

patients (95.7% vs 93% by NICE1). 41/46 patients had complete resection (R0) (89.1% vs 86.5% by NICE1). There were 2 cases of intra-operative bleeding (7.4% vs 22.6% by Oka S. *et al*), where haemostasis was achieved using triclips. There was 1 delayed bleed (2% vs 0–9% by Oka S. *et al*) requiring laparotomy. 1 perforation (2% vs 4% by NICE1) occurred requiring laparotomy for gastric repair. 2 patients (4%) were readmitted within 30 days post ESD - 1 with post laparotomy abdominal dehiscence, and the other with post polypectomy syndrome. There were no recurrence or metastases in our cohort (0% vs 10% by NICE1). [Median follow up 20.5 months/range 3–38 months).  $P > 0.5$  (*ns*) for all parameters.

**Conclusion** These results represent first phase practise audit against NICE guidance. These data may enhance utilisation of ESD within the UK CSF as clear efficacy against nationally set guidelines is achievable. However, it is mandatory that ongoing multicentre efficacy data is collected. Should CSF accept this technique in full, with agreed tariff, a 'roll out' of a national registry and advanced training curriculum is mandatory.

**Disclosure of Interest** None Declared.

## REFERENCE

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## PTH-035 SALVAGE ENDOSCOPIC SUBUCOSAL DISSECTION FOR REFRACTORY POST POLYPECTOMY FIBROSIS AND RECURRENT INTRAEPITHELIAL NEOPLASIA: EXPANDING THE TECHNOLOGICAL ENVELOPE IN THE UK

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**Introduction** Submucosal desmoplasia post EMR confers the natural history of regenerative luminal healing. Index R1 or Rx dissections of colorectal neoplasia using either EMR, EPMR or simple snare polypectomy complicated by remnant or recurrent intraepithelial is clinically challenging. Formal open surgical resection or ablation is usually inevitable in this cohort. We describe, using video presentation data, the technique of primary endoscopic fibrosis divisional dissection with curative intent for recurrent or remnant intraepithelial neoplasia of the right-hemi colon post index EMR.

**Methods** Recurrent disease or refractory intraepithelial neoplasia was defined according to Higaki criteria. Patients were consented for progression to salvage dissection prior to endoscopy. Pre-resection peripheral margin APC 'mark out' was performed following index indigo carmine chromoscopy to delineate the lesion's horizontal axis with thermal mucosal tattoos placed 2–4 mm away from the lesion margin and within a type I crypt mucosal zone. Peripheral smi with 1/10,000 adrenaline solution was performed with 6 mm marginal circumferential 6 mm incisions made to the level of the deep submucosal layer using the straight flex knife. Dissection of the exposed submucosal desmoplastic fibrosis layer was then performed using a fixed en face IT knife distance coupled with a blunt tractional endoscopic 'tunnelling' technique. Prophylactically, sm vessels were ablated or clipped prior to tissue recovery.

**Results** n = 12 patients. Paris class LST-NG/G (6)/0-IIa (6). Median operating time 64 mins (range 34–82). Median lesion size 22mm (range 12–46 mm). Asymmetrical, partial or complete NL = 12 (100%). Perforation rate 0/12. Median hospital stay 24 hours (range 6–120).

30 day mortality 0%. R0 resection achieved in 11/12 (92%). Endoscopic recurrence rate 0% (median follow-up 18/12 (range 2–43 months). Post dissection late bleed occurred in 3/12 (25%) of the cohort all treated conservatively. There were no cases of immediate or early dissection bleeding.

**Conclusion** Salvage endoscopic dissection of remnant or recurrent intraepithelial neoplasia post index EMR, EPMR or conventional polypectomy is technically possible in the UK in this pilot clinical experience. Dissection is however technically demanding, is complicated by a high delayed bleeding risk and is time consuming. In an appropriately selected patient cohort however this novel therapy may negate the need for formal surgical excision which in the elderly and those with significant comorbidity becomes an attractive therapeutic modality changing the paradigm away from palliative ablative methods in those unfit for formal surgical resection.

**Disclosure of Interest** None Declared.

## PTH-036 IS THE UK READY FOR SUB-SPECIALISATION IN ADVANCED COLONOSCOPIC POLYPECTOMY?

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**Introduction** European guidelines have proposed four levels of competency for polypectomy. The highest competence (level 4) is expected of only a small number of regionally based colonoscopists, to whom patients with large or complex polyps might be referred. We wished to explore whether such a model could be applied to current UK practise.

**Methods** In a UK national survey of advanced polypectomy, a number of questions were designed to reveal attitudes and beliefs underlying clinical decision-making and referral practises. The survey was directed to all BSG members and BCSP colonoscopists.

**Results Respondents** 268 independent colonoscopists in UK practise with a median lifetime experience of 3000 procedures. 64% were BCSP colonoscopists and 86% undertook endoscopic mucosal resection (EMR) of polyps > 20mm.

**Competence Level** When asked to describe the most complex polyp they would tackle, 3.4% fell into competence level 1, 31% level 2, 35% level 3 and 30% level 4. Of the 81 self-rated level 4 operators, 17% had never removed a polyp > 5cm and 32% performed ≤20 EMRs in the previous year. Only 56% of level 4 operators agreed that they would attempt any polyp where EMR was technically feasible. Others felt constrained by their own technical ability or by time and resource limitations.

A quarter of all the respondents considered that they operated close to the limit of what was technically possible by EMR but only 15 operators (5.6%) were identified who had a workload of > 50 EMRs per year and had removed a polyp > 6cm at some point in their career.

**Referral behaviour** 51% had referred at least one benign polyp for surgical excision in the previous year. 12% refer straight to surgery for any polyp they cannot tackle themselves. 47% had referred a polyp to a colleague for EMR (34% refer to an endoscopist within their own unit, 28% to another hospital and 12% to an expert in a different region). 70% of all respondents declared they would be happy to receive EMR referrals from a colleague.

**Future directions** 59% indicated support for accreditation in advanced polypectomy but only 41% wanted to see nominated EMR experts for each region. Just 18% supported the concept of an integrated national referral network for complex polyps. The proposal for 3–4 national referral centres was also unpopular.