adenoma removal at colonoscopy (LRNC) 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 Tyneside screening centre from 2008–2010 who had attended for subsequent colonoscopy (episodes 1 and 2) 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:

<table>
<thead>
<tr>
<th>Episode</th>
<th>No neoplasia</th>
<th>Low risk 'benign' neoplasia</th>
<th>Intermediate risk 'benign' neoplasia</th>
<th>High risk neoplasia</th>
<th>Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>57</td>
<td>13</td>
<td>6</td>
<td>1</td>
<td>1**</td>
</tr>
<tr>
<td>3</td>
<td>10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**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**

**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...
with rectal adenocarcinoma who received long course neoadjuvant chemoradiation followed by surgery were analysed and categorised based on the Tumour Regrression Grade(TRG) into 2 groups- Group 1(Good response, TRG 0,1) and Group 2 (Poor response, TRG 2,3). Other factors (clinical and pathological features like lymphovascular/perineural invasion, discontinuous extramural tumour deposits, resection margin status and pTNM stage of tumour) were also evaluated and all variables along with TRG were correlated with disease progression and 5 year survival. Statistical analysis used: IBM SPSS version 20.0 software. Categorical variables expressed using frequency and percentage and the continuous variables presented using mean and standard deviation. The chi-square test was used for finding prognostic factors. Univariate analyses of survival were carried out by Kaplan-Meier method and the evaluations of differences were performed with Log Rank test. 

**Results** Group 1 showed reduced risk for disease progression (p = 0.01) and better mean disease free period and overall survival. Poor tumour regression was associated with lymphovascular and perineural invasion and regional lymph node metastases (p<0.001).

**Conclusions** Pathological assessment of tumour regression serves as a good predictor for disease outcome and should be assessed in all neoadjuvant treated rectal resection specimens.

**PTU-055**

**FLEXIBLE SIGMOIDOSCOPY-BASED ASSESSMENT FOR SUSPECTED CRC – A SERVICE REVIEW OF THE RAPID ACCESS CLINIC**

**Abstract**

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**Introduction**

10%–15% of colorectal cancer (CRC) is due to Microsatellite Instability(MSI). The aim of the study was to determine the prognostic significance of detecting MSI in Stage II CRC and to understand the demographic and pathological characteristics of the disease in the Indian scenario.

**Methods**

This was an 8 year retrospective study (2010 to 2017) of 195 patients with Stage II colorectal adenocarcinoma who were categorised into Microsatellite stable (MSS) or MSI based on immunohistochemical expression of the DNA Mismatch Repair(dMMR) proteins. Various clinical and pathological factors as per the Revised Bethesda criteria were compared and analysed between the MSI and MSS groups by Chi-square test and T Test. Kaplan-Meier method was used to calculate the Disease Free Survival (DFS) and Overall-survival (OS) for the 2 groups. Log Rank test was applied to know the strength of association between the DFS and OS with each of the parameters. The data was analysed using IBM SPSS version 20 software.

**Results**

There were 53 (27%) patients in the MSI group. Younger age, and presence of synchronous or metachronous malignancies, right sided location of tumour, poorly differentiated adenocarcinoma, mucin production and presence of peri-tumoral Crohn’s like lymphocytic response showed statistically significant association with MSI. A definite relationship of MSI status with family history could not be established. The mean DFS in MSI group was 74.7±3.496 months as compared to 69.2±3.631 months in MSS group. Disease related death was seen in 2.8% and 15.7% of patients in MSI and MSS group respectively, p=0.042. Overall survival among the MSI patients was significantly higher (76.6±4.149 months) than the MSS patients (65.05±3.555) p=0.04. MSI patients did not show improved survival with adjuvant therapy.

**Conclusions**

Early stage MSI related CRC has good prognosis even without adjuvant chemotherapy. Knowledge of the MSI status in CRC is useful in management decisions and prognostication. In addition it can help to detect those with Lynch Syndrome who may not fulfil the Revised Bethesda criteria.