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

¹Adolfo Parra-Blanco*, ²Khalid Mohiuddin, ²Balamurali Bharathan, ¹Stefano Sansone, ¹Shiv Budihal, ¹Krish Ragnath, ²Ayan Banerjee. ¹Gastroenterology, Nihl Nottingham Digestive Diseases Biomedical Research Centre, Nottingham University Hospitals NHS Trust, Nottingham, UK; ²Colorectal Surgery, Nottingham University Hospitals NHS Trust, Nottingham, UK

10.1136/gutjnl-2018-BSGAbstracts.393

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

Roopa Paulose*, Preethi Menon, Renjitha Bhaskaran, K Sundaram. *Amrita Institute Of Medical Sciences And Research Centre, Kochi, India*

10.1136/gutjnl-2018-BSGAbstracts.394

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 Regression 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-054 MICROSATELLITE INSTABILITY IN STAGE II COLORECTAL CARCINOMA

Assoc. Prof Roopa Paulose*, Divya Ail, Shital Biradar, K Sundaram. *Amrita Institute Of Medical Sciences And Research Centre, Kochi, India*

10.1136/gutjnl-2018-BSGAbstracts.395

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 peritumoral 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.

PTU-055 FLEXIBLE SIGMOIDOSCOPY-BASED ASSESSMENT FOR SUSPECTED CRC – A SERVICE REVIEW OF THE RAPID ACCESS CLINIC

¹Aikaterini Peleki*, ¹Yafit Nahari, ¹Hasan Jamjoom, ¹Mahmood Vazirian-Zadeh, ¹George Flahn, ¹Raj Patel, ¹Anthony Kawesha, ²Neil Fisher. ¹*Department of General and Colorectal surgery, Russells Hall Hospital, Dudley, UK;* ²*Department of Gastroenterology, Russells Hall Hospital, Dudley, UK*

10.1136/gutjnl-2018-BSGAbstracts.396

Introduction The colorectal rapid access clinic (RA) was established in our district general hospital in 2001 to provide a streamlined diagnostic service for patients with suspected colorectal cancer (CRC). It offers direct clinician-led flexible sigmoidoscopy (FS) when appropriate clinical criteria are met (i.e. distal colonic symptoms) as indicated on the GP referral form. Video FS is carried out in JAG-approved facilities in the OP clinic. For many patients this acts as a 'one-stop' clinic and reduces the need for further attendance. The aim of this study was to provide a descriptive review and evaluate patient outcomes over a 4 year period.

Methods A retrospective analysis of electronic records was carried out for all patients undergoing FS as first investigation during the 12 month period of January-December 2013. Demographics, clinical indications, FS diagnosis, further investigations and final diagnosis were recorded and analysed. A subgroup analysis was carried out according to clinical presentation and cancer outcomes were validated with the Somerset CRC database.

Results 1021 patients underwent FS in the RA clinic. Mean age was 72.5 years, 1.1 F:M ratio. The main referral criteria were rectal bleeding (41.8%), diarrhoea (37.0%), unspecified altered bowel habit (13.8%), constipation (7.4%), abdominal pain (5.1%) and weight loss (2.6%). Diagnosis at examination was: normal (24.8%), diverticulosis (32.9%), polyps (17.5%), haemorrhoids (26.8%), malignancy (5.2%). Further investigations done after FS included barium enema (30%), colonoscopy (21%), contrast abdominal CT (35%) or CT colonogram (0.5%). A further 16 cases (1.5%) were diagnosed with CRC after full colonic assessment. Discharge rate was 12.9% after FS and 76.2% following further investigations. Follow up of patients discharged after RA assessment revealed that four new cases of CRC (0.4%) were diagnosed within 3 years of discharge.

Conclusions This unique RA pathway, with FS followed by selective referral for further colonic assessment, offers a quick and reliable service for the exclusion of suspected CRC with excellent diagnostic accuracy. The incidence of interval CRC is within acceptable limits as compared with other colonic imaging.