

Methods Single endoscopist using ESD and Hybrid ESD (H-ESD) technique was retrospectively audited from April 2004 to August 2012. Service evaluation data of 38 patients with large sessile polyps who underwent ESD and Hybrid ESD was reviewed from a cohort of 224 colonoscopies referred for large polyp EMR. All procedures were intended as ESD. NICE recommendations for case selection were followed in 92% cases. Due to challenges in submucosal dissection of the large lesions, piecemeal resection was done after circumferential cutting. First follow-up endoscopy was performed at 3–6 months and the second at 12–14 months.

Results Mean age was 70 with 16 males and 22 females. Mean size of polyp in ESD group was 26mm. Range 15–50mm. Mean size in the H-ESD group was 49mm. Range 20–100mm. Complete resections were achieved in 17 (44%) out of 38 cases. Due to piecemeal resection pathologists were not able to confirm adequacy of excision in 12 cases. In 9 cases resection was reported incomplete on index procedure. ESD performed in 13 (34%) cases. Complete resection achieved in 6. Out of 7 incomplete resections in the ESD group, 3 were reported by pathologists as lesion extending to the lateral margin hence incomplete excision. Histology did not comment on margin clearance in 3 ESD. 1 ESD was a sub mucosal lipoma on histology. This was an unintentional ESD for lipoma. Histology: ESD group: TVA with LGD 7, TVA with HGD 5. H-ESD was performed in 25 (65.7%) cases. Complete resection achieved in 11 cases, incomplete resection in 7 and lateral margin clearance not confirmed in 7 H-ESD cases due to piecemeal resection. Histology: H-ESD group: TVA with LGD 16, TVA with HGD 6 and adenocarcinoma in 2 cases-one's lateral and deep margins were clear and the other was incomplete and referred to MDT In 4 ESD and 7 H-ESD cases there was minor bleeding controlled endoscopically at the time. 1 delayed post- H-ESD bleeding required 11 days of hospital stay and 2 units of blood transfusion. 1 retroperitoneal perforation and 1 case of serosal cut managed conservatively with clips and antibiotics. APC performed in 16 (42%) out of 38. Recurrence was identified in 6 H-ESD cases (15.7%). 5 local recurrences detected at 3 months and 1 local recurrence detected at 24 months. In 13 ESD cases no perforation or recurrence upto 14 months was noted despite 5 histologically incomplete dissections.

Conclusion ESD in bowel is challenging and has a long learning curve. These procedures should be performed by trained endoscopists in accredited units and a national registry should be maintained.

Disclosure of Interest None Declared.

PTH-062 ENDOSCOPIC MUCOSAL RESECTION OF LARGE COLORECTAL POLYPS IN NON SCREENING COLONOSCOPIES HAS A HIGH RECURRENCE RATE:

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Introduction EMR of large colorectal polyps has been reported to be a safe and effective technique in UK. Although the success of large polyp EMR has been reported within regional bowel cancer screening centres, there is a paucity of data comparing outcomes between screening and non-screening centres.

Methods A total of 61 screening and 60 non-screening EMR of polyps 2cm or greater were performed from January 2008 to December 2011. Data was collected from 3 hospitals for screening EMR and 1 district hospital for non-screening EMR.

Results The table below summarises the findings at initial EMR for both groups.

Abstract PTH-062 Table 1

Characteristics	Results for Screening group n (%)	Results for non-screening group n (%)
Number of patients	61	60
Mean size (in mm)	35	43
Location (Left colon)	43(70)	36(60)
Histology (Low Grade Dysplasia)	47(83)	36(67)
Histology (High Grade Dysplasia)	7(12)	11(20)
Histology (Adenocarcinoma)	3(5)	7(13)
Bleeding Complication	2(3)	3(5)
Perforation	0(0)	1(2)

Surveillance data was available for 37 patients in the non-screening group compared to all 61 patients in the screening group up-to 3 months post EMR. Number of recurrences were 6 (10%) with mean polyp size of 25mm in the screening group compared to 10 (27%) in the non screening group with mean polyp size of 50mm.

All recurrences in both groups were resected and complete. Histology confirmed low grade dysplasia (LGD) in 80%, while 2 patients had evidence of high grade dysplasia (HGD) in the non-screening group. All showed LGD in the screening group. At 12 months surveillance post EMR, 43 screening patients had follow-up data with 8 recurrences detected compared to 14 in the non screening group with 4 recurrences.

Conclusion Endoscopic mucosal resection of polyps in screening group appears to be safer with low complication rates and low recurrence rate up to 12 months post EMR compared to the non-screening groups. This may be due to a multitude of factors such as patient age, co-morbidities and the characteristics of polyps. Clinical features of patients undergoing EMR were similar in both groups. There was a trend to higher recurrence and complication rate in the non screening group. The follow up post EMR was less consistent in the non screening group possibly due to less stringent protocols for follow up. This may have affected the surveillance and recurrence rates.

Disclosure of Interest None Declared.

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PTH-063 ESTABLISHING AUDIT STANDARDS FOR COLONIC STENT INSERTION WILL FACILITATE SERVICE EVALUATION AND PLANNING FOR A RAPIDLY GROWING SERVICE

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Introduction Self-expandable metal stent (SEM) placement is the recommended treatment option by the National Institute for Clinical Excellence (NICE) for acute colorectal obstruction in the palliative management of inoperable colorectal cancer (CRC) as well as a bridge to planned single stage surgical intervention[1]. NICE guidance recommends that centres offering this treatment modality should have teams with expertise and capacity to stent 15 people per million population per annum[2]. It does not however provide any suitable standard for audit.