PWE-011 DIAGNOSING ABDOMINAL TUBERCULOSIS IN THE ACUTE ABDOMEN

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Introduction Despite recent improvements in medical treatments, the incidence of abdominal tuberculosis (ATB) in the United Kingdom has increased over the past two decades. This case series examined the difficulties encountered in correctly diagnosing this infection.

Methods A retrospective study was undertaken, reviewing the records of 36 patients diagnosed with ATB from 2000 to 2012 at a district general hospital in outer East London.

Results The commonest presenting feature was abdominal pain in 67 (%) of patients, and the most common sites of infection were the iliocaecal junction and peritoneum, seen in 36.1 (%) and 33.3 (%) respectively. Six patients were initially investigated for Crohn's disease and one for ileitis. The highest disease prevalence was seen in patients born in India and Pakistan, which was 27.8 (%) and 19. 4(%) of patients respectively.

Colonoscopy was performed in nine patients, and three of these reported normal findings. The other six reported visible non-specific inflammatory changes. Three patients had abdominal x-rays reported and one patient had an abdominal ultrasound, all of which were normal. An abdominal computerised topography (CT) scan was performed in 26 patients and a chest CT was undertaken in 19 patients. Varying degrees of inflammatory changes were seen in all of the patients who had CT scans. Microbiological culture was positive for mycobacterium tuberculosis or acid-fast bacilli in 71(%) of patients.

Conclusion Abdominal tuberculosis can be very difficult to diagnose as symptoms are non-specific and can mimic other types of granulomatous inflammatory bowel diseases. Radiology appears largely unhelpful due to the non-specificity of any positive imaging findings, and there is a lack of diagnostic procedural and microbiological tests with high specificity and sensitivity. In view of the increasing incidence of tuberculosis in the United Kingdom, there should be a high index of suspicion for ATB in individuals from high-incidence countries who present with non-specific abdominal symptoms.

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Disclosure of Interest None Declared.

PWE-012 AUDIT OF NHS TAYSIDE COLONOSCOPY SURVEILLANCE PROGRAMME

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Introduction Symptoms associated with organic bowel disease such as cancer or adenomatous polyps are extremely non-specific.[1] Therefore, for individuals at moderate and high risk of colorectal cancer (CRC), the current practice involves surveillance colonoscopy.[1] The BSG Guidelines for colorectal cancer screening and surveillance are a benchmark for UK clinicians.[1] Approximately 2500 patients are under regular endoscopic surveillance in NHS Tayside; appointments are booked following a review and telephone consult by nurse specialists.

Methods Aim

To determine the level of adherence to the BSG guidelines, and the pathology findings from recent colonoscopies.

Methods Patients on the surveillance register who were reviewed between September 2012 and June 2013 were studied. Electronic data was retrieved from Unisoft, ICE and Clinical Portal to view colonoscopy reports, pathology findings and follow-up plans.

Results 434 patients were reviewed. 319 requests adhered to the guidelines (adherence 73.5%), 328 patients (75.6%) were scoped: 27 declined, 1 moved out with Tayside, 1 referred to genetics, 31 weren't required, 10 were unfit, 33 weren't due for colonoscopy whilst 3 patients postponed. 44 patient's colonoscopies fell out with the guidelines; 2 weren't due, 4 weren't required, with the rest (38) being brought back too early/late.

Median age 66 (range 21 – 96); Males 60%. Females 40%. Indication for surveillance was previous polyps (71%), carcinoma (11%), IBD (4%) or a genetic family history (14%). Colonoscopy identified normal bowel (58%), polyps (40%; 67% of these were adenomas), IBD (2%) and cancer (1%).

Of 132 patients under 3 year follow-up for previous polyps; 54% had normal colonoscopy, 32% had adenomas. Of 60 patients under 5 year follow-up for previous polyps, 67% had normal colonoscopy, 18% had adenomas. Of 21 patients under 5 year follow-up for previous carcinoma 67% were normal, 19% had adenomas and there was one cancer. An additional 8 patients had a history of cancer within 3 years; 3 were found to have adenomas. Of 45 genetic family history patients 69% had normal colonoscopy, 18% adenomas. Out of 13 IBD patients 7 had normal colonoscopy, 2 active IBD and 4 polyps with 1 being an adenoma.

Conclusion In Tayside the adherence to BSG guidelines was 73.5%. The Nurse Specialist review saved a significant number of appointments. The majority of surveillance colonoscopies were normal; with the highest rate observed in those with a genetic family history. These findings suggest that alternative means of regular surveillance should be evaluated.

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Disclosure of Interest None Declared.

PWE-013 BOWEL CANCER SCREENING IN THE CZECH REPUBLIC : CURRENT STATUS, PROBLEMS, CLINICAL VIEW OF THE SINGLE MUNICIPAL SCREENING CENTRE AND THE NEWS IN 2014

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Introduction Incidence of CRC in the Czech Republic (CR) =7800–8200/in population of 10 M people. Approximately

50% of patients (pts.) die of CRC annualy, one of the reasons being late diagnosis (>50% pts diagnosed in stage 3/4). 5 year survival increased in CR by 10%/last decade: exceeds 60%, leading to increased prevalence of CRC by 64%. Alarming data is that 20.5% of these pts. are younger than 60 yrs. Screening programme (ScP) in CR was introduced in 2000 as opportunistic double-step programme based on GP provided gFOBT test. Screening colonocopies were introduced in 2009 and are evaluated by Czech Statistical Center. Currently: 225 screening centres (audited for quality and safety by Ministry of Health).

Methods Top 4 problems of ScP: 1. Insufficient coverage of target population (25% in 2011 × 45% to 65% is desirable). 2. Incomplete switch to iFOBT although the numbers are increasing (71% in 2013 iFOBT). Optimal cut-off for our population in Czech pilot study =75 ng/ml 3. Roughly 16% pts. in whom CRC was not their first cancer (probably reflects our "tunnel vision") 4. Measures of good quality colonoscopy are not regularly evaluated by all centres. Overall in CR, ADR in 2006–12= 33% for FOBT+colonoscopies and 25% for scr. colonoscopies.

Results Quality of colonoscopy is one of the crucial points of ScP success–results of our screening centre: Endoscopist No. of colonoscopies/yr–ADR2010–2011–2012–2013-Caecal int. rate

E1 457/277/243/383–40.3% >44.3% >34.6% >40.7% >99/99.3/97.1/100 E2 280/279/389/601–40.7% >32.2% >35.3% >40.5% >97.2/95/98.7/99.3 E3 227/174/162/160–23.6% >26.9% >27.0% >36.6% >93.5/92.5/89/85.7 E4 167/145/267/330–28.6% >19.6% >20.9% >19.0% 99.2/89.7/96.9/95 E5 (as of 2011)–/116/115/176–30.5% >28% >22.9% >–/86.3/91.3/93. It is advisable that endoscopists with ADR <20% measure their extubation time regularly. ADR (2013) of screening colonoscopies = 33.8% (M40.0%, F27.2%). Of interest is also a non-negligible number of adenomas in patients <50 years (11.1% in 2013). Future: Personalised invitation. To increase the effectiveness of ScP, in 2014 started system of population-wide personalised invitations. Health Insurance Companies invite clients who did not undergo any screening during last 5 years (birthday letter): uniform algorithm of invitations. Number of screen colonoscopies should increase by 20–30% and we expect some harvesting effect (increased incidence of CRC during first years). It should lead to earlier diagnosis and treatment of CRC and should bring savings.

Conclusion Opportunistic ScP in CR during last 3 years reached achievable limit and system of population-wide personalised invitation letters by health care payers should lead to increased uptake of screening colonoscopies. The necessity of good quality colonoscopy service for the community is also ´Conditio sine qua non´ for the programme to be effective.

Disclosure of Interest None Declared.

PWE-014 JESREY FLEXIBLE SIGMOIDOSCOPY BOWEL CANCER PROGRAMME: ONE YEAR'S EXPERIENCE

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Introduction Randomised control trials (RCTs) have demonstrated that once-only flexible sigmoidoscopy (FS) between ages of 55 to 64 reduces both incidence and mortality from colorectal cancer. A key marker of quality in FS screening is adenoma detection rate (ADR), which relies on effective bowel preparation and good technique. The States of Jersey introduced once-only FS at age 60 in February 2013. This study aims to evaluate the one-year outcomes of the programme.

Methods Jersey residents aged 60 were invited by post to participate in the programme. Responders were telephone pre-assessed for eligiblity and bowel habit and assigned one of two bowel cleansing regimes; two fleet enemas + senna/bisacodyl or moviprep. FS were performed, unsedated, by two experienced gastroenterologists using paediatric colonoscopes, with the aim of visualising at least 60cm (straightened endoscope) of the left colon. Clients with poor bowel preparation had additional fleet enema and re-scoped on the same day or returned on a later day following moviprep. All polyps =1 cm were removed during FS. Indication for colonoscopy was the presence of high-risk lesions (adenoma =1 cm, adenoma with high grade dysplasia or a villous component and = 3 adenomas). After FS, clients were given a questionnaire, which included a pain score.

Results 768 clients were invited. 60 were ineligible. 453 had the FS. The uptake was 69.2% and overall ADR was 15.7% (Table 1) which are higher than in the RCTs.

Abstract PWE-014 Table 1

		Adenomas detected (%)		
	No. screened (M/F)	Low risk (%)	High risk (%)	Total
Endoscopist 1	244 (120/124)	23	13	36
Endoscopist 2	209 (94/115)	24	11	35
	453 (213/239)	74 (16.3%)	24 (5.3%)	71 (15.7%)

FS was well tolarated. Only 36 (13.9%) required entonox. 79% reported no or mild discomfort and only 1% reported severe discomfort. 1 client had an incomplete examination due to pain.

435 (96.03%) had 2 fleet enemas plus senna or bisacodyl and 18 (3.97%) had moviprep as the first bowel prep. The quality was excellent or good in 83%. Only 32 (7%) had poor prep and needed repeat bowel preperation.

There were no major complications during bowel preperation or the FS. 1 patient reported abdominal cramps during bowel preparation and 2 and vasovagal episodes immediately after the FS. None required hospital admission.

Conclusion FS screening using two enemas is acceptable and safe. Better bowel preparation and complete examination of the left colon contributed to the high ADR. The impact of the uptake and high ADR on the incidence and mortality of CRC in Jersey will likley be greater than that seen in the RCTs.

Disclosure of Interest None Declared.

PWE-015 BIOMARKERS FOR EARLY DETECTION OF COLORECTAL CANCER AND POLYPS: SYSTEMATIC REVIEW

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Introduction Early detection of colorectal cancer plays an important role in patient survival. A screening program for colorectal cancer has been proven to reduce mortality from the disease. There is a growing interest in potential biomarkers to predict early colorectal cancer as current screening modalities