patients, commonly with respect to anticipation of pain or the results of the procedure. The ranked preference scores suggested that interaction with the endoscopist, including technical skill of the endoscopist, discomfort during the procedure, manner of the endoscopist and the pre-and post procedure discussions were considered as most important to patients. A majority of patients (55%) preferred the endoscopist to explain the findings, but only 26% specified that they needed to explain the procedure itself. Environmental factors were considered of relatively low importance, including the single sex environment (least important), noise levels, explanation of delay, privacy and intra department waiting time. A majority (82.1%) thought that having a single sex environment was minimally/not important, and only 14.3% of patients were prepared to have a delayed appointment for a single sex environment.

**Conclusion**
Patients undergoing colonoscopy appear to highly prioritise aspects of care relating to the interaction with the endoscopist and the procedure itself. Environment factors are considered to have much less value and specifically having a single sex environment. These findings may assist in service redesign around patient-centred care and patient priorities, and the development of patient satisfaction surveys in endoscopy.

**Competing interests** None declared.

### PTU-218 PILOT RANDOMISED CROSS-OVER STUDY COMPARING THE EFFICACY OF TRANSNASAL ENDOSEATH® TO STANDARD ENDOSCOPY TO DETECT BARRETT’S OESOPHAGUS

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**Introduction** A less expensive and safer alternative to standard sedated endoscopy (SE) needs to be considered as a screening method to detect Barrett’s oesophagus (BE) in the population, with the aim of reducing the mortality associated with oesophageal adenocarcinoma. The Endosheath® transnasal oesophagoscopy (TNE) can potentially offer a new alternative to conventional standard endoscopy in diagnosing Barrett’s oesophagus. The Endosheath® technology uses a sterile, disposable sheath which covers the ultra thin flexible oesophagoscope and isolates it from the patient. The oesophagoscope is placed in a new sheath prior to each procedure which obviates the need for machine washing and permits a quick turnaround. **Aim:** A pilot study to evaluate the efficacy of TNE in diagnosing BE compared with SE and to assess patient acceptability of TNE.

**Methods** Patients referred for surveillance endoscopy for BE or a clinically indicated routine endoscopy were recruited to both TNE and SE in a randomised cross-over design. The interval between the procedures was at least 6 weeks. TNE findings of endoscopic BE, and presence of intestinal metaplasia (IM) on the biopsy samples were compared against SE, which was used as gold standard. A 10-point visual analogue scale (0 represented the worst experience and 10 the best experience) to assess the post-endoscopy experience and a single question addressing preference for endoscopy type were used to measure patient acceptability of the procedures.

**Results** 15 patients completed the study. 10 males and 5 females with a mean age of 62.85 years (range 50–76 years). Nine of which were BE surveillance patients and six were referred for a clinically indicated routine endoscopy. Eight patients were randomised to the SE as the first procedure. All the 11 patients with an endoscopic diagnosis of BE on SE were accurately identified with the TNE (sensitivity 100%; specificity 100%). Biopsies were taken in all the 11 Barrett’s segments except in one <1 cm segment with TNE due to technical difficulty. IM was detected in 9 out of the 11 patients with BE on SE compared to 7 out of the 11 patients with BE on TNE (sensitivity 77.8%; specificity 100%). Patients reported significantly better experiences of endoscopy with TNE with scores of 6.9 (±0.81 SEM) compared with 3.7 (±0.37 SEM) for SE (p=0.001). Eight patients (53%) reported a preference for TNE compared with 1 (7%) for SE.

**Conclusion** Endosheath® transnasal oesophagoscope is accurate in diagnosing endoscopic BE and can detect IM. It is better tolerated and preferred by patients, making it a useful screening tool for BE with potential for use in primary care.

**Competing interests** None declared.

### PTU-219 INTRAOPERATIVE ENDOSCOPY: THE FIRST SINGLE-CENTRE UK EXPERIENCE

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**Introduction** Intra-operative enteroscopy (IOE) is the gold standard for examination of the small bowel. However, with the invention of
capsule endoscopy (CE) and double balloon endoscopy (DBE), the role of IOE has been questioned. Our aim was to identify the indications for IOE and associated morbidity and mortality. We also made comparisons between CE and IOE.

**Methods** All patients that underwent IOE between 2003 and 2011 were included. Data collected included demographics, clinical indications, co-morbidity, transfusion requirements, findings at IOE and subsequent follow-up.

**Results** There were 17 IOEs, 8 males, with a mean age of 57 years (range 34–93). The median follow-up period was 9 months (range 0–48 months). The indication was iron deficiency anaemia (IDA) in all patients (occult bleeding (n=10) and overt bleeding (n=7)). Ten patients were transfusion dependent. The median haemoglobin pre-IOE was 7.7 g/dl (SD 1.4). 71% (n=12) had significant co-morbidity which included ischaemic heart disease, diabetes and bronchiectasis. Small bowel investigations prior to IOE included DBE (n=9) and CE (n=16). Two patients had therapeutic intervention at DBE, both argon plasma coagulation (APC) to angiodysplasia. In seven patients the abnormality on CE was not reached at DBE. The diagnostic yield for IOE was 88% (15/17). In two patients, the IOE was normal. Findings at IOE included Meckels diverticulum (n=2), arteriovenous malformations (n=7), small bowel tumours (n=3: benign glomus tumour, leiomyoma and carcinoid), bleeding point at surgical anastomosis (n=2: post hepatectomy and at a transplanted pancreatic bed) and small bowel ulceration secondary to NSAIDs and nicosandil. Intervention at IOE occurred in 82% (n=14). These included small bowel resections, two APC, one revision of anastomosis, one oversewing of angiomata. While the morbidity rate was 18% (n=3) with two post-operative bleeds requiring transfusion and a seizure secondary to hyponatraemia, there were no deaths within 30 days. Evidence of recurrent GI bleeding occurred in four patients all of whom have lower transfusion requirements than before, 1 being on tranexamic acid, and 1 on somatostatin analogue. In the two patients with a normal IOE, the patient with IDA remains well 6 months post IOE while the second patient with diarrhoea and pain remains asymptomatic without a diagnosis. A comparison of CE against IOE as the gold standard diagnosis. A comparison of CE against IOE as the gold standard.

**Conclusion** IOE has a high diagnostic yield (88%) with a significant proportion having intervention at IOE. There remains an important role for IOE in a select group of patients with transfusion–dependent anaemia.

**Competing interests** None declared.

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**REFERENCES**


**Competing interests** None declared.