

time was significantly longer (24mins vs 40 mins,  $p = 0.04$ ), although this group tended to have more unwell patients (ASA grade) and a higher difficulty grade of ERCP ( $p = 0.06$  and  $0.05$  respectively). There were no significant differences in frequency of adverse events between PCPS and standard sedation ( $p = 0.87$ ). Also, there were no significant differences in recovery time, although Aldrete scores tended to be higher in the PCPS group. Endoscopist rating of how sedation was tolerated was significantly higher in the PCPS group ( $p = 0.04$ ). 2 cases that had failed under standard sedation were subsequently completed using PCPS.

**Conclusion** PCPS is an effective method of sedation for ERCP. This small UK based study shows that PCPS is at least as safe as standard sedation techniques, even when used in complex procedures in severely unwell patients. In the future, with appropriate training and governance, PCPS might be utilised without anaesthetic support.

**Disclosure of Interest** None Declared.

#### PWE-039 INFORMING PATIENTS AND THE MULTI DISCIPLINARY TEAM OF A DIAGNOSIS OF GASTRO-INTESTINAL MALIGNANCY

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**Introduction** The management of gastro-intestinal (GI) malignancy is largely determined by multi-disciplinary team (MDT) discussion, where members have not met the patient. The quality of information given to the patient immediately following endoscopy, and subsequently to the MDT, is variable.

**Methods** A 3 month retrospective audit of all outpatient endoscopic diagnoses of upper and lower GI malignancies at Derriford Hospital, Plymouth. The endoscopy report (Endosoft), endoscopy care pathway and medical notes were reviewed. Information provided regarding the description of pathology; post endoscopic patient discussion; GI Cancer Nurse Specialist (CNS) involvement and request for staging imaging was interrogated. Inpatients were excluded.

**Results** There were 65 patients with GI malignancy (oesophago-gastric cancer [OGC]  $n = 24$ ; colorectal cancer [CRC]  $n = 41$ ). For patients with confirmed OGC the report recorded suspected malignancy in 19/24 (79%). Post endoscopy patient discussion was recorded on the report in 7/19 (37%); patient informed & recorded only in the nurse's care pathway in 5/19 (26%); no evidence of discussion with patient in 7/19 (37%). GI CNS involvement was documented on the report in 5/19 (26%); the report documented requesting of staging imaging by the endoscopist in 10/19 (53%). For patients with confirmed CRC the report recorded suspected malignancy in 33/41 (80%). Post endoscopy discussion was recorded on the report in 10/33 (30%); patient informed & recorded only in the nurse's care pathway in 13/33 (39%); no evidence of discussion with patient in 10/33 (30%). GI CNS involvement was documented in 15/33 (45%). The report documented requesting of staging imaging by the endoscopist in 22/33 (67%).

**Conclusion** The MDT relies upon patients being informed of their suspected diagnosis, and accurate endoscopic documentation in order to make informed decisions and to allow direct referral to Surgical and Oncological specialities. However, a significant proportion of patients with upper and lower GI cancer leave the endoscopy department without a diagnosis of suspected cancer being made, and even when it is suspected, are frequently not informed by the endoscopist.

**Disclosure of Interest** None Declared.

#### PWE-040 PREVALENT ROUND STAGE SHIFT IN THE NATIONAL BOWEL CANCER SCREENING PROGRAMME IN WALES; DATA FROM THE FIRST 3 YEARS AT A SINGLE SCREENING CENTRE

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**Introduction** Colorectal cancer screening is based on early detection of cancers and removal of premalignant polyps though this adenoma to carcinoma sequence is thought to progress over several years. The Bowel Screening Programme in Wales based on guaiac FOBt and colonoscopy for individuals resting positive began roll-out in October 2008, with the aim of reducing mortality through cancer detection at an early stage. The aim of this study was to investigate whether screen detected cancers in Cardiff and the Vale of Glamorgan demonstrated any shift in the stage of cancer during the first three years of screening (initial prevalent round).

**Methods** Data was collected prospectively to compare the staging of colorectal cancer diagnosed in the BCSP with cancers diagnosed in the non-screening population in the same geographical region from 1st October 2008 to 31st December 2011. All information was cross checked with Cancer Registry data.

**Results** Screen detected cancer was found in 69 individuals (44 male, 25 female), with a positive predictive value of colonoscopy (after positive FOB testing) of 8.7%. Complete clinical staging was available for all 69 individuals; two patients did not undergo surgical resection due to the presence of metastases after radiological staging. There were 696 non-screening detected cancers during the same time period. For the purposes of this analysis, polyp cancers (cancer that was removed by endoscopic means at the time of colonoscopy/flexible sigmoidoscopy) were included in Duke's stage A, except for one polyp cancer that required subsequent surgical resection and was staged as Duke's C1. The results are shown in table 1. Three-quarters of cancers diagnosed in the BCSP were Dukes A or B, compared to 44.1% in the non-screening population. Of Duke's D cancers, only 2.8% were diagnosed through screening, with 27% diagnosed in the non screening population ( $p < 0.0001$ ).

**Abstract PWE-040 Table 1** Stage of cancer diagnosed with comparable data from non-screening population

Stage	BCSP	Non-screening population	p Value
Duke's A	35 (50%)	115 (16%)	$p < 0.0001$
Duke's B	14 (25%)	192 (28%)	$p = 0.67$
Duke's C1	11 (16%)	120 (17%)	$p = 0.87$
Duke's C2	4 (6%)	27 (4%)	$p = 0.35$
Duke's D	2 (3%)	192 (28%)	$p < 0.0001$
Dukes unknown	-	49 (7%)	

**Conclusion** This data strongly supports significant stage shift of colorectal cancer even within the initial prevalent round in this single Bowel Cancer Screening centre in Wales that the benefits of screening may be demonstrable in outcomes at a relatively early stage of the programme.

**Disclosure of Interest** None Declared.

#### PWE-041 HISTOPATHOLOGICAL UNCERTAINTIES IN THE MANAGEMENT OF EARLY COLORECTAL CANCERS RESECTED THROUGH ENDOSCOPIC THERAPY

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**Introduction** Standards for Colorectal cancer (CRC) resection specimen histology reporting consider factors thought to have apparent significance for prognosis and further therapy. Whilst well validated for surgical resection, the increasing use of advanced endoscopic resection for polyps containing previously unknown early CRC presents challenges in interpretation of these factors. In addition to tumour budding, unfavourable tumour grade, and vascular invasion, Ueno *et al*[1] proposed parameters for width and depth of submucosal invasion as risk for adverse outcome. This study aims to analyse any association between pathological factors and outcome with endoscopic resection of early CRC.

**Methods** Retrospective review of all CRC removed endoscopically between March 2006 and March 2011. All endoscopic and surgical resection specimens were reviewed by two expert gastrointestinal histopathologists, with measurement of width and depth of submucosal invasion made. All follow up procedures, including radiology, were reviewed.

**Results** 35 cases were identified (24 males, 11 females, median age 69 years). All patients were alive after median follow-up period of 32 months; no residual/recurrent cancers were found in any patient managed with endoscopic therapy alone. Of the 12 patients who had further surgical intervention due to reported incomplete endoscopic resection on histology, none had residual carcinoma in the subsequent resection specimen. Three patients (8.6%) were found to have Dukes C1 cancers (all T1 N1 M0). These cancers were not associated with poor differentiation or lymphovascular invasion ( $p = 0.546$ ) or tumour budding of low or high intensity ( $p = 1.000$ ). The relationship between the width and depth of submucosal invasion and Dukes C1 did not reach statistical significance ( $p = 0.096$ ), although these three cancers did fulfil Ueno criteria. Presence of lymph node metastases was associated with Haggitt level 4 ( $p = 0.03$ ), but not with the presence of tumour at the excision margin ( $p = 1.000$ ) in the subsequent surgical resection group.

**Conclusion** Our experience highlights the challenges in applying histopathological criteria to individual cases of early CRC resected via endoscopic therapy. Most patients underwent surgery for an unclear resection margin, however no residual cancer was present in the resection specimens and aside from a Haggitt level 4, found no other predictors of risk lymph node metastases. Suggestions for future studies include piloting a more minimally invasive approach, such as regional lymph node dissection in selected cases as well as studying biomarkers for refining risk stratification.

**Disclosure of Interest** None Declared.

#### REFERENCE

1. Ueno H *et al*. Risk factors for an adverse outcome in early invasive colorectal carcinoma. *Gastroenterology* 2004; 127: 385–394

#### PWE-042 COLONOSCOPY QUALITY MEASURES: EXPERIENCE FROM A WELSH BOWEL CANCER SCREENING CENTRE

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**Introduction** The NHS Bowel Cancer Screening Programme (BCSP) in England has demonstrated high quality colonoscopy [1]. Bowel Cancer Screening in Wales began in October 2008. We report results of first 3 years of screening in a single Welsh centre. Comparison is made with results from the English BCSP.

**Methods** Data was collected prospectively for participants undergoing FOBt testing and colonoscopy or flexible sigmoidoscopy between October 2009 and December 2011 in Cardiff and the Vale of Glamorgan. Quality indicators were calculated where appropriate.

Adenomas were confirmed after correlation with histopathology reports. with no adenoma double counted.

**Results** 42630 faecal occult blood test kits were returned from 91414 sent (46.6%), leading to 933 colonoscopies (795 index) and 82 flexible sigmoidoscopies (not index but mostly for therapeutic procedures) undertaken by four accredited screeners. Mean ADR per colonoscopist was 54.1%, mean number of adenomas per procedure (MAP) was 1.24 and the mean adenomas per positive procedure (MAP+) was 2.3, with a mean polyp retrieval rate of 98%. Mean midazolam dose was 2 mg (range 0.5–4 mg) and fentanyl 50mcg (range 25–100 mcg). Hyoscine n-butyl bromide was used in 34.5% of cases, with no increased ADR ( $p = 1.000$ ). Only 2% of patients reported severe discomfort. Bowel cancer was detected in 69 individuals; a positive predictive value of colonoscopy (after positive FOBt) of 8.7%.

#### Abstract PWE-042 Table 1 Comparison of colonoscopy performance and complication between Cardiff and English BCSP

	Cardiff and Vale	English BCSP	p Value
Unadjusted caecal intubation rate	887/933 (95.1%)	32020/33635 (95.2%)	$p = 0.917$
Adenoma detection index round	422/795 (53.1%)	1334/2282 (46.3%)	$p = 0.009$
Adenoma detection prevalent round	54/79 (68.4%)	13216/28607 (46.2%)	$p = 0.0001$
Perforation	1/1025 (0.1%)	35/38168 (0.09%)	$p = 0.951$
Bleeding			
All	4/1025 (0.39%)	155/38168 (0.41%)	$p = 0.937$
Major	1/1025 (0.0.9%)	4/38168 (0.01%)	$p = 0.301$

**Conclusion** Our centre is providing high quality colonoscopy, with statistically significant higher rates of adenoma detection in both the index and prevalent rounds of screening colonoscopies compared to data from the English BCSP, and a low rate of adverse events given an increased need for endoscopic therapy. Measures of total adenoma detection (MAP and MAP+) also compare favourably. Further information is required to ascertain the clinical outcome measure of the missed cancer rate following a screening colonoscopy within the BCSP across the UK.

**Disclosure of Interest** None Declared.

#### REFERENCE

1. Lee TJW *et al*. Colonoscopy quality measures: experience from the NHS Bowel Cancer Screening Programme. *Gut* 2011; 61: 1050–7

#### PWE-043 THE MANAGEMENT OF LARGE SESSILE COLORECTAL POLYPS: EXPERIENCE OF A SINGLE WELSH SCREENING CENTRE

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**Introduction** Previous studies on large sessile colorectal polyps (LSCPs) suggest that management (Endoscopic vs Surgical) and outcomes (complication rates, incomplete resection, recurrence rates) may vary. The advent of the Bowel Cancer Screening Program (BCSP) provides opportunities to study this lesion subgroup systematically. We report the experience and outcomes of managing LSCPs in a single Welsh screening centre undertaking screening colonoscopy within an established local multidisciplinary discussion forum (colorectal surgery, endoscopy, radiology & histopathology).

**Methods** Outcome data was collected prospectively for BCSP participants with a benign adenoma greater than 20mm between October 2009 and December 2011 in Cardiff and the Vale of Glamorgan. Each patient was discussed at a multidisciplinary team meeting. Standard protocol for piecemeal EMR or histology suggesting