

we need a more specific target audience, excluding certain patient groups (variceal surveillance and diabetics) and prioritising others (2 week waits). Variceal surveillance patients had high DNA rates and would be more appropriate on a daytime list where a DNA can be replaced by an inpatient. Diabetics would benefit from morning lists, both for easier glycaemic control and to reduce food bolus (with a longer overnight fast). Improved patient fasting information is essential with specific guidance for pre-fasting meals, with focus on reducing 'heavy' foods, particularly rice based meals. Further work is needed to identify other areas for improvement and refine the service, and ultimately produce a protocol for evening endoscopy that is generalisable to UK endoscopy departments.

#### REFERENCE

1 NHS Improvement. Rapid Review of Endoscopy Services, March 2012; www.improvement.nhs.uk

**Disclosure of Interest** None Declared.

#### PTH-064 ARE OUTCOMES FOLLOWING ENDOSCOPY FOR EMERGENCY UPPER GI BLEEDING WORSE AT NIGHT AND WEEKENDS?

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**Introduction** Patients admitted out of hours or at weekends may have an excess mortality due to the fact that they undergo emergency endoscopy by junior staff. We retrospectively looked at the predictors of mortality in patients undergoing emergency endoscopy for severe bleeding in Leeds.

**Methods** The survival of patients with the most significant upper GI bleeding lesions who underwent emergency endoscopy in Leeds between end of April 2008 and middle of December 2011 were selected for retrospective analysis using data from our endoscopy reporting system and hospital records.

**Results** A total of 1663 emergency endoscopies were carried out during this period. From this number, 390 examinations (23% of total) were selected for more careful scrutiny as the following significant bleeding lesions had been recorded; 136 duodenal ulcers, 84 gastric ulcers, 134 oesophageal varices, 25 gastric varices, 11 Dieulafoy's and 9 other bleeding lesions.

After 23% of procedures (91/390), the patient died within 30 days. As expected, patients who died had a significantly higher

Rockall score (7.5 vs. 5.9  $p < 0.0001$ ), a higher ASA level (3.5 vs. 2.8  $p < 0.001$ ) and a lower systolic BP at the time of the examination (95 vs. 102  $p = 0.025$ ). Patients who died following endoscopy for bleeding ulcers were significantly older than those who survived (76.6 vs. 67.2 yrs,  $p = 0.006$ ). There was no significant difference in mortality with the type of bleeding lesion, Hb (7.9 vs. 8.0) or heart rate (100 vs. 102 bpm) at the time of the endoscopy between those who survived and those who died.

Furthermore, undergoing an emergency gastroscopy at night or during the weekend or bank holiday was not associated with an increased risk of death ( $P = 0.24$  and  $p = 0.53$  respectively).

Whether the examination was carried out by an SpR or a Consultant made no difference to the survival of the patient. The only link between endoscopic intervention and patient outcome was the finding that patients with varices requiring balloon tamponade were significantly more likely to die (15/36 vs. 16/98  $p = 0.01$ ).

**Conclusion** Our study had the statistical power to detect all the recognised risk factors for death following admission with an acute upper GI bleed including advancing age, increasing comorbidity and hypotension. We found no evidence that undergoing an emergency endoscopy at night or during the weekend or a bank holiday had any adverse effect on outcomes. Similarly, the level of seniority of the endoscopist did not affect outcomes.

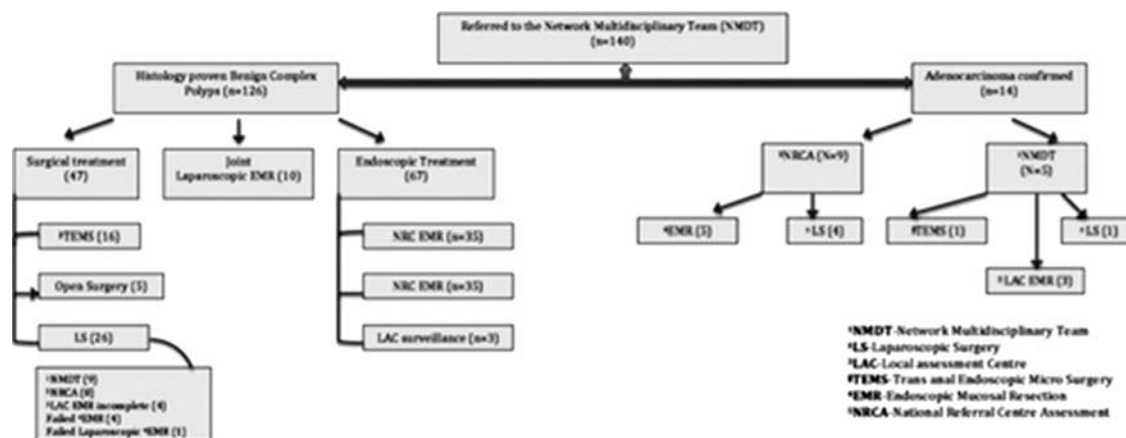
**Disclosure of Interest** None Declared.

#### PTH-065 IMPACT OF A STANDARDISED CLINICAL MANAGEMENT NETWORK FOR COMPLEX POLYPS WITHIN THE BOWEL CANCER SCREENING PROGRAMME (BCSP)

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**Introduction** Initial data from the UK BCSP demonstrated variation in referrals to surgery and management for complex polyps encountered in colonoscopy. Associated factors included local availability of operator skills and expertise with endoscopic resection, lack of a structure for discussion and standardised management at the Local assessment centres (LAC). Inappropriately high



**Abstract PTH-065 Figure 1** Management outcomes for complex colon polyps following referral to the NMDT