be risky. Balloon sphincteroplasty had prevented the further need for ERCP, and its associated cost and morbidity.

REFERENCE
Maydeo A, Bhandari S, et al., *Endoscopy* 2007; 39 (11)

Disclosure of Interest None Declared.

PTH-009 ERCP UNDER PROPOFOL: DO PATIENTS PREFER IT?

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Introduction Endoscopic retrograde cholangiopancreatography (ERCP) is an invasive procedure involving heavy sedation. Use of propofol as sedation in ERCP has been demonstrated to be safe, but is it preferred by patients?
Methods A prospectively collected dataset of patient satisfaction questionnaires post ERCP, using a Likehart scale. Patients excluded were those who declined to do so, those unable to consent for themselves. After 30 days patients were contacted by an ERCP-trained nurse to discuss any problems and complications arising in that time.
Results 128 questionnaires have been completed and followed up at 30-days. 26 had the procedure under propofol +/- midazolam and fentanyl (administered by an anaesthetist) and 102 under a combination of midazolam and fentanyl as per standard unit practice administered by the ERCPist. 30-day FU: 93 of 103 agreed to contact, 16 of whom were uncontactable (based on 2–3 separate attempts to call them on the number provided), 4 of 23 uncontactable from propofol group. 5 propofol patients reported problems in the 30 day follow up (2 were serious), compared to 24 of the sedation group (4 of which were serious).

There was no difference in overall satisfaction between the groups, the propofol group reported less discomfort during the procedure ($p < 0.001$), less wretching ($p = 0.015$) and were more willing to have the procedure repeated ($p = 0.051$).

Using a score of 1 and 2 for satisfied and anyone reporting a score of 3–7 as less or not satisfied, the factors associated with less satisaction were discomfort during the procedure (=0.006), overall discomfort ($p = 0.001$), overall rating of experience and unwillingness to repeat the procedure ($p < 0.001$). After adjusting for age, gender and number of interventions there was no association between propofol use and non satisfaction (adjusted OR 1.12 (95% CI: 0.28–4.45), $p = 0.868$).
Conclusion Patients do prefer ERCP under propofol, but not by much. They get less discomfort (where 0 was a scale of no discomfort and 7 of extreme pain) and therefore are more willing to have the procedure done again. Interestingly propofol procedures are not taking longer than normally-sedated procedures and there are not higher numbers of therapeutic interventions. This may reflect the current bias in selecting a propofol list for a patient or form part of the learning curve of finding the role of propofol-ERCP in the therapeutic strategy.

Further data collection is required to see if ERCP under propofol reduces the number of repeat procedures and therefore can justify itself as cost-effective.
Disclosure of Interest None Declared.

PTH-010 THE SAFETY AND EFFICACY OF TRANSPANCREATIC SPHINCTEROTOMY FOR DIFFICULT CBD CANNULATION DURING ERCP: A DISTRICT GENERAL HOSPITAL'S EXPERIENCE

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Introduction Transpancreatic sphincterotomy (TPS) for difficult common bile duct cannulation during ERCP was first described by Goff in 1995. Since then its safety and efficacy has been debated with some concerns regarding high post ERCP pancreatitis rates (PEP). In published data from recent years PEP can range from 6–20% when TPS is carried out. The majority of TPS is carried out in tertiary referral centres but it is a technique that we have increasingly adopted in our district general hospital when common bile duct cannulation is proving difficult. We wished to review the safety and efficacy of this technique and compare our results to the literature
Methods We reviewed all procedure notes from ERCPs that been had been carried out from October 2011 - October 2013. The reports were reviewed and any cases where transpancretic sphincterotomy was performed were identified. We subsequently reviewed our radiology reporting system, the patients discharge letter and blood results as well as any subsequent hospital admissions to determine any complications. We noted any post ERCP pancreatitis, upper GI bleeding, perforation or death. Complications were classified using the system proposed by Cotton *et al*. We compared our complication rates to our departments overall complication rates
Results Out of 811 ERCPs carried out in the date range 31 patients were identified who had a transpancreatic sphincterotomy performed. 21 cases (68%) were performed by a consultant whilst 10 cases (32%) were performed by a senior registrar. Successful CBD cannulation was achieved in 25 patients (80%) and in the 6 that failed it was subsequently successful at a later date in 4 patients. Our complication rates are shown in the below table
Conclusion Our results show that transpancreatict sphincterotomy can be carried out at a district general hospital with similar levels of success and complications as reported in the literature from tertiary centres worldwide. In such a small data set a single patient death can bias the results and on reviewing the notes the patient died from a perforation due to a common bile duct stent

Abstract PTH-010 Table 1 Complication rates

complication	Standard complication rate	TPS complication rate and severity
Perforation	0.18%	3% (1 patient) - Fatal
Bleeding	0.33%	3% (1 patient) moderate
Post ERCP pancreatitis	0.42%	6% (2 patients) both moderate
Death	0.23%	3% (1 patient)

migrating into the duodenal wall. We concluded this was not related to the technique of PDS and should not deter us from continuing this practice. As expected our complication rates are higher that our units normal complication rates which reflects the challenging nature of the cases when PDS is attempted.
Disclosure of Interest None Declared.

PTH-011 CHANGING TRENDS OF ERCP, A DECADE APART

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Introduction ERCP has become a well established therapeutic intervention. Indications and practice of ERCP have changed over the years due to advent of new imaging modalities. Our aim was to evaluate the ERCP indications, diagnosis and complications over 12month period, a decade apart.
Methods Retrospective observational audit, data extracted from endoscopy reporting system and electronic patient's records. Consecutive patients undergoing ERCP over 12 months in 2002 and 2012.
Results Total number of ERCP's performed was 233 and 212 in the year 2012 and 2002. Median age was 73 and 69 with IQR (58–82) and (56–80) years respectively. Gender ratio in 2012 of 1:1.1 and 1:1.5 in 2002.

Diagnosis: in year 2012: stone disease 109 (46%). Pancreatic Cancer 31 (13.7%). Normal biliary tree 22(9%)whilst in the year In the year 2002 stone disease 90(42%). Pancreatic Cancer 16(7.5%). Normal Biliarytree 60(28%).

Interventions: Year 2012: stent insertion 72(30.9%) and sphincterotomy 155(66.5%). year 2002 stent insertion 39 (18.3%) and sphincterotomies 86(40.6%).

Technical success rate in both the years was 95%.

Complications: 30 day mortality in 2012 was 22(9.4%)and 12(5.7%) in 2002. There was one procedure related death in year 2012 (0.4%), none in 2002. Bleeding requiring transfusion : 14(6%) in 2012 6(2.6%) in 2002. Pancreatitis 6(2.6%) and 6 (3.3%) in 2012 and 2002. Seven patients required sedation reversal in year 2002 as opposed to 0 in 2012. Reflecting the significantly reduced doses being used in the latter year.
Conclusion 1) Work load remained the same. 2) Less number of normal ERCP'S 3) More pancreatic malignancies identified 4) More therapeutic procedures undertaken.
Disclosure of Interest None Declared.

PTH-012 RESPONSE TO PERI-AMPULLARY BOTOX INJECTION AND SUBSEQUENT LONG TERM RESPONSE TO ENDOSCOPIC SPHINCTEROTOMY IN TYPE 2/3 SPHINCTER OF ODDI DYSFUNCTION

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Introduction Pain relief following the peri-ampullary injection of Botulinum toxin A may offer a safe alternative to biliary manometry that accurately identifies patients with Type 2/3 Sphincter of Oddi Dysfunction (SOD) who will benefit from endoscopic sphincterotomy.
Methods From 2007 to 2012, patients with probable biliary or pancreatic type 2 or 3 Sphincter of Oddi Dysfunction based on Rome III revised Milwaukee criteria underwent injection of 100 units Botox divided into four quadrants close to the major papilla.. Response was characterised as complete (CR), partial (at least 50% improvement) (PR) or no response (NR) using a 10-point Likert Scale. Patients that showed either CR or PR were offered an endoscopic sphincterotomy when symptoms returned or worsened.
Results 91patients with median age 39 (22–64), 92.3% female were studied.

93% patients with suspected Type 2 biliary SOD (n = 15) had prior cholecystectomy: 73% had a response to Botox (5CR, 6PR). 7 underwent ES for recurrent symptoms, 2CR and 5PR (100% responders). The time from Botox to ES ranged from 12 to 42 weeks (median 20 weeks). Of the 7 who underwent ES 4 of the responders had no further intervention, 3 underwent extension of their ES for recurrent symptoms within 5 to 8 months. Of 3 NR to Botox who underwent ES only 1 responded. Of the NR none had any further intervention.

84% patients with suspected Type 3 biliary SOD (n = 64) had prior cholecystectomy: 53% had a response to Botox (17CR, 23PR). 26 underwent ES for recurrent symptoms, 8CR and 15PR (88% responders). Of 13 Botox NR who underwent ES, only 3 responded (23%). The time range from Botox to ES ranged from 6 to 58 weeks (median of 17.5 weeks). Of the 26 who underwent ES and were CR or PR 18 had no further intervention and 8 had extended ES for recurrent symptoms within 2 to 30 months. Of the 3 responders to ES but not Botox 2 had further ES 1 with CR and 1 NR.

83% patients with suspected Type 3 pancreatic SOD (n = 6) had prior cholecystectomy: 83% had a response to Botox (4CR, 1PR). 2 underwent ES within 12 to 19 weeks post Botox, and both responded with one having extension of ES for recurrent symptoms with a PR.
Conclusion Botox injection identifies patients likely to respond to ES avoiding the risks of manometry. Manometry may be helpful in a proportion of Botox non-responder in whom SOD is still suspected.
Disclosure of Interest None Declared.

PTH-013 ROUTINE COAGULATION PROFILE PRIOR TO ERCP – AN UNNECESSARY INVESTIGATION?

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Introduction From the first reported endoscopic retrograde cholangiopancreatography (ERCP) in 1968 to the invention of endoscopic sphincterectomy in 1974, ERCP has evolved to an almost entirely therapeutic procedure. It is appreciated that approximately 54,000 patients undergo ERCP each year.[1] The 2008 British guidelines include routine pre-procedural coagulation screen within 3 days prior to ERCP.[2] However, the American Society for Gastrointestinal Endoscopy guidelines state that the prothrombin time, International Normalised Ratio (INR), and activated partial thromboplastin time in patients without clinical evidence of bleeding disorder or coagulopathy do not predict or correlate with either intraoperative or postoperative haemorrhage.[3]
Methods A 12-month retrospective study of 440 patients undergoing ERCP in a single UK tertiary institution was undertaken. The correlation between the presence of a biochemical cholestatic picture and the INR was assessed.