was made. Chase Farm Hospital is a district general hospital that has a clinical decision unit, a short stay ward along with a speciality based ward triage for GIM patients. Data were obtained from medical notes and discharge summaries.

Results 62 patients (29 male, 33 female), median age 72.5 years were admitted over the study period. 38 patients (61.3%) had no other acute non-GI diagnoses requiring prompt treatment. 24 patients (38.7%) had at least one other non-GI diagnosis (range 1–2): 16 patients (25.8%) had one and eight patients (12.9%) had two active non-GI diagnosis. The most common non-GI diagnosis was cardiovascular in origin (9, 37.5%). Other non-GI diagnoses were respiratory (6, 25%), renal (6, 25%), endocrine (6, 25%), or other (4, 16.6%). Of these patients, 5 (20.8%) required referral to a specialist team for further investigation and/or treatment of their condition.

Conclusion A significant number of patients (~39%) admitted as an acute medical emergency with a primary GI diagnosis have other active non-GI medical diagnoses. The majority of these were managed by gastroenterology and only in one in five patients was a specilaist opinion sort for further management. By training and maintaining skills in GIM, gastroenterologists are more able to independently manage acute medical patients admitted with a primary GI diagnosis and avoid inter-specialty referral in up to 25% of patients. From this study we support the dual accreditation sought by gastroenterology trainees in GIM.

Competing interests None declared.

PTU-264 PROVIDING A COLONIC STENTING SERVICE FOR MALIGNANT BOWEL OBSTRUCTION: A DISTRICT GENERAL HOSPITAL EXPERIENCE

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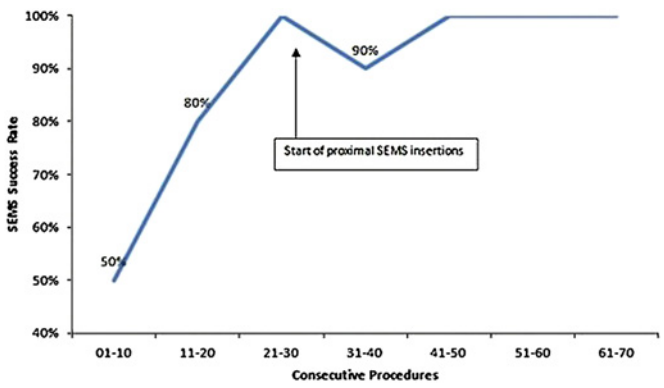
Introduction There is growing evidence for the efficacy and safety for the insertion of self expanding metal stents (SEMS) in the treatment of acute malignant colonic obstruction.[1] This allows either palliation or a bridge to surgery in an otherwise acutely unwell patient. Colonic stenting literature quotes technical success rates in excess of 85%.[1–4] Our unit has been inserting colonic SEMS since 2006. Prior to this we had extensive experience in therapeutic endoscopy but not in colonic stenting. We have observed a learning curve with colonic stenting that is encouraging for endoscopists who are considering implementing the technique.

Methods All SEMS insertions from July 2006 to December 2011 were analysed retrospectively by examining a combination of endoscopy reports, the CRC database and patient notes. A successful SEMS deployment was defined as: satisfactory radiological and endoscopic evidence of colonic decompression at time of deployment and clinical improvement. All SEMS insertion successes and failures were collated and the data compared in consecutive groups of ten procedures.

Results 70 SEMS insertions were attempted in 62 patients. Each procedure is carried out endoscopically with radiological guidance by a gastroenterologist. Ten (14.3%) of the stents were proximal to the splenic flexure. The overall success rate for SEMS deployment was 88.6% (n=62). Abstract PTU-264 figure 1 shows the success rates improvement with the number of procedures carried out. 7 of the 8 failures occurred in the first 20 procedures carried out in our unit. Reasons for unsuccessful procedures are failure to traverse stricture with guidewire (n=5), stent slippage (n=2) and poor bowel prep & excessive looping (n=1). Overall complications rates were low. There were two perforations (2.9%), one of which underwent emergency surgery while the other was managed conservatively. Restenosis occurred in two patients (2.9%) and tumour overgrowth occurred in 1 (1.4%).



Abstract PTU-264 Figure 1

Conclusion SEMS technology is now readily available and is a safe and effective means of treating malignant colonic obstruction. As with all new techniques there is a learning curve associated with its implementation. We have shown that the learning curve is surmountable and that potentially any unit could offer a colonic SEMS service.

Competing interests None declared.

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Trainees

PTU-265 IMPROVING EDUCATION QUALITY AND ATTENDANCE OF A REGIONALLY DELIVERED GASTROENTEROLOGY EDUCATION PROGRAMME

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Introduction The 2010 competency based speciality-training curriculum for gastroenterology requires trainee's to obtain multiple learning objectives. To ensure these are met training programme directors and postgraduate deaneries need to implement changes in delivery of local education programmes. The aim of this study was to determine factors in the delivery of a locally organised and delivered gastroenterology teaching programme that have the greatest impact on improving educational quality and attendance.

Methods All consultants and gastroenterology trainees within a deanery received a questionnaire evaluating the 2009–2010 competency based training programme. Responses were compared with data obtained evaluating a previous training programme between 2003 and 2009 designed around the 2003 gastroenterology curriculum involving 6-weekly, half day events at local hospitals organised by individual consultants. Significant interventions made to the new programme included a predetermined programme guide, whole day events, single venue, keynote speakers, continual professional development points, a local training website and increased trainee involvement in programme development.