Methods All patients with a diagnosis of bowel cancer, at the Cheshire Bowel Cancer Screening Programme, were asked to complete a second symptom assessment questionnaire. A direct comparison between the reported symptoms pre and post colonoscopy could then be made. The post colonoscopy questioning also included duration of symptoms.

Results In total 83 patients replied to the second questionnaire. The symptoms reported pre and post colonoscopy were similar. PR bleeding was the most commonly reported symptom in the pre and post assessment questionnaire. 42 (49%) patients reported this in the pre questioning, whilst 31 reported in after their diagnostic procedure. The next most common symptom was change in bowel habit. The number of patients reporting this was the same in both the pre and post assessment (n = 25). Further symptoms were assessed in the post procedure questionnaire, 19% and 14% of patients report straining and abdominal bloating respectively. There was also an increase in the reporting of family history of malignancy in the post assessment process, namely of Breast and Ovarian carcinoma. 30% of patients with diagnosed bowel cancer reported a family history of bowel cancer during the pre and post assessment questionnaire. Only 11% patients reported both a family history of bowel cancer and PR bleeding during pre-assessment. When comparing multiple symptoms the results in the two assessments were fairly similar. 16 patients in the pre-assessment reported both bleeding and change in bowel habit, with 14 in the post assessment group.

Table showing numbers of patients reporting combinations of symptoms, pre and post assessments.

Table 1

### Abstract PTU-028

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Pre assessment</th>
<th>Post assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>PR bleeding and change in bowel habit</td>
<td>16</td>
<td>14</td>
</tr>
<tr>
<td>PR bleeding and weight loss</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>PR bleeding, weight loss and change in bowel habit</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

Conclusion PR bleeding is the most reported symptom in those found to have bowel cancer. However, more than 50% patients with diagnosed bowel cancer did not report PR bleeding. When comparing all symptoms together we found that 23% patients were totally asymptomatic. Comparison of questionnaires collected prior and post colonoscopy on bowel cancer screening programme has shown accurate and consistent reporting of symptoms.

Disclosure of Interest None Declared

---

**Disclosure of Interest** None Declared

**REFERENCES**


---

**Disclosure of Interest** None Declared

**REFERENCES**


---

**Disclosure of Interest** None Declared

**REFERENCES**


---

**Disclosure of Interest** None Declared

**REFERENCES**

about half of affected patients. It is usually performed if rapid diagnosis is needed or in a patient who has ileus. However, some patients with CD colitis will have pseudomembranes only in the right colon. Our aim was to assess whether patients, with confirmed CDAD, had their management altered following FS.

Methods A single centre, retrospective analysis of patients who had a FS with stool culture confirmed CDAD admitted to our CD ward (CDW) over 7 years (March 2005–2012) was performed at a district general hospital in North London. The medical notes, endoscopy database and electronic results of patients on CDW undergoing FS was scrutinised.

Results 18 patients on CDW had a FS during the study period. 2 patients were excluded as they were found to be CD negative. 16 of the 1555 (1.04%) patients diagnosed with CDAD at our hospital during this period had a FS. The mean age was 74.1 (range 37–93) with 6 males. FS was requested 27 days (range 1 – 100) and the procedure was performed 40 days (range 10–110) after the diagnosis of CD was made. The indications were persistent diarrhoea in 82% (15/16), bleeding 6% (1/16), abnormal CT scan 6% (1/16) and previous CMV colitis 6% (1/16). 8(50%) patients had a normal FS, 2(13%) had pseudomembranous colitis, and 1 (6%) patient each had adenocarcinoma, colonic polyps, diverticulosis and infective colitis. 2 (13%) patients were newly diagnosed to have ulcerative colitis and were started on mesalazine and steroids along with CD treatment.

Conclusion In this study only a small proportion of patients (1.04%) with CDAD underwent FS. However, when FS is performed in patients with CDAD with persistent symptoms it aids in clarification of the diagnosis with an abnormal FS noted in 50% of patients. From our observation we would recommend FS in CDAD if symptoms persist despite treatment due to the high positive findings at FS.

Disclosure of Interest None Declared

PTU-031 ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGAM (ERCP) IN PREGNANCY WITHOUT RADIATION

doi:10.1136/gutjnl-2013-304907.123

Introduction Pregnancy is associated with an increased risk of gallstone formation, which in turn causes cholangitis and pancreatitis. The prevalence of gallstones in pregnancy has been reported as 3.3 – 12.2%. Cholecystectomy is the second most common non-obstetric surgical procedure in pregnancy, exceeded only by appendicectomy. ERCP is the first-line treatment of choice for cholangitis and pancreatitis caused by choledocholithiasis. However, the use of ERCP in pregnancy is limited because of the primary concern of foetal safety in relation to exposure to ionising radiation. A clear-cut safe radiation dose for ERCP in pregnancy is still unknown. There have been only a few studies of non-radiation ERCP during pregnancy. Our aim is to present our experience with pregnant patients who underwent ERCP without using radiation, and to evaluate the safety and efficacy of this therapeutic pathway for ERCP during pregnancy.

Methods A retrospective analysis of ERCP’s in pregnant women in a single centre in North London (Chase Farm Hospital) between January 2005 and November 2011 was performed. The unit policy of ERCP in pregnant women is to perform the procedure in the left lateral position using midazolam/pethidine combination. Guide wire cannulation of the bile duct is adopted with bile aspiration and/or visualisation of bile oozing around the guide wire used as confirmation of biliary cannulation. Bile duct clearance after sphincterotomy is then performed. No fluoroscopy is used during the procedure, but was available if required. Confirmation of successful therapeutic ERCP was made by laboratory and clinical improvement of the patients.

Results Out of 2255 procedures, 4 (0.17%) were performed on pregnant women. The mean age was 31 years (range 29–36), the mean gestation was 16.75 weeks (range 4–30), with two patients in their first, one in their second and third trimesters each. The indications for ERCP were cholangitis and pancreatitis (two), cholangitis (one) and choledocholithiasis on ultrasoundography (one). In two cases, precut papillotomy with a needle-knife was used, since the stone was impacted. Sphincterotomy was used in two cases. Stones were removed by balloon or basket trawls and no stents were placed. After ERCP, jaundice resolved in all cases. Post-ERCP complications, premature birth, abortion or intrauterine growth retardation were not observed.

Conclusion Our series showed that in experienced hands, successful therapeutic ERCP’s with wire-guided cannulation can be performed safely without radiation in pregnant women with strong indications. We would recommend use of this technique (wire-guided cannulation without radiation) if ERCP is required during pregnancy.

Disclosure of Interest None Declared

PTU-032 WOULD YOU LIKE A TRAINEE TO PERFORM YOUR COLONOSCOPY?

doi:10.1136/gutjnl-2013-304907.124

Introduction Quality assurance in colonoscopy is underpinned by a framework of nationally agreed quality indicators and auditable outcomes to maintain minimum standards. High quality colonoscopy training is a vital part of ensuring these standards and is important that quality is assured during training lists so these patients receive the same standard of care. It is understandable that patients may be concerned if a trainee is performing their procedure and vital that evidence based consent is obtained to address concerns. This study aimed to compare quality delivered on training and non-training colonoscopy lists in order to inform patients.

Methods A 12 month period (Jan 2012 to Jan 2013) of data from the endoscopy reporting system was retrospectively analysed. Caecal intubation rates, procedure duration, endoscopist reported pain score, sedation usage and polyp detection rates were analysed for seven training endoscopists. Data was compared for seven training endoscopists between training and non-training lists. Statistical analyses used χ2 testing and linear regression in Stata 11.

Results Complete data were available for 422 training lists and 956 Service colonoscopies (500 BCSF).

Mean(SD) age was similar in service and trainee groups; 61.0(12.3) and 60.6(14.2) years respectively, p = 0.657. There was no difference in caecal intubation rates between groups (trainees 93.8% and service 94.4%, p=0.657).

Polyp detection was similar amongst trainees 119(28.2%) as non-BCSF service procedures 186(29.3%), p = 0.71.

Midazolam was used less frequently during service lists(737 (78.7%)) vs (867 (87.6%)) (p < 0.001). A statistically but not clinically significantly larger average doses was used 2.3 (0.7) and 2.2(0.7) mg, p = 0.001 during service lists. Interestingly mean doses of fentanyl were similar 59.5(23.2) and 57.7(23.2) mcg, p = 0.46, but lower mean doses of pethidine 36.3 (12.5) and 43.2 (12.2) mcg, p = 0.001 were used during training lists.

Endoscopist reported pain scores were greater on service lists, with 225 (52.8%) trainees and 332 (35.5%) trainers reporting no symptoms, 431 (46.1%) and 143 (33.9%) mild, 149 (15.9%) and 53 (12.6%) moderate, and 24 (2.6%) and 3 (0.7%) severe symptoms respectively (p < 0.001).