*BP<100mmHg and/or HR>100BPM NS: Not Significant
Table 2. Clinical Outcome in Homeless and Common Patients

	Homeless n=67	Non-homeless n=225	p
Rebleeding	7 (10.4%)	20 (8.9%)	NS
Mean (range) Blood units transfused	3.8 (0-19)	1.6 (0-14)	<0.0001
Surgery	7 (10.4%)	2 (0.9%)	<0.0001
Deaths	1 (1.5%)	1 (0.4%)	NS

NS: Not Significant

M1036

Determination of the Minimal Clinically Important Difference of Health-Related Quality of Life Improvement in GERD Patients As Assessed By Gerdyzer™

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PURPOSE: Improvement of Health-related quality of life (HRQoL) is now considered an important treatment outcome. The aim of this study was to determine, which improvement in HRQoL can be considered clinically relevant,using different methods. METHODS: GERDyzer™ is a 10-dimension validated questionnaire for the assessment of HRQoL in reflux disease (GERD). Each dimension is illustrated with pictogram-like drawings and HRQoL is assessed using 100 mm visual analogue scales (VAS). Data from a patient database with endoscopically confirmed erosive esophagitis (EE) Grades A-D (LA-classification) were included irrespective of treatment regimen (n=1257). HRQoL was assessed weekly using GERDyzer™ and GERD symptoms were measured daily with the ReQuest™ questionnaire. The minimal clinically important difference (MCID) of the GERDyzer™ sum score (min-max: 0-70) was determined using different methods: the measurement error was determined using the standard deviation (SD) and Cronbach's alpha and 2 external anchors - the GERDyzer™ dimension general well-being (determined using VAS) and the ReQuest™-GI subscale. Using log linear regression the GERDyzer™ sum score was transformed to the GERDyzer™ dimension general well-being and ReQuest™-GI, respectively. The MCID for the GERDyzer™ sum score was estimated as the smallest value corresponding to 'excellent' general well-being subscale and in addition to the well known GERD symptom threshold for ReQuest™-GI. The GERDyzer™ sum score corresponding to the GERD symptom threshold for ReQuest™-GI (90% percentile) determined the MCID by ReQuest™-GI subscale. RESULTS: The MCID of GERDyzer™ sum score using the measurement error was 3.78. For the external anchor general well-being the MCID value was 4.15. For the external anchor ReQuest™-GI the MCID value was 3.62. CONCLUSIONS: Based upon our data, an improvement of the GERDyzer™ score by 3.78 points can be considered clinically relevant. Using two different external anchors this result could be confirmed within the expected variance. Thus an improvement of at least 3.78 points can be considered the benchmark and for example the time until this threshold has been reached compared for various therapeutic interventions.

M1037

Quality of Colonoscopy Preparation with Polyethylene Glycol At a Va Medical Center

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BACKGROUND: We developed a computer-based decision support tool (DST) to tailor preparation (prep) for patients (pts) undergoing outpt colonoscopy (CY). When appropriate, the DST would allow pts to use sodium phosphate (NaP) instead of polyethylene glycol (PEG), and would identify pts who might benefit by adding a stimulant laxative. As part of this project, we obtained and analyzed baseline data about prep quality with PEG at our VA hospital. OBJECTIVE: To describe and quantify the impact of CY prep with PEG on pt- and system-specific factors. METHODS: We surveyed endoscopists about prep quality upon completion of CY for pts at the Indianapolis VAMC from 11/05 through 6/06. The survey included rating prep quality using a modified Aronchick scale (1 [excellent] to 4 [poor]); it asked about the effect of prep quality on: 1) whether the CY was aborted because of the prep; 2) the likelihood of having missed a polyp 5-9 mm; 3) CY time, and; 4) surveillance or re-screening interval. We correlated responses with the time of day CY was performed (AM vs. PM) and with CY findings. RESULTS: We received randomly completed surveys from 14 endoscopists on 609 (41%) of 1484 outpts (mean age 60.7 +/- 9.6 years; 94% men) and for 28 (80%) inpts, all of whom had PEG prep. Among outpts, CY indication included screening (44%), symptoms (25%), surveillance (24%), occult bleeding (7%), and abnormal radiographic findings (1%). Prep quality was excellent in 7%, good in 55%, fair in 26%, & poor in 11%; resulted in aborted CY in 9.6%, and prolonged CY time in 62%. Endoscopists were somewhat likely (28%) or very likely (12%) to have missed a 5-9 mm polyp due to prep quality. For 38% of the pts, re-screening or surveillance was recommended earlier than in published guidelines because of prep quality. When dichotomized into satisfactory (excellent or good prep quality) and unsatisfactory (fair or poor quality), PM CY was more often unsatisfactory than AM CY (45% vs. 34%; RR=1.20; 95% CI, 1.05-1.39). Prep quality was worse for inpts than for outpts (mean quality score: 2.38 vs. 2.22; P=0.01), a finding that persisted after adjustment for pt age, gender, time of day, and neoplastic findings. In multivariable analyses that controlled for age, BMI, endoscopist experience, and time of day, prep quality was unrelated to polyp detection. CONCLUSION: Inadequate prep quality is prevalent at our VAMC and impacts negatively on systems factors because of the need to reschedule aborted CY, by prolonging CY time, and by the scheduling of early follow-up CY. Improving prep quality is likely to impact positively on systems variables, and may improve both polyp detection and patient satisfaction.

M1038

Is the Risk of Colon Rectal Cancer Elevated in Chronic Ulcerative Colitis in the Community?

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Aim: Ulcerative Colitis (UC) has been associated with an increased risk of colon rectal cancer (CRC) in the literature when present for > 7 years. This has not been our clinical observation, so we undertook this study to obtain our actual experience over the past 16.5 years. Methods: A retrospective study of all patients with UC in our private GI practice in Orlando, Fl. was undertaken between 1/1990-6/2006. Only patients who have had colonoscopic and pathological verification of UC, and were followed for > 1 year in a surveillance program were included in our study. Results: 426 patients were identified, 132 with pancolitis (PC), 262 with left-sided colitis (LSC) and 32 with proctitis. The mean age was 45 years. 48% were male, 52% female. 22/426 patients (5%) had concommitant tubular adenomas. 20/426 (5%) had low grade dysplasia (LGD) on at least one set of biopsies. No cases of LGD progressed to cancer and no cases of high grade dysplasia were encountered. 25/426 (6%) had undergone colectomy for medical or quality of life issues. No cancers were found in those specimens. One patient with LSC developed rectal cancer one year after a benign colonoscopy (UC without dysplasia, polyps or masses).Of 132 patients with PC, 75 (57%) had a duration of disease > 7 years and a mean duration of 19.6 years, with a range out to 59 years. 36% (48) patients had PC for > 20 years. There were no prevalence cases of CRC. Conclusions: 1. Over the past 16.5 years, of 426 patients with chronic UC that were in our surveillance program, only one developed CRC. 2. The one patient with CRC was a 42 year old male with LSC for 7 years, had a father with CRC and had a colonoscopy 1 year earlier that showed non-dysplastic LSC, without polyps or masses. 3. No patients with PC developed CRC despite a mean duration of > 20 years in 48 patients. 4. In our patient population, the risk of CRC in chronic UC does not exceed the expected risk of CRC in the general population.

M1039

Subspecialty Consultations and GI Testing Following a Diagnosis of Non-Cardiac Chest Pain

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Background: Non-cardiac chest pain (NCCP) is typically defined by substernal chest pain in the absence of significant stenoses in the major epicardial coronary arteries. Little is known about the rate of health care utilization and GI diagnostic testing in this population. Methods: A previous study identified 2068 Olmsted County, MN residents presenting to 1 of the county's 3 EDs with acute chest pain between 1/1/85 and 1/31/92. From this cohort, 359 patients were dismissed after hospitalization with a diagnosis of NCCP. Of these, 227 patients were labeled as chest pain of unknown origin (NCCP-U) while 93 received a gastrointestinal diagnosis (NCCP-GI). The Mayo medical record of these 320 patients was reviewed between 1/1/93 and 1/1/06 and GI diagnostic tests (EGD, esophageal manometry, and 24 hour pH probe) and health care visits (GI, cardiology, and ED visits) were recorded. Health care utilization and GI testing was compared between the NCCP-GI and NCCP-U subset using Poisson Regression. Results: 47% of the total population sought care in the ED (604 visits), 40% received cardiology consults (562 visits), and 15% percent received GI consults (164 visits). 46% of the NCCP-U subset were seen in the ED (424 visits), 91% were seen by a cardiologist (416 visits), and 15% were seen by a gastroenterologist (148 visits), whereas 46% of the NCCP-GI subset was seen in the ED (180 visits), 40% were seen by a cardiologist (146 times), and 11% were seen by a gastroenterologist (16 visits). Rate ratios were used to compare utilization between the NCCP-U and NCCP-GI subsets and were 0.8 for ED visits (p=0.35), 1.0 for cardiology visits (p=0.9), and 3.3 for GI visits (p=0.004). In regards to GI testing, this population of 320 patients received 247 EGDs, 13 manometry tests, and 6 pH probes. In the NCCP-U subset 35% received an EGD (173), 4% received manometry (9), and 2% received a pH probe (5). In the NCCP-GI subset 43% received an EGD (74), 3% received manometry (4), and 1% received a pH probe (1). Rate ratios were used to compare GI test usage for the NCCP-U group versus the NCCP-GI group and were 0.8 for EGD testing (p=0.46), 0.8 for manometry testing (p=0.56), and 1.8 for pH probe testing (0.14). Conclusion: The frequency of health care utilization in the NCCP population is high. There is a paucity of GI consultations. Once NCCP patients receive GI consultation, EGDs are performed frequently, and further tests including 24 hour pH probes and manometry are performed infrequently. In this population, patients with NCCP of unknown origin received 3 times as many GI consults than their counterparts with NCCP secondary to a known GI disorder.

M1040

The Direct and Indirect Economic Costs of Irritable Bowel Syndrome in a Large Us Employer Population

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Background: Irritable bowel syndrome (IBS) is a common disorder of the gastrointestinal tract, reported to occur in 10%-20% of the US population. IBS most often affects persons in their prime working years (30-50 years of age). This study assessed the economic burden of IBS in the US using a unique database of retrospective claims from a large population spanning multiple employers. *Objectives:* The primary objective of this analysis was to estimate the direct and indirect costs contributing to the total economic burden of IBS in a large employer population. *Methods:* Data were extracted from Medstat's MarketScan® Health and Productivity Management database, combining medical and pharmaceutical claims linked to workplace absence and short-term disability from six large US employers over a four year period (2000-2003). Subjects aged ≥18 years who had at least one primary or non-primary diagnosis of IBS were eligible for inclusion, and were compared with demographically matched controls. The primary outcome measures were average annual healthcare utilization, missed work time due to absence or short-term disability, and associated costs. *Results:* A total of 11,306 adults were identified with a diagnosis of IBS. Patients of prime working age (25-54 years) represented >80% of both the IBS and control samples, and the majority