Introduction Faecal incontinence (FI) is a common and distressing problem with diverse aetiology and a significant economic burden1,2. First-line therapy includes dietary modification, medication and biofeedback. Surgical options include sphincteroplasty, artificial bowel sphincter insertion, sacral nerve stimulation and stoma formation3.

Recently, magnetic sphincter augmentation has been used successfully in gastro-oesophageal reflux disease4. A magnetic anal sphincter (MAS) (Torax Medical, Mn, USA) have been developed to reinforce an incontinent anal sphincter in FI. The MAS device consists of magnetic cores hermetically sealed within a series of titanium beads interlinked on independent titanium wires, forming a ring that rests around the external anal sphincter. The force required to separate the beads is approximately 100g, equivalent to normal defaecatory force5.

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Methods

Two patients with obstetric aetiologies reported significant improvement in continence at 6 weeks (St. Mark’s Score 19 to 4 and 14 to 5 (24 = max worst score). The third patient, with anterior resection syndrome, developed a recalcitrant wound infection with subsequent device extrusion and explantation.

Conclusion

MAS insertion is a novel, promising technique for management of FI. Further study is required prior to making definitive conclusions.

Disclosure of Interest None Declared.

REFERENCES


PTH-023

SCREEN DETECTED COLORECTAL CANCER: BENEFITS AND CHALLENGES OF CATCHING THEM YOUNG

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Introduction

The bowel cancer screening programme (BCSP) is known to detect majority of colorectal cancer (CRC) at an earlier stage. We aimed at determining the outcome of screen detected CRC (SDCRC).

Methods

165 patients diagnosed with CRC through BCSP were compared to a control group, which included 179 age matched patients diagnosed with CRC before the implementation of BCSP. Survival analysis was performed at a median follow up of 36 months.

Results

The SDCRC and control groups were similar with respect to gender distribution and vascular invasion (VI). SDCRC were more likely to be detected at an earlier Modified Dukes’ stage (p < 0.001). The stage distribution of SDCRC was similar to the national pilot (1) except for a higher percentage with metastatic disease (9% v 1%). During the follow up of SDCRC, 23 patients developed recurrent CRC and 19 patients died. While the overall survival (OS) was significantly better in SDCRC (p < 0.001), the recurrence free survival (RFS) in SDCRC was similar to the control group (p = 0.798). Left sided tumours (p = 0.022, HR-5.3) and VI (p = 0.004, HR-8.3) had an independent adverse influence on RFS in SDCRC. VI had a significant influence on RFS in both polyp (p = 0.006) and non-polyp cancers (p = 0.012) among SDCRC.

Conclusion

While the OS was significantly better in the SDCRC, there was no significant difference in the RFS between the two groups. While the benefits of screening are clear, we need to be aware of the challenge posed by the expanding group of aggressive early CRC. Longer follow up is necessary to carefully quantify the survival and economic benefits achieved through NHS BCSP.

Disclosure of Interest None Declared.