Abdominal X-ray was requested at 6 weeks post-ERCP to assess expulsion of the stent. Complications were recorded.

**Results**

Of the 24 participants 16 were female. Abdominal X-rays were obtained in all patients at a median of 6 weeks (5–12 weeks) post-ERCP. Stents were retained in 2 (8.3%) patients. Spontaneous stent self-expulsion rate was therefore 91.7%. There were no other complications. Hyperamylasaemia occurred in 2 (8.3%) patients—unrelated to stent retention. Prior to routine stent insertion pancreatitis occurred in seven patients (46%), thus we have shown a reduction in ERCP-induced pancreatitis (p = 0.003).

**Conclusion**

In the absence of pancreatic and biliary disease stents will self-expel by 12 weeks. We have also shown that the deployment of small pancreatic stents is safe and well tolerated. Comparison with ERCP performed prior to routine stent placement has shown a significant reduction in the rate of pancreatitis. Both retained stents were removed without complication by a standard OGD.

**Competing interests**

None declared.

**REFERENCES**


**DETECTION OF DYSPLASIA ARISING IN BARRETT’S OESOPHAGUS IS ASSOCIATED WITH BETTER QUALITY ENDOSCOPIC TECHNIQUE**

1J Dunn,* 1J Ooi, 2F Chang, 1J Meenan. 1Gastroenterology, Guy’s & St Thomas’ Hospitals NHS Trust, London, UK: 2Histopathology, Guy’s & St Thomas’ Hospitals NHS Trust, London, UK

**Introduction**

Barrett’s columnar lined oesophagus (CLO) is the pre-malignant lesion to oesophageal adenocarcinoma (OAC). The presence of dysplasia, when diagnosed in surveillance programmes, is an important marker of risk of progression and an indication for endoscopic therapy. Barrett’s surveillance should be undertaken with a minimum of four quadrant biopsies every 2 cm, with documentation of length of BE segment by Prague classification. This lends support to the argument that Barrett’s surveillance should be centralised and undertaken on dedicated lists by trained endoscopists with a specialist interest, in order to maximise dysplasia detection rates. A prospective study is warranted.

**PTU-207 LAPAROSCOPIC ASSESSED ENDOSCOPIC MUCOSAL RESECTION (LAP-EMR)**

doi:10.1136/gutjnl-2012-302514c.207

1J Turner,* 2J Torkington, 2M Davies, 1S Dolwani. 1Gastroenterology, University Hospital Llandough, Cardiff, UK; 2Colorectal Surgery, University Hospital Llandough, Cardiff, UK

**Introduction**

Successful colonic endoscopic mucosal resection (EMR) may be limited by several factors such as lesion size, position, access and complexity. We present a series of cases performed by Lap-EMR, which has the potential to overcome these difficulties, safely extending the application of EMR.

**Methods**

Cases were identified from a prospectively held database recording patient demographics, polyp details, procedural complications and follow-up outcomes.

**Results**

15 patients (62% male) underwent Lap-EMR between September 2009 and 2011. Median patient age 64 years old. Median polyp size 35 mm (range 12–60 mm). 58% of lesions were located within the right colon and 51% at either the hepatic or splenic flexures. Three patients required laparoscopic resection either due to lesion extension into the appendix (n=2) or failure to lift with submucosal injection (n=1), where histology revealed a focus of adenocarcinoma. One patient underwent a laparoscopic right hemicolectomy due to post-polypectomy haemorrhage. No other peri-operative complications occured. The median post-operative hospital stay was 2 days (range 1–19 days). Small residual adenoma was identified in 3 out of 6 patients that have undergone 3-month follow-up to date, successfully treated with argon photocoagulation. No adenoma was identified in these patients at follow-up 1 year later.

**Conclusion**

Lap-EMR is safe and effective in treating lesions that would otherwise require segmental colonic resection. It provides the option of localised laparoscopic resection, which is of particular benefit for lesions visible at the appendiceal orifice where suitability for resection can be difficult to assess at diagnostic colonoscopy.

**Competing interests**

None declared.