that traditionally quoted (1). The true complication rate of flexible sigmoidoscopy is of particular importance as the UK is introducing the Bowel Cancer Screening Programme (BCSP) by which all citizens will be offered the procedure at age 55.

Methods The aim of this study was to identify the morbidity and related healthcare costs of unexpected hospital attendance following outpatient flexible sigmoidoscopy. An observational study of A&E attendances and admissions occurring within 14 days of all outpatient flexible sigmoidoscopies which took place in 2011 was conducted. All procedures took place at West Middlesex University Hospital, London. Data was collected using the hospital’s electronic records system, enterpriseCAMIS®. Cases were analysed to assess whether readmittance could be attributed to the procedure, and healthcare costs were determined.

Results Of the 1137 outpatient flexible sigmoidoscopies performed, 18 patients (1.58%) presented to A&E within 14 days. Only 2 of these attendances were thought to be related to the procedure (0.18%). 1 case resulted in a 5 day admission due to bleeding post polypectomy. The second A&E attendance was also due to bleeding. The cost of the above admission was £4,682. Including the related A&E attendance, the total financial burden of unrelated readmittance following flexible sigmoidoscopy was approximately £4,827 in 2011. This equates to an additional cost of £4.25 per procedure.

Cost of hospital attendance within 14 days of outpatient flexible sigmoidoscopy (WMUH 2011, n = 1137):

<table>
<thead>
<tr>
<th>Total A&amp;E Attendances</th>
<th>A&amp;E Attendances Related to procedure</th>
<th>Admissions Related to procedure</th>
<th>All episodes related to procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>18</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Average Cost Per Attendance</td>
<td>£145</td>
<td>£145</td>
<td>£4,682</td>
</tr>
<tr>
<td>Total Cost</td>
<td>£2,610</td>
<td></td>
<td>£4,827</td>
</tr>
</tbody>
</table>

Conclusion This study suggests outpatient sigmoidoscopy is relatively safe, with complications necessitating readmittance occurring following 0.18% procedures. The financial burden of hospital readmittance within our UK based study population was minimal, supporting the cost effectiveness of extending services for National bowel cancer screening programmes.

Disclosure of Interest None Declared.

REFERENCES


PWE-035 DIAGNOSTIC YIELD AND SAFETY OF ‘BITE ON BITE’ TUNNELED BIOPSY FOR SAMPLING OF UPPER GASTRO-INTESTINAL SUBMUCOSAL LESIONS

doi:10.1136/gutjnl-2013-304907.324


Introduction Submucosal lesions are detected incidentally in a small proportion of diagnostic upper gastro-intestinal endoscopies. Endoscopic ultrasound guided fine needle aspiration (EUS-FNA) and endoscopic submucosal resection (ESMR) are useful diagnostic investigations for the assessment of such submucosal lesions with studies reporting diagnostic yields of 42% - 92% and 87% respectively. However, access to these techniques is usually limited to specialist centres and they can have complications, with bleeding rates for ESMR ranging from 0–24%. The diagnostic yield with standard sized biopsy forceps is recognised as very low when assessing submucosal lesions. However, there is some evidence that this diagnostic yield might be increased to 17–38% by using a repeated “bite on bite” technique with larger capacity forceps.

Methods We evaluated the diagnostic yield and safety of “bite on bite” tunneled biopsy in diagnosing submucosal lesions found on upper gastro-intestinal endoscopy.

Data from 30 patients who underwent tunneled biopsy was prospectively collected over an 18 month period. The acquisition of tissue required repeated biopsies consisting of 6 bites from the same point using a biopsy forceps with an open jaw diameter of 7mm (Radial jaw 4 large capacity, Boston Scientific).

Results 30 patients were included; (18 male, median age 60 years; range 31–79). The diagnostic yield on tunneled biopsy was 7/30 (23.33%). Positive sample sites were: 4/12 oesophageal (1 mycobacterium tuberculosis, 3 leiomyomas), 0/13 gastric, 3/5 duodenal (1 pancreatic tissue, 2 endocrine carcinomas). No sampling led to bleeding requiring additional therapy to gain haemostasis. No patient required readmission with complications related to tunneled biopsy within 30 days of their procedure.

Conclusion The tunneled ‘bite on bite’ biopsy technique produced a low positive diagnostic yield of 23.33% when compared to EUS-FNA and ESMR. However, there were no complications with this method. Despite its low yield, tunneled biopsy could still be considered as an initial diagnostic method for investigating incidental submucosal lesions as it is inexpensive to perform, safe and universally available.

Disclosure of Interest None Declared.