uncertain margins was to cheque the site at 3 months and 12 months post index therapeutic procedure.

Results LCSP accounted for 3.42% of adenomas, mean size 32.2mm (1.02% were LSCP > 40mm). 33/40 (82.5%) LCSP were managed endoscopically, with either enbloc EMR, piecemeal EMR, or laparoscopically-assisted EMR. Of these, 84.8% had successful endoscopic resection with no recurrence at 3 to 12 months. Recurrent or residual polyp was detected in 1/28 (3.6%) at 3 months, with no recurrence at 12 months. 4/29 (13.8%) of lesions initially managed endoscopically subsequently required surgery. 3/4 (75%) went on to undergo TEM and 1/4 (25%) a segmental colonic resection. Indications included technical limitations to endoscopic management; difficult access or previous attempts at endoscopic resection at a different centre. No significant adverse events occurred in the endoscopically managed group. There was a cancer rate (in lesions initially managed endoscopically) of 5.7% - no residual cancer was detected following definitive treatment.

Surgery was the initial therapeutic modality in 7/40 (17.5%); 5/7 (71.4%) had segmental colectomy and 2/7 (28.6%) had TEM. No cancer was found in any surgically resected specimen.

Conclusion Most patients with LSCPs can be managed endoscopically with good outcomes, including a low adverse event profile and recurrence rate. A small proportion of cases may turn out to have carcinoma that was not possible to diagnose in pre-procedure biopsies and thus require further surgery. Our study supports high quality endoscopic assessment and multidisciplinary team discussion as important factors in achieving optimal patient management and has resulted in piloting a change of practise across the BCSP to minimise variation in outcomes.

Disclosure of Interest None Declared.

PWE-044 CURRENT PRACTICE IN COMPLEX LOWER GI POLYPECTOMY: A UK NATIONAL SURVEY

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Introduction In recent years there have been considerable developments in polypectomy techniques. However, even among experienced colonoscopists, there remains a wide variation in practise. This survey attempts to evaluate current UK practise in more advanced polypectomy.

Methods NHS Bowel Cancer Screening Programme (BCSP) colonoscopists and BSG members were invited to complete an anonymous online questionnaire regarding their approach to large polyps.

Results Respondents: Complete responses were obtained from 268 colonoscopists practising independently in the UK. 75% were consultant gastroenterologists, 10% surgeons and 9% nurse endoscopists. 41% did at least one session in a teaching hospital. 64% were BCSP accredited. All regions were well represented in the survey, although there were only 2 responders from Wales. Median lifetime colonoscopy experience was 3000 and typical workload was about 10 procedures per week.

Experience & Practice: 86% felt confident to remove lesions > 2cm by endoscopic mucosal resection (EMR). 27% of this group had done < 10 EMR procedures in the previous year; 14% claimed > 50 EMRs per year. When asked to describe the most complex polypectomy they would undertake, 30% (81) judged themselves capable of resecting very large flat or polypoid lesions that are also suitable for surgery (i.e. Level 4 polypectomy). Of these Level 4 operators, 17% had never tackled a polyp greater than 5cm and 10% had performed < 10 EMRs in the previous year. Video recording was used in the assessment of difficult polyps by only 20%. 32% declared that they would routinely biopsy a potentially resectable polyp they did

not feel comfortable to remove themselves, with 3.5% opting to snare a large piece for histology.

Endoscopic Submucosal Dissection (ESD): 7 responders perform full ESD and a further 13 use ESD as part of a hybrid technique. 11% had referred a patient to another specialist for ESD in the last year.

Complications: Among those performing EMR, 10% admitted to a perforation in the previous year and 23% reported significant bleeding.

Conclusion This is the first "snap shot" of advanced polypectomy practise across the UK. Although the sample was self-selected, a range of experience is represented. Most experienced colonoscopists appear happy to attempt piecemeal EMR even if their annual numbers are low. As expected, very few colonoscopists are performing ESD. A surprising number of colonoscopists regarded themselves as Level 4 experts, suggesting that the current definition of what constitutes very advanced practise needs to be modified, or at least better defined. The limited use of video documentation is disappointing and unhelpful practises, such as routine polyp biopsy (or partial polypectomy), are still relatively common

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PWE-045 TRAINING IN ADVANCED POLYPECTOMY: RESULTS FROM A NATIONAL UK SURVEY

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Introduction Despite considerable developments in polypectomy techniques, the training of the skills necessary for removal of complex polyps remains a challenge. Little is known about the level of formal training in polypectomy among colonoscopists currently practising in the UK.

Methods As part of a national survey of advanced polypectomy, targeted at BSG members and Bowel Cancer Screening Programme (BCSP) colonoscopists, individuals were asked about the training they had received in polypectomy and their perceived training needs.

Results Respondents 268 fully trained colonoscopists with a median lifetime experience of 3000 procedures. 64% were BCSP colonoscopists. All but 4 had been involved in a hands-on colonoscopy-related training course and almost half had acted as course faculty.

Competence 86% reported competence in endoscopic mucosal resection (EMR) of sessile polyps > 2cm and half of responders had been doing EMR for > 5 years. 30% felt comfortable removing lesions up to 3cm with good access, 35% would tackle larger lesions (by EMR) or smaller lesions with difficult access. 30% considered themselves able to remove very large flat or polypoid lesions that were also suitable for surgery.

Formal Training In relation to EMR, 58% regarded themselves as predominantly self-taught. 24% had been on an attachment at a recognised training centre and 36% had attended a hands-on advanced colonoscopy or polypectomy course. 20% reported that their only formal education in EMR was at a demonstration workshop or study day.

Training Needs When asked what limited their advanced polypectomy practise, 18% identified lack of formal training in EMR, 18% lack of opportunity to gain experience and 7.5% lack of guidelines in the management of large polyps. Surprisingly, even colonoscopists claiming to operate at the most expert level admitted that they might decide against tackling a potentially resectable polyp because of lack of confidence in assessing surface morphology (7%). 2.5%

indicated uncertainty about the correct techniques to use and 2.5% lacked confidence in managing immediate complications. Lack of formal training in endoscopic submucosal dissection was mentioned as a constraint to practise by 40% of responders. Overall 58% indicated they would welcome a national training scheme for complex polypectomy.

Conclusion Less than half of this self-selected group of experienced colonoscopists felt they had been formally trained in advanced polypectomy. Lack of confidence appears to limit practise. Some of this stems from uncertainties that could be addressed through guidelines and formal courses in advanced polypectomy. There is support for a national training programme in this area.

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PWE-046 EARLY CLINICAL EXPERIENCE OF ENDOCLOT™ IN THE TREATMENT OF ACUTE GASTRO-INTESTINAL BLEEDING

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Introduction EndoClot™ is a new novel haemostatic powder for the treatment of gastrointestinal bleeding. We report our initial experiences of EndoClot™ as an adjunct haemostatic therapy. This is the first UK report of its endoscopic use in gastrointestinal bleeding.

Methods EndoClot™ was used as an adjunct therapy in the treatment of continued bleeding following a therapeutic intervention, either for acute upper gastrointestinal bleeds, or after elective endoscopic mucosal resections. Up to 1g of AMP® (absorbable modified polymers) was applied in each patient using the EndoClot™ air compressor and applicator.

Results EndoClot™ was used in a total of 6 patients, (5 men, 1 woman; aged between 49 and 83 years, mean age 68 years). In 2 patients, EndoClot™ was applied following endoscopic mucosal resection of a rectal polyp after bleeding was not resolved with cautery. In a further 2 patients, EndoClot™ was applied over a duodenal ulcer with endoscopic stigmata of recent haemorrhage when there was residual bleeding despite adrenaline injection and gold probe cautery. In another patient, EndoClot™ was applied following clipping of a spurting vessel at the gastro-oesophageal junction (likely Mallory-Weiss tear). In these 5 patients, application of EndoClot™ resolved any continued bleeding. There was also no rebleeding within 14 days of the procedure, no mortality or major adverse events.

A sixth patient had EndoClot™ applied to what was first thought to be a duodenal ulcer with a probable vessel, when there was residual bleeding despite adrenaline injection and gold probe cautery. This patient was re-scoped the following day after further bleeding and subsequent investigations confirmed a carcinoma of the pancreatic head with duodenal infiltration.

Conclusion EndoClot™ appears to be a safe and effective adjunct to existing therapies in the treatment of gastrointestinal bleeding. Large prospective studies are required to establish its exact role alongside established methods of haemostasis.

Disclosure of Interest None Declared.

PWE-047 A PROSPECTIVE, COMPARATIVE AUDIT OF TWO COMMONLY USED, LOW VOLUME BOWEL PREPARATIONS FOR ROUTINE COLONOSCOPY: MOVIPREP VERSUS A SENNA AND CITRAMAG COMBINATION

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Introduction Colonoscopy is the principal therapeutic tool for colorectal cancer prevention. Adenoma removal has been shown to decrease the incidence of colorectal cancer in screened populations. Good visualisation of the entire colonic mucosa is essential for high rates of adenoma detection. The optimal preparation regimen for bowel preparation has not yet been defined.

Methods The aim was to assess the effectiveness of different regimens for bowel preparation, comparing low volume polyethylene glycol (Moviprep, Norgine, UK) with senna and magnesium citrate (Citramag, Sanochemia Diagnostics UK). Split dosing was used for afternoon appointments. All patients received instructions on dietary restrictions before the procedure.

Those undergoing colonoscopy in the first month of the trial were given senna and magnesium citrate; those in the following month were administered Moviprep unless there were contraindications to the intended bowel preparation. The quality of the bowel preparation was independently assessed using the validated 10-point Boston Bowel Preparation Scale (BBPS) by nurses trained in its use.

Results Patients who had undergone segmental colectomy were excluded. In total, 580 eligible procedures were performed. 251 patients received Moviprep; 326 were given senna and Citramag. Bowel cleansing with Moviprep was statistically superior in each assessed segment of the colon as well as overall (mean score 6.56, $p = 0.027$). Patients given Moviprep were more likely to have a perfect preparation score of 9 ($p < 0.001$). The reasons for failure in patients who were not fully imaged were recorded. 3 procedures were aborted due to poor bowel preparation; all of these patients received Moviprep ($p = 0.08$). The patient-assessed taste of Moviprep was significantly worse than senna and Citramag ($P < 0.001$). There was no significant difference between both groups with regards to age, sex or percentage of patients who finished the preparation ($p = 0.14$).

Abstract PWE-047 Table

	Moviprep	Senna/Citramag	p value
Left colon	2.22	2.12	0.036
Transverse colon	2.18	2.08	0.036
Right colon	2.10	2.01	0.05
TOTAL	6.56	6.20	0.027

Key: 3 = perfect preparation, 2 = minor amount of residual staining, 1 = portion of mucosa of the segment seen, 0 = unprepared segment

Conclusion These data – the largest in the literature comparing these two preparations – show that both produce acceptably high levels of bowel cleansing for colonoscopy. Moviprep appears to cleanse slightly better throughout the colon but was judged by patients to be less palatable.

Disclosure of Interest K. Patel Grant/Research Support from: Norgine provided the Moviprep gratis. No input into study design, data collection, analysis, or writing of the abstract., R. Fofaria: None Declared, S. Thomas-Gibson: None Declared, B. Saunders: None Declared

PWE-048 AN EVALUATION OF SCREENING COLONOSCOPISTS' PERFORMANCE AFTER A STRUCTURED ACCREDITATION PROCESS

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Introduction Colorectal cancer screening with colonoscopy has been shown to reduce mortality by removal of adenomatous polyps with potential for malignant change. Colonoscopists with higher adenoma detection rates have lower rates of interval cancer. The