PWE-199 QUALITY OF FLEXIBLE SIGMOIDOSCOPY FOR COLORECTAL CANCER SCREENING: ARE WE THERE YET?

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Introduction Colorectal cancer (CRC) screening with flexible sigmoidoscopy (FS) has been associated with reduced incidence and mortality from CRC. The NHS in UK is introducing FS screening for all men and women at 55 years of age following a multicentre randomised controlled trial which found that FS was a safe and practical test which, when offered only once conferred a substantial and lasting benefit. Quality in performance of FS will be important for success within the screening programme. One aspect of quality of FS performance is the depth of insertion. The definition of an adequately inserted screening FS is subjective and not currently defined. However, in clinical practice, one should examine as much of the distal colon as possible, recognising that it can be difficult to precisely define the furthest extent. It is expected that the rectum and sigmoid colon should be inspected completely and the descending and more proximal colon can often also be visualised. By taking the analogue of colonoscopy one could expect the "descending colon intubation rate" to be at least 90%. In addition, the preparation should be such that the endoscopist is confident that lesions other than small polyps (5 mm or smaller) are not obscured. If adequate insertion is not achieved or the sigmoid colon is not adequately prepared, the procedure may have to be repeated increasing the burden on an already overstretched endoscopy service.

Methods To assess the completion rate (depth of insertion in FS) defined as examination up to at least the descending colon and reasons for incompleteness. A single centre, retrospective study in a district general hospital endoscopy unit in London of consecutive FS over a 2-month period in 2011. The FS reports were scrutinised for depth of insertion and if splenic/ascending colon was not reached the reason for this.

Results Within the study period, the splenic flexure was reached in 40% (58 of a 148), and the descending colon in 66% (94 of 148). The reasons stated for not reaching the descending colon/splenic flexure include: inadequate bowel prep (26/148), pathology encountered (16/148), patient discomfort (4/148), planned limited procedure (7/148). In 87/148 no reason for not reaching the splenic flexure/ascending was documented.

Conclusion In this study, in the majority of patients undergoing FS the splenic flexure in not reached. Only 66% of patients have the rectum and sigmoid colon assessed during planned FS. The reasons for failure of examination to descending colon is not documented in the majority, and this may be because clear guidelines on "descending colon intubation rates" are not available. In order to implement FS as screening for CRC we recommend development of clear quality standard including one of depth of intubation (or "descending colon intubation rate") as is currently available for colonoscopy.

Competing interests None declared.

PWE-200 THE IMPACT OF BOWEL PREPARATION ON OTHER COLONOSCOPY QUALITY INDICATORS

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Introduction Poor quality of bowel preparation may be a major obstacle to the effectiveness of colonoscopy. Poor bowel preparation results in repeat of the procedure or shortening the interval of repeat scheduled procedure all of which increase the economic burden of

the test. Quality indicators of colonoscopy are an important assessment of an endoscopy unit to fulfil for formal accreditation from JAG (Joint Advisory Group of Gastrointestinal Endoscopy). These indicators include the caecal intubation rate, adenoma detection rate and polyp retrieval rate. Poor quality bowel preparation may affect all of these quality indicators of colonoscopy. The impact on the quality of bowel preparation on completion of colonoscopy and polyp detection/retrieval was assessed in this study.

Methods To test the hypothesis that poor bowel preparation results in reduced caecal intubation, reduced adenoma detection and polyp retrieval rates. This was a retrospective analysis of all colonoscopies performed at a district general hospital in the North of London for 1-year from June 2009. The quality of bowel preparation was documented as good, satisfactory or poor. The caecal intubation rate, adenoma detection rate and polyp retrieval rate within each of the types of quality of bowel preparation was scrutinised.

Results A total of 1261 colonoscopies were performed in the study period. The caecal intubation rates were 94%, 86% and 82% for good, satisfactory and poor bowel preparation respectively. The polyp detection rate were 20%, 20% and 16% and polyp retrieval rate of 92%, 87% and 77% for good, satisfactory and poor bowel preparation respectively.

Conclusion Patients undergoing colonoscopy whose bowel preparation is poor have significantly lower rates of caecal intubation, polyp detection and polyp retrieval compared those with good bowel preparation. This study demonstrates the importance for units to endeavour to improve bowel preparation for patients undergoing colonoscopy to improve completeness of colonoscopy. While individual colonoscopist will look to improve their quality indicators of colonoscopy by safer sedation scores and improvement in withdrawal times, the quality of bowel prep needs to be assessed by the unit.

Abstract PWE-200 Table 1

Preparation	Total	Caecal intubation (CI)	CI %	Polyp detection (PD)	PD %	Polyp retrieval (PR)	PR %
Good	440	415	94.3	88	20	81	92
Satisfactory	661	573	86.6	134	20	117	87
Poor	184	152	82.6	31	16	24	77

Competing interests None declared.

PWE-201 TECHNIQUES FOR REMOVAL OF POLYPS FROM THE RIGHT COLON: HOW ARE WE DOING THEM?

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Introduction Polypectomy is a commonly performed therapeutic intervention and all colonoscopists should be able to perform the procedure safely and effectively. Complications can include perforation and bleeding. Practice has evolved considerably in recent years and there is a range of equipment and techniques available for different clinical settings. The recommended technique for removal of polyps from the right colon include cold snaring for polyps up to 7 mm and hot snare for polyps 8 mm or greater. It is recommended to avoid cold biopsy except in tiny polyps and to avoid using hot biopsy altogether. We wanted to assess the polypectomy techniques used in our hospital and compare these to recommendations provided by the British Society of Gastroenterology guidance document.

Abstract PWE-201 Table 1

Polypectomy technique	Number of polyps removed	Range of polyp size (mm)	Gastroenterologist: surgeon
Cold biopsy	10	2–8	7:3
Cold snare	17	3–9	16:1
EMR	4	2–15	4:0
Hot biopsy	3	1–5	0:3
Hot snare	5	2–12	2:3

Methods The aim was to assess the method of colonic polypectomy used in comparison to recommendations by all endoscopists at our district general hospital. A prospective assessment of polypectomy technique from the right colon was performed from a district general hospital in North London over 6 months from October 2009. Endoscopy nursing staff were asked to document site and method used to remove and retrieve the polyp. Patients were identified prospectively from nursing records of the procedures from the endoscopy registry book and then the polypectomy technique used was scrutinised.

Results A total of 39 polypectomies from the right colon were documented during the 6 months study period, with 29 completed by a Gastroenterologist and 10 by a surgical colleague. The size of polypectomy varied between 2 mm and 15 mm. In the Cold biopsy group, there were 3 polyps >6 mm (6, 7 and 8 mm) in size and these three were completed by a surgeon. In the Cold Snare group, there was 1 polyp >7 mm (9 mm) in size and this was removed by a surgeon by this method. In the Hot biopsy group, there were 3 polyps (1, 4, 5 mm) in size and all were removed by a surgeon with this technique.

Conclusion Our results show that there are varying techniques and methods used to excise polyps from the right colon. Despite increasing awareness of the thinness of the right colonic wall and hence increase risk of transmural thermal injury associated with hot biopsy this continues to be performed, in our study by surgical colleagues only. Despite cold biopsy technique likely to leave behind residual tissue, it continues to be used for polyps up to 8 mm in our study. For the cold snare technique guidance recommends use for polyps up to 7 mm to reduce risk of bleeding yet, in our study one cold snare was carried out for a 9 mm polyp. More awareness is required in the appropriate polypectomy technique for right sided polyps to improve efficacy.

Competing interests None declared.

Abstract PWE-202 Table 1

	Cancers/dysplasia	Submucosal/others	Curative resection	Recurrence	Bleeding	Perforation	Surgery
Oesophagus 10	7 Barrett's LGD: 2, HGD: 1 SM2/3: 3 SCC: 1	3 GIST: 1 Leiomyoma: 1 Papilloma: 1	8/10 (80%)	0	0	1/10 (10%)	4/9 (44%) All curative
Stomach 14	9 IMC: 2 HGD: 3 LGD: 2 Hyperplastic: 1 IFP: 1	5 Carcinoid: 4 Lipoma: 1	13/14 (94%)	0	0	1/14 (0.7%)	
Duodenum 1	Adenoma LGD: 1		1/1 (100%)	0	0		
Colon Total: 66 R: 14 (21%) L: 52 (79%)	<u>Morphology:</u> LST: 38 Sessile: 25 Flat: 3 <u>Histology:</u> SM1:2 SM2:2 IMC:1 HGD:15 LGD: 46	0	62/66 (94%)	4/66 (6%)	4/66 (6%)	4/66 (6%)	2/66 (3%) 1 curative 1 for perforation

PWE-202 FEASIBILITY, SAFETY AND OUTCOMES OF AN ENDOSCOPIC SUBMUCOSAL DISSECTION SERVICE IN A UK SETTING

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Introduction Endoscopic Submucosal Dissection (ESD) is an established treatment of early gastrointestinal neoplasia in Japan. It carries a greater risk of complications than conventional EMR. Use and experience of ESD in the west is limited with most centres having only performed small numbers of cases. We aim to evaluate the outcomes of ESD service in our centre.

Methods Upper and Lower Gastrointestinal Endoscopic Resections database was evaluated to identify patients who underwent ESD and their demographics, histology, techniques, complications and outcomes were analysed.

Results Upper Gastrointestinal: 25 ESD were performed in 23 patients between 2006 and 2011 (11 males). Mean age was 61.5 years. 14/25 involved en bloc ESD (where a circumferential incision is made to remove the whole lesion) and 11/25 involved a hybrid technique (where a circumferential incision is made followed by resection using a snare). 2/25 perforations occurred, both managed with endoscopic clips requiring no surgical intervention. 22/25 procedures were completed successfully. In 2/25, lesions were unable to be fully resected and 1/25 was abandoned due to perforation. Due to advanced histology, four proceeded to radical or palliative treatment. **Colonic:** 66 patients underwent ESD between 2006 and 2011 (21 males). Mean age was 68.5 years. 43/66 had en bloc ESD and 13/66 a hybrid procedure. 14/66 was in the right colon and 52/66 in the left colon. 24 lesions were LST-G, 8 were LST-NG and six were unspecified LST. Bleeding occurred in four cases (three delayed) all treated endoscopically. Perforation occurred in four cases, only one required surgery and the rest were managed with endoscopic clips. 4/66 had incomplete primary resection (one had perforation requiring surgery). 4/66 had recurrence requiring further sessions. 2/66 patients required curative surgery due to advanced histology.

Conclusion (1) ESD service is feasible, safe and effective in a UK setting. (2) Our data demonstrates that ESD can be used to treat a wide variety of lesions through out the gut. (3) Perforation remains a significant risk but effective clipping technique can avoid the need for surgery. (4) ESD should be centralised to high volume expert centres to achieve good outcomes and establish training programmes.

Competing interests None declared.