associated with the procedure. From this study, excluding such patients could have avoided 20 colonoscopy screening lists (approximately 80 procedures) over 3 years in our unit. If findings are similar in other centres, current national guidelines should be changed.

Disclosure of Interest None Declared.

OC-047 | **ADENOMA SURVEILLANCE IN THE NATIONAL NHS BOWEL CANCER SCREENING PROGRAMME – IS THE HIGH/INTERMEDIATE RISK STRATIFICATION APPROPRIATE?**

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Introduction The NHS Bowel Cancer Screening Programme (BCSP) guidelines advocate surveillance of high and intermediate risk subjects with adenomas, due to the risk of developing future advanced neoplastic lesions. This study aims to evaluate and compare the yield of colorectal neoplasia during first surveillance in NHS BCSP among these two cohorts.

Methods Data on each patient entering the NHS BCSP are contemporaneously recorded on the national BCSP database (BCSS). BCSS was interrogated to identify all high-risk (HR) and intermediate-risk (IR) subjects at screening who completed their first surveillance episodes during the period of June 2006 to July 2012. Participants with histology data available at surveillance were included. The data were then analysed to assess the detection of colorectal cancer (CRC), advanced adenoma (size ≥ 10 mm/ > 25% villous histology/ high grade dysplasia) and non-advanced adenoma in the two groups. Chi-square tests were performed to determine significance of difference in proportions among them.

Results Table showing subjects with different pathologies at first surveillance:

During the study period 5579 HR and 4723 IR subjects completed their first surveillance procedures, of which 5118 HR and 4569 IR subjects had their histology results available, and were included for final analysis. 39 (0.76%) HR and 20 (0.47%) IR subjects were diagnosed with colorectal cancer (CRC). Detection of CRC and colorectal adenomas during the first surveillance were significantly higher in HR group (table).

Conclusion Only a small number of subjects had CRC during their first surveillance, indicating that the current surveillance intervals for HR and IR groups are safe. The higher yield of all colorectal neoplasia (CRC, AA and NAA) during the first surveillance in HR subjects illustrates that the current risk stratification is valid and justified. The finding of significant

Abstract OC-047 Table 1

Risk category and p values	CRC N (%)	Advanced adenoma (AA) N (%)	Non-advanced adenoma (NAA) N (%)	Others N (%)	Total N
High risk (HR)	39 (0.76)	739 (14.44)	2184 (42.67)	2156 (42.13)	5118
Intermediate risk (IR)	20 (0.47)	385 (8.42)	1393 (30.48)	2771 (60.63)	4569
Chi-square p value	0.04	<0.001	<0.001	<0.001	

and higher proportion of IR subjects with non-neoplastic findings during first surveillance suggests that, they have less potential to develop colorectal neoplasia and further study needed to evaluate whether their surveillance interval can be safely prolonged.

REFERENCE
1   Guidelines for colorectal cancer screening and surveillance in moderate and high risk groups (update from 2002). *Gut* 2010;59:666–690

Disclosure of Interest None Declared.

OC-048 | **TRANS-ANAL SUBMUCOSAL ENDOSCOPIC RESECTION (TASER): A NEW ENDO-SURGICAL APPROACH TO THE RESECTION OF GIANT RECTAL LESIONS**

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Introduction Trans-anal surgical (TEMS/TAMIS) and advanced endoscopic resection (ESD, P-EMR) procedures have the potential to provide complete and successful eradication of giant rectal polyps. Both approaches however have limitations in terms of practicality and safety. We describe a new endo-surgery technique called Trans-Anal Submucosal Endoscopic Resection (TASER) which combines the advantages of both the endoscopic and transanal surgical approach.

Methods The GelPoint Path trans-anal access port allows simultaneous passage of an endoscope and two laparoscopic retractors. Working with the endoscopic image the laparoscopic retractors (Johen 33 mm forceps) allow dynamic tissue retraction to facilitate endoscopic dissection (Flush knife–BT) or snare placement (Olympus snare master/spiral snare). All procedures were performed under general anaesthesia and with patients in the lithotomy position.

Results Eleven patients (mean age 55 years, 3 male/8 female) underwent TASER for 11 lesions, distributed from the lower rectum to the recto-sigmoid junction and with a median size of 85 mm, range 40–180 mm. Polyp morphology was (3/11 flat (Paris 2a), 4/11 sessile (Paris 1s) and 4/11 mixed type (Paris 2a +1s). In all cases a circumferential mucosal incision was made and histology confirmed free lateral margins in all cases. 10/11 rectal polyps were adenomatous and one had a small focus of moderate differentiated adenocarcinoma (incomplete local excision).

Complete endoscopic excision in a single session was achieved in 10/11 cases (91%). Median completion time of the procedure was 215 min, range 120–480 min. Tissue retraction was used in every case and resection was completed by ESD alone (4/11), ESD + EMR (4/11) ESD + EMR + trans-anal surgical excision (3/11). Intra-procedural bleeding occurred in 8 cases, controlled with hemostatic clips and Coagrasper (Olympus); surgical suturing was required in one case (1/8). Prophylactic clips (2/11) and surgical sutures (1/11) were placed to treat deep muscle injury. There were no perforations and no delayed bleeding episodes. Patients were discharged the day following TASER in all cases. Surveillance at 3–6 months revealed no recurrence in 6 cases, whereas in four cases the follow up procedure is still pending. The malignant polyp case was referred to surgery with a good clinical outcome (T3, N0, M0).