

associated with the procedure. From this study, excluding such patients could have avoided 20 colonoscopy screening lists (approximately 80 procedures) over 3 years in our unit. If findings are similar in other centres, current national guidelines should be changed.

Disclosure of Interest None Declared.

OC-047 ADENOMA SURVEILLANCE IN THE NATIONAL NHS BOWEL CANCER SCREENING PROGRAMME – IS THE HIGH/INTERMEDIATE RISK STRATIFICATION APPROPRIATE?

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10.1136/gutjnl-2014-307263.47

Introduction The NHS Bowel Cancer Screening Programme (BCSP) guidelines advocate surveillance of high and intermediate risk subjects with adenomas, due to the risk of developing future advanced neoplastic lesions. This study aims to evaluate and compare the yield of colorectal neoplasia during first surveillance in NHS BCSP among these two cohorts.

Methods Data on each patient entering the NHS BCSP are contemporaneously recorded on the national BCSP database (BCSS). BCSS was interrogated to identify all high-risk (HR) and intermediate-risk (IR) subjects at screening who completed their first surveillance episodes during the period of June 2006 to July 2012. Participants with histology data available at surveillance were included. The data were then analysed to assess the detection of colorectal cancer (CRC), advanced adenoma (size ≥ 10 mm/ > 25% villous histology/ high grade dysplasia) and non-advanced adenoma in the two groups. Chi-square tests were performed to determine significance of difference in proportions among them.

Results Table showing subjects with different pathologies at first surveillance:

During the study period 5579 HR and 4723 IR subjects completed their first surveillance procedures, of which 5118 HR and 4569 IR subjects had their histology results available, and were included for final analysis. 39 (0.76%) HR and 20 (0.47%) IR subjects were diagnosed with colorectal cancer (CRC). Detection of CRC and colorectal adenomas during the first surveillance were significantly higher in HR group (table).

Conclusion Only a small number of subjects had CRC during their first surveillance, indicating that the current surveillance intervals for HR and IR groups are safe. The higher yield of all colorectal neoplasia (CRC, AA and NAA) during the first surveillance in HR subjects illustrates that the current risk stratification is valid and justified. The finding of significant

Abstract OC-047 Table 1

Risk category and p values	CRC N (%)	Advanced adenoma (AA) N (%)	Non-advanced adenoma (NAA) N (%)	Others N (%)	Total N
High risk (HR)	39 (0.76)	739 (14.44)	2184 (42.67)	2156 (42.13)	5118
Intermediate risk (IR)	20 (0.47)	385 (8.42)	1393 (30.48)	2771 (60.63)	4569
Chi-square p value	0.04	<0.001	<0.001	<0.001	

and higher proportion of IR subjects with non-neoplastic findings during first surveillance suggests that, they have less potential to develop colorectal neoplasia and further study needed to evaluate whether their surveillance interval can be safely prolonged.

REFERENCE

- 1 Guidelines for colorectal cancer screening and surveillance in moderate and high risk groups (update from 2002). *Gut* 2010;59:666–690

Disclosure of Interest None Declared.

OC-048 TRANS-ANAL SUBMUCOSAL ENDOSCOPIC RESECTION (TASER): A NEW ENDO-SURGICAL APPROACH TO THE RESECTION OF GIANT RECTAL LESIONS

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10.1136/gutjnl-2014-307263.48

Introduction Trans-anal surgical (TEMS/TAMIS) and advanced endoscopic resection (ESD, P-EMR) procedures have the potential to provide complete and successful eradication of giant rectal polyps. Both approaches however have limitations in terms of practicality and safety. We describe a new endo-surgery technique called Trans-Anal Submucosal Endoscopic Resection (TASER) which combines the advantages of both the endoscopic and transanal surgical approach.

Methods The GelPoint Path trans-anal access port allows simultaneous passage of an endoscope and two laparoscopic retractors. Working with the endoscopic image the laparoscopic retractors (Johen 33 mm forceps) allow dynamic tissue retraction to facilitate endoscopic dissection (Flush knife–BT) or snare placement (Olympus snare master/spiral snare). All procedures were performed under general anaesthesia and with patients in the lithotomy position.

Results Eleven patients (mean age 55 years, 3 male/8 female) underwent TASER for 11 lesions, distributed from the lower rectum to the recto-sigmoid junction and with a median size of 85 mm, range 40–180 mm. Polyp morphology was (3/11 flat (Paris 2a), 4/11 sessile (Paris 1s) and 4/11 mixed type (Paris 2a +1s). In all cases a circumferential mucosal incision was made and histology confirmed free lateral margins in all cases. 10/11 rectal polyps were adenomatous and one had a small focus of moderate differentiated adenocarcinoma (incomplete local excision).

Complete endoscopic excision in a single session was achieved in 10/11 cases (91%). Median completion time of the procedure was 215 min, range 120–480 min. Tissue retraction was used in every case and resection was completed by ESD alone (4/11), ESD + EMR (4/11) ESD + EMR + trans-anal surgical excision (3/11). Intra-procedural bleeding occurred in 8 cases, controlled with hemostatic clips and Coagrasper (Olympus); surgical suturing was required in one case (1/8). Prophylactic clips (2/11) and surgical sutures (1/11) were placed to treat deep muscle injury. There were no perforations and no delayed bleeding episodes. Patients were discharged the day following TASER in all cases. Surveillance at 3–6 months revealed no recurrence in 6 cases, whereas in four cases the follow up procedure is still pending. The malignant polyp case was referred to surgery with a good clinical outcome (T3, N0, M0).

Conclusion TASER appears to be a safe and efficient approach providing an optimal platform for resection of large rectal lesions. In our experience it provides the optimal platform for the minimally-invasive management of these high risk lesions.

Disclosure of Interest None Declared.

OC-049 RECTAL NEUROENDOCRINE TUMOURS: MANAGEMENT AND SURVIVAL IN 60 PATIENTS

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10.1136/gutjnl-2014-307263.49

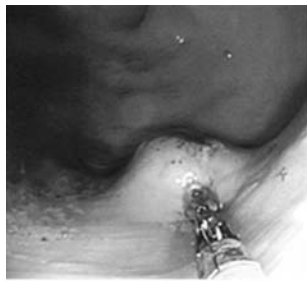
Introduction Rectal neuroendocrine tumours (rNETs) are increasing in incidence, with more found incidentally on routine colonoscopy. Our aim is to retrospectively analyse a cohort of rNETs to characterise diagnostic features and clinical behaviour.

Methods Patients (pts) with confirmed diagnosis of rNET were identified from a database.

Results 60 pts evaluated, median age 55 years (range 23–78). Most common presentation was rectal bleeding n = 29 (48%). 29/60 pts had tumour <1 cm, 7/60 pts 1–2 cm, 22/60 >2 cm, 2/60 size was unknown. Of patients with tumour size <1 cm, 3/29 did not require endoscopic follow-up (pT1a) and of the other 26, none had evidence of recurrence on endoscopic follow-up (follow-up range 6 to 88 m). 24/60 pts had metastases at presentation, 5/60 developed metastases during follow-up (of these 29 pts 86% liver, 40% bone, 10% lung). Of 29 pts with metastases, 24/29 had somatostatin receptor imaging with 62% avid uptake. Chromogranin A available in 23/29 pts: not elevated in 83%. Of 29 pts with metastases, 19/29 had chemotherapy, 10/29 somatostatin analogues (SST), 15/29 surgery and 10/29 peptide-receptor-radionuclide-therapy (PRRT). Chemotherapy: 1/19 pts partial response, 2/19 stable disease (SD), 12/19 progressive disease (PD) (median time to progression 4 months (m)); 4/19 no data. PRRT: 4/10 had SD (follow-up range 24 to 53 m), 4/10 PD (median time to progression 4 m, range 2–9), 2/10 no data. SST: 2 sustained SD (range 12–27 m), 7/10 PD, (median time to progression 3m, range 2–5); 1/10 no data. During median follow-up of 20 m (range 3–170 m), 100% of pts with primary tumour <1 cm, 86% with tumour size 1–2 cm, and 25% with size >2 cm are currently alive. Tumour size >2 cm have poorer outcome than the other 2 groups (p < 0.001).

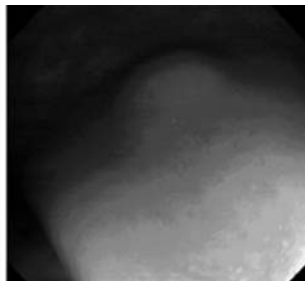
Conclusion Tumours >2 cm are associated with poor prognosis. Chromogranin A is mostly normal even in advanced disease. Prospective studies are needed to determine progression free survival data for systemic therapy.

Disclosure of Interest None Declared.



Picture 1: Histology: 12mm tumour G2

Typical appearance of rectal NET polyps- round sessile polyp covered with yellow-discoloured mucosa



Picture 2 Histology: 4mm G1 tumour

Abstract OC-049 Figure 1

Trainee section symposium and free papers

OC-050 THE UGIB-DOPS: IMPROVING TRAINING IN GI BLEED MANAGEMENT IN THE ENDOSCOPY UNIT

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10.1136/gutjnl-2014-307263.50

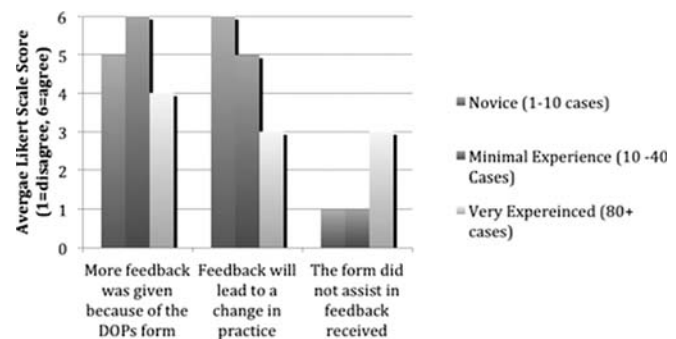
Introduction The 2007 GI Bleed Audit highlighted significant deficiencies and inconsistencies in service provision and care of patients presenting with UGIB. There is a pressure on UK hospitals to provide a 24/7 endoscopy service to meet NICE guidance on timely endoscopic intervention in upper GI bleeding (UGIB), resulting in an urgent need to determine an endoscopist's competence. JAG provide quality assurance in UK endoscopy by using compulsory summative assessment in diagnostic endoscopy and more recently polypectomy.

There is currently no structured, formal tool or criteria with which to assess and provide feedback for the specific generic and endoscopic skills required for effective management of UGIB. DOPS are used as a tool to assess endoscopic skills by providing a framework for experts to observe, assess and provide feedback on a procedure. We developed a new DOPS tailored to the specific aspects of therapeutic endoscopic management of UGIB to improve training, with a view to developing the tool for use in summative assessment for JAG accreditation.

Methods A working group of expert endoscopists was formed at University College London Hospital. UGIB task deconstruction was undertaken and, after multiple revisions, consensus was reached on the individual aspects of management, and then to define what was considered a satisfactory endoscopic performance in each of these domains. The performance rating scale was based on the degree of independence demonstrated by the trainee in each performance domain. These aspects of performance, definitions of standards and rating scales were then used to construct the UGIB-DOPS.

We evaluated the feasibility, validity and educational impact of UGIB-DOPS using 8 trainees paired with trainers using questionnaires and semi-structured interviews.

Results The trainee cohort displayed a range of experience from novices (n = 2) to trainees who had managed >80 cases (n = 2). Qualitative assessment of the educational impact of UGIB-DOPS found universal agreement that the tool's defined assessment criteria facilitated structured feedback and it was perceived the overall grade awarded reflected trainee's current competence. Thematic interview analysis revealed recurring concepts of how UGIB-DOPS facilitated training: creation of an observed teaching event, knowledge of the required



Abstract OC-050 Figure 1