Methods We performed a retrospective analysis of all patients undergoing CT imaging of the large bowel, both CT colonography or plain abdominal CT (if CT colonography was not possible) at one south London hospital in a 13 month period between 2012–2013. Any extracolonic findings were determined either significant, where requiring further investigation or treatment, or insignificant by the reviewer. Any subsequent outcome of the significant findings was also sought.

Results A total of 257 scans were reviewed comprising of 250 (97%) CT colonography and 7 (3%) plain abdominal CTs in 104 (40%) male and 153 (60%) female patients. The average age was 68 years (range 39–91). A total of 163 (63%) of scans detected at least one extracolonic finding, with 55 (21%) of these significant. Sites included 13 liver, 7 lung, 6 pancreatic, 5 renal and 5 adrenal. Further investigation based on these findings revealed 5 (1.9%) malignancies. One patient was found to have a renal cell carcinoma and went on to have curative surgery. One patient was diagnosed with pancreatic cancer and one with hepatocellular carcinoma, both of which were managed palliatively, and one patient was found to have peritoneal recurrence of a previously treated colonic adenocarcinoma. One scan discovered lung and liver metastases along with the causative colonic primary. Other notable findings included a 5.3cm AAA and a pulmonary embolus seen in a segmental lower lobe pulmonary artery. There were a 209 insignificant findings in 139 (54%) of the CTs, with a maximum of 5 in a single scan.

Conclusion This study helps to highlight the potential additional benefit of CT colonography over endoscopic visualisation of the large bowel. The prevelance of extracolonic findings in this cohort was high, in keeping with previous studies, with CT colonography having value is its detection of extracolonic malignancies, staging and other serious conditions. However there was also a substantial rate of additional investigation for subsequently benign findings.

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Disclosure of Interest None Declared.

PWE-005 MANAGEMENT OF HIGH RISK COLONIC POLYPS

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Introduction Colorectal cancer is a significant health problem, the importance of which will increase substantially in the coming years. Demand for colonoscopy will increase and so will demand for complex polypectomy to deliver a reduction in incident rates.

Methods Colonoscopy reports with an endoscopic diagnosis "high risk colonic polyp" were examined over a 6 month period. Histology was reviewed to determine the precise histological classification of all polyps. Repeat procedures over the following 2 years were reviewed for completeness of initial resection. Complete adenoma clearance rates were calculated based on observation of residual polyps or residual polyp tissue at previous polypectomy site.

Results Twenty one colonoscopists performed 2139 colonoscopies. The median caecal intubation rate was 93%. The number of procedures performed by individual endoscopists varied between 14–464. The median was 64 procedures. In 564 (24%) cases, one or more than one polyp were identified. Individual endoscopist adenoma detection rates (ADR) did vary. The median ADR was 24% (0–44%). In 79 cases the endoscopic diagnosis was reported as "high risk". When the initial reports were analysed with histology, 52 (69 %) cases met BSG high-risk criteria. Of the 52 high-risk polyp cases, histology confirmed adenocarcinoma in 10 cases. Surgery was performed for 5 benign cases. Of the 44 benign lesions managed endoscopically, 35 (80%) patients were recommended to undergo a repeat procedure (s). In total 24 patients underwent one repeat procedure, 8 underwent 2 repeat procedures and 3 patients underwent 3 repeat procedures over the follow up period.

Complete adenoma clearance rate at index endoscopy in this audit was achieved in 11 (31%) cases. Two further cases were regarded as having complete clearance following a subsequent resection.

Conclusion The finding of multiple or complex polyps puts pressure on colonoscopists. Difficult procedures may adversely affect ADR. Although key performance indicators such as caecal intubation rate have improved with national training programmes, this audit and other studies have demonstrated variation in therapeutic outcomes.[1] Scoring systems for complex polypectomy should be employed to encourage endoscopists to defer polypectomy in some situations.[2] Designated therapeutic lists will benefit patients and endoscopy units with reduction in repeated procedures and improved mentoring/training opportunities in complex polypectomy.

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Disclosure of Interest None Declared.

PWE-006 NICORANDIL USAGE IS ASSOCIATED WITH COMPLICATED DIVERTICULITIS

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Introduction Nicorandil is widely used in the treatment of ischaemic heart disease, but over the last ten years there has been a growing body of literature reporting the association between nicorandil and ulceration of the gastrointestinal tract. In the setting of diverticulosis/diverticulitis, any superimposed ulceration may lead to significant complications, but data on whether or not nicorandil contributes to this is scanty and limited to one study which only investigated intestinal fistulae.[1] Our aim is to identify if any potential association between all forms of complicated diverticulitis and nicorandil exists.

Methods We reviewed 100 reports of colonic resections with diverticular disease received in a single institution over a 6 month period (from June 2013 to January 2014) and divided them into those with complicated diverticulitis (defined as active diverticulitis in combination with perforation, fistulation, abscess formation or structuring)[2] and those with uncomplicated diverticulitis or uninflamed diverticulosis. The age, sex, surgical indication and use of nicorandil were recorded for both groups.

Results 51 patients had complicated diverticulitis and 45 had uncomplicated diverticulitis or diverticular disease (7 diverticulosis