Conclusion AFI reduces time to detection in novice endoscopists and could be a valuable training tool for trainees to improve their skills in detecting dysplasia in a time efficient manner. Advanced imaging endoscopic techniques may therefore help trainee endoscopists more than experienced endoscopists.

Disclosure of Interest None Declared.

PWE-047 WHEN SHOULD I TAKE TERMINAL ILEAL BIOPSIES? EXPERIENCE FROM A SINGLE UNIT

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Introduction Terminal ileum (TI) intubation at colonoscopy may be useful in the investigation of patients with diarrhoea or possible inflammatory bowel disease (IBD).^{1,2} The yield of TI biopsies is variable and there are no standards for current practice.^{2,3} Furthermore, in the UK concerns remain regarding the potential for prion transmission.

Methods We aim to establish the yield of TI biopsies in a single unit. All TI biopsies recorded on the pathology system in a 3-year period were reviewed. Colonoscopy reports and case notes were reviewed to establish if biopsy results were clinically relevant (defined as altering management). Statistical analysis was performed using SPSS. P values were calculated using Fisher's exact test to show any difference in biopsy yield between normal and abnormal looking mucosa for each indication. The values were calculated for all abnormal biopsy results and clinically relevant biopsy results.

Results 129 TI biopsies were taken between September 2010 and September 2013, 49 (38%) male and 80 (62%) female. Mean age 44 years (s.d. 17.2). There were 29 (22.5%) cases of known IBD. 5 (3.9%) cases were completion colonoscopies after colorectal cancer surgery where TI biopsies are taken to prove a complete examination.

Conclusion We demonstrate that when investigating patients with diarrhoea, abdominal pain or IBD, if the terminal ileum is visually normal, biopsies do not add to the clinical picture. There is a higher yield of relevant biopsy abnormalities when the TI appears abnormal. We can recommend within our practice that visual assessment of a normal terminal ileum is adequate, thereby reducing unnecessary biopsies. This reduces the workload for pathology laboratories, reduces risk from

biopsies and improves patient care as normal results can be communicated sooner to the patient.

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PWE-048 RECURRENCE RATES FOLLOWING PIECEMEAL RESECTION OF 2 CM ADENOMATOUS POLYPS

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Introduction Piecemeal endoscopic mucosal resection (pEMR) is a minimally invasive endoscopic technique for the resection of sessile/flat colorectal polyps (larger than 2 cm). It has been suggested that patients should have a check procedure at 3 or 6 months to ensure complete initial excision of the lesion, and subsequent colonoscopic surveillance at between 1 and 3 years to identify recurrence.

Methods This is a retrospective observational audit, including all patients with sessile/flat colorectal polyps of more than 20 mm in diameter who underwent pEMR in 2010, across 4 London Teaching Hospitals. Patients were either local or tertiary referrals. Data was obtained from colonoscopy and histology reports. The primary outcome measured was the follow up rate at first, check colonoscopy (3 months, 6 months or 1 year), and at the subsequent surveillance colonoscopy (1, 2 or 3 years). Recurrence rate at both check and surveillance was a secondary outcome. A high-risk recurrence was considered to be more than or equal to 10 mm and a low-risk recurrence less than 10mm.

Results 153 patients were included in the cohort; 53 (34.6%) patients were local referrals and 100 (65.4%) were tertiary referrals. 128 (83.6%) patients had a check colonoscopy and 74 patients (49.0%) had a surveillance colonoscopy. Adenoma recurrence occurred in 44 (34.4%) patients at check colonoscopy, with 3 (2.4%) polyps having high-risk recurrence, and in 12 (16.3%) patients at surveillance colonoscopy, with 3 (4.1%)

Abstract PWE-047 Table 1

Indication (n)	Ileoscopy abnormal			Ileoscopy normal			P value (all/ clinically relevant)
	Number	Biopsy abnormal	Clinically relevant	Number	Biopsy abnormal	Clinically relevant	
Diarrhoea (67)	15	11	9	52	7	3	<0.001/<0.001
Abdo pain (39)	12	9	8	27	3	2	<0.001/<0.001
IBD assessment (29)	12	10	9	17	3	3	<0.001/0.006
Other* (18)	2	2	1	16	3	1	0.194/0.284
Total# (129)	34	25	21	95	14	1	<0.001/<0.001

*includes alternating bowel habit, rectal bleeding, low B12, iron deficiency anaemia, weight loss.
#some had diarrhoea and abdominal pain so feature more than once.