PTU-250
MANAGEMENT OF ANTICOAGULANT AND
ANTIPLATELET THERAPY IN PATIENTS UNDERGOING
ENDOSCOPIC PROCEDURES: COMPLIANCE WITH
EXISTING GUIDELINES

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Introduction It is not uncommon for patients on anticoagulants and
antiplatelets to undergo endoscopic procedures. The main issue
in such cases is balancing the risk of gastro-intestinal bleed and the
need for anticoagulation. Recognising this, the British Society of
Gastroenterology (BSG) issued in 2008 practice guidelines on the
management of anticoagulants and antiplatelet therapy in patients
undergoing endoscopic procedures. Aspirin, Clopidogrel and
Warfarin are the most commonly used antiplatelets and anti-
coagulants in the UK. Aspirin is recommended to be continued for
all endoscopic procedures while Clopidogrel and Warfarin should
be tailored to the bleeding risk category of the procedure and the
thrombotic risk of the patient’s condition. Our clinical practice was
retrospectively audited to assess adherence to the BSG guidelines.

Methods All patients on antiplatelets and anticoagulants under-
going endoscopic procedures except ERCP were included in the
audit. Data were collected from case notes, endoscopy records and
the Éclair pathology reporting system.

Results 48 patients were identified to have 52 procedures with 37
(64%) on Aspirin alone, 6 (10%) on Clopidogrel alone, 9 (16%) on
Warfarin alone, 4 (7%) on Aspirin and Clopidogrel and 2 (3%) on
Aspirin and Warfarin. 16/37 (45%) in Aspirin alone group had it
stopped inappropriately for 3–7 days. 5/6 (50%) Clopidogrel alone
patients had it stopped while having one high risk procedure and
two low risk procedures. Warfarin was stopped inappropriately in 7/
9 (78%) patients undergoing eight procedures.

Conclusion Endoscopic procedures have evolved over the years to
include increasingly complex and invasive procedures carrying risk
of serious complications including bleeding. Also significant
proportions of patients are on multiple medications including
anticoagulants and antiplatelets. It is therefore essential that
appropriate management plan for the anticoagulant and antiplatelet
therapy should be made to minimise the haemorrhagic and
thromboembolic risk when requesting endoscopic procedures. The
findings of this audit underline significant non-compliance to
existing guidelines with potential serious implications for the
standard of patient care. While endoscopy is performed by trained
endoscopists, the procedures are requested by clinicians with vari-
able knowledge and awareness of the existing BSG guidelines. This
hurdle can be overcome using a combination of raising awareness
through educational events and modification of the endoscopy
requesting software by including a link to the anticoagulation
management guideline flow chart making it accessible to the cli-
nicians at the time of requesting. We hope these measures will result
in improvement of service and make endoscopy safer in our hospital.

Competing interests None declared.

REFERENCE

PTU-251
IMPACT OF APPLYING CURRENT BSG GUIDELINES ON
COLORECTAL CANCER SCREENING AND SURVEILLANCE
COLONOSCOPY PROCEDURES

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Introduction The demand for colonoscopy is ever increasing, with
greater pressures on endoscopy units. In order to provide a more
efficient and timely service we conducted a review of our practice.
Our aim was to audit colorectal cancer screening and surveillance
colonoscopy procedures and determine the impact of the updated
BSG guidelines (2010) on service provision.1

Methods The clinical letters, pathology reports and previous
endoscopy reports were reviewed for all patients scheduled for
surveillance colonoscopy over a period of 3 years (2010–2012). Data
gathered included patient demographics, indication for procedure
and outcome when audited against the current BSG guidelines. If
the procedure did not meet the current guidelines with respect to
indication or timing, the responsible clinician contacted both
patient and GP, offering a clinic appointment to discuss further if
needed.

Results A total of 254 colonoscopy requests were reviewed. Median
age of the group was 62 years (range 22–98 years), male to female
ratio 1.7:1. Indications included polyp surveillance 214 (60%), IBD
surveillance 55 (15%), family history of colon cancer 50 (14%), high-
risk disease and family groups 17 (5%), previous colon cancer 9 (3%)
and other indications 9 (3%). 152 (49%) were appropriate when
audited against the current guidelines with no changes made to their
procedures. Of the remaining 202, 106 (52%) had the time to follow-
up procedure extended (mean 3.25 years), 75 (37%) did not meet the
criteria for a repeat procedure and 23 (11%) procedures were inap-
propriately delayed (mean 1.30 yrs). 125 colonoscopy requests were
relevant to the updated guidelines for IBD surveillance, family
history of colon cancer and high-risk disease and family groups.
There were 57 IBD surveillance requests, of which 24 (42%) had the
time to follow-up procedure extended (mean 1.75 yrs). Out of 51
requests with family history of colorectal cancer, 25 (45%) had the
time to scheduled screening procedure extended (mean 8 yrs).

Conclusion Evaluating existing colonoscopy referrals against up to
date BSG guidelines will contribute towards providing a more effi-
cient colonoscopy service. In our practice a fifth of patients on the
waiting list were inappropriate for further surveillance and a further
third had the time to their procedure extended, therefore increasing
capacity and efficiency to allow timely delivery of procedures for
those needing surveillance.

Competing interests None declared.

REFERENCE
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PTU-252
CA19.9—ARE WE USING IT APPROPRIATELY AND IS IT
COST EFFECTIVE?

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Introduction CA19.9 is frequently used in the assessment of patients
with suspected pancreatic cancer or cholangiocarcinoma. Although
specific guidelines are not available, data suggests that it should not
be used for screening and only used in conjunction with appropriate
imaging. The aim of this study was to investigate the clinical utility
and cost effectiveness of using CA19.9 as a marker for pancreatic
cancer and cholangiocarcinoma in a district general hospital.

Methods A retrospective analysis was undertaken of all patients
with a CA19.9 measurement over a period of 12 months. Data on
liver biochemistry and abdominal imaging were collected. The
results were compared to identify those patients in whom; (i) a
positive CA19.9 result was associated with the presence of biliary or
pancreatic malignancy (ii) those patients in whom CA19.9 was
inappropriately requested. A cost analysis was undertaken.
**Results** 492 CA19.9 assays were performed in 12 months. 245 were documented in patients who had not had abdominal imaging or LFTs measured. 247/492 had both imaging and LFTs and were included in the initial analysis. 102/247 had a positive CA19.9. A total of 45/247 were found to have a pancreatic or biliary malignancy 38/45 had a positive CA19.9. This was negative in 7/45. The overall clinical utility of CA19.9 was poor. From the 492 assays performed during the year a positive CA19.9 was associated with a new malignancy in just 7% (38/492). Overall 63% of patients with a positive CA19.9 did not have pancreatic cancer (PPV 37%). Conversely 5% of those with a negative result did (95% NPV). 22% of patients with pancreatic malignancy had normal LFTs at the time of diagnosis. In total 103/492 (20%) of assays were duplicates. Only 36/103 (35%) were in patients with confirmed malignancy. 67 assays were requested in patients with normal abdominal imaging or in the absence of imaging and LFTs. The total cost for all assays was £7580. £6165 was spent on inappropriate requests or where the diagnosis was not pancreatic malignancy.

**Conclusion** The clinical utility of CA19.9 is poor with only 7% of samples resulting in a new diagnosis of pancreatic malignancy. The assay is frequently requested inappropriately, often without abdominal imaging being available. LFTs should not be used to guide testing. CA19.9 measurement should only be undertaken in patients where imaging results are available and suggestive of pancreatic malignancy. There are significant cost savings from this approach.

**Competing interests** None declared.

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**PTU-254 WHAT DO GENERAL PRACTITIONERS WANT FROM GASTROENTEROLOGY SERVICES IN SECONDARY CARE, AND WHAT ARE THEY HAPPY MANAGING IN PRIMARY CARE?**

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**Introduction** Recent changes in the NHS have focussed on moving more services into primary care. General Practitioners (GPs) are rarely consulted over planning of secondary care services, nor are they asked on their own comfort in managing gastroenterological conditions. The results of a GP survey of confidence and service development are presented. 

**Methods** An online survey (created on Google Docs) was emailed to 102 GP practices. GPs were asked to rate their confidence in managing gastroenterological conditions as well as rate service developments using a 5-point Likert scale (1—very low, 5—very high). Free text boxes allowed GPs to provide additional comments for qualitative analysis. Responses (n=52) within 28 days were analysed in Microsoft Excel.

**Table 1. GPs confidence in managing Gastroenterological conditions**

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<th>Condition</th>
<th>Average</th>
<th>Median</th>
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<td>GORD and Dyspepsa</td>
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<td>Iron Deficiency Anaemia</td>
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<td>Glut Stone and Biliary Disease</td>
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<td>Weight Loss</td>
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**REFERENCE**