Abstracts

**PTU-031**  
***Interval type*** | **Non-interval type**
---|---
**Detected prior to recommended screening/ surveillance interval** | **Detected after recommended screening/ surveillance interval** | **Where no screening/ surveillance interval had been recommended**
Examples | Patient with a small adenoma that is advised to return for surveillance in 5 years; 4 years later develops anaemia; colonoscopy reveals CRC. | Patient with a 15 mm adenoma that is advised to return for surveillance in 3 years. Patient misses this, returns 4 years later with CRC investigation recommended. 5 years later patient develops symptoms and a colonoscopy reveals CRC. | Patient with a CRC is advised to return for surveillance in 3 years, a CRC is found later with CRC investigation recommended. | Patient with a CRC is advised to return for surveillance in 3 years, a CRC is found later with CRC investigation recommended. 5 years later patient develops symptoms and a colonoscopy reveals CRC.

**PTU-032**  
**POST-COLONOSCOPY COLORECTAL CANCER RATES IN IBD ARE HIGH AND VARY BY NHS TRUST IN ENGLAND**

Nicholas Burr*, Roland Valori, Venkatakrishnan Subramanian, Mark Hull, Jon Shelton, Clare Pearson, Andy Smith, Eva Morris, Matthew Rutter. University of Leeds; Gloucestershire Hospitals; Cancer Research UK; North Tees University Hospitals NHS Trust

Introduction  
Colorectal cancer (CRC) risk is increased in those with inflammatory bowel disease (IBD). Guidelines advocate surveillance colonoscopy for patients with longstanding IBD. Post-colonoscopy colorectal cancer (PCCRC) is a key quality indicator of colonoscopy. There is limited data exploring the rate of PCCRC in those with IBD and potential risk factors associated with IBD-related PCCRC.

Conclusion  
The rate of PCCRC-3 yr is higher in those with IBD, with a higher proportion of cases occurring within 3 years of colonoscopy. Factors associated with IBD-related PCCRC were investigated.

**PTU-033**  
**COLORECTAL CANCER AND EXPERIENCE IN TESTING FOR LYNCH SYNDROME IN A WEST LONDON HOSPITAL**

Anna Cavazza*, Chandni Radia, Christopher Harlow, Kevin J Monahan. Family History of Bowel Cancer Clinic, Department of Gastroenterology, West Middlesex University Hospital, Chelsea and Westminster Hospital NHS Foundation Trust, London, UK

Introduction  
Colorectal cancer (CRC) is diagnosed in over 46 000 people in the UK annually, and is the second most common cause of cancer death. NICE guideline DG27 recommends universal testing for Lynch Syndrome (LS) at diagnosis of colorectal cancer, by testing the CRC for mismatch repair (MMR) status, a hallmark of the disease.

Methods  
We collected data prospectively from November 2016 to December 2017 of consecutively diagnosed CRC patients with IBD to optimise surveillance and prevention of CRC in IBD.

Conclusion  
The rate of PCCRC-3 yr is higher in those with IBD, with a higher proportion of cases occurring within 3 years of colonoscopy. Factors associated with IBD-related PCCRC were investigated.

**PTU-034**  
**POST-COLONOSCOPY COLORECTAL CANCER RATES IN IBD ARE HIGH AND VARY BY NHS TRUST IN ENGLAND**

Nicholas Burr*, Roland Valori, Venkatakrishnan Subramanian, Mark Hull, Jon Shelton, Clare Pearson, Andy Smith, Eva Morris, Matthew Rutter. University of Leeds; Gloucestershire Hospitals; Cancer Research UK; North Tees University Hospitals NHS Trust

Introduction  
Colorectal cancer (CRC) risk is increased in those with inflammatory bowel disease (IBD). Guidelines advocate surveillance colonoscopy for patients with longstanding IBD. Post-colonoscopy colorectal cancer (PCCRC) is a key quality indicator of colonoscopy. There is limited data exploring the rate of PCCRC in those with IBD and potential risk factors associated with IBD-related PCCRC.

Conclusion  
The rate of PCCRC-3 yr is higher in those with IBD, with a higher proportion of cases occurring within 3 years of colonoscopy. Factors associated with IBD-related PCCRC were investigated.

**PTU-035**  
**COLORECTAL CANCER AND EXPERIENCE IN TESTING FOR LYNCH SYNDROME IN A WEST LONDON HOSPITAL**

Anna Cavazza*, Chandni Radia, Christopher Harlow, Kevin J Monahan. Family History of Bowel Cancer Clinic, Department of Gastroenterology, West Middlesex University Hospital, Chelsea and Westminster Hospital NHS Foundation Trust, London, UK

Introduction  
Colorectal cancer (CRC) is diagnosed in over 46 000 people in the UK annually, and is the second most common cause of cancer death. NICE guideline DG27 recommends universal testing for Lynch Syndrome (LS) at diagnosis of colorectal cancer, by testing the CRC for mismatch repair (MMR) status, a hallmark of the disease.

Methods  
We collected data prospectively from November 2016 to December 2017 of consecutively diagnosed CRC patients with IBD to optimise surveillance and prevention of CRC in IBD.
patients at West Middlesex University Hospital (WMUH) in London. CRCs were universally screened for tumour features suggestive of LS (Defective MMR, or dMMR) with immunohistochemistry. We also collected clinicopathological data including age at diagnosis, stage, tumour site, histological findings and MMR tumour-status. Statistical analysis was performed using chi-square test and 2 tailed T test for binary and continuous variables respectively.

**Results**

A cohort of 123 consecutive CRC patients were universally tested for dMMR. Twelve patients (9.8%) were MMR-deficient of which only 6 (50%) were predicated by the Bethesda Criteria. 11/12 dMMR CRCs were early stage tumours (Dukes’ A or B, p=0.002), and in 20 Dukes’ B CRCs in patient under 70 years of age, the result was directly relevant to personalised treatment with 5-FU based chemotherapy. The median age in patients with normal or abnormal MMR IHC was 64.6 years and 68.3 years respectively (p=0.41). With regard to histological features: mucinous tumours were more frequently manifested dMMR (p=0.0052), with the presence of this, signet ring cells or a lymphocytic response predictive of dMMR CRC (p=0.023). In all 12 patients with dMMR the cancer was located in the right colon (p=0.00001). MMR germline mutations were found in a total of 4 patients of which 2 (50%) had mutation of MLH1, in 1 case (25%) of MSH2 and in 1 case (25%) of MSH6.

**Conclusions**

Our results demonstrate that universal testing is feasible and effective in the UK. There were significant differences with regard to dMMR CRC site, stage and histological features compared to proficient MMR CRCs. Our data also indicates the importance of genetic testing and personalised oncological care as we were able to identify patients that may have not be selected for MMR testing by the Bethesda criteria.

**PTU-034**

**GETTING THE BEST OUT OF FAECAL IMMUNOCHEMICAL TESTS AND FAECAL CALPROTECTIN**


10.1136/gutjnl-2018-BSGAbstracts.375

**Introduction**

NICE DG30 recommends the use of quantitative faecal immunochromatography tests (FIT) in patients at ‘low risk’ for colorectal cancer (CRC). No lower age limit is advised. Colorectal cancer (CRC) is rare under the age of 50 years representing 6% of all cases, whilst inflammatory bowel disease (IBD), is much more prevalent. In support of NICE DG11 we have successfully introduced a pathway for the use of faecal calprotectin (FC) to support the diagnosis of IBD. It is not known what the relative roles of FIT and FC are in this ‘low risk’ cohort.

**Methods**

We analysed pre-existing clinical outcome data on FC from diagnostic accuracy studies and pathway evaluations performed at York Hospital. We identified those that did not fulfil criteria for the ‘two week wait’ referral (NICE NG12: recommendations 1.3.1 to 1.3.3) and stratified them based on age and symptomatology. We calculated sensitivity and specificity of FC in each cohort and compared it with a published FIT comparator (Mowat et al 2015).

**Results**

2917 patient outcomes were reviewed. 1229 presented with a change in bowel habit under the age of 60 years, so fulfilling DG30 criteria. The prevalence of CRC was 0.5%.

The sensitivity and specificity of FC as used in the York Fecal Calprotectin Care Pathway (≤100 mcg/g) is presented below both for CRC and for IBD, high risk adenomatous polyps and IBD combined, aged stratified. This is compared with FIT ≥10 mcg/g outcomes.

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<tr>
<th>Abstract PTU-034 Table 1</th>
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<tbody>
<tr>
<td><strong>Age range</strong> (yrs)</td>
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<td>--------------------------</td>
</tr>
<tr>
<td>CRC</td>
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<tr>
<td>FIT: ≤10 mcg/g*</td>
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<td>FC&lt;100 mcg/g</td>
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<tr>
<td>CRC, polyps and IBD</td>
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<tr>
<td>FIT: ≤10 mcg/g*</td>
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<td>FC&lt;100 mcg/g</td>
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Similar outcomes were obtained when combining all patients fulfilling DG30 criteria (that is including those with unexplained weight loss, abdominal pain and iron deficiency anaemia).

**Conclusion**

Despite the large numbers evaluated, the small numbers of patients with CRC make it difficult to draw any conclusions for a lower age limit upon which to apply DG30 and use FIT instead of FC. However when looking at combined CRC, high risk adenomatous polyps and IBD in this ‘low risk’ cohort, FC behaves similarly or better than FIT in those <50 years. As FIT is introduced in support of DG30 its performance should be benchmarked against existing FC pathways.

**PTU-035**

**THE BSG POSITION STATEMENT ON SESSEILE SERRATED LESIONS WILL HAVE LIMITED IMPACT ON SURVEILLANCE WORKLOAD**

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10.1136/gutjnl-2018-BSGAbstracts.376

**Introduction**

There is a lack of evidence to inform guidelines for the management of pre-malignant colorectal sessral serrated lesions (SSL). Northern Ireland (NI) is the only UK region where pathologists have diagnosed SSL (or synonyms) during reporting of Bowel Cancer Screening (BCS) specimens since inception of the programme. The aim of this study is to profile SSL diagnoses, and their risk stratification for surveillance, within BCS in NI.