patients (95.7% vs 93% by NICE1). 41/46 patients had complete resection (R0) (89.1% vs 86.5% by NICE1). There were 2 cases of intra-operative bleeding (7.4% vs 22.6% by Oka S. *et al*), where haemostasis was achieved using triclips. There was 1 delayed bleed (2% vs 0–9% by Oka S. *et al)* requiring laparotomy. 1 perforation (2% vs 4% by NICE1) occurred requiring laparotomy for gastric repair. 2 patients (4%) were readmitted within 30 days post ESD - 1 with post laparotomy abdominal dehiscence, and the other with post polypectomy syndrome. There were no recurrence or metastases in our cohort (0% vs 10% by NICE1). [Median follow up 20.5 months/range 3–38 months). $P > 0.5$ *(ns)* for all parameters.

Conclusion These results represent first phase practise audit against NICE guidance. These data may enhance utilisation of ESD within the UK CSF as clear efficacy against nationally set guidelines is achievable. However, it is mandatory that ongoing multicentre efficacy data is collected. Should CSF accept this technique in full, with agreed tariff, a 'roll out' of a national registry and advanced training curriculum is mandatory.

Disclosure of Interest None Declared.

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PTH-035 SALVAGE ENDOSCOPIC SUBUCOSAL DISSECTION FOR REFRACTORY POST POLYPECTOMY FIBROSIS AND RECURRENT INTRAEPITHELIAL NEOPLASIA: EXPANDNING THE TECHNOLOGICAL ENVELOPE IN THE UK

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Introduction Submucosal desmoplasis post EMR confers the natural history of regenerative luminal healing. Index R1 or Rx dissections of colorectal neoplasia using either EMR, EPMR or simple snare polypepctomy complicated by remnant or recurrent intraepithelial is clinically challenging. Formal open surgical resection or ablation is usually inevitable in this cohort. We describe, using video presentation data, the technique of primary endoscopic fibrosis divissional dissection with curative intent for recurrent or remant intraepithelial neoplasia of the right-hemi colon post index EMR.

Methods Recurrent disease or refractory intraepithelial neoplasia was defined according to Higaki criteria. Patients were consented for progression to salvage dissection prior to endoscopy. Pre-resection peripheral margin APC 'mark out' was performed following index indigo carmine chromoscopy to deliniate the lesion's horizontal axis with thermal mucosal tattoos placed 2–4 mm away from the lesion margin and within a type I crypt mucosal zone. Peripheral smi with 1/10,000 adrenaline solution was performed with 6 mm marginal circumfrential 6 mm incisions made to the level of the deep submucosal layer using the straight flex knife. Dissection of the exposed submucosal desmoplastic fibrosis layer was then performed using a fixed en face IT knife distance coupled with a blunt tractional endoscopic 'tunnelling' technique. Prophylactically, sm vessels were ablated or clipped prior to tissue recovery.

Results n = 12 patients. Paris class LST-NG/G (6)/0-IIa (6). Median operating time 64 mins (range 34–82). Median lesion size 22mm (range 12–46 mm). Asymetrical, partial or complete NL = 12 (100%). Perforation rate 0/12. Median hospital stay 24 hours (range 6–120). 30 day mortality 0%. R0 resection achieved in 11/12 (92%). Endoscopic recurrence rate 0% (median follow-up 18/12 (range 2–43 months). Post dissection late bleed occured in 3/12 (25%) of the cohort all treated conservatively. There were no cases of immediate or early dissection bleeding.

Conclusion Salvage endoscopic dissection of remnant or recurrent intraepithelial neoplasia post index EMR, EPMR or conventional polypectomy is technically possible in the UK in this pilot clinical experience. Dissection is however technically demanding, is complicated by a high delayed bleeding risk and is time consuming. In an appropriately selected patient cohort however this novel therapy may negate the need for formal surgical excision which in the elderly and those with significant comorbidity becomes an attractive therapeutic modality changing the paradigm away from palliative ablative methods in those unfit for formal surgical resection.

Disclosure of Interest None Declared.

PTH-036 IS THE UK READY FOR SUB-SPECIALISATION IN ADVANCED COLONOSCOPIC POLYPECTOMY?

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Introduction European guidelines have proposed four levels of competency for polypectomy. The highest competence (level 4) is expected of only a small number of regionally based colonoscopists, to whom patients with large or complex polyps might be referred. We wished to explore whether such a model could be applied to current UK practise.

Methods In a UK national survey of advanced polypectomy, a number of questions were designed to reveal attitudes and beliefs underlying clinical decision-making and referral practises. The survey was directed to all BSG members and BCSP colonoscopists.

Results Respondents 268 independent colonoscopists in UK practise with a median lifetime experience of 3000 procedures. 64% were BCSP colonoscopists and 86% undertook endoscopic mucosal resection (EMR) of polyps > 20mm.

Competence Level When asked to describe the most complex polyp they would tackle, 3.4% fell into competence level 1, 31% level 2, 35% level 3 and 30% level 4. Of the 81 self-rated level 4 operators, 17% had never removed a polyp > 5cm and 32% performed ≤20 EMRs in the previous year. Only 56% of level 4 operators agreed that they would attempt any polyp where EMR was technically feasible. Others felt constrained by their own technical ability or by time and resource limitations.

A quarter of all the respondents considered that they operated close to the limit of what was technically possible by EMR but only 15 operators (5.6%) were identified who had a workload of > 50 EMRs per year and had removed a polyp > 6cm at some point in their career.

Referral behaviour 51% had referred at least one benign polyp for surgical excision in the previous year. 12% refer straight to surgery for any polyp they cannot tackle themselves. 47% had referred a polyp to a colleague for EMR (34% refer to an endoscopist within their own unit, 28% to another hospital and 12% to an expert in a different region). 70% of all respondents declared they would be happy to receive EMR referrals from a colleague.

Future directions 59% indicated support for accreditation in advanced polypectomy but only 41% wanted to see nominated EMR experts for each region. Just 18% supported the concept of an integrated national referral network for complex polyps. The proposal for 3 – 4 national referral centres was also unpopular.

Conclusion Many colonoscopists appear willing to refer cases to a colleague for EMR, even if it involves transfer to another hospital. Evidence emerged for a small group of experts capable of handling very large polyps, yet referral for surgery remains common. A national referral network might reduce the rate of surgical intervention but while so many colonoscopists perceive themselves to be performing at the "cutting edge" support for this is likely to remain limited.

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PTH-037 DO PATIENTS WITH A PREVIOUS NEGATIVE COLONOSCOPY AND POSITIVE FOB TEST NEED A BOWEL CANCER SCREENING COLONSCOPY?

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Introduction Patients with a positive faecal occult blood test invited for screening colonoscopy may have undergone previous colonoscopy. Excluding such patients from a repeat colonoscopy may reduce endoscopy waiting lists and avoid repeated and unnecessary invasive investigations. This study investigates the prevalence of previous colonoscopy in Bowel Cancer Screening Programme (BCSP) patients and considers whether repeat colonoscopy is required.

Methods All patients undergoing BCSP colonoscopy over a 30-month period at our unit were identified and cross-referenced against colonoscopy records for the preceding 3 years. New diagnoses of colorectal cancer in the cohort were identified and cancer yield in those with and without recent colonoscopy compared using the chi-squared test.

Results 1419 BCSP colonoscopies were performed in 1339 patients over the study period. 109 colonoscopies were repeats with median interval to repeat 378 days. Indication for prior colonoscopy included prior BCSP invitation (n = 90), polyp surveillance (n = 6) and symptoms (n = 13). There were 111 diagnoses of colorectal cancer in the cohort but no patient with a previous colonoscopy was found to have colorectal cancer. Cancer yield in first time BCSP colonoscopy was greater than in repeated colonoscopy (8% *vs.* 0% p = 0.002).

Conclusion Cancer yield is reduced in BCSP patients with a recent negative colonoscopy. Excluding such patients would reduce pressure on endoscopy units and any morbidity associated with repeat colonoscopy. However, such an approach would be associated with a small risk of missed pathology. Larger studies are required to define the safety of this approach and inform national guidance.

Disclosure of Interest None Declared.

PTH-038 FINDINGS ON BACK-TO-BACK COLONOSCOPIES: AN AUDITABLE STANDARD FOR COLONOSCOPY QUALITY?

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Introduction An important marker of colonoscopy quality is detection of pathology and incidence of missed pathology. Back-to-back colonoscopies cannot ethically be performed for quality assurance alone yet may be required for clinical reasons. This study aims to investigate the incidence of new findings in colonoscopies repeated within a 12 month period.

Methods All colonoscopies performed over a 3-year period at an Endoscopy training unit were studied. Colonoscopies repeated within a 12-month period were included. Repeats following incomplete colonoscopy were excluded. Data on indication and outcome were collected.

Results 5747 colonoscopies were performed over the study period. 137 repeat colonoscopies were included with median interval 174 days and indications including requirement for endoscopic mucosal resection (n = 47), inflammatory bowel (n = 13) or polyp surveillance (n = 37), previous imaging or endoscopic abnormalities (n = 15), and persistent or new symptoms (n = 25). 19 (14%) repeat colonoscopies yielded new findings including 1 new cancer, 234 days following a normal colonoscopy. Additional polyps were identified in 13 colonoscopies indicating a missed polyp rate of 9%. A median number of 2 polyps per colonoscopy with median size 5.5mm were found. Crohn's disease (n = 1), and diverticular disease (n = 3) were also diagnosed at repeat colonoscopy. There was no morbidity associated with repeat colonoscopy in this series.

Conclusion New pathology was identified in 14% of repeat colonoscopies. Analysis of clinically indicated repeat colonoscopies and rate of detection of new pathology may offer utility in colonoscopy quality assurance. Larger studies are required to define and validate this criterion as an auditable standard for colonoscopy quality.

Disclosure of Interest None Declared.

PTH-039 SHOULD ANTICOAGULANTS BE STOPPED BEFORE DIAGNOSTIC COLONOSCOPY?

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Introduction With increasing age and polypharmacy, an increasing proportion of patients undergoing diagnostic colonoscopy take anticoagulant medication. Under UK guidelines anticoagulants are continued for diagnostic colonoscopy and which may necessitate a second colonoscopy for 'high risk' procedures after stopping anticoagulants. This may increase endoscopy waiting times and subject often frail patients to a second invasive procedure. This study aims to identify the incidence of and indication for repeat colonoscopy.

Methods All colonoscopies performed over a 3 year period were studied. Any patients that underwent 2 colonoscopies within a 12-month period were included. Data on colonoscopy indication and outcome were collected.

Results 5747 colonoscopies were performed over the study period. Of these, 193 colonoscopies were repeats performed within 12 months. Incomplete colonoscopy (n = 54) due to poor bowel preparation (n = 45) was the commonest indication for a repeated procedure. Requirement for endoscopic mucosal resection (EMR) or polypectomy indicated a repeat colonoscopy in 48 cases. Patients requiring EMR on warfarin (n = 12) or clopidigrel (n = 2), accounted for 7% of all repeated colonoscopies with a median delay repeat colonoscopy of 37 days. There was no morbidity associated with repeated colonoscopy in this series.

Conclusion Repeated colonoscopy due to previous anti-coagulation accounts for a small proportion (7%) of repeated procedures and an insignificant proportion (0.2%) of all colonoscopies performed. Cessation of anti-colagulation for diagnostic colonoscopy would not result in a significant reduction in endoscopy workload but subject patients to an unnecessary risk of thromboembolic disease.

Disclosure of Interest None Declared.