Abstract PTH-047 Table 1

<table>
<thead>
<tr>
<th></th>
<th>Pre-Bundle Population</th>
<th>Post-Bundle Population</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good Visualisation</td>
<td>23</td>
<td>30</td>
<td>53</td>
</tr>
<tr>
<td>Moderate/Poor Visualisation</td>
<td>29</td>
<td>7</td>
<td>36</td>
</tr>
<tr>
<td>Total</td>
<td>52</td>
<td>37</td>
<td>89</td>
</tr>
</tbody>
</table>

P-value = 0.0008; two-tailed Fisher’s exact test.

Conclusion Our study - the first looking at the effect of a bowel cleansing care bundle on inpatients - shows that its implementation conferred significantly better visualisation scores at colonoscopy with a dramatic reduction in poor visualisation.

Disclosure of Interest None Declared.

REFERENCES

Abstract PTH-048 Figure 1

Conclusion Comparison of the ‘cultures of practise’ are interesting, revealing significant differences of approach in UGI examination.

In the Japanese cohort a 48% higher yield of pathological findings was achieved despite the average screening time being only one minute longer per case.

Although there are differing disease prevalence’s in the background populations, it seems likely that better cleaning of the upper GI tract, use of mucosal enhancement techniques, care in image capture, and better awareness of upper GI pathology will have significantly contributed to increased detection.

Further investigation is needed into which factors can be used as independent measures of quality in UGI examination, including time taken to examine the upper GI tract and measures of endoscopists’ lesion recognition skills (not currently assessed as part of endoscopy training).

Disclosure of Interest None Declared.

Abstract PTH-049 Table

<table>
<thead>
<tr>
<th></th>
<th>Japan</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall screening time (min)</td>
<td>00:53:21</td>
<td>02:10:45</td>
</tr>
<tr>
<td>% of cases where the low residue pre-procedure</td>
<td>69.2</td>
<td>18.3</td>
</tr>
<tr>
<td>% of procedures where rectal washout was washed</td>
<td>50.2</td>
<td>13.7</td>
</tr>
<tr>
<td>% of cases with a correct bowel preparation</td>
<td>92.3</td>
<td>96.1</td>
</tr>
<tr>
<td>% of cases using abdominal imaging</td>
<td>7.3</td>
<td>2.0</td>
</tr>
<tr>
<td>% of cases using VB</td>
<td>37.9</td>
<td>0.0</td>
</tr>
<tr>
<td>% of cases using yellow</td>
<td>57.3</td>
<td>0.0</td>
</tr>
<tr>
<td>% of cases using hidex examination</td>
<td>49.2</td>
<td>0.0</td>
</tr>
<tr>
<td>% of cases using laser</td>
<td>5.1</td>
<td>0.0</td>
</tr>
<tr>
<td>Average polyps taken</td>
<td>6.7</td>
<td>2.4</td>
</tr>
<tr>
<td>Average biopsy taken</td>
<td>3.6</td>
<td>2.0</td>
</tr>
<tr>
<td>% of cases with sessile polyps</td>
<td>13.7</td>
<td>10.3</td>
</tr>
</tbody>
</table>

Abstract PTH-049

Introduction Modern colonoscopic surveillance follows clear evidence based guidelines, and clinical decisions appear straightforward. However, the guidelines do not define what should be done in cases with sub-optimal preparation.

Methods We retrospectively reviewed all adenoma and post carcinoma surveillance colonoscopies over 5 years (2006–2011) with a further year follow up looking for incident cancers.

Polyp site, number, size, and colonoscopy completion rates were recorded.

Two cleaning regimes were used: standard - Fleet; second line and in older patients/renal failure - KleanPrep, picolax and senna. Preparation was graded by the performing colonoscopist as satisfactory, sub-optimal or unsatisfactory.

Results 2176 patients underwent 2649 surveillance colonoscopies. Average patient age was 68.8 years. Mean follow up was 3.4 years.

3758 polyps were identified in 1539 procedures; 525 polyps were 1cm or larger. There was a marked trend towards lower polyp detection with worsening bowel preparation (p = 0.056 Chi²) with a marked reduction in mean number of polyps particularly on the right side with worsening preparation.

12 colorectal cancers were detected in this population. The overall cancer rate in this high risk population was 1 in 181 patients (95% C.I. 103 – 350).

73 patients with sub-optimal or unsatisfactory preparation had a repeat colonoscopy. In 64% the preparation was satisfactory, 28% were sub-optimal, and 8% had an unsatisfactory examination.

Disclosure of Interest None Declared.

REFERENCES
1. *R J Mead, Y C Lim, E Cameron. ’Gastroenterology, Cambridge University Hospitals NHS Trust, Cambridge; ’Gastroenterology, Royal Glamorgan Hospital, Llantrissant, UK

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Aim

Weight loss but have a negative endoscopy for malignancy. No consensus guidelines advising the most appropriate ‘next-step’ for those patients with weight loss, a negative gastroscopy for cancer.

Methods

134/140 (96%) did not have cancer, whilst 91 (65%) revealed a positive test. Weight loss where no upper GI cancer was found. 6/140 (4%) were found to have either oesophageal or gastric malignancy. 6.5% of patients may harbour malignancy elsewhere. 1 For those referred for suspected upper gastrointestinal (UGI) cancer under the 2 week-wait (2WW), it has been shown that 10.5% will have endoscopic evidence of malignancy, whilst 6.5% of patients may harbour malignancy elsewhere. 1

Results

In patients with sub-optimal or unsatisfactory bowel preparation there is a significant reduction in overall polyp detection which is particularly marked in the right colon. This does not appear to be the case with larger polyps.

In patients with sub-optimal or unsatisfactory preparation undergoing a complete colonoscopy, shorter surveillance intervals should be considered taking other patient related factors into account.

Disclosure of Interest

None Declared.

REFERENCE


Conclusion

15% of procedures in our surveillance population have sub-optimal or unsatisfactory bowel preparation, making the interpretation of the clinical guidelines difficult.

Patients who have sub-optimal or unsatisfactory preparation have a high proportion of further sub-optimal or unsatisfactory procedures. Endoscopy units should have a strategy for improving this.

In patients with sub-optimal or unsatisfactory bowel preparation there is a significant reduction in overall polyp detection which is particularly marked in the right colon. This does not appear to be the case with larger polyps.

In patients with sub-optimal or unsatisfactory preparation undergoing a complete colonoscopy, shorter surveillance intervals should be considered taking other patient related factors into account.

Disclosure of Interest

None Declared.