according to the ICD 10th Revision codes C18 (colon) and C19/C20/C21 (rectum, recto-sigmoid and anus). To allow comparisons over time data on anal cancers and from Wales are included. Rates in age groups never offered screening were compared with those potentially screened (age group 65–74 years). Joinpoint analysis was undertaken to look for changes in trends.

Results Comparing 2005 and 2016 CRC mortality rates we found a decline of 28.8% in men and 27.4% in women in the 65–74 year olds, the age group where screening would be expected to have had greatest effect. In comparison in 50–59 year olds there was a 21.3% decline in CRC mortality in men and a 5.5% decline in women. Whilst joinpoint analysis identified no step change in mortality rate over time, closer examination of the data showed that the decline in CRC mortality has been predominantly in the C18 code (colon). For C18 there was a 37.8% decline in men and a 37.7% decline in women. In comparison there were 36.0% and 29.2% declines respectively in the 50–59 year olds. For the C19–21 code there was a mortality decline of 15.4% in men and 6.2% in women in the 65–74 year olds and in the 50–59 year olds a decline of 2.2% in men and an increase of 39.0% in women.

Conclusion Overall CRC mortality has shown a steady decline. Declines have been substantially greater in the screened age groups although no step change was identifiable with joinpoint analysis. At this time-point the mortality reductions are predominantly in colon cancer (C18). Despite concerns that gFOBT screening maybe less effective in women mortality reductions were similar to men.

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OTU-025 GASTROINTESTINAL CONSEQUENCES OF CANCER: AN EVALUATION OF TEN YEARS EXPERIENCE AT A TERTIARY CENTRE

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OTU-026 FEASIBILITY & ECONOMIC EVALUATION – CHROMOENDOSCOPY FOR DETECTING PROXIMAL SERRATED NEOPLASIA: RANDOMISED CONTROLLED TRIAL, CONSCOP

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Introduction Most post-colonoscopy interval colorectal cancers occur in the proximal colon. Serrated lesions are often precursors to these and considered harder to detect. Chromocolonoscopy may improve detection rates, however the safety, feasibility and economic impact of this intervention to detect and resect proximal serrated neoplasia are not known.

Methods We conducted a parallel randomised controlled, open label trial within centres in the Bowel Screening Wales (BSW) programme. Participants testing positive on Faecal Occult Blood Test were randomised to standard white light colonoscopy or chromocolonscopy. Randomisation was performed centrally via an internet based minimisation algorithm. Data from index colonoscopies and associated clearance procedures were analysed. All proximal polyps were centrally reviewed by an expert pathology panel.

Results Between November 2014 and June 2016, 741 people (360 white light, 381 chromocolonoscopy) from all BSW centres consented to participate in the study and all were included in the analysis. For participants in the chromocolonoscopy arm, the procedure took an average of 6.3 (95% CIs: 4.2–8.4) min longer but serious adverse reaction rates, bowel preparation scores, completion rates, endoscopist assessment of procedural difficulties, procedure comfort scores, technical quality indicators, and types of sedation were similar in each arm. The proximal serrated polyp detection rate was significantly higher in the chromocolonoscopy arm (23/360 (6.4%) vs 45/381 (11.8%); univariable OR 1.96, 95% CI: 1.16–3.32, p=0.012; multivariable OR 2.04, 95% CI: 1.18–3.50, p=0.010). A 1% likelihood increase in additional significant serrated lesions retrieval would cost £35.22.

Conclusions A large RCT of index chromocolonoscopy powered for improved significant serrated polyp detection within a screening population is safe and feasible and initial efficacy results are encouraging. ClinicalTrials.gov: NCT01972451.

OTU-027 A STUDY OF POST COLONOSCOPY COLORECTAL CANCER (PCCRC) IN ENGLAND

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Introduction PCCRC is a key quality indicator for the detection and prevention of colorectal adenocarcinoma (CRC). It is not known whether rates of PCCRC are changing over time. There is limited evidence of factors associated with PCCRC that might be amenable to quality improvement interventions.

This study investigated trends in rates of PCCRC in the NHS in England; the extent of variation between NHS trusts; and potential causal associations with PCCRC.

Methods Using linked national Hospital Episode Statistics and National Cancer Registration and Analysis Service data all individuals who had undergone a colonoscopy procedure between 1/1/2006 and 31/12/2012 and who developed a CRC to 31/12/2015 were identified. NHS trust provider status and potential associations with PCCRC were included in the analysis.

International consensus methodology was used to calculate the PCCRC – 3 year rate (PCCRC-3 yr).[1 2] Colonoscopies

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