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
	Total (n = 128)	**84 (65.6%)**	**41 (32.0%)**	**3 (2.4%)**
Surveillance colonoscopy	1 year (n = 45)	36	6	3
	2 years (n = 25)	23	2	0
	3 years (n = 4)	3	1	0
	Total (n = 74)	**62 (83.7%)**	**9 (12.2%)**	**3 (4.1%)**

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 colonscopy. 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)

MS Mohammad*, R Robinson, J DeCaestecker. *Gastroenterology, University Hospitals of Leicester, Leicester, UK*

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Introduction Large sessile colonic polyps are increasingly managed by endoscopic mucosal resection (EMR); a large multicentre 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

[1]N Hawkes*, [2]H Heard, [2]S Dolwani. *[1]Gastroenterology, Cwm Taf University HB, Llantrissant, UK; [2]Bowel Screening UK, Public Health UK, Llantrisant, UK*

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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

nature of incident. Trained QA assessors and mentors are required to provide detailed observation of performance in the context of colonoscopist's usual working environment, using validated DOPS methodology (incorporating discussion around decision-making). The final step involves the colonoscopist agreeing a tailored training plan based on feedback from BSW QA advisors, assessors and mentors. This states 1) the nature of the concerns identified; 2) specific goals to be achieved; 3) timetabling and 4) tools to be employed to measure progress. Where there is serious concern for participant safety the BSW Colonoscopy Panel may consider suspension pending appropriate investigation and training. The outcome of training will be reviewed by this Panel to determine ongoing suitability to perform as a screening colonoscopist.

Conclusion A pragmatic Performance Management Framework for BSW Colonoscopists has been developed. It seeks to provide a safe and supportive environment for both patients and colonoscopists respectively undergoing and performing complex therapeutic interventions, aiming to provide early identification of problems through central data analysis and specific, targeted training interventions where required.

Disclosure of Interest None Declared.

PWE-051 BOWELSCOPE: EARLY RESULTS FROM THE PILOT SITES

[1,2]R Bevan*, [3]C Nickerson, [3]J Patnick, [4]R Loke, [5]B Saunders, [6]J Stebbing, [7]R Tighe, [8]A Veitch, [2]J Painter, [2,9,10]CJ Rees. *[1]Northern Region Endoscopy Group, Newcastle; [2]South of Tyne and Wear BCSC, Gateshead, UK; [3]NHS Cancer Screening Programmes, Sheffield, UK; [4]West Kent and Medway BCSC, Tunbridge Wells, UK; [5]St Marks BCSC, London, UK; [6]Surrey BCSC, Guilford, UK; [7]Norwich BCSC, Norwich, UK; [8]Wolverhampton BCSC, Wolverhampton, UK; [9]Durham University, Stockton on Tees, UK; [10]Northern Region Endoscopy Group, Newcastle Upon Tyne, UK*

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Introduction UK population colorectal cancer (CRC) screening has been successfully implemented with Bowel Cancer Screening Programme (BCSP) faecal occult blood testing biannually from age 60–75.

A large UK study of once-only flexible sigmoidoscopy (FSIG) demonstrated a reductions in CRC incidence of 33% and death rates of 43% (1). This, with the screening centre infrastructure developed for the FOB programme, allowed provision of a new arm of BCSP, offering FSIG to 55 year olds in England, known as BowelScope screening.

BowelScope screening began May 2013, with 6 pilot sites performing FSIGs in the first 7 months.

Methods We aim to describe procedural data from the early months of BowelScope screening.

Data were obtained from The Bowel Cancer Screening System (BCSS) database for all participants invited and participating in BowelScope FSIGs May-Dec 2013. Procedural data were recorded, including insertion depth, FSIG length, adenoma detection rates (ADR), cancer detection, discomfort levels, entonox usage and colonoscopy conversion rates.

Results 13927 people were invited or opted in to BowelScope screening at 6 centres. Overall uptake is 43.5% (range 37.0–51.9%). 4 cancers were detected. Polyps were detected in 16.4–23.8% of FSIGs (mean 20.7%). Mean ADR 8.4%. One centre has a significantly higher ADR than the other five sites ($p < 0.05$) (see Table 1).

Most (53%) procedures took 6–10 min.

79% of procedures were reported as causing no or minimal pain only, with only 34 procedures (1%) reporting severe pain.

Conclusion Uptake has varied between centres, but is lower than for the FOB arm of BCSP. Average ADR is 8.4% (range 6.1–12.1%), lower than in the UK flexible sigmoidoscopy screening trial (12.1%[1]) although the age range studied in the trial differs from the cohort described here.

Further work will be required to investigate the variation in uptake rates and to improve these rates. ADR variations may also need to be addressed; further analysis of patient groups may explain these differences.

REFERENCE

1 Atkin *et al. Lancet* 2010:375:1624–1633

Disclosure of Interest None Declared.

PWE-052 BOWELSCOPE SCREENING – THE SOUTH OF TYNE AND WEAR EXPERIENCE

[1,2]R Bevan*, [1]H Miller, [1]D Thapa, [1]M Ritchie, [1]J Painter, [1,3,4]C Rees. *[1]South of Tyne and Wear BCSC, Gateshead, UK; [2]Northern Region Endoscopy Group, Newcastle, UK; [3]Northern Region Endoscopy Group, Newcastle Upon Tyne, UK; [4]Durham University, Stockton on Tees, UK*

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Introduction The National Bowel Cancer Screening Programme has been extended to include a one-off flexible sigmoidoscopy (FSIG) to all aged 55, after a large UK study demonstrated reduction in colorectal cancer incidence and death rates when FSIG is performed and adenomas removed.

BowelScope screening is being piloted in 6 centres – South of Tyne and Wear (SOTW), Norwich, St Mark's, Surrey, Kent and Medway, and Wolverhampton. SOTW was the first centre to offer screening.

Methods We describe delivery of BowelScope at SOTW.

The Bowel Cancer Screening System (BCSS) database was interrogated for procedural data. A study was performed recording timings of lists. Patients complete a satisfaction survey the morning after the procedure; anonymised results are provided to the centre.

Abstract PWE-051 Table 1 Outcomes by anonymised centre

Screening centre	Invitees*	Attended*	Uptake†%	FSIG with adenomas	ADR%	Cancer	Colonoscopy required (%)
1	3125	1128	(51.9)	100	8.9%	1	39 (3.5)
2	1866	524	37.0	64	12.1%	0	23 (4.4)
3	3779	1070	40.9	90	8.4%	0	50 (4.7)
4	986	311	46.6	25	8.0%	0	12 (3.9)
5	1970	625	47.4	38	6.1%	2	21 (3.4)
6	2181	479	37.2	30	6.2%	1	18 (3.8)
Total	**13927**	**4135**	**43.5**	**347**	**8.4%**	**4**	**163 (3.9)**

*as of 20.12.13.
†Uptake is calculated from invitees invited ≥16 weeks before 20.12.13 to allow time to respond to invitations and attend for screening.