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.

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PWE-208 HIGH PREVALENCE OF HYPERPLASTIC POLYPOSIS SYNDROME IN THE NHS BOWEL CANCER SCREENING PROGRAMME

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Introduction Hyperplastic Polyposis Syndrome (HPS) is a rare syndrome (estimated 1:3000, 0.033% general population¹) in which multiple hyperplastic polyps can predispose to an increased risk of colorectal cancer of up to 7% at 5 years,² and a risk for first degree relatives of HPS patients of fivefold compared to the general population.³ Proximal serrated polyps are commonly associated with advanced neoplasia.⁴ Currently the Bowel Cancer Screening Programme (BCSP) does not offer surveillance for serrated polyps. We aimed to assess how common HPS is in our BCSP population.

Methods We reviewed endoscopic and pathology records for all patients presenting for Bowel Cancer Screening in Oxfordshire between April 2010 (programme start) and January 2012. Three endoscopists performed the procedures. Patients were defined as HPS if they met either of the two main WHO criteria for HPS: either ≥ 20 hyperplastic polyps throughout the colon, or five hyperplastic polyps in the proximal colon with $2 \geq 10$ mm. Patients who were 1st degree relatives of HPS patients were not considered.

Results In total 755 patients attended for screening colonoscopy. Five patients met WHO criteria for HPS, of whom three had a synchronous advanced adenoma (see Abstract PWE-208 table 1). The prevalence of HPS in our BCSP population was 0.66% (95% CI 0.24% to 1.52%), a 20-fold increase compared to the estimated rate in the general population.

Conclusion HPS appears to be relatively common in BCSP patients and is often associated with advanced neoplasia. Detection of a large serrated polyp or multiple hyperplastic polyps should alert BCSP

colonoscopists to the possibility of HPS where they may wish to augment detection with dye-spray or advanced imaging techniques. BCSP surveillance for large proximal serrated polyps may need to be reviewed to ensure such patients are not overlooked.

Competing interests None declared.

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PWE-209 ENDOSCOPY INCREASES THE RISK OF VENOUS THROMBOEMBOLISM—CASE CONTROL STUDY

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Introduction Venous thromboembolism (VTE) is a major cause of mortality contributing up to 25 000 deaths per year. There are no published studies that have linked the risk of VTE to endoscopic procedures. The current study was designed to assess whether endoscopic procedures increase the risk of venous thrombosis.

Methods A retrospective case-control study of cases of patients (pts) with VTE from the Trust's Haemophilia department database over a 3-year period from 1 January 2009 to 31 December 2011. Each case was age and sex matched to one control patient, who attended an outpatient appointment during the same period. The notes and endoscopy reports of cases and controls were reviewed to identify those patients, who had undergone endoscopy in the preceding 3 months of the VTE diagnosis. All adult patients were included in the study. Pts undergoing OGD, flexible sigmoidoscopy, colonoscopy and ERCP were included. Endoscopic US and bronchoscopy pts were excluded. Study sample size was calculated from a literature review of an approximate 2% occurrence of endoscopy in the population and our internal pilot study suggesting a 5% incidence of endoscopy in patients with VTE. With a 5% significance level and 80% power we calculated that 425 subjects per group were required to confirm a difference in endoscopy between pts with VTE and controls. The difference in occurrence of endoscopy between cases and controls was examined using the McNemar test. The risk of VTE occurring following endoscopy was quantified using ORs.

Results 45/445 (10.1%) patients had endoscopy in the VTE group compared to controls (14/445, 3.2%; $p < 0.001$) of which, 21 had OGD, 17 colonoscopy, one had ERCP and six Sigmoidoscopy. The number of pts in each endoscopy procedure category was insufficient to confirm whether the risk of VTE was dependent on the type of procedure performed. The OR for developing a VTE after an endoscopic procedure was 3.58 (95% CI 1.86 to 7.46).

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

	Age at index colonoscopy	Gender	No adenomas	Largest adenoma and location	No hyperplastic polyps in whole colon	No hyperplastic polyps ≥ 10 mm in proximal colon*	No hyperplastic polyps in proximal colon*	No SSPs in whole colon
Patient 1	69	M	7	13 mm sigmoid	21	2	12	1
Patient 2	64	F	1	15 mm sigmoid	24	5	24	4
Patient 3	62	M	8	32 mm sigmoid	37	0	5	8
Patient 4	64	M	2	8 mm descending	43	3	13	5
Patient 5	68	F	0	—	6	4	6	6

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

Conclusion 10% of patients with confirmed VTE had an endoscopy in the preceding 3 months of the diagnosis compared to 3% in the control group ($p<0.001$). Pts undergoing endoscopy have a 3.6-fold increased risk of VTE compared to controls. Larger studies may highlight whether the type of endoscopic procedure or diagnosis may alter this risk.

Abstract PWE-209 Table 1

Analysis	Group	N	Endoscopy, N (%)	OR (95% CI)	p Value
All subjects	Controls	445	14 (3.2%)	3.58 (1.86 to 7.46)	<0.001
	Cases	445	45 (10.1%)		

Competing interests None declared.

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PWE-210 ENDOBRONCHIAL VIDEOSCOPE FOR TRANSESOPHAGEAL/TRANSGASTRIC EUS-FNA IN SPECIAL SITUATIONS: A NOVEL TOOL FOR THE GASTROINTESTINAL ENDOSONOGRAPHER

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Introduction Oesophageal strictures/narrowing pose a distinct challenge during linear pancreatobiliary endoscopic ultrasound (EUS) examination as the linear echoendoscope has a relatively rigid tip, large diameter and is oblique viewing. Significant oesophageal narrowing may therefore preclude linear EUS guided fine needle aspiration (FNA). The ultrasonic endobronchial videoscope (EBUS) has a much thinner diameter but, is considerably shorter and does not have air insufflation. It may however be of use in scenarios when there is oesophageal narrowing.¹

Methods We report the retrospective assessment of our experience of using the EBUS scope to characterise and FNA pancreatic and mediastinal lesions that were unsuitable for EUS examination using the linear echoendoscope. Our unit performs in excess of 750 pancreatobiliary EUS examination a year.

Results Patient 1: 76-year-old man presented with mass in body of pancreas. He had an oesophageal stricture which impeded passage of a linear echoendoscope (Pentax EG-3870UTK). The Pentax endobronchial videoscope EB-1970OUK (EBUS) was used, which passed the stricture easily. EUS demonstrated multiple hypoechoic lesions. Tissue elastography revealed a blue predominant pattern with elevated strain ratio suggesting malignancy. FNA confirmed metastatic renal cell carcinoma. Patient 2: 63-yr-old female presented with progressive dyspnoea, dysphagia and stridor. CT showed massive mediastinal lymphadenopathy compressing the airway (over 13 cm) and the oesophagus. The length of compression meant an airway stent was not feasible. EUS-FNA was requested to obtain tissue to assess suitability for chemo-radiotherapy. The linear echoendoscope would not pass. EBUS scope documented massive mediastinal lymphadenopathy. FNA confirmed high grade neuroendocrine/small cell carcinoma. Patient 3: A 72-year-old gentleman presented with inoperable pancreatic malignancy based on CT scan abdomen. EUS-FNA was requested prior to initiation of chemotherapy. The linear echoendoscope would not pass the narrowed gastro-oesophageal junction probably secondary to achalasia. The EBUS scope was negotiated. There was a 27 mm mass in the body of pancreas extending posteriorly and involving the portal vein confluence. FNA was successfully obtained.

Conclusion We report the successful usage of EBUS scope to examine abnormalities inaccessible to the standard linear echoendoscope.

This work stresses the need to adopt new technologies to enhance the available diagnostic strategies for our patients.

Competing interests None declared.

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PWE-211 LONGITUDINAL SURVEILLANCE OF SUBMUCOSAL TUMOURS BY ENDOSCOPIC ULTRASOUND: A SINGLE OPERATOR EXPERIENCE

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Introduction Endoscopic ultrasound (EUS) provides increasingly improved assessment of submucosal tumours (SMT). The low yield of fine needle aspiration and the benign nature of the majority of lesions leave the optimal management for smaller, asymptomatic lesions unclear as further invasive procedures or surgery may be avoidable. Longitudinal studies characterising interval change of SMT are lacking and may provide information useful in optimising management. We report the experience of a single operator in the EUS surveillance of SMTs.

Methods Patient cases were reviewed at two tertiary referral hospitals and one private hospital for patients who had serial EUS of the same lesion. EUS was performed by a single operator (RYC). For patients who had more than two EUS studies, details of the first and last were examined. Site, maximal diameter and layer of involvement were recorded. Paired data were analysed using a paired t-test with tests for correlation.

Results 73 patients with SMT had at least two EUS procedures between February 2002 and October 2011. Lesions were found in the oesophagus (14), stomach (51) and duodenum (8) with involvement of the submucosa (40), deep submucosa/muscularis propria (4) and muscularis propria (29). The range between first and last EUS was 4–80 months. The lesions varied between 4 and 50 mm with a mean maximal diameter of 15.13 mm (95% CI 12.78 to 17.49) for the first EUS and 15.73 mm (95% CI 13.36 to 18.09) for the second EUS. Paired t-test analysis between the first and last measurements show that there was no significant difference ($p=0.2321$), with good correlation and effective pairing ($r=0.9128$, $p<0.0001$).

Conclusion In our study of submucosal tumours smaller than 50 mm, we showed no significant change in size on surveillance EUS. Further longitudinal studies are needed to determine optimal surveillance regimen for SMTs.

Competing interests None declared.

PWE-212 ACHIEVING DEFINITIVE HAEMOSTASIS IN NON-VARICEAL UPPER GASTROINTESTINAL BLEEDING—A SINGLE UK TERTIARY CENTRE EXPERIENCE

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Introduction Despite advances in endoscopic therapy for non-variceal upper gastrointestinal bleeding (NV-UGIB), achieving definitive haemostasis remains a challenge.¹ Radiological intervention with embolisation is an alternative to surgery where endoscopic