

The duodenal ampulla was reliably identified in 3/47 (6.4%) examinations. Pathology was identified in 11/47 (23.4%) examinations.

Conclusion Side-viewing VCE was well tolerated and completed examination results were available for 76.4% of patients examined. Our findings did not correlate with previous reported results (71%) regarding the identification rate of the duodenal papilla as a small bowel landmark with side-viewing VCE.

Advantages of the side-viewing VCE are not needing the patient to wear a recorder, with the data being stored in the capsule itself. This enables multiple patients to be examined on the same day and the number of examinations is not limited by available data recorders. Patients can also take the capsule home and take the capsule at any time which can be useful in the investigation of obscure GI bleeding. Side-viewing VCE is comparable to forward viewing VCE with respect to cost and accuracy.

Disclosure of Interest None Declared.

PTU-045 FLEXIBLE ENDOSCOPIC TREATMENT OF ZENKER'S DIVERTICULUM USING A SOFT DIVERTICULOSCOPE AND AN ENDOSCOPIC KNIFE – VIDEO ABSTRACT

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Introduction Zenker's diverticulum is a mucosal outpouching through the posterior pharyngeal wall resulting from increased hypopharyngeal pressure. Symptoms may include dysphagia and regurgitation of food. Treatment consists of myotomy of the cricopharyngeus muscle, which is commonly done through an endosurgical approach using a rigid endoscope. We describe a novel method of endoscopic diverticulotomy using a flexible diverticuloscope and an endoscopic knife.

Methods With the patient under general anaesthesia, a guidewire is inserted under direct vision into the oesophageal lumen through a gastroscope. The gastroscope is removed and the guidewire is threaded through a hole on the long flap of the flexible diverticuloscope (ZD overtube, ZDO-22 _ 30; Cook Endoscopy, Winston-Salem, North Carolina). The overtube is gently advanced to 20cm until resistance is felt. The gastroscope is then inserted through the overtube and its position adjusted so that the longer flap is in the true oesophageal lumen and the shorter flap is in the diverticulum. The septum is now clearly visualised and stable between the two flaps.

A 3 mm needle-knife is used to incise the septum. The cut is performed until the muscle fibres are completely cut, and then the cut is extended to a section of the anterior diverticulum and posterior oesophageal wall up to approximately 1 cm from the bottom. At the end of the procedure, one to three endoclips are placed to prevent perforation or bleeding.

Results We have performed this procedure in 3 patients. 1 patient had no previous surgical intervention, 1 had recurrence following previous surgical diverticulotomy, and 1 patient had severe cervical spondylosis due to which surgery could not be performed as adequate extension of the neck for the surgical procedure was not possible. There have been no complications.

Conclusion Endoscopic Zenker's diverticulotomy can be safely performed using a flexible diverticuloscope. We demonstrate the feasibility of performing endoscopic diverticulotomy in patients with recurrence after surgery, or in those who are unsuitable for

surgery. We aim to illustrate the principles and technique of this procedure by video demonstration.

Disclosure of Interest None Declared.

PTU-046 MIND OVER MATTER? GASTROINTESTINAL BLEEDING DUE TO THE USE OF NOVEL ORAL ANTICOAGULANTS IN STROKE PREVENTION

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Introduction The occurrence of stroke secondary to the pro-thrombotic effects of AF is well recognised, with warfarinisation the established therapy for prevention. This is not without complications and so the introduction of the novel oral anticoagulants (NOAC), Dabigatran a factor IIa inhibitor and Rivaroxaban a Xa inhibitor have been received with enthusiasm. Advantages include single dosing, fewer drug interactions and freedom from monitoring, whilst data has demonstrated non-inferiority with respects to stroke prevention. A reported greater propensity to gastrointestinal (GI) bleeding is concerning given the lack of accepted reversal agents, in a cohort of patients who tend to be elderly with comorbidities. We aim to establish the GI complications associated with NOACs in stroke prevention.

Methods We retrospectively analysed 170 consecutive patients from our TIA clinic, who were found to have AF. They were commenced on either Dabigatran or Rivaroxaban, with a total of 86 patient-years of exposure at the time of analysis. We interrogated our computer-based database to ascertain the incidence of anticoagulation related admissions and subsequent management

Results Our cohort of 170 patients had a mean age of 76 years, with a male to female ratio of 8:9. Dabigatran at 220–300 mg/day was prescribed to 45% (n = 77), whilst 55% (n = 93) received Rivaroxaban 20–15 mg/day. Rivaroxaban was stopped in one patient due to drug induced hepatitis. One patient was switched from Dabigatran to Rivaroxaban due to dyspepsia.

GI bleeds occurred in 5% (n = 4) of the Dabigatran group, with 2 upper and 2 lower GI bleeds, occurring on average after 25 days. These patients had a mean age of 84 years, with at least 2 comorbidities. Endoscopy revealed an oesophageal ulcer requiring clipping, new diagnosis of colorectal cancer, haemorrhoids and in one patient no cause was found. GI bleeding occurred in 1% (n = 1) of the Rivaroxaban group. The patient had a rectal bleed, was 96 years and too frail for investigation, therapy was stopped. The average blood transfusion requirement was 4 units. One individual required resuscitation with 16 units of blood, 12 of fresh frozen plasma, 4 of cryoprecipitate and 1 pool of platelets. Average length of admission was 8.4 days.

Conclusion Existing data suggests that the GI bleed rate whilst on warfarin ranges from 1.3–2.6%, compared to a rate of 2.3–3.6% in association with NOACs. In our series there was an overall GI bleed rate of 3%, with 1.8% that could be considered to be significant, requiring blood products and cessation of anticoagulation. Should NOACs become more widely used the lack of established reversal techniques will require local GI units to provide a prompt and skilled bleed service.

Disclosure of Interest None Declared.