Results  A total of 65 OCEs (50 patients; 27 M/23 F; mean age: 52.7 ± 13.7 years) were carried out in the aforementioned period. 32% pts had haemophilia (16/50 patients/album; mean age: 51.6 ± 9.8 years; range 31–78 years; 28 OCEs); 5 pts had repeat OCEs (1 pt: 1 repeat, 2 pts: 2 repeat, 1 pt: 8 repeat & 1 patient: 4 repeat OCEs). All haemophiliacs were infected with HCV; 2 pts were co-infected with HIV. 3/16 (18.75%) of haemophiliacs had established cirrhosis, 5/16 (31.25%) probable cirrhosis. In haemophiliacs, indications for OCE were: variceal surveillance (OCEs group A: 17/28; 60.7%) and/or other upper GI symptoms (OCEs group B: 11/28; 39.3%). PillCam®ES01 was used in 15/28 (53.6%) occasions and PillCam®ES02 for the rest (13/28; 46.4%). The overall diagnostic yield (DY) of OCE in haemophiliacs was 76% (21/28). The DY was similar in OCEs group A: 64.7% (findings in 11/17) and OCEs group B: 54.5% (findings in 6/11), P = 1.0. Oesophageal transit times were mean: 166s; range: 3–1171s. All capsules reached the stomach, but only 8/28 (28.5%) capsules entered the duodenum.

Conclusion OCE is a useful and acceptable alternative to conventional endoscopy in selected groups of patients. In particular, OCE in haemophiliacs has a high DY and should be considered a first line investigation to guide further endoscopic intervention.

Disclosure of Interest None Declared.

REFERENCES

**Abstract PTH-069 Table 1**

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In the 5 year study period, 140,459 BCSP colonoscopies were performed for a positive faecal occult blood (FOB) indication. Sigmoid colon cancers were found in 3.4% of procedures (n = 4738). Sigmoid diverticulosis was documented in 27.4% of procedures (n = 88480). Patients with sigmoid diverticulosis were less likely to have co-existing sigmoid colorectal cancer (3.99% of those patients without sigmoid diverticulosis had sigmoid colorectal cancer versus 2.23% of those patients with sigmoid colorectal cancer, p < 0.0001).

Conclusion This inverse association between sigmoid cancer and diverticulosis has not previously been reported but warrants further investigation. Potential explanations include increased likelihood of FOB positive result with diverticulosis (false positive; we consider this the most likely explanation), under-reporting of diverticulosis when a cancer is detected, missed lesions within the diverticular segment (unlikely, as for this to account for the difference this would mean almost half of sigmoid cancers being missed), or possibly a protective effect due to changes in bacterial flora in the diverticular segment. Further study in non-FOB populations is appropriate.

Disclosure of Interest None Declared.

REFERENCES
1. Logan RFA et al. Gut 2011

**PTH-070 ENDOSCOPIC RESECTION OF GIANT (>4CM) SESILE/FLAT COLONIC POLYPS: TECHNIQUES AND OUTCOMES**

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Introduction Giant, sessile/flat colon polyps (>4cm) are challenging to remove endoscopically and many lesions are still treated with laparoscopic or open segmental resection.

Methods From our prospective, tertiary referral, polypectomy database of large colorectal polyps, 107/297 consecutive patients with 109/316 colon polyps, were referred for endoscopic resection of > 4 cm flat/sessile colon polyps with a mean size (± SD), 52 ± 22mm. Reasons for tertiary referrals were large polyp size/extent with moderate to severe submucosal fibrosis (SF) (37%), difficult endoscopic access (36%) or failure to adequately lift (24%). Polyps were assessed and treated using ‘inject and cut’ piecemeal Endoscopic Mucosal Resection (P-EMR) or P-EMR with Endoscopic Mucosal Ablation (P-EMR/EMA). Supplementary techniques such as Endocuff-assisted polypectomy (EAP) and Laparoscopic-assisted endoscopic polypectomy (LAP) were employed to improve endoscopic access. Completion rates, recurrence, and adverse events were documented prospectively.

Results Nineteen P-EMR/EMA hybrids, 29 Spiral snare (Olympus) P-EMR’s and 2 EAP’s were performed to treat polyps with SF (42% previously failed polypectomy attempt at referring centre, 7.5% tattoo under polyp and 51.5% lesion-related fibrosis) and improve endoscopic access. Polypectomy was considered successful in 94.5% in a single session with mean procedure time (± SD), 43 ± 12.2 min. One deep submucosal tear (0.9%) was successfully treated with endoclips. Eight patients (7.4%) required hospitalisation due to delayed post-polypectomy bleeding with one undergoing emergency laparotomy. There was no mortality. First follow up (3/6 months) was attended by 92/107 patients with no recurrence in 41/92 benign recurrence of <10mm in 39/92 and >10mm recurrence in 12/92 (one patient with large rectal recurrence had a TEMS procedure and two patients with histology showing malignancy had segmental resections). A second f/u (9/15 months post initial resection) was performed in 40/92 patients with no recurrence in 28/40, < 10 mm benign recurrence in 11/42 (continued surveillance) and one benign recurrence > 10mm (continued surveillance).

Conclusion Endoscopic resection of giant, >4cm, sessile/flat colon polyps demands a multi-modality approach, but good medium term