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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¹A Sasegbon, ¹N Hossain. ¹Department of Gastroenterology, University Hospitals of Leicester NHS Trust, Leicester, UK

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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¹B Krishnan, ¹V Sehgal, ¹K Besherdas. ¹Gastroenterology, Chasefarm Hospital, London, UK

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

about half of affected patients. It is usually performed if rapid diagnosis is needed or in a patient who has ileus. However, some patients with CD colitis will have pseudomembranes only in the right colon. Our aim was to assess whether patients, with confirmed CDAD, had their management altered following FS.

Methods A single centre, retrospective analysis of patients who had a FS with stool culture confirmed CDAD admitted to our CD ward (CDW) over 7 years (March 2005–2012) was performed at a district general hospital in North London. The medical notes, endoscopy database and electronic results of patients on CDW undergoing FS was scrutinised.

Results 18 patients on CDW had a FS during the study period. 2 patients were excluded as they were found to be CD negative. 16 of the 1535 (1.04%) patients diagnosed with CDAD at our hospital during this period had a FS. The mean age was 74.1 (range 37–93) with 6 males. FS was requested 27 days (range 1–100) and the procedure was performed 40 days (range 10–110) after the diagnosis of CD was made. The indications were persistent diarrhoea in 82% (13/16), bleeding PR 6% (1/16), abnormal CT scan 6% (1/16) and previous CMV colitis 6% (1/16). 8(50%) patients had a normal FS, 2(13%) had pseudomembranous colitis, and 1 (6%) patient each had adenocarcinoma, colonic polyps, diverticulosis and infective colitis. 2 (13%) patients were newly diagnosed to have ulcerative colitis and were started on mesalazine and steroids along with CD treatment.

Conclusion In this study only a small proportion of patients (1.04%) with CDAD underwent FS. However, when FS is performed in patients with CDAD with persistent symptoms it aids in clarification of the diagnosis with an abnormal FS noted in 50% of patients. From our observation we would recommend FS in CDAD if symptoms persist despite treatment due to the high positive findings at FS.

Disclosure of Interest None Declared

PTU-031 ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAM (ERCP) IN PREGNANCY WITHOUT RADIATION

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¹B Krishnan, ¹V Sehgal, ¹K Besherdas, ¹N van Someren. ¹Gastroenterology, Chasefarm Hospital, London, UK

Introduction Pregnancy is associated with an increased risk of gallstone formation, which in turn causes cholangitis and pancreatitis. The prevalence of gallstones in pregnancy has been reported as 3.3 – 12.2%. Cholecystectomy is the second most common non-obstetric surgical procedure in pregnancy, exceeded only by appendicectomy. ERCP is the first-line treatment of choice for cholangitis and pancreatitis caused by choledocholithiasis. However, the use of ERCP in pregnancy is limited because of the primary concern of foetal safety in relation to exposure to ionising radiation. A clear-cut safe radiation dose for ERCP in pregnancy is still unknown. There have been only a few studies of non-radiation ERCP during pregnancy. Our aim is to present our experience with pregnant patients who underwent ERCP without using radiation, and to evaluate the safety and efficacy of this therapeutic pathway for ERCP during pregnancy.

Methods A retrospective analysis of ERCPs in pregnant women in a single centre in North London (Chase Farm Hospital) between January 2005 and November 2011 was performed. The unit policy of ERCP in pregnant women is to perform the procedure in the left lateral position using midazolam/pethidine combination. Guide-wire cannulation of the bile duct is adopted with bile aspiration and/or visualisation of bile oozing around the guide wire used as confirmation of biliary cannulation. Bile duct clearance after sphincterotomy is then performed. No fluoroscopy is used during the procedure, but was available if required. Confirmation of successful

therapeutic ERCP was made by laboratory and clinical improvement of the patients.

Results Out of 2255 procedures, 4 (0.17%) were performed on pregnant women. The mean age was 31 years (range 29–36), the mean gestation was 16.75 weeks (range 4–30), with two patients in their first, one in their second and third trimesters each. The indications for ERCP were cholangitis and pancreatitis (two), cholangitis (one) and choledocholithiasis on ultrasonography (one). In two cases, precut papillotomy with a needle-knife was used, since the stone was impacted. Sphincterotomy was used in two cases. Stones were removed by balloon or basket trawls and no stents were placed. After ERCP, jaundice resolved in all cases. Post-ERCP complications, premature birth, abortion or intrauterine growth retardation were not observed.

Conclusion Our series showed that in experienced hands, successful therapeutic ERCPs with wire-guided cannulation can be performed safely without radiation in pregnant women with strong indications. We would recommend use of this technique (wire-guided cannulation without radiation) if ERCP is required during pregnancy.

Disclosure of Interest None Declared

PTU-032 WOULD YOU LIKE A TRAINEE TO PERFORM YOUR COLONOSCOPY?

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¹B Arnold, ¹B Hudson, ¹A Sinha, ²C L Gregson, ¹B J Colleypriest. ¹Gastroenterology; ²Older Persons Unit, Royal United Hospital, Bath, UK

Introduction Quality assurance in colonoscopy is underpinned by a framework of nationally agreed quality indicators and auditable outcomes to maintain minimum standards. High quality colonoscopy training is a vital part of ensuring these standards and is important that quality is assured during training lists so these patients receive the same standard of care. It is understandable that patients may be concerned if a trainee is performing their procedure and vital that evidence based consent is obtained to address concerns. This study aimed to compare quality delivered on training and non-training colonoscopy lists in order to inform patients.

Methods A 12 month period (Jan 2012 to Jan 2013) of data from the endoscopy reporting system was retrospectively analysed. Caecal intubation rates, procedure duration, endoscopist reported pain score, sedation usage and polyp detection rates were analysed for seven training endoscopists. Data was compared for seven training endoscopists between training and non-training lists. Statistical analyses used χ testing and linear regression in Stata 11.

Results Complete data were available for 422 training lists and 936 Service colonoscopies (300 BCSP)

Mean(SD) age was similar in service and trainee groups; 61.0(12.3) and 60.6(14.2) years respectively, $p = 0.657$. There was no difference in caecal intubation rates between groups (trainees 93.8% and service 94.4%, $p = 0.657$).

Polyp detection was similar amongst trainees 119(28.2%) as non-BCSP service procedures 186(29.3%), $p = 0.71$.

Midazolam was used less frequently during service lists(737 [78.7%]) vs (367 [87.0%]) ($p < 0.001$). A statistically but not clinically significantly larger average doses was used 2.3 (0.7) and 2.2(0.7) mg, $p = 0.001$ during service lists. Interestingly mean doses of fentanyl were similar 59.5(23.2) and 57.7(22.2) mcg, $p = 0.46$, but lower mean doses of pethidine 36.8 (12.5) and 43.2 (12.2) mg, $p = 0.001$ were used during training lists.

Endoscopist reported pain scores were greater on service lists, with 223 (52.8%) trainees and 332 (35.5%) trainers reporting no symptoms, 431 (46.1%) and 143 (33.9%) mild, 149 (15.9%) and 53 (12.6%) moderate, and 24 (2.6%) and 3 (0.7%) severe symptoms respectively ($p < 0.001$).