

with 2 or more risk factors for poor bowel preparation. Data was analysed using SPSS.

**Results** 1840 colonoscopies were carried out during the time period. Total number analysed was 1704. Mean age was 61.7 years with a range of 16–94. 404 patients were pre assessed. Pre-assessment has significantly increased the quality of bowel preparation across all groups (OR = 1.605,  $p = 0.002$ ). In groups 1 and 2 the odds of good quality bowel preparation was 80% and 72% higher respectively in patients who had been pre-assessed however these improvements were not statistically significant. Patients stratified into group 3 were 52% more likely to have good bowel preparation ( $p = 0.039$ ) compared to those who were not pre-assessed. 88 patients had eGFR <60 ml/min. They had eGFR checked before and after administration of OBCA. There was a significant difference in the percentage change in eGFR between those patients that had Pre-assessment (Median = 7.7%) compared with those who did not (Median = -6.6%) ( $p = .006$ , Mann-Whitney).

**Conclusion** Face-to-face pre-assessment improved the quality of bowel preparation for patients undergoing colonoscopy. It helps to minimise the risk of renal injury in patients with CKD. Those stratified to group 3 saw a significant improvement in the quality of their bowel preparation. We conclude pre-assessment is a prerequisite for patients who are at risk of poor bowel preparation and with significant co-morbidities.

#### REFERENCE

Rapid Response Report NPSA/2009/RRR012. Reducing risk of harm from oral bowel cleansing solution. February 2009. National Patient Safety Agency.

**Disclosure of Interest** None Declared.

#### PWE-032 ENDOSCOPIC RESECTION OF LARGE COLORECTAL POLYPS IN A TERTIARY REFERRAL UNIT IS SAFE WITH A LOW RISK OF COMPLICATIONS

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**Introduction** Patients with large sessile colorectal polyps can be technically challenging to resect endoscopically and have been subject to colorectal resection in the United Kingdom. Our aims were to determine the safety and efficacy of endoscopic resection of large colorectal lesions at a tertiary referral unit.

**Methods** A prospective observational study of all patients referred for endoscopic resection to a single endoscopist. Consecutive patients were included in the study from June 2010 to March 2013. All patients underwent magnification chromoendoscopy and NBI for polyp assessment under conscious sedation. ESD was undertaken for lesions that were LST – non granular, flat and pseudodepressed type and those with type Vi pit pattern. Piecemeal EMR was undertaken for the remainder of the lesions.

All patients underwent colonoscopic surveillance at 3 and 12 months by the same endoscopist to check for recurrence at the scar.

**Results** One hundred and fourteen patients underwent 134 endoscopic resections. There were 54 (47.4%) women and 60 (52.6%) men with a mean age of 71.2 (SD = 10.3 years). 120 lesions underwent EMR (89.6%) and 14 had enbloc resection with ESD (10.5%) with complete resection. The mean size of the lesions was 56 mm (SD 37.1mm). The median lesion size was 50mm (range 25–150 mm).

Histological analyses revealed 8 hyperplastic lesions, 28 tubular adenomas, 90 tubulovillous adenomas, 3 serrated adenomas and 5 early submucosal invasive cancers invading to the upper third of the submucosa (sm1). Endoscopic diagnosis of the colorectal polyps using magnification colonoscopy identified all patients with cancer correctly with 100% sensitivity. All lesions underwent endoscopic resection with curative intent. Overall, there were 2 patients who sustained intra-procedural perforation (perforation rate overall 1.8%) of the bowel, both of which were closed with endoscopic clips without the need for surgery.

13 patients were admitted to hospital post procedure (9.8%). 6 patients were for medical reasons (2 perforation, 3 self limiting abdominal pain, 1 patient with pericolic inflammation on CT scan and abdominal pain) and 7 patients were admitted for social reasons.

Median follow up duration was 8.27 months (range 0.39–34.6 months, IQR 12.04 months). 6 patients had documented recurrence (5.1%) with a median time to detected recurrence being 4.45 months (range 2.83–15.74 months, IQR 11.85 months).

**Conclusion** Endoscopic resection of large colorectal lesions in a tertiary setting is a safe procedure often performed as a day case. Perforations detected during the procedure can be managed endoscopically without the need for surgical intervention. Meticulous technique utilising magnification chromoendoscopy to examine the scar post resection offers a low incidence of recurrence

**Disclosure of Interest** None Declared.

#### PWE-033 COMPARISON OF PATIENT EXPERIENCE OF COLONOSCOPY AND CT COLONOGRAPHY IN THE ENGLISH BOWEL CANCER SCREENING PROGRAMME

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**Introduction** The English Bowel Cancer Screening Programme (BCSP) uses colonoscopy to investigate positive faecal occult blood test results. CT colonography (CTC) is employed if colonoscopy is infeasible. Patient experience is monitored with a questionnaire, posted 30 days after colonic testing. We used these to compare patient experience of CTC and colonoscopy.

**Methods** The study was approved by the BCSP Research Committee. Screenees tested between 1/1/11 and 31/12/12 and responding to at least one questionnaire item were included. Multiple imputation of missing data was conducted under the missing-at-random assumption. Likert scale data (“strongly agree” to “strongly disagree”) were analysed via ordered logistic regression using test category (CTC or colonoscopy) as the predictor variable and age, gender, deprivation score, screening centre and screening result as covariates (results presented as odds ratios).

**Results** 79,493 questionnaires were analysed; 61,899 contained at least one response. 2,119 CTC and 60,581 colonoscopy questionnaires were included (some individuals completed both tests). There was no difference in results between complete-case analysis and multiply-imputed analysis.