intubation: group A (antergrade) and group B (retrograde). The primary outcome variable of the study was the successful completion of the procedure. Failed procedure is defined as the procedure can not be completed by using PBS technique or sedation-related serious adverse events such as severe hypoxaemia (SpO2 <85% more than 3 min and can not relief by airway management), severe cardiorespiratory instability, are occurred. The secondary outcome variables were sedation-related complications, mortality rate and haemodynamic parameters.

Results 108 patients underwent SBE procedure during the study period. After matching age, gender, weight, height, ASA physical status, duration of endoscopy and indications of procedures, there were 21 patients in group A and 19 patients in group B. There were no significant differences in age, gender, weight, height, ASA physical status, duration and indication of procedures, type of enteroscopy, anaesthetic personnel and haemodynamic parameters between the two groups. All procedures were successful completion of the endoscopies. Mean dose of propofol, fentanyl and midazolam in both groups was comparable. Overall and cardiorespiratory-related adverse events were not significantly different between the two groups. All adverse events were transient, mild degree and easily treatable. Serious adverse events were none.

Conclusion Propofol for SBE procedure in adult patients by experienced anaesthesiologist is relative safe and effective. The success rate of the endoscopy does not depend on the route of intubation. Serious adverse events were rare in our population.

Competing interests None declared.

PROPFOOL DEEP SEDATION FOR ELDERLY PATIENTS: A COMPARISON BETWEEN EUS WITH OR WITHOUT FINE NEEDLE ASPIRATION PROCEDURE

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Introduction The aim of this study was to evaluate and compare the clinical efficacy of propofol deep sedation (PDS) for elderly patients underwent EUS with or without fine needle aspiration (FNA) procedure in a teaching hospital in Thailand.

Methods We undertook a retrospective review of the sedation service records of patients who underwent EUS procedures from December 2006 and September 2009. All patients were classified into two groups according to the type of procedure. In group A, EUS was only done for diagnosis. In group B, EUS with FNA was done. The primary outcome variable of the study was overall complication rate. The secondary outcome variables were sedation and procedure-related complications during and immediately after the procedure and haemodynamic parameters.

Results PDS was provided for 513 patients. After matching age, gender, weight and ASA physical status, there were 47 patients in group A, and 40 patients in group B. There were no significantly differences in age, gender, weight, ASA physical status, mean sedative agents used, and indications of endoscopy between the two groups. However, duration of procedure in group B was significantly longer than in group A. All patients in both groups were concluded with the successful completion of the procedure. There were no significant differences in overall complication rate, sedation and procedure-related complications as well as haemodynamic parameters among the two groups. All complications were easily treated, with no adverse sequelae.

Conclusion PDS for EUS with or without FNA procedure in elderly patients by trained anaesthetic personnel with appropriate monitoring was relatively safe and effective. Complications in both groups were comparable. Serious complications were rare in our population.

Competing interests None declared.

BILE DUCT LEAKS FROM AN ABERRANT DUCT OF LUSCHKA

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S Thayalasekaran,* M Gibson, J Kinchen, J Booth, M Booth, A Luschka during surgery, the laparoscopic approach was converted to an open procedure and one patient had a drain inserted at initial laparoscopy. Eight patients had a repeat laparoscopy with a washout and drain insertion. Two patients had CT guided drain insertion. Time to ERCP after presentation varied from 1 to 10 days, with the majority being done between day two and day five. Of the eleven, four patients had a sphincterotomy and stent insertion, five had stent insertion alone and two patients had no therapeutic intervention as the leak was felt to be too small. Eight patients had a repeat ERCP with stent removal and no residual leak on cholangiogram. One person was lost to follow-up. No patients required surgery after ERCP to control the leak. Arrow below: leaking aberrant Duct of Luschka.

Abstract PWE-207 Figure 1

PROPOFOL DEEP SEDATION FOR ELDERLY PATIENTS: A COMPARISON BETWEEN EUS WITH OR WITHOUT FINE NEEDLE ASPIRATION PROCEDURE
Conclusion In this study the likelihood of a post cholecystectomy bile leak arising from an aberrant duct of Luschka was 13%, in keeping with previous smaller series where the rate ranged from 0% to 21%. The standard management with stent insertion +/- sphincterotomy appears to be effective even though the leak is not covered by the stent, presumably by providing preferential drainage.

Competing interests None declared.

REFERENCES

Abstract PWE-208 Table 1 Characteristics of patients diagnosed with HPS

<table>
<thead>
<tr>
<th>Patient</th>
<th>Age at index colonoscopy</th>
<th>Gender</th>
<th>No adenomas</th>
<th>Largest adenoma and location</th>
<th>No hyperplastic polyps in whole colon</th>
<th>No hyperplastic polyps &gt;20 mm in proximal colon*</th>
<th>No hyperplastic polyps in proximal colon*</th>
<th>No SSPs in whole colon</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient 1</td>
<td>69</td>
<td>M</td>
<td>7</td>
<td>13 mm sigmoid</td>
<td>21</td>
<td>2</td>
<td>12</td>
<td>1</td>
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<tr>
<td>Patient 2</td>
<td>64</td>
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<td>1</td>
<td>15 mm sigmoid</td>
<td>24</td>
<td>5</td>
<td>24</td>
<td>4</td>
</tr>
<tr>
<td>Patient 3</td>
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<td>M</td>
<td>8</td>
<td>32 mm sigmoid</td>
<td>37</td>
<td>0</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Patient 4</td>
<td>64</td>
<td>M</td>
<td>2</td>
<td>8 mm descending</td>
<td>43</td>
<td>3</td>
<td>13</td>
<td>5</td>
</tr>
<tr>
<td>Patient 5</td>
<td>68</td>
<td>F</td>
<td>0</td>
<td>—</td>
<td>6</td>
<td>4</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>

*Proximal colon is defined as proximal to the recto-sigmoid. SSP, sessile serrated polyp.