Abstract PWE-029 Table 1 Patient position most often used by endoscopists who almost always or usually change position and those who sometimes, occasionally or rarely change position

Position change usage	Segment	Right lateral	Supine	Left lateral	In which ever position they arrive
Almost always or usually	Caecum to hepatic flexure	7.8%	25.3%	60.2%	7.8%
	Transverse colon	1.2%	93.4%	5.4%	0.6%
	Splenic flexure and descending colon	51.2%	34.4%	11.4%	3.6%
Sometimes, occasionally or rarely	Caecum to hepatic flexure	0%	31.6%	34.2%	34.2%
	Transverse colon	0%	34.2%	28.9%	36.8%
	Splenic flexure and descending colon	7.9%	31.6%	26.3%	34.2%

patients supine while examining the transverse colon and nearly half examined the right and descending colon in a sub-optimal position (Table 1).

Of those respondents who sometimes, occasionally or rarely changed a patient's position, 42% were unconvinced that routine position change was beneficial. A further 21.1% felt it took too long, 7.8% felt it was inconvenient for the patient and 7.8% felt it was inconvenient for the endoscopist. These respondents were most likely to examine segments without changing patient position.

Free text responses revealed that some endoscopists position patients differently during insertion and withdrawal and also use position change to optimise access during therapy.

Conclusion Most BCSP colonoscopists change patients' position during most colonoscope withdrawals, but the patient position is often sub-optimal. Increased awareness of the existing literature and further research assessing positioning strategy is warranted.

REFERENCE

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Disclosure of Interest None Declared.

PWE-030 ENTONOX USE DURING COLONOSCOPY: A SURVEY OF ENGLISH BOWEL CANCER SCREENING PROGRAMME COLONOSCOPISTS

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Introduction Entonox may be used to improve patient experience during colonoscopy. Nitrous oxide is rapidly eliminated which minimises after effects and inconvenience to patients. Despite its advantages, Entonox is used in only a minority of procedures in the UK. We sought to understand the reasons for its low utilisation.

Methods Colonoscopists within the English Bowel Cancer Screening Programme (BCSP) were invited to participate in a web-based survey, assessing the availability, current practices and perceptions of Entonox during colonoscopy. Respondents were able to select pre-defined answers or offer written responses. Free text responses were assessed using thematic analysis. Categorical data was compared using the $\chi 2$ test.

Results The survey was completed by 208/298 (70%) of the English BCSP colonoscopists. Entonox was available to 152/208 (73%) respondents but this varied between NHS deaneries. Nearly half (47%) of the respondents stated that Entonox was used in < 20% of examinations. Colonoscopists who administered Entonox frequently (>20% of examinations) rated its efficacy (49% vs. 76%, OR: 3.3, p = 0.001) and usefulness (69% vs. 95%, OR: 8.4, p < 0.0001) more favourably. But there were no differences in how they rated its safety (90% vs. 97%, OR: 4.2, p = 0.085), frequency of side effects (92% vs. 96%, OR: 2.3, p = 0.31) or influence on discharge time (70.4 vs. 79.5%, OR: 1.63, p = 0.26). Most respondents for whom nitrous oxide was available stated that they would use it if they were to have a colonoscopy themselves (74%).

Most respondents reported their patients were advised to use Entonox 'as required' (92%) rather than continuously (8%) and from the start of colonoscopy rather than as rescue medication when other medications are inadequate. Some respondents never combined Entonox with other sedatives. Many respondents indicated that Entonox was used for the patients and the procedures which are expected to have least discomfort.

Most of the colonoscopists for whom Entonox wasn't available had considered introducing it (94%). Practical difficulties (37%) and satisfaction with current analgesics and sedation (28%) were the most common reasons it was not available. The introduction of the English flexible sigmoidoscopy screening programme was cited as the reason for its introduction by several respondents.

Conclusion Entonox is used in a minority of colonoscopy examination. It is generally perceived to be safe, effective and most colonoscopists would use it if they required a colonoscopy. Entonox is often chosen when patients wish to avoid the inconvenience caused by intravenous sedation and analgesics. Its use is likely to increase with the introduction of the English screening programme.

Disclosure of Interest None Declared.

PWE-031 IS FACE-TO-FACE PRE-ASSESSMENT PRIOR TO COLONOSCOPY USEFUL?

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Introduction In 2009, the NPSA issued a report alerting healthcare providers to the potential risk of harm from using oral bowel cleansing agents (OBCA). Recently published consensus guidelines recommend pre-assessing patients undergoing colonoscopy before the use of OBCA. First, to determine whether pre-assessment improved the quality of bowel preparation for patients undergoing colonoscopy at our unit. Secondly whether pre-assessment helps to prevent deterioration in renal function in CKD patients. Thirdly, to define risk stratifying criteria for poor bowel preparation and use these to deploy resources to patients who are most at risk of poor bowel preparation.

Methods Data was collected prospectively over of 12 months. Patients were stratified to one of three risk groups based on the presence of risk factors for poor bowel preparation taking 'at risk' medication and those with significant co-morbidities. Group 1 patients had no risk factors and group 3 consisted of patients

with 2 or more risk factors for poor bowel preparation. Data was analysed using SPSS.

Results 1840 colonoscopies were carried out during the time period.. Total number analysed was 1704. Mean age was 61.7 years with a range of 16–94. 404 patients were pre assessed. Pre-assessment has significantly increased the quality of bowel preparation across all groups (OR = 1.605, p = 0.002). In groups 1 and 2 the odds of good quality bowel preparation was 80% and 72% higher respectively in patients who had been pre-assessed however these improvements were not statistically significant. Patients stratified into group 3 were 52% more likely to have good bowel preparation (p = 0.039) compared to those who were not pre-assessed. 88 patients had eGFR <60 ml/min. They had eGFR checked before and after administration of OBCA. There was a significant difference in the percentage change in eGFR between those patients that had Pre-assessment (Median = 7.7%) compared with those who did not (Median= -6.6%) (p = .006, Mann-Whitney).

Conclusion Face-to-face pre-assessment improved the quality of bowel preparation for patients undergoing colonoscopy. It helps to minimise the risk of renal injury in patients with CKD. Those stratified to group 3 saw a significant improvement in the quality of their bowel preparation. We conclude pre-assessment is a pre-requisite for patients who are at risk of poor bowel preparation and with significant co-morbidities.

REFERENCE

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Disclosure of Interest None Declared.

PWE-032 ENDOSCOPIC RESECTION OF LARGE COLORECTAL POLYPS IN A TERTIARY REFERRAL UNIT IS SAFE WITH A LOW RISK OF COMPLICATIONS

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Introduction Patients with large sessile colorectal polyps can be technically challenging to resect endoscopically and have been subject to colorectal resection in the United Kingdom. Our aims were to determine the safety and efficacy of endoscopic resection of large colorectal lesions at a tertiary referral unit.

Methods A prospective observational study of all patients referred for endoscopic resection to a single endoscopist. Consecutive patients were included in the study from June 2010 to March 2013. All patients underwent magnification chromoendoscopy and NBI for polyp assessment under conscious sedation. ESD was undertaken for lesions that were LST – non granular, flat and pseudodepressed type and those with type Vi pit pattern. Piecemeal EMR was undertaken for the remainder of the lesions.

All patients underwent colonoscopic surveillance at 3 and 12 months by the same endoscopist to check for recurrence at the scar.

Results One hundred and fourteen patients underwent 134 endoscopic resections. There were 54 (47.4%) women and 60 (52.6%) men with a mean age of 71.2 (SD = 10.3 years). 120 lesions underwent EMR (89.6%) and 14 had enbloc resection with ESD (10.5%) with complete resection. The mean size of the lesions was 56 mm (SD 37.1mm). The median lesion size was 50mm (range 25–150 mm).

Histological analyses revealed 8 hyperplastic lesions, 28 tubular adenomas, 90 tubulovillous adenomas, 3 serrated adenomas and 5 early submucosal invasive cancers invading to the upper third of the submucosa (sm1). Endoscopic diagnosis of the colorectal polyps using magnification colonoscopy identified all patients with cancer correctly with 100% sensitivity. All lesions underwent endoscopic resection with curative intent. Overall, there were 2 patients who sustained intra-procedural perforation (perforation rate overall 1.8%) of the bowel, both of which were closed with endoscopic clips without the need for surgery.

13 patients were admitted to hospital post procedure (9.8%). 6 patients were for medical reasons (2 perforation, 3 self limiting abdominal pain, 1 patient with pericolic inflammation on CT scan and abdominal pain) and 7 patients were admitted for social reasons.

Median follow up duration was 8.27 months (range 0.39–34.6 months, IQR 12.04 months). 6 patients had documented recurrence (5.1%) with a median time to detected recurrence being 4.45 months (range 2.83–15.74 months, IQR 11.85 months).

Conclusion Endoscopic resection of large colorectal lesions in a tertiary setting is a safe procedure often performed as a day case. Perforations detected during the procedure can be managed endoscopically without the need for surgical intervention. Meticulous technique utilising magnification chromoendoscopy to examine the scar post resection offers a low incidence of recurrence

Disclosure of Interest None Declared.

PWE-033 COMPARISON OF PATIENT EXPERIENCE OF COLONOSCOPY AND CT COLONOGRAPHY IN THE ENGLISH BOWEL CANCER SCREENING PROGRAMME

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Introduction The English Bowel Cancer Screening Programme (BCSP) uses colonoscopy to investigate positive faecal occult blood test results. CT colonography (CTC) is employed if colonoscopy is infeasible. Patient experience is monitored with a questionnaire, posted 30 days after colonic testing. We used these to compare patient experience of CTC and colonoscopy.

Methods The study was approved by the BCSP Research Committee. Screenees tested between 1/1/11 and 31/12/12 and responding to at least one questionnaire item were included. Multiple imputation of missing data was conducted under the missing-at-random assumption. Likert scale data ("strongly agree" to "strongly disagree") were analysed via ordered logistic regression using test category (CTC or colonoscopy) as the predictor variable and age, gender, deprivation score, screening centre and screening result as covariates (results presented as odds ratios).

Results 79,493 questionnaires were analysed; 61,899 contained at least one response. 2,119 CTC and 60,581 colonoscopy questionnaires were included (some individuals completed both tests). There was no difference in results between complete-case analysis and multiply-imputed analysis.