PTH-027

UPDATED BSG GUIDELINES FOR CANCER SURVEILLANCE IN IBD – IMPROVING CONSENSUS AND CHANGING PRACTICE?

doi:10.1136/gut.2011.239301.428

B Hudson,^{1,*} J T Green,² M Lockett¹ ¹Department of Gastroenterology, North Bristol NHS Trust, Bristol, UK; ²Department of Gastroenterology, University Hospital Llandough, Cardiff, UK

Introduction BSG guidelines for screening and surveillance in IBD have been recently updated to account for changes in consensus opinion and evidence since their initial publication in 2002.^{1,2} Changes include use of pancolonoscopic dye spray, suggested intervals between colonoscopies, and use of therapeutic endoscopy. The current work aims to assess contemporary practice, opinion and understanding among gastroenterologists in relation to the updated guidelines.

Methods A questionnaire survey was electronically distributed to gastroenterology consultants and trainees within Severn and Wales deaneries. A 31.4% (37/118) response rate was achieved across 14 NHS trusts. Guidelines were available to all respondents.

Results Variations in local protocols included the choice of bowel preparation, the number of 'points' allocated per colonoscopy (range 1–4), and in the targeting of colonoscopies to endoscopists with a special interest (35% of institutions). Pancolonoscopic dye spray was used routinely by only 30% of respondents, with the majority (60%) employing the previously recommended strategy of taking two to four random biopsies at 10 cm intervals.² The average number of biopsies taken during routine surveillance colonoscopy ranged from 4 to 50 (mean=18.83).

A general consensus with guidelines in respect to the timing of initial screening colonoscopy, and of the surveillance intervals necessary in proctitis and pancolitis was demonstrated. Nonetheless, widespread confusion regarding optimum surveillance intervals in high risk groups (eg, PSC, family history) and in cases where definition of disease extent was unclear (eg, UC extending to sigmoid – classified as left sided disease by Montreal criteria³) was evident. With the notable exception of low grade dysplasia, lesion management was broadly consistent and in keeping with BSG guidelines. Responses were similar in both consultant (n=25) and trainee (n=12) groups.

Conclusion A similar study undertaken in relation to the 2002 BSG guidelines highlighted widespread controversy and uncertainty surrounding IBD surveillance.⁴ Analysis of results from the current work suggest that, although the updated guidelines clarify some areas, notable variations in local and individual practice remain, and areas of confusion persist. In particular a reluctance to use pancolonoscopic dye spray, uncertainty regarding surveillance intervals in high risk groups, a lack of clarity in classification of disease extent, and disparity in management of low grade dysplasia are demonstrated.

If these findings are representative of opinion and understanding nationally, it would seem that uniform, quality surveillance in IBD is not yet accepted standard practice.

Competing interests None.

Keywords colorectal cancer, guidelines, inflammatory bowel disease, surveillance.

REFERENCES

1. Cairns SR, Scholefield JH, *et al.* Guidelines for colorectal cancer screening and surveillance in moderate and high risk groups (update from 2002). *Gut* 2010;59:666–90.
2. Eaden JA, Mayberry JF. Guidelines for screening and surveillance of asymptomatic colorectal cancer in patients with inflammatory bowel disease. *Gut* 2002;51(Suppl 5):v10–12.
3. Silverberg MS, Satsangi J, Ahmad T, *et al.* Toward an integrated clinical, molecular and serological classification of inflammatory bowel disease: report of a working party of the 2005 Montreal World Congress of Gastroenterology. *Can J Gastroenterol* 19 (suppl A):5A–36.
4. Hudson B, Green J. British Society of Gastroenterology guidelines for ulcerative colitis surveillance: creating consensus or confusion. *Gut* 2006;55:1052–53.