE UK. HAVE THE ESGE CREATED CONSENSUS?

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Introduction Post ERCP pancreatitis (PEP) occurs in 3.5% of unselected cases 10% of which are severe. PEP is significantly higher in certain patient groups, for example patients with Sphincter of Oddi dysfunction or with a pre-cut sphincterotomy. The 2010 European Society for Gastrointestinal Endoscopy (ESGE) guidelines on PEP prophylaxis recommend routine use of rectal NSAIDs and the insertion of pancreatic stents (PS) in high risk patients¹. This study surveys UK practise of PEP prophylaxis in view of ESGE guidelines.

Methods 220 ERCPists were invited to complete an online survey concerning their awareness of ESGE guidelines, patient selection for PEP, and use of rectal NSAIDs and insertion of PS. 67 responses from 53 UK hospitals were received (response rate = 30.4%).

Results 79% of respondents were aware of ESGE guidelines, of which 47% had subsequently changed their practise. Only 9% of respondents used PEP for all patients as recommended by the ESGE. The majority (66%) used PEP in selected patients, whilst 25% never used PEP. Choice of PEP is demonstrated in the below table. Concerns relating to ESGE guidelines were expressed in a free text comments sections

Abstract PTU-027 Table

Form of PEP used by survey respondents	
Rectal NSAID	16.4%
Pancreatic Stent	23.8%
Both (NSAID/PS)	34.3%
Never use PEP	25.4%

Conclusion If this study is representative of wider practise it would suggest there is widespread variation in the administration of PEP in the UK. Only a minority of respondents were adherent to ESGE guidelines, although the majority had considered them. A significant number of departments were in the process of developing separate local guidelines. Stenting otherwise uncannulated pancreatic ducts and NSAID nephrotoxicity were commonly raised reasons for not adopting ESGE guidelines. Given there are currently no UK guidelines for PEP, this may be an opportunistic time for collaboration. A coordinated strategy of national guidelines or research may contribute to creating a consensus in practise across the UK and ultimately reduce the incidence of PEP.

Disclosure of Interest None Declared

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PTU-028 SYMPTOM ASSESSMENT OF PATIENTS IN THE CHESHIRE BOWEL CANCER SCREENING PROGRAMME WITH A FINDING OF CANCER

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Introduction When attending the bowel cancer screening (BSC) programme patients undergo pre-colonoscopy assessment of their symptoms. This is conducted by the specialist screening practitioner for the BCS programme. Following a diagnosis of bowel cancer at colonoscopy the questions were asked again, after a 3–6 month period. Comparison could then be made to assess the validity of the pre-assessment questionnaire. It would also allow us to look at whether patients reported all symptoms during pre-assessment.

Methods All patients with a diagnosis of bowel cancer, at the Cheshire Bowel Cancer Screening Programme, were asked to complete a second symptom assessment questionnaire. A direct comparison between the reported symptoms pre and post colonoscopy could then be made. The post colonoscopy questioning also included duration of symptoms.

Results In total 83 patients replied to the second questionnaire. The symptoms reported pre and post colonoscopy were similar. PR bleeding was the most commonly reported symptom in the pre and post assessment questionnaire. 42 (49%) patients reported this in the pre questioning, whilst 31 reported in after their diagnostic procedure. The next most common symptom was change in bowel habit. The number of patients reporting this was the same in both the pre and post assessment ($n = 25$). Further symptoms were assessed in the post procedure questionnaire, 19% and 14% of patients report straining and abdominal bloating respectively. There was also an increase in the reporting of family history of malignancy in the post assessment process, namely of Breast and Ovarian carcinoma. 30% of patients with diagnosed bowel cancer reported a family history of bowel cancer during the pre and post assessment questionnaire. Only 11% patients reported both a family history of bowel cancer and PR bleeding during pre-assessment. When comparing multiple symptoms the results in the two assessments were fairly similar. 16 patients in the pre-assessment reported both bleeding and change in bowel habit, with 14 in the post assessment group.

Abstract PTU-028 Table 1

Symptoms	Pre assessment	Post assessment
PR bleeding and change in bowel habit	16	14
PR bleeding and weight loss	5	5
PR bleeding, weight loss and change in bowel habit	1	3

Table showing numbers of patients reporting combinations of symptoms, pre and post assessments.

Conclusion PR bleeding is the most reported symptom in those found to have bowel cancer. However, more than 50% patients with diagnosed bowel cancer did not report PR bleeding. When combining all symptoms together we found that 23% patients were totally asymptomatic. Comparison of questionnaires collected prior and post colonoscopy on bowel cancer screening programme has shown accurate and consistent reporting of symptoms.

Disclosure of Interest None Declared

PTU-029 UNIVERSITY HOSPITALS OF LEICESTER COLONOSCOPY AUDIT 2011–2012

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Introduction

Aims and Objectives:

To:

1. Assess the success rate of all colonoscopies carried out in University Hospitals of Leicester (UHL) NHS Trust between September 2011 and 2012. This will then be compared with the results of audits in 2006–2007, 2007–2008, and 2010–2011.
2. Assess the complication rate and reasons for failure of colonoscopies carried out during the audit period.
3. Enable improvement in practise by highlighting poor practise and encouraging reflection.

Audit Standards

1. Caecal Intubation: > 90%.
2. Perforation rate: < 1:1000 colonoscopies.

Methods A retrospective search was made of the colonoscopy database of all colonoscopies performed on patients above the age of eighteen in UHL between September 2011 and September 2012. In addition a comparison was made between the colonoscopy database and patients presenting to UHL hospitals with a diagnosis of perforation. This was to identify late presentation of perforations potentially due to colonoscopies. The procedural notes were analysed looking for: Successful visualisation of the Caecum, Ileum/neo TI or anastomosis; reasons for failure, if applicable and complications. The results were then pooled and compared against the audit standard.

Results 4001 colonoscopies were performed over the audit period. 3680 (92%) were successful. There were 80 complications (2%) in total. Most common complications were difficult intubation and patient distress with 52 (1.3%) and 16 (0.4%) instances respectively. 1 (0.02%) perforation occurred. Success rate over 5 years: 69% in 2006–2007, 89% in 2007–2008, 93% in 2010–2011 and 92% in 2011–2012.

Abstract PTU-029 Figure

Conclusion Over the audit period UHL achieved its colonoscopy targets with a success rate of 92% and a perforation rate of 1 in 4001. Over the past five years the colonoscopy success rate has steadily improved from 69% in 2006–2007 to 92% in 2011–2012. Over the past two years UHL has achieved its target with success rates of 93% and 92% respectively. The results of each audit are reviewed by the endoscopy lead who meets people who have completion rates below the national average and also those who are doing less than a hundred and fifty colonoscopies a year. The aim of the meeting is to inform them of their performance and offer opportunities for improvement e.g. training. This shows the value of these audits in highlighting poor practise and prompting reflection and improvement.

Disclosure of Interest None Declared

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PTU-030 CLOSTRIDIUM DIFFICILE ASSOCIATED DIARRHEA (CDAD) IN HOSPITALIZED PATIENTS – DOES FLEXIBLE SIGMOIDOSCOPY (FS) ALTER MANAGEMENT?

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Introduction Clostridium difficile (CD) colitis is a major complication of antibiotic therapy. The most widely used test for diagnosing C. difficile colitis is a test that detects toxins produced by CD in a stool sample. Flexible sigmoidoscopy (FS) or colonoscopy can show the characteristic pseudomembrane plaque appearance in