90/235 (38%) patients had polyp cancer. 83% of them in rectosigmoid.

(1) 13/90 were pedunculated polyps (mean size 23 mm, range 12–35 mm)

(2) 77/90 were flat polyp cancers (mean size 24 mm, range 8–80 mm)

See table 1 below

13/13 pedunculated polyp cancers were endoscopically resected. In 6/13 cases cancer was suspected prior to resection. Histology was reported accurately on 12/13 (92%) polyp cancers using Haggitt classification. 1/13 required surgery due to invasive features on histology.

30/77 (39%) of flat or sessile polyp cancers were endoscopically resected. Endoscopist suspected cancer in only 13/30 (43%) cases prior to resection. Histology was reported confidently by Kukuchi levels in 19/30 (63%) of lesions. 9/19 required surgery due to invasive features on histology. In 11/30 (37%) cases the histology report was inconclusive due to a poor quality EMR specimen. This led to surgery in all 11 patients but no residual disease or LN involvement was found.

Abstract PTU-047 Table 1 Breakdown of polyp cancer size and morphology

Size(mm)	Pedunculated	Flat	Total
0–10	0/13 0%	17/77 22%	17/90 19%
11–20	6/13 46%	27/77 35%	33/90 37%
> 20	7/13 54%	33/77 43%	40/90 44%

Conclusion

1. The in-vivo endoscopic diagnosis of cancer prior to resection is suboptimal and can be improved
2. Post EMR histology reporting is inconclusive in a large proportion of flat polyps leading to unnecessary surgery
3. Clinical care could be improved by optimising in-vivo diagnostic skills and resecting large flat lesions in single piece by ESD.

Disclosure of Interest None Declared

PTU-048 THE EFFECT OF THE COLONOSCOPE MAGNETIC IMAGING DEVICE (SCOPEGUIDE ®) ON IMPLANTABLE CARDIAC DEVICES

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Introduction Use of the colonoscope magnetic imaging device (ScopeGuide®, Olympus) is currently contraindicated by the manufacturer for patients with implantable cardiac devices. This group of patients is increasing every year, as is the number of colonoscopies being performed. This is the first study which examines the safety of ScopeGuide® in patients with permanent pacemakers (PPMs), implantable cardioverter defibrillators (ICDs) and cardiac resynchronisation therapy (CRT).

Methods Before any patient experiments, ex-vivo proof of concept studies were performed. Non-implanted devices were exposed to the electromagnetic field (EMF) of ScopeGuide® and monitoring demonstrated no evidence of interference or change in settings. Following this, ethical approval was obtained and consecutive patients attending device cheque clinics were prospectively recruited and exposed to ScopeGuide® EMF. After an initial device cheque, patients were attached to a device programmer and underwent continuous external cardiac monitoring. A colonoscope was placed curled on the abdomen over their clothing with patients lying supine to simulate the EMF generated during colonoscopy. The colonoscope was connected to ScopeGuide®. After 2 minutes of observation to assess for any interference, ScopeGuide® was disconnected and devices were checked for any change in settings.

Results 143 patients were invited to participate and of these 70 were recruited to take part in the study (46 male, 24 females, mean age 68.5 years SD 10.3). Device type, indication and manufacturer are summarised in Table 1. No evidence of interference was seen on device leads nor was any change in programming detected following exposure to ScopeGuide® EMF in any patient.

Abstract PTU-048 Table 1 Summary of baseline characteristics of recruited patients

Sample Size	M:F (total) Mean age (range, SD)	46:24 (70) 68.5 (30–80, 10.3)
Indications	Complete heart block	12
	1°, 2° or trifasicular block	12
	Tachybradyarrythmia	9
	Sick sinus syndrome	5
	Sinus bradycardia	4
	Dilated cardiomyopathy	10
	Others (IHD, VT/VF, AF, Syncope)	18
Device Type	PPM	45
	ICD	14
	CRT (Pace only : Defibrillator)	11 (6:5)
Manufacturer	Boston Scientific	31
	Meditronic	37
	Other	2

Conclusion The ScopeGuide® does not cause any interference or change in settings and appears to be safe to use in patients with implantable cardiac devices.

Disclosure of Interest None Declared

PTU-049 ENDOSCOPIC RESECTION AND STEPWISE ENDOSCOPIC ABLATION FOR EARLY NEOPLASIA IN BARRETT'S OESOPHAGUS: OUTCOME IN A LARGE OESOPHAGUS CANCER CENTRE

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Introduction Endoscopic mucosal resection (EMR) followed by radiofrequency ablation (RFA) is now considered standard for treatment of high grade dysplasia (HGD) and intramucosal cancer in Barrett's oesophagus (BE). Complete ablation of the Barrett's epithelium is recommended to reduce the risk of metachronous neoplasia. However, RFA is an expensive treatment modality, often requiring repeat procedures and endoscopic surveillance thereafter and may not be necessary in all patients.

Methods We analysed our database of oesophageal EMR procedures performed for HGD or early cancer from 2008 to 2012. Patients' demographics, Barrett's length, histology, number of procedures, remission and complication were assessed. All patients referred for endoscopic treatment of early Barrett's neoplasia were investigated using EUS to exclude obvious infiltration of deeper structures. EMR was performed using band ligation mucosectomy. Patients were followed up 3 monthly with endoscopy and EMR repeated as required. If no dysplasia was found after a year, follow up interval was increased to 6 months.