Aspirin. We recommend larger studies to interrogate the safety of continuing Aspirin in such patients.

PTU-117 SPLIT DOSE BOWEL PREPARATION: ASSESSING PATIENTS' WILLINGNESS TO WAKE UP EARLY

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Introduction Split dose preparation has been shown to optimise mucosal cleansing, enhance endoscopic views, and improve pathology detection. Split dosing for morning appointments necessitates waking early to take the second dose at an appropriate time. Many units therefore advise that all the preparation is taken the day before the procedure. Our aim was to assess whether patients would be willing to wake-up early to facilitate split dose preparation.

Methods Consecutive patients attending for bowel cancer screening and symptomatic colonoscopy were invited to complete a standardised questionnaire. The results were collated, and logistic regressions were performed in both groups.

Results 418 patients were asked to complete the questionnaire (119 screening and 299 symptomatic); 8 questionnaires were incomplete (6 screening and 2 symptomatic) and were excluded. The M:F ratio was 1.64:1 and 1.03:1; and ages ranged from 55–74 (mean 64.5) and 17–81 (mean 51.5), in the screening and symptomatic groups respectively. Overall, 89% of screening and 85% of symptomatic patients reported they would be willing to wake up early to take split-dose preparation for morning appointments. 78% of screening and 61% of symptomatic patients would be willing to wake between 4–6 am, to facilitate split dosing for morning scheduled colonoscopies. In the screening patients, 3 factors were found to affect willingness to wake up early: scheduled appointment time, whether they perceived the bowel preparation had a severely unpleasant taste and whether taking the preparation had made them interrupt their journey to the hospital to defaecate.

Conclusions This study indicates that most patients would be willing to wake-up early to take adequately spaced split doses of bowel preparation, irrespective of age, sex, socioeconomic background, indication, or previous colonoscopy. In the screening group, those that felt that the preparation tasted severely unpleasant and those who had to interrupt their journey to hospital to use a toilet, were less likely to be willing to wake early to take bowel preparation. All endoscopy units should be encouraged to invite patients scheduled for morning colonoscopy to wake early to facilitate split dose bowel preparation.

PTU-118 ENDOLUMINAL VACUUM THERAPY FOR THE MANAGEMENT OF BOERHAAVE SYNDROME

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Introduction Boerhaave syndrome is associated with high morbidity and mortality rates. Outcomes are dependent on early recognition and intervention. Until recently, surgery has been

the mainstay of management. However, with recent advances in therapeutic endoscopy, there has been increasing interest in endoscopic options, including endoluminal vacuum therapy (EVT). EVT is a minimally invasive technique, allowing wound debridement and drainage; promoting granulation tissue formation to enable wound healing. EVT has been associated with excellent clinical outcomes, including lower mortality rates when compared to both surgery and oesophageal stenting. EVT has been adopted into practice across Europe for the management of oesophageal perforations. However, in the UK there have only been two cases reported. We report a case of a 66 year old female with Boerhaave syndrome, successfully managed with EVT.

Methods EVT for oesophageal perforation involves the placement of a polyurethane sponge into the wound cavity. The cavity is initially assessed with an endoscope before an overtube is introduced under visual control. The sponge is pushed into the cavity through the overtube. Once the sponge is in place, the overtube is removed; allowing the sponge to unfold. Sponge position is confirmed endoscopically and adjusted if necessary. The sponge is connected via a trans-nasal drain to continuous negative pressure. Sponge exchange is performed every 3–5 days.

Results Having been deemed unfit for surgical intervention, due to difficulties with ventilation and haemodynamic instability, our patient was initially stabilised on the Intensive Care Unit (ICU) with the aid of radiologically placed chest drains and intravenous antibiotics. She was subsequently referred for EVT, using the EsoSPONGE® (B.Braun, Medical Ltd, Sheffield, UK). Her first therapeutic endoscopy took place on Day 10 of admission; revealing a 5 cm defect in the oesophageal wall and an adjacent cavity; major vessels and the chest drains could be visualised endoscopically. The EsoSPONGE was placed into the cavity and connected to suction. She remained on ICU for 3 months and during this period her EsoSPONGE was exchanged 16 times; resulting in resolution of sepsis and healing of the defect. She was successfully stepped down from ICU and has now been discharged.

Conclusions EVT was an effective management strategy for our patient with Boerhaave syndrome. Use of the EsoSPONGE aided drainage of the septic focus and closure of the defect; with this our patient made an excellent recovery. Mortality for this case would otherwise have been extremely high as she was too unstable for surgery. This case supports the evidence that EVT provides a promising approach for the management of Boerhaave syndrome.

PTU-119 ROBOT CONTROLLED MAGNET-ASSISTED CAPSULE GASTROSCOPY IS BETTER TOLERATED AND ACCEPTED BY PATIENTS THAN FLEXIBLE GASTROSCOPY

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Introduction OGD is performed commonly but often poorly tolerated. Capsule endoscopy is well tolerated. Robot controlled magnet assisted capsule endoscopy (MACE) allows control of a capsule endoscope resulting in a non-invasive endoscopic examination of the upper GI tract. No controlled comparisons of patient tolerance and acceptability between MACE and OGD have been performed. Post procedure Endoscopy Concerns Scale (ECS) scores correlate with patient