ilaeo-caecal resection were excluded. Demographic data, TI pathology (endoscopic and histopathologic) and indications for colonoscopy were analysed.

**Results** 8016 colonoscopies were performed with a caecal intubation rate of 90.3%. The endoscopists were of different grades including gastroenterologists, colorectal surgeons and a nurse endoscopist. 206 with ileo-caecal resection were excluded. Mean age was 61 with a female preponderance at 52.6%. The TI was intubated in 1845 (23.5%). Endoscopic TI pathology was identified in 42 patients (2.3%). Histology was available for 31, of which 23 (1.3%) had confirmed histological abnormalities. Diagnoses on ileoscopy included one adenocarcinoma, one carcinoid tumour, one metastatic malignant melanoma and 20 with terminal ileitis, of which, 6 had histological Crohn’s disease. The most common indications in those with TI pathology were diarrhoea (13), abdominal pain (8) and rectal bleeding (8).

**Conclusion** Although the overall diagnostic yield was low, TI intubation identified significant pathologies requiring further action, including three malignancies. Ileoscopy at colonoscopy is a simple manoeuvre, which, apart from quality assurance can identify important pathology. The most common indication in those with confirmed TI pathology was diarrhoea, therefore ileoscopy may have added diagnostic value in this context.

**Disclosure of Interest** None Declared.

**PWE-064 MANAGEMENT OF LARGE COLONIC POLyps IN THE SEVERN DEANERY HOSPITALS: AN AUDIT of CURRENT PRACTICE**

**Introduction** Large (>2 cm) colonic polyps present a challenge to the colonoscopist. The British Colorectal Cancer Screening Programme (BCSP) recently drafted guidelines to standardise their management. We compared our current practice with the proposed guidelines.

**Methods** This was a retrospective audit in four South-West hospitals with comparison between screening and non-screening patients. Patients were identified using clinical coding. Case notes were reviewed. Polyps were scored using SMSA system to standardise difficulty of endoscopic resection. Data was compared against 9 auditable outcomes.

**Results** 104 cases were identified (24 BCSP, 80 symptomatic). There was no significant difference in mean size (2.9 cm BCSP, 2.7 cm symptomatic, \( \text{p} = 0.14 \)) or mean SMSA grading (2.8 BCSP, 2.9 symptomatic, \( \text{p} = 0.46 \)). 6 polyps were malignant (1 BCSP, 5 symptomatic); all had position marked by tattoo. 1 malignant polyp was resected endoscopically in the symptomatic group. Mean time to definitive resection was 34 and 30 days (BCSP and symptomatic respectively). Recurrence of adenoma at EMR site was low at 3 months (0/22 BCSP, 1/37 symptomatic) and 12 months (0/22 BCSP, 2/37 symptomatic). However fewer EMR sites were checked if the index endoscopy was performed by a non-BCS colonoscopist (10/13 vs. 8/24). Complication rates were low: 1 haemorrhage requiring admission (symptomatic group); 0 perforations. 17 benign polyps were referred for surgery (3 BCSP, 14 symptomatic; \( \text{p} = 0.49 \)). In both groups the mode SMSA score was 4. Benign polyps were referred directly for surgery; only those polyps with malignant histology were discussed at a formal multi-disciplinary meeting. There were no deaths or significant morbidity associated with surgery for benign polyps.

**Conclusion** Overall management was comparable to draft guidelines. The frequency of large polyps outside BCSP indicates that non-BCS endoscopists will gain experience with these lesions. Approximately 17% of benign polyps were referred for surgery, similar to other series. However, none had been discussed with local EMR experts. Consequently a large polyp referral pathway has been established at two centres within the region.