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 pre-requisite for patients who are at risk of poor bowel preparation and with significant co-morbidities.

REFERENCE

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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.

Abstract PWE-033 Figure 1

Understanding of test risks was greater for colonoscopy than CTC: 95.7% understood risks of colonoscopy vs 86.9% for CTC (odds ratio=1.88 95% CI: 1.71–2.07, p < 0.0001). Test benefits were also better understood for colonoscopy than for CTC: 98.2% understood colonoscopy benefits vs. 93.6% for CTC (OR=1.67 95% CI: 1.52–1.84 p < 0.0001). Just over one-quarter found CTC more uncomfortable than expected (25.7%), more than for colonoscopy (20.8%; OR = 1.34 95% CI: 1.24–1.46, p < 0.0001, Figure 1). Post-procedural pain showed no significant difference between tests (CTC = 14.6%, colonoscopy=14.3%; OR = 1.07 95% CI: 0.93–1.22, p = 0.35). More patients understood their colonoscopy result (97.0%) than CTC (90.5%, OR=2.19 95% CI: 1.99–2.41, p < 0.0001).

Direct CTC-related complications were rare (n = 16; 0.5%) although a further 20 (0.6%) suffered complications from subsequent procedures provoked by CTC. Colonoscopy complication rates were similar (n = 779; 1.0%).

Conclusion Although CTC is generally well-tolerated, it is more frequently judged unexpectedly uncomfortable than colonoscopy. Similarly, while overall understanding of test risks, benefits and results is high, rates are lower than for colonoscopy. Post-procedural discomfort and complication rates are similar between both tests. Clear communication of the risks, benefits, procedural experience and results of CTC is required in the BCSP.

Disclosure of Interest None Declared.

PWE-034 PATIENT-REPORTED EXPERIENCE OF COMFORT AND DIGNITY IN FLEXIBLE SIGMOIDOSCOPY: DATA FROM THE NHS BOWEL SCOPE SCREENING PILOT

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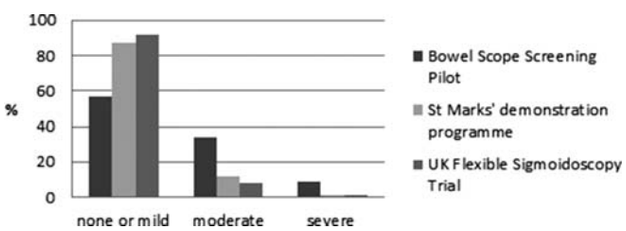
Introduction The NHS Bowel Cancer Screening Programme started flexible sigmoidoscopy (FS) screening (also known as Bowel Scope Screening, BSS) at six centres across England (Gateshead, Guildford, London, Medway, Norwich, Wolverhampton) in March 2013. The aim of this analysis was to investigate the extent to which high levels of patient satisfaction recorded in previous UK trials can be replicated in the early stages of a routine screening programme.



Abstract PWE-034 Figure 1 Patient-reported levels of pain

Methods We used used data from an ongoing study monitoring patient-reported experience in the pilot phase of the BSS Programme. We report data from the 'post-AM questionnaire' which is given to patients at the end of their FS appointment and supposed to be completed on the following day.

Results As of January 2014, we had received 2,324 questionnaires. Satisfaction with the test was high with 98.8% of patients being either satisfied (21.1%) or very satisfied (77.7%). Nonetheless, 43% of patients reported moderate (34%) or severe pain (9%) which was high compared with the St Marks' demonstration programme[1] and the UK Flexible Sigmoidoscopy Trial[2] (Figure 1). Women were three times as likely to report severe pain during the test than men (14.3 vs 4.6%), and twice as likely to find the test as more painful than they had expected (39.9 vs 20.1% respectively). Only about 1 in 10 patients reported being moderately (9.8%) or severely (1.4%) embarrassed during the test, with women being slightly more likely than men to fall into these categories (13.4 vs. 8.9%). Women also had a much stronger preference for the test to be carried out by a female practitioner than men (41.2% vs 7.1% respectively).

Conclusion The vast majority of patients were satisfied with their experience of FS screening. However, levels of pain appear high when compared with previous trials. Emphasis should be placed on ensuring that patients have as comfortable a procedure as possible. Additional consideration should be given to women being able to choose the sex of the practitioner performing the test.

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Disclosure of Interest None Declared.

PWE-035 PATIENTS' EXPERIENCE OF COLONOSCOPY IN THE ENGLISH BOWEL CANCER SCREENING PROGRAMME

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Introduction In the English Bowel Cancer Screening Programme, colonoscopy is the standard investigation to exclude cancer in participants who receive a positive faecal occult blood test result. A questionnaire is sent to all patients 30 days post-test. These data were used to assess patients' experience of colonoscopy.

Methods Anonymised data were extracted from the Bowel Cancer Screening System. These included all patients who had colonoscopy between 01/01/11 and 31/12/12. Questionnaire items on the pre-test experience (whether patients understood the risks/benefits), the hospital experience (the test itself, issues of dignity/privacy) and post-test