

**Competing interests** R Krishnamoorthy: None declared, K Abrams: None declared, K Ragunath Conflict with: Member of the shortlisting panel for the Endoscopy section of the BSG., T Thomas: None declared.

## REFERENCE

1. **van Vilsteren FG**, Pouw, ER, Seewald S, *et al*. Stepwise radical endoscopic resection versus radiofrequency ablation for Barrett's oesophagus with high-grade dysplasia or early cancer: a multicentre randomised trial. *Gut* 2011;**60**:765–73.

## PWE-193 OUT OF HOURS GI BLEEDER SERVICE: THE LEICESTER EXPERIENCE

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R D Ramiah,\* P Wurm. *Department of Gastroenterology, University Hospitals of Leicester, Leicester, UK*

**Introduction** The incidence of upper gastrointestinal bleeds is 50–150 cases per 100 000.<sup>1</sup> The introduction of the CROMES: “Scope for improvement” toolkit<sup>2</sup> has focused on the need for provision of a comprehensive GI bleed service. The RR-adjusted mortality in hospitals without an out of hours rota is 1.21 compared to those with a rota.<sup>1</sup> Despite this only 52% of hospitals have a formal out of hours (OOH) endoscopy rota.<sup>1</sup> The University Hospitals of Leicester (UHL) established a rota in 2006 which now provides 24/7 cover. We examined procedures performed since the rota was commenced.

**Methods** The audit period covered August to January for each of the five consecutive years. We analysed procedures carried out on weekdays (17:00–9:00) and weekends and Bank holidays (24 h). Data were gathered from OOH books where all endoscopies are recorded and from formal endoscopy reports (Unisoft). In each case we considered the indication for endoscopy; appropriateness for an “urgent” procedure; findings at index endoscopy and the need for therapeutic intervention.

**Results** The bulk of OOH work was performed on weekend mornings with weekdays accounting for much less; 6% in 2010–2011. Since commencement an increasing proportion of endoscopies were performed for “inappropriate” indications, as judged by UHL criteria (see Abstract PWE-193 table 1). There was an increase from 17% to 27% in the number of endoscopies where no pathology was found. Interestingly the proportion of patients with varices or variceal bleeds remained static at 9% throughout. Findings of peptic ulcer disease and gastritis/duodenitis have fallen by 16% over the period. The need for therapeutic intervention has almost halved. However, of those requiring intervention use of variceal banding and adrenaline injection significantly increased. Short-term outcomes were very good with over 90% of patients each year having their bleeding controlled and being returned to their ward. Longer-term outcomes were difficult to ascertain due to difficulties obtaining data.

Abstract PWE-193 Table 1

Appropriate indications	Inappropriate indications
Haematemesis	Dysphagia
Haematemesis + melaena	Nausea + vomiting
Melaena	Weight loss
Liver disease + evidence of bleed	Diarrhoea
Liver disease + drop in Hb	Campylobacter infection
Dysphagia + haematemesis	Anaemia
Intermittent rectal bleeding	Abdominal pain
Overt rectal bleeding	Constipation
	Previous peptic ulcer
	IBD assessment

**Conclusion** The data shows trends towards an increasing number of procedures with fewer positive findings and less need for therapeutic intervention. While this is likely to be multi-factorial, one likely contributing factor is the ever-present shortage of acute medical beds leading to more routine work in order to expedite discharges. This does not necessarily constitute a misuse of the service, as early specialist endoscopic input is likely to improve patients' management. However, these factors need consideration before offering such a service.

**Competing interests** None declared.

## REFERENCES

1. **Hearnshaw S**, *et al*. “Acute upper gastrointestinal bleeding in the UK: patient characteristics, diagnoses and outcomes in the 2007 UK Audit”. 2010.
2. <http://www.rcplondon.ac.uk/press-releases/new-guidance-stop-people-dying-acute-gastric-bleeding#main-content> (accessed 10 Dec 2011).

## PWE-194 WE'VE GOT TO THE CAECUM...NOW WHAT WILL WE DO WITH THE POLYPS?

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<sup>1</sup>R Bevan,\* <sup>2,3</sup>T Lee, <sup>4</sup>M Warren. <sup>1</sup>*Cumberland Infirmary, Carlisle, UK;* <sup>2</sup>*Freeman Hospital, Newcastle, UK;* <sup>3</sup>*Institute of Health and Society, Newcastle University, Newcastle, UK;* <sup>4</sup>*Gastroenterology, North Tyneside General Hospital, North Shields, UK*

**Introduction** Recent work, especially in the national Bowel Cancer Screening Programme (BCSP) has focussed on adenoma detection and removal as a marker of quality of colonoscopy. It is vital that this quality assurance is applied to all patients undergoing colonoscopy and that we move away from caecal intubation rate (CIR) as the main marker of a successful colonoscopy. We aimed to review practice in terms of adenoma detection and removal technique among all NHS colonoscopist in a busy district general hospital.

**Methods** Procedural data were retrospectively collected from Endo-soft reporting software for all colonoscopies performed in a 6-month period. BSCP lists were excluded. The reports were reviewed and data collected including operator, size of list, extent of procedure, and details of polyps found—size, location, description, whether removed or biopsied, method of removal and if tattoo used. In addition, the completeness of the report was recorded. Where polyps were removed, the histology result was also recorded.

**Results** 472 procedures were performed by 18 operators—three trainees, two nurse endoscopists, and 13 consultants (eight gastroenterology, five surgical). 159 procedures identified polyps (246 polyps in total), with a unit polyp detection rate of 33.7%. Individual polyp detection rates varied between 14.7% and 58.8%. Histology showed a unit adenoma detection rate (ADR) of 21%. Eight cancers and one polyp cancer were detected. Documentation of polyp location was good (240/246) but size and description were less well documented (171 and 185 out of 246 respectively). 211 polyps were removed, 31 left in situ, and unclear in 4. 26 polyps removed were  $\geq 10$  mm, of which nine with a snare and 16 by EMR (one unknown.) Smaller polyps were removed by a variety of methods (Abstract PWE-194 table 1).

**Conclusion** ADR in this unit is comparable to elsewhere in the UK, but not as high as within the BCSP, although this represents a different patient population. Documentation of these polyps varied greatly, and could be improved. Detection rate and removal methods varied widely between endoscopists. This prompted the creation of an “aide memoir” poster (see Abstract PWE-194 figure 1) to be displayed in the endoscopy room, advising on documentation and highlighting the current guidance for management of polyps. Teaching was also undertaken at dedicated “polypectomy afternoons,” with a view to re-assessing polyp management at a later date, using ADR as quality marker.