Methods We reviewed endoscopy reports of all patients who had surgery for colorectal neoplasia during a 12-month period. The report was deemed fully compliant if the following were clearly documented: location of the tattoos, correct location of the tattoos, the number of tattoos placed and a correct number of tattoos placed, hence, scoring 4/4. Non-compliance was defined if none of the parameters was mentioned and partial compliance was awarded to those scoring between one and three points.

Results 155 patients were identified, of which 114 had reports available. The overall compliance with the protocol was observed in 71 cases (62%) whereas 19 cases (17%) were partially compliant and 24 cases (21%) were non-compliant. Rates for full, partial and incomplete compliance were better for patients diagnosed though the BCSP (71% 26% and 3% respectively) when compared to those diagnosed through non-screening (58%, 13% and 29% respectively). Incomplete documentation (22 cases) and inability to place tattoos proximal to obstructing lesions (19 cases) were the major causes of reduced compliance.

Conclusion Educational intervention is necessary to address poor documentation. However, changes to our protocol are also required. We have therefore revised our protocol recommending that all tattoos should be placed distal to the lesion regardless of the anatomical position.

Competing interests None declared.

REFERENCE

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PMO-185 DUODENAL TAMPONADE: A CASE SERIES AND FOURTH MODALITY IN GASTROINTESTINAL BLEED CONTROL

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Introduction The mortalitiy associated with gastrointestinal bleeding is around 10%, a figure which has remained roughly constant despite continuing innovation in therapy. The use of injection, thermocoagulation, and endo-clips is widely practiced in the context of bleeding duodenal ulcers. However a number of patients will re-bleed in spite of dual or even triple therapy. In cases where co-morbidity precludes surgical intervention further therapeutic options may be non-existent.

Methods We describe a case series of five patients with multiple co-morbidity who presented with upper gastrointestinal haemorrhage from duodenal lesions. A variety of therapeutic modalities were employed that is, injection with Adrenaline, thermocoagulation or endoclips. Unfortunately haemostasis was not achieved and surgical intervention deemed inappropriate. Our technique involves tamponade with a 18 mm CRE (constant radial expansion) balloon inflated in the duodenum. The gastroscope with the deflated balloon is passed via the pylorus. The balloon is then inflated keeping the proximal portion of the balloon under direct vision at all times to ensure correct placement. Tamponade is maintained for up to 50 min.

Results This procedure achieved haemostasis in all five cases. The tamponade was maintained for a total of between 10 and 50 min.

Conclusion Duodenal tamponade to control Haemorrhage has been described previously only twice and has required either specialist equipment[1] or surgical intervention.[2] The CRE balloon is readily available within most endoscopy units and therefore no expenditure is required to use this new modality. In addition the technique is easily learnt and can be readily applied to lesions whose orientation makes targeted intervention difficult. Tamponade is a useful adjunct and may prove lifesaving in an otherwise hopeless situation.

Competing interests None declared.

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PMO-186 COMPLICATION RATES OF COLONOSCOPIC REMOVAL OF LARGE COLORECTAL POLYPS IN A DISTRICT GENERAL HOSPITAL: A RETROSPECTIVE AUDIT

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Introduction Colonoscopic removal of large colorectal polyps, sessile or pedunculated, can pose a challenge. Techniques most commonly used are hot snare polypectomy or endoscopic mucosal resection using electrocautery snare. The bigger the size of the polyp greater the skill needed to avoid complications. The potential complications are bleeding and perforation. According to the British Society of Gastroenterology guidelines post polypectomy bleeding requiring transfusion should be <1:100 (for >1 cm polyps) and post polypectomy perforation rate should be <1:500.

Methods A retrospective audit was taken between the dates of October 2009 to October 2010 and included patients who had large polyps, defined as polyps equal to and >20 mm in size, removed from the colorectal region by various colonoscopists during their routine colonoscopy lists in a district general hospital. The size of the polyp was confirmed from both the colonoscopy and histology report.

Results In total 64 patients with large colorectal polyps were treated. Majorities were pedunculated (n=49) and the rest were sessile (n=15). In the group of patients who had pedunculated polyp, 29 were male and 20 were female with a mean age of 62.72 years. The average size of the polyp was 26.22 mm (range:

Abstract PMO-185 Table 1

Patient	Age	Co-morbidity	Initial endoscopic intervention	Tamponade in minutes	Outcome
1	77	Rheumatoid arthritis recurrent falls	Adrenaline injection thermocoagulation	50	Survived and discharged
2	88	Renal failure	Adrenaline endoclips three procedures in 4 days	10	Survived GI bleed but passed away from unrelated cause
3	89	Osteoarthritis, admitted with fractured neck of femur	Adrenaline infection thermocoagulation	10	Survived and discharged
4	79	Alcoholic liver disease type 2 diabetes	Awkwardly placed lesion at D1, injection with adrenaline only	10	Survived and discharged
5	88	Renal failure	Adrenaline injection	10	Survived and discharged