

Abstract PWE-048 Table 1

	Time from index	No recurrence	Low risk recurrence	High risk recurrence
Check colonoscopy	3 months (n = 92)	57	35	0
	6 months (n = 26)	18	5	3
	1 year (n = 10)	9	1	0
	<b>Total (n = 128)</b>	<b>84 (65.6%)</b>	<b>41 (32.0%)</b>	<b>3 (2.4%)</b>
Surveillance colonoscopy	1 year (n = 45)	36	6	3
	2 years (n = 25)	23	2	0
	3 years (n = 4)	3	1	0
	<b>Total (n = 74)</b>	<b>62 (83.7%)</b>	<b>9 (12.2%)</b>	<b>3 (4.1%)</b>

polyps having high-risk recurrence. Of the patients with recurrence at surveillance, 5 (41.6%) also had polyp recurrence at check colonoscopy, equating to failure to clear the initial recurrence in 11.4%. In 7 patients the check colonoscopy showed no recurrence.

**Conclusion** The rate of check colonoscopy within our cohort was high, but the rate of surveillance colonoscopy was low. The frequency of adenoma recurrence was considerable at the check colonoscopy, but much reduced at the surveillance colonoscopy. There was, however, a low rate of high-risk recurrence, suggesting that pEMR is an effective endoscopic technique to excise sessile/flat polyps as, in most cases, treatment of recurrence at the check colonoscopy was effective. A substantial proportion of individuals with recurrence at surveillance had recurrence at check colonoscopy, but recurrence was found at surveillance despite a normal check procedure. Strict adherence to follow-up protocols is, therefore, essential.

**Disclosure of Interest** None Declared.

#### PWE-049 AUDIT ON EMR OF LARGE COLONIC POLYPS (SIZE >20 MM)

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**Introduction** Large sessile colonic polyps are increasingly managed by endoscopic mucosal resection (EMR); a large multi-centre Australian study of 479 patients showed that 89% of sessile polyps were removed in a single session, 20% recurred of which 90% were successfully retreated.

**Methods** To assess success of EMR of colonic sessile polyps (2 operators, 1 centre), recurrence, complications and need for surgery.

68 patients Mean patient age 68.5 years; 70 sessile polyps (2 patients had 2 large polyps each); mean size 35 mm (range: 20–100 mm), underwent EMR 2009–2013.

Follow up: mean 11 months (range: 3–38 m).

Indications: 25% of patients from BCSP.

Site: rectum (46%), sigmoid (27%), descending (3%), transverse (7%), ascending (7%) and caecum (10%).

**Results** 4/70 polyps contained foci of adenocarcinoma. 1/4 with cancer had surgery and 11/70 await check endoscopy; thus, 47/59 (80%) had no recurrence at repeat endoscopy (including 3/4 with foci of cancer). Of 12/59 (20%) recurrences, 8 were retreated (2 required more than 1 re-treatment) and remain polyp free. 1 further recurrence is still under endoscopic FU.

**Surgery:** The remaining 3 recurrences had surgery (2 rectal, 1 caecal); the surgical specimen from 1 rectal recurrence contained

unsuspected cancer. The one patient who had surgery for a polyp-cancer showed no residual tumour in the operative specimen.

**Complications:** There were no deaths nor surgery required for complications. 13 (19%) procedural bleeding successfully treated (diathermy/clips); 1 perforated rectal EMR clipped and 1 post-polypectomy pain syndrome, both resolved with conservative management.

**Conclusion** Large sessile colonic polyps can be managed safely and effectively with EMR. We achieved 93% complete eradication of the polyps (8 after retreatment).

#### REFERENCE

Moss A, Bourke MJ, Williams SJ, et al. *Gastroenterology* 2011 140(7):1909–18

**Disclosure of Interest** None Declared.

#### PWE-050 DEVELOPMENT OF A PERFORMANCE MANAGEMENT FRAMEWORK FOR BSW COLONOSCOPISTS

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**Introduction** The Bowel Screening Wales (BSW) programme has completed 12,000 colonoscopies since 2008. All Screening Colonoscopists are assessed, approved and quality assured by BSW. Colonoscopy is an invasive procedure with inherent risks. Complication rates in the BSW programme have occurred at expected levels but investigation has highlighted potentially preventable causes. We have developed a Performance Management Framework (PMF) to support colonoscopists where lesion assessment or therapeutic decision-making was associated with a pattern of adverse outcomes.

**Methods** A researcher (NH) conducted semi-structured interviews with BSW colonoscopists following active diary collection on BSW lists (Jan–Feb 2013). Narrative data was examined related to documented or recalled near-miss episodes or complications and evaluated alongside existing published case-control or cohort studies and BSW root-cause analysis data to inform the development of the PMF. The main criteria used in its development were; fairness, transparency, consistency of application, practicality and alignment to existing BSW QA frameworks (centralised data, feedback, QA visits and training). A draft PMF was presented to BSW Lead Colonoscopists in November 2013.

**Results** The framework comprises the following steps: 1) Identification of issues; 2) Investigation; 3) Observation; 4) Training. Issues may be identified from performance data, reported near-miss episodes, self- or peer-reported complications or from patient complaints. Investigations review all documentation, endoscopic images, pathology and radiology depending on the