

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.

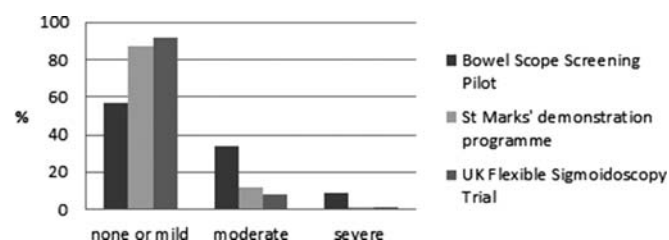
Disclosure of Interest None Declared.

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



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

(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.

Methods We 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 programme¹ and the UK Flexible Sigmoidoscopy Trial² (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

complications (bleeding/pain) were analysed. Pearson chi-square tests were used to compare experiences by gender, high vs. low levels of socioeconomic deprivation (using Index of Multiple Deprivation scores), and whether patients reported receiving sedation or not.

Results After excluding patients outside the target date range and those who did not have colonoscopy, 76,717 patients were eligible for analysis, of whom 60,581 (79.0%) responded to the questionnaire. Nearly all patients felt they understood the risks (95.7%) and benefits (98.2%) of the test, and 97.8% felt the preparation instructions were clear. Comparison by gender and deprivation did not yield clinically meaningful ($\geq 3\%$) differences. In terms of the hospital experience, virtually all patients felt they were treated with respect (98.5%) and had privacy (98.0%), but 20.8% experienced more discomfort than expected (although only 5.2% asked for the test to be stopped/paused). Procedural discomfort was moderated by gender, with more women than men reporting higher-than-expected discomfort (25.4% vs. 17.9%; $p < 0.0005$), and requesting that the test be stopped/paused (7.1% vs. 3.9%; $p < 0.0005$). Use of sedation showed only a weak association with patient experience: 22.2% of sedated vs. 20.2% of non-sedated patients reported unexpected discomfort; 6.4% vs. 4.8% asked for the test to be stopped/paused; both p -values < 0.0005). Post-test, 14.3% of patients reported pain and 6.9% reported rectal bleeding. Pain was more common in women (18.0% vs. 11.9%; $p < 0.0005$) but there were no other clinically meaningful differences post-test related to gender or deprivation level.

Conclusion Most patients referred for colonoscopy as part of the Bowel Cancer Screening Programme have a positive colonoscopy experience. The most negative aspect of the experience was the test being unexpectedly uncomfortable. Patients are extensively counselled pre-procedure but more emphasis on managing expectations, along with continued measures to reduce discomfort and pain are required, particularly for women.

Disclosure of Interest None Declared.

PWE-036 USE OF AN ULTRASLIM PAEDIATRIC COLONOSCOPE TO COMPLETE DIFFICULT COLONOSCOPIC PROCEDURES

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Introduction Discomfort and failure to progress beyond the sigmoid are the commonest reasons for non-completion of colonoscopy¹ We anecdotally observed that the use of a new ultraslim paediatric colonoscope (Olympus PCF-PQ260L) when the standard colonoscope failed often led to completion of difficult cases.

Methods We analysed 19 reports from cases at the Gloucestershire Royal hospital where the PCF-PQ260L was used as a second endoscope on an examination started with a regular colonoscope (Olympus H260 or Q260 colonoscopes) over the period January to August 2013.

Results 95% (18/19) of the time the extent of a non-completed colonoscopy was the sigmoid colon. 50% of the time this was due to diverticular disease with patient discomfort the second most common cause. In 80% of these cases, the subsequent use of the PCF-PQ260L enabled the endoscopist to reach the caecum. In addition, in those procedures that failed due to discomfort, comfort scores were improved in 50% during the second procedure with the PCF-PQ260L. The

CIR of the GI consultants working at GRH averaged 96% for 2013.

Conclusion The PCF-PQ260L enabled the negotiation of the sigmoid colon in 80% of cases where a standard endoscope failed in the hands of skilled colonoscopists. This limited study suggests that the PCF-PQ260L is an exciting new tool in the colonoscopist's inventory.

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Disclosure of Interest None Declared.

PWE-037 PANENTERIC CAPSULE ENDOSCOPY: AN ALTERNATIVE NON-INVASIVE TOOL TO SCREEN FOR IDIOPATHIC INFLAMMATORY BOWEL DISEASE (IBD)

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Introduction Compared to conventional endoscopy, capsule endoscopy (CE) is potentially safer, non-invasive, performed in out-patients and may be an alternative first line investigation in patients with suspected inflammatory bowel disease (IBD). In colon CE (CCE), a dormant mode (to save battery) is followed by device activation when small bowel mucosa is recognised. In this pilot study patients with suspected small and/or large bowel disease underwent a pan-enteric assessment using combined small bowel (SBCE) and CCE.

Methods Patients underwent combined SCE and CCE using a novel protocol. Patients had new GI symptoms (group A: symptoms alone or those with additional abnormal results - GI symptoms plus) or underwent assessment of known IBD (group B). Main outcome measures: diagnostic yield (relevant findings only), complications, CE completion rates and colon cleanliness (scored 1–4: excellent to poor).

Results Patients (group A, $n = 56$; group B, $n = 26$; mean age 41) had refused (50%), had incomplete (21%) prior colonoscopy or chose to have CCE (29%). Group A patients had diarrhoea (62%) and abdominal pain (54%); 17 had GI symptoms plus anaemia (13), acute phase response (9), hypoalbuminaemia (4), radiological abnormalities (3). Mean SBCE and CCE SB examination times: 255 and 92 mins respectively. Mean C examination time: 167mins; median cleanliness score 2. SBCE was complete in 73 (89%) and CCE in 58 patients (71%). In group B, pathology was identified in 62%, 16/26 (all active Crohn's) which was significantly higher than in Group A (20%: 11/56, $p = 0.0003$). New diagnoses in Group A: Crohn's disease ($n = 5$) and one each of NSAID colitis, proctitis, leiomyoma, angioectasia, diverticulae and idiopathic ulcerated small bowel stricture. 9/11 were in the symptoms plus group. 95% of pathology identified on SBCE was also identified on CCE. No complications were reported.

Conclusion 62% of patients known to have IBD had active disease, but diagnostic yield was as high as 20% in those with new symptoms. IBD was the commonest and no complications occurred. Studies of the respective roles of faecal biomarkers, CE and histology in the diagnosis of IBD are needed. Almost all small bowel pathology was recognised by CCE suggesting its use as a remote panenteric endoscopic tool only awaits further battery development.

Disclosure of Interest None Declared.