

Abstract PWE-056 Table 1 *Assistant screening practitioner also present for lists

Centre	First list	Endoscopists (BCSP colonoscopists)	Endoscopist grade				Lists per week	Evenings/ Weekends	SSPs per list
			Consultant	Registrar	Staff/ other grade	Nurse endoscopist			
Norwich	08.07.13	6 (1)	0	3	0	3	6	Yes/Yes	1*
South of Tyne	07.05.13	2 (0)	0	1	1	0	2.5	Yes/Yes	2
St Marks	22.07.13	8 (2)	1	5	0	2	7	Yes/No	1*
Surrey	07.11.13	6 (6)	6	0	0	0	2	No/Yes	2
West Kent and Medway	11.06.13	7 (3)	1	0	5	1	4	No/Yes	2
W'hampton	07.08.13	6 (3)	4	0	2	0	6	No/No	1

Introduction The NHS Bowel Cancer Screening Programme (BCSP) is being expanded to include a single flexible sigmoidoscopy (FSIG) called BowelScope, offered to all 55 year olds in addition to biannual faecal occult blood testing from age 60–75 years.

6 pilot sites began BowelScope screening in May 2013, with a view to full English coverage by the end of 2016.

Methods We aim to describe practical issues involved in the delivery of BowelScope screening at the pilot centres, covering unit set-up, list format, and endoscopists delivering lists.

A survey was sent to the 6 pilots for completion by screening staff. Data were also retrieved from the national BCSP database.

Results The first BowelScope list was delivered in the South of Tyne Screening Centre on 7th May 2013. By December 2013, 4135 flexible sigmoidoscopy procedures had been performed in 6 centres.

Centres have delivered 20–80 lists each, performing 2–7 lists per week. Sessions are run at varying times of day including evenings and Saturdays.

35 endoscopists undertake lists regularly, of whom 15 were already BCSP accredited. Other BCSP colonoscopists provide back up for lists when required. All non-BCSP were accredited through a combination of direct observation of procedural skills (DOPS) and an MQC exam.

Specialist Screening Practitioners (SSPs) attend all lists, and are deployed in a variety of ways including: following patient journey, consenting or giving information, and supervision assistant SSPs.

Table 1 shows details of screening lists by centre.

Conclusion BowelScope screening is being successfully delivered at the six pilot centres. Each centre has developed a screening template and organisational pattern that works around patient needs and existing endoscopy and bowel screening services. New patterns of working have been required to deliver BowelScope and challenges remain regarding adequate numbers of endoscopists.

Disclosure of Interest None Declared.

PWE-057 A COMPOSITE MEASURE OF COLONIC INTUBATION (CIRC) IS BETTER ABLE TO DISTINGUISH PERFORMANCE OF COLONOSCOPY AND IS ASSOCIATED WITH HIGHER POLYP DETECTION RATES

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Introduction Caecal intubation rate (CIR) is a key performance indicator of colonoscopy. CIR with acceptable tolerance is only achieved in some patients with more sedation. As most colonoscopists achieve >90% intubation, CIR alone cannot define

excellence. This study proposes a more discerning, composite measure of colonoscopy intubation (CIR^C) combining CIR, patient comfort and sedation. Characteristics of patient, unit, equipment and colonoscopist associated with CIR^C, and the relation of CIR^C to pathology detection are reported.

Methods Data from 20085 colonoscopies reported in the 2011 UK national audit (Gut 2013;62:242–249) were used for this analysis. The CIR^C was defined as percentage of procedures achieving caecal intubation with median dose of midazolam or less, and nurse assessed comfort score of 1–3 (max 5). Multivariate analysis using binary logistic regression assessed patient, unit and colonoscopist factors in order to derive Odds Ratios (ORs) and 95% confidence intervals (CIs) for factors independently associated with CIR^C after controlling for effects of all model variables. ORs have a significance level of <0.001 unless stated.

Results Overall achievement of CIR^C was 54.1% (n = 10865 procedures). The CIR^C was better able to distinguish differences in performance than single measures such as CIR and polyp detection. Older age, male sex (OR 1.40; CI:1.32–1.49), adequate or excellent bowel prep and FOBT screen positive as indication were all associated with a higher chance of achieving CIR^C. Unit (JAG) accreditation (OR 1.26; CI 1.16–1.35) and the presence of one or more magnetic imagers in the unit (OR 1.29; 1.19–1.40) were associated with higher CIR^C. Surgical speciality, greater annual volume, fewer years' experience and higher training/trainer status were associated with higher CIR^C. Achieving the CIR^C was associated with significantly higher polyp detection rates (OR 1.12; 1.04–1.20) and higher cancer detection rates (OR 1.14; 0.98–1.32, p = 0.10).

Conclusion The CIR^C provides a richer picture of colonoscopic intubation than CIR alone and is better able to discern factors associated with intubation competence in relation to patients, units, equipment and colonoscopists. Unit (JAG) accreditation was associated with higher CIR^C. Colonoscopists who perform more procedures, who have more experience of training or being trained, who have practised fewer years and who are in a surgical speciality had significantly higher rates of CIR^C. The CIR^C was associated with a significantly higher polyp detection rate. It is proposed that CIR^C replaces CIR as the key performance indicator for intubation of the colon.

Disclosure of Interest None Declared.

PWE-058 INCREASING USE OF ENDOSCOPIC RESECTION, SINGLE-CENTRE EXPERIENCE

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Introduction Endoscopic Resection (ER), a technique, first pioneered in Japan for treating early gastric cancers, has gained

popularity globally. The delivery of an ER service requires specialist expertise and is therefore limited to a few centres in the UK. Here in Bradford, an ER service was established in 2007, and is delivered by a single operator. The aim of this study was to observe changes in our ER practice over time.

Methods This was a prospective study of all patients who had undergone ER between August 2007 and December 2012 in Bradford Royal Infirmary. Patients were referred by experienced consultants, from the same trust or neighbouring hospitals, and were considered difficult cases, due to lesion size and/or access. Data from every ER case were recorded into a spreadsheet and divided into upper gastrointestinal (GI) ER or lower GI ER. We recorded patient demographics, lesion size and site, sedation, outcome, complications, and lesion removal (whole/piecemeal). Cases performed before 2010 (pre-2010) were separated from those performed in or after 2010 (post-2010). Data were analysed separately for the 2 time periods and then compared.

Results There were a total of 245 ER cases over the study period (47 upper GI, and 198 lower GI).

The number of upper GI ER cases increased from 15, pre-2010 to 32, post-2010. The success rate improved over time from 87 to 97% and the complication rate fell from 26 to 6%. Complications included 1 gastric perforation and 5 cases of minor bleeding treated endoscopically. The mean doses of Midazolam (2.5 mg) and Fentanyl (30 mcg) remained the same over time; however cases performed under general anaesthesia (GA) increased sharply from 7% to 37%. Mean polyp size also increased from 14 to 18 mm, although the distribution of polyps in the upper GI tract remained the same over time, with around 50% found in the stomach. Whole piece removal increased from 53% to 66%, despite increasing polyp size.

The number of lower GI ER cases also increased substantially from 62, pre-2010, to 136, post-2010. Success rate improved from 92 to 95%, whilst the complication rate remained the same at 5%. Complications included 1 postpolypectomy syndrome and 6 cases of bleeding. Doses of Midazolam (1.5 mg) and Fentanyl (75 mcg) remained the same over time, and interestingly the use of GA in lower GI ER was considerably lower (<1%) compared to upper GI cases. There were no changes in polyp size (26 mm), polyp distribution or whole piece removal (40%) over time.

Conclusion Our results demonstrate an increasing use of ER for upper and lower GI lesions. Over time, and thus, with more experience the success rate and complication rate have improved. These results are in line with other studies, emphasising ER as a safe technique, which should be considered before surgery for managing large and difficult GI lesions.

Disclosure of Interest None Declared.

PWE-059 ENDOSCOPIC RESECTION OF GIANT COLONIC POLYPS – SIZE MATTERS!

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Introduction Colonic polyps sized 50 mm and above are traditionally treated by surgical resection. Endoscopic resection has now become increasingly common as the expertise of western endoscopists improves. There is very little published literature on endoscopic resection of these giant polyps.

We aim to evaluate the feasibility, safety and efficacy of endoscopic resection of giant polyps ≥ 50 mm in size.

Abstract PWE-059 Table 1 Recurrence rates with polyps of different sizes

Recurrence	Size			
	≤ 55 mm	≤ 60 mm	≤ 70 mm	> 70 mm
21/90 (23.3%)	3/34 (8.8%)	7/54 (12.9%)	9/63 (14.2%)	12/27 (44.4%)
P = 0.002				

Methods Prospective cohort study. All patients who underwent endoscopic resection of colonic polyps ≥ 50 mm from 2007–2013 were prospectively entered into a database. We excluded all polyps with fibrosis related to previous intervention. All patients were tertiary referrals from experienced gastroenterologists. All procedures were performed by a single experienced endoscopist.

Results N = 124 polyps in 122 patients. Mean polyp size = 71 mm. Range 50–170 mm. 27(22%) in right colon and 97 (78%) in left colon. M:F ratio 1.1:1. All polyps were resected in a piecemeal fashion. The mean procedure time was 120 min (range 90 to 240).

The complication rate was 11/124(8.9%). All these patients required inpatient stay. There were 9 bleeds (3 immediate and 6 delayed), 1 post polypectomy syndrome and 1 case of split muscle fibres (clipped endoscopically). 1 case of immediate bleeding required surgery to control the bleeding. All the others were managed conservatively. 4 of the 9 bleeds required blood transfusion. The complication rate was independent of polyp size, resection technique or site of the lesion.

Follow up data was available for 90 polyps. The recurrence rate was 21/90 (23.3%). Of the 21 recurrences, 16/21(76%) patients achieved complete clearance with a further 1 to 2 endoscopic procedures. The recurrence rate was significantly dependent on polyp size and was not dependent on the resection technique or the site of the lesion. Recurrence gradually increased with an increase in polyp size up to 70 mm. Recurrence was seen in 3/34(8.8%) polyps ≤ 55 mm, in 7/54 (12.9%) polyps ≤ 60 mm, Shemm and in 9/63 (14.2%) polyps ≤ 70 mm. However, in polyps > 70 mm, the recurrence rate greatly increased to 12/27 (44%) (p = 0.002).

Conclusion

1. It is safe and feasible to endoscopically resect polyps 50–170 mm in size.
2. Recurrence is significantly dependent on polyp size.
3. Giant polyps resected endoscopically have a significant recurrence rate. The majority of these can be cleared by further endoscopic procedures. However, we believe that the recurrence rate in polyps above 70 mm is very high and surgery should be considered in these cases.
4. Complication rates are independent of size.

Disclosure of Interest None Declared.

PWE-060 POLYPECTOMY PRACTICES IN THE ENGLISH BOWEL CANCER SCREENING PROGRAMME

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Introduction Most polyps are < 10 mm in size and a range of polypectomy techniques are available with wide variations in