adenoma removal at colonoscopy (LNRC) should have no surveillance or colonoscopy interval of 5 years.¹ However patients in the Bowel Screening Program (BCSP) who have LRNC are enrolled for subsequent faecal occult blood testing (FOBT) every 2 years. If test is positive, they are offered a further colonoscopy. Thus, it is possible that a BCSP patient who has LRNC can have up to 2 additional colonoscopies within the BCSP before the surveillance colonoscopy of a similar patient with LRNC, not in the BCSP who chose 5 year interval. **AIM:** To determine if or not surveillance colonoscopy <5 years from index LRNC led to intermediate or high risk neoplasia findings. **Methods** We identified all patients with previous LRNC in the North of Tyne screening centre from 2008–2010 who had attended for subsequent colonoscopy (episodes 2 and 3) because they had further positive FOBT. 2 authors (EC and HD) reviewed all endoscopy and histology reports to obtain patient details and identify presence of neoplasia and other pathologies. Colon neoplasia was deemed as low, intermediate or high risk according to BSG surveillance guidelines. **Results** 81 patients had colonoscopy (episode 2) for positive FOBT after LRNC. Full dataset was obtained for 78 (58% male). 10 of these had a 3rd colonoscopy (episode 3). Interval between episodes 1 and 2 was 2 years(yrs) in 86% and 4 years in 12%. Interval between episodes 2 and 3 was 2 years in 78%, 3 years in 11% and 4 years in 11%. The table below shows colonoscopy findings:

Abstract PTU-051 Table 1

Episode	No neoplasia	Low risk 'benign' neoplasia	Intermediate risk 'benign' neoplasia	High risk neoplasia	Cancer
2	57	13	6	1	1**
3	10	0	0	0	0

** T3 (Dukes C) rectosigmoid cancer

Conclusions

1. Majority (90%) of patients who with positive FOBT after initial LRNC will not require further surveillance colonoscopy
2. 9% of patients who have 2nd colonoscopy as FOBT pos. after LRNC will have neoplasia requiring further surveillance (i.e. become intermediate or high risk)
3. In our cohort, colonoscopy in 1 patient with positive FOBT after previous LRNC identified a cancer

Our data would support a recommendation that patients with positive FOBT with 2 previous LRNC's within the BCSP should not be offered further colonoscopy within 5 years of their second procedure.

REFERENCE

1. *Gut* 2010;**59**:666–690.

PTU-052 MANAGEMENT OF LARGE SESSILE COLONIC POLYPS BY INTRAOPERATIVE COLONOSCOPY WITH LAPAROSCOPIC SUPPORT

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Introduction Endoscopic management of large colonic polyps can be challenging, and may lead to incomplete resection/recurrence. Laparoscopic control can facilitate the endoscopic observation and approach to the lesions, and also to recognise and treat complications. Our aim was to study the feasibility and safety of intraoperative colonoscopy (IOC) in facilitating definitive treatment for complex colonic polyps otherwise deemed unsuitable for endoscopic resection.

Methods Patients discussed at the MDT with complex colonic polyps (large and sessile, recurrent, non-lifting but no evidence of malignancy), deemed unsuitable for conventional endoscopic resection, were scheduled for IOC. Procedures were performed under GA with surgical support available. Depending on endoscopist's and surgeon's preference and after discussion, colonoscopy was performed initially without surgical access, or with laparoscopic control, that could be conventional or with single incision (SILS). A PCF-260 JL was utilised, with a soft distal attachment, ERBE 300D diathermy unit and CO2 for insufflation. Resection techniques included Endoscopic Mucosal resection (EMR), Hybrid Endoscopic Submucosal Dissection (ESD), and conventional ESD. Data on all patients undergoing IOC was collected prospectively and analysed from the hospital computer records.

Results Thirteen patients underwent IOC (median age 60, IQR 59.5–75 years). Median size was 5 cm (IQR 4.5–6.7 cm). Macroscopic type was sessile with/without flat portion in 12/13 cases. Ten cases underwent endoscopic resection with laparoscopic control, 2 exclusively endoscopic resection, and one only surgical treatment. Laparoscopic interventions included SILS (2), SILS + Right hemicolectomy (1), laparoscopic control (6), laparoscopy + suture of resection site (1), laparoscopy + right hemicolectomy (2), Endoscopic interventions included EMRp (4), Hybrid ESD (8), all in more than one fragment, and without any significant complications. Median procedure time (including endoscopy and surgery) was 235 min (IQR 150–250). Histology revealed: TVA+LGD (10), TVA+HGD (2), T1 cancer (1)(0.5 mm, R0). Nine patients have undergone endoscopic follow up (median 5 months, IQR 4.25–7.5 months). There were two adenoma recurrences on follow up, managed endoscopically.

Conclusion Large/complex colonic polyps can be safely resected by combined endoscopic and laparoscopic approach. In this series colectomy was avoided in 10/13 (77%) cases, with no significant complications. This combined approach should be considered in the armamentarium for the management of large/complex colonic polyps.

PTU-053 PROGNOSTIC SIGNIFICANCE OF TUMOUR REGRESSION GRADE IN RECTAL CARCINOMA – A 5 YEAR STUDY

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Introduction Multimodal therapy is the current recommended treatment of choice for rectal cancer. The effects of the neo-adjuvant therapy/tumour regression can be assessed histologically in the resection specimen.

Methods This is a 5 year retrospective study at a tertiary centre in South India to assess the prognostic significance of the pathological grading of tumour regression in rectal cancer pre-treated with long course neoadjuvant therapy. 137 patients