To investigate current practice in patient preparation prior to gastroscopy across the UK.

**Methods** A list of all Hospitals in the UK was obtained from the JAG website (391). Hospitals that did not perform endoscopy were excluded (14), as were Children’s Hospitals (5) and private hospitals (165). The number of hospitals included was 207. A structured telephone survey was conducted with each endoscopy unit. The method of preparation prior to gastroscopy was established.

**Results** 195 (95%) endoscopy units responded to the survey. 11 (5%) of hospitals excluded patients (14), as were Children’s Hospitals (5) and private hospitals (165). The number of hospitals included was 207. A structured telephone survey was conducted with each endoscopy unit. The method of preparation prior to gastroscopy was established.

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**Compelling interests** None declared.

**REFERENCES**


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**PTU-212**

TO ANALYSE THE RISK OF STENT MIGRATION WITH THE NITI-S COVERED FLARED BILIARY STENT

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**Introduction** Stent migration occurs in 6%–12% of patients undergoing biliary stenting. The Niti-S fully covered metal stent (Taewoong Medical, Seoul) has a flared end which acts as an antimigration. Few studies have evaluated the efficacy of these stents and are contradictory.

**Methods** This was a retrospective cohort study. 32 Niti-S stented patients were enrolled between January 2010 and July 2011. Of the patients’ records were analysed. The indication for stent, size and whether there had been any previous endoscopic therapy was recorded. The cholangiograms were then re-reviewed by an experienced radiologist to assess stricture length and position of the stent proximal to the stricture.

**Results** 10 out of 32 stents (31%) had migrated. Nine were placed for benign strictures and one for a malignant stricture. There was no significant difference between the stents that did and did not migrate comparing the length of stricture (mean 11.8 mm vs 12.4 mm), or where the stent was placed (mean proportion of stent above the proximal end of the stricture 16 mm vs 17.5 mm). There also appeared to be no association with previous endoscopic therapy: in 6 (60%) of the procedures where the stents had migrated there had been previous therapy, compared to 14 of the remaining 22 procedures (64%). Of the 9 (44%) patients with migrated stents were subsequently admitted to hospital with cholangitis, compared to 1 patient who did not have a migrated stent.

**Conclusion** The flared end covered metal stents significantly migrate despite the theories behind the design. Direct cost implications of this should be sought. There appears to be no association between aetiology, length of stricture, previous endoscopic therapy or where the stent was placed and subsequent migration.

**PTU-213**

SELF EXPANDABLE METAL STENTS (SEMS) FOR OBSTRUCTING COLORECTAL CANCER IN ENGLAND: LINKAGE ANALYSIS OF HOSPITAL EPISODE STATISTICS

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**Introduction** Colorectal cancer (CRC) is the 4th commonest cancer worldwide. Hospital admission with large bowel obstruction occurs in 15% and requires urgent decompression. SEMS can provide palliative treatment in advanced disease (avoiding surgical defunctioning) or preoperative bridging to elective surgery for operable disease. We aimed to describe a national profile for incidence (activity) of SEMS, volumes per Trust, length of stay and rates of readmission, reintervention and mortality for CRC in England.

**Methods** We developed techniques within the SPSS software package to identify a 1-year cohort of incident cases of CRC, starting with a merged file of raw HES data for all cancer episodes in English hospitals for 2006/7 and 2007/8. We selected only patients with first coding of CRC in the middle 12 months (October–September), then extracted all their admissions within 6 months (before and after) of first cancer coding, ordering them chronologically and then screening to identify admissions for SEMS and surgical procedures. Linkage to death registry provided date of death. Patients with SEMS and no subsequent surgical resection were flagged as palliative patients and those with a subsequent resection as bridge patients.

**Results** Overall: 517 patients were identified nationally as having SEMS placement for obstructing CRC (mean age: 72.6 yrs [SD: 12.0]; 62.5% male), with mean LOS of 7.9 [SD 11.5] days and overall mortality at 30 d (10.5%) and 90 d (18.0%). The 30 d emergency readmission rate was 15.1%. SEMS were coded by 122 (81.3%) of acute Trusts in England, with volumes ranging from 1 to 24 per institution. Palliative group: (n=421, 81.4% of cases), mean LOS for index admission 9.2 [SD: 14.6] days and mortality at 30 d (12.1%) and 90 d (21.2%). Emergency readmission within 30 d (17.8%). Subsequent surgical colostomy coded in 9.5%. Palliative procedures were recorded in 122 Trusts (Volumes: 1–15 per institution). Bridge group: (n=96, 16.6% of cases), mean LOS for index admission 9.5 [SD: 10.4] days and mortality at 30 d (2.1%) and 90 d (4.2%). Emergency 30 d readmission (8.7%). Colostomy coded as part of surgery in 38.4%. Bridge procedures were coded in 48 (52%) acute Trusts (Volumes: 1–12).

**Conclusion** Analysis of HES data suggests SEMS insertion in English hospitals is predominantly for palliative purposes and most cases selected for this intervention survive beyond 30 days and avoid operative decompression. The use of SEMS as a bridge to surgery...