Abstracts

had an oesophageal biopsy. Histology findings for these 48 cases are reported in table 1. 21 (19.4%) patients with no visible lesion had further investigation after endoscopy: 8 (7.4%) barium swallow, 9 (8.3%) CT and 3 (2.8%) manometry.

Abstract PTH-018 Table 1

	Number	%
Normal	23	41.8
GORD	22	40.0
EOE	4	7.3
Barretts (BE)	5	9.1
Oesophageal ulcer	1	1.8

Final diagnosis for all patients who had no structural lesion (6 months after initial OGD): 64 (59.3%) had no diagnosis, 26 (24.1%) had GORD, 5 (4.6%) had a dysmotility disorder, 4 (3.7%) had EoE and 6 (5.6%) had BE.

Conclusion Two thirds of patients had no visible cause of dysphagia identified at endoscopy, but only half of these patients had oesophageal biopsies taken as recommended by the BSG. Where there were taken the most common finding was normal histology (41.8%), while 40.0% had GORD and only 7.3% had EOE.

Nearly 60% of patients with dysphagia who are referred for endoscopy have no formal diagnosis made 6 months after initial endoscopy.

PTH-019 'MISSED' OESOPHAGO-GASTRIC CANCERS ON GASTROSCOPY: ARE WE REALLY MISSING THEM ALL?

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Introduction Oesophago-Gastric (OG) cancer usually present late with consequent poor prognosis. The failure to detect early stage OG cancer at endoscopy may contribute to poor prognosis. A recent meta-analysis reported miss rates of 11.3% for OG cancers at endoscopy up to 3 years prior to diagnosis (1). We looked at our data in the Trust to quantify how often opportunities to diagnose cancer at an earlier stage are missed.

Method A retrospective review was carried out, on the medical records of newly diagnosed gastro-oesophageal cancer patients at County Durham and Darlington NHS Trust between the period 01/08/2014 – 31/07/2017. The data was extracted on patients who had standard light gastroscopy within a period of 3 years prior to the diagnosis. Endoscopic images were reviewed by a panel of 3 consultant gastroenterologists.

Results A total of 181 patients were diagnosed as having gastro-oesophageal cancers during the study period, of whom 12 had gastroscopy within three years. Amongst them, 3 had gastroscopy within one year prior to the diagnosis. The index endoscopy was performed by consultant gastroenterologist in 6 patients, nurse endoscopist in 4 and others in 2 patients.

The overall incidence of cancers in patients who had gastroscopy within 3 years and 1 year were 6.6% and 1.6% respectively. Amongst those, 8 were oesophageal, 3 were gastric and 1 of them was junctional cancer. Endoscopic photo

documentation was fully retrievable for 6 patients who had endoscopy within 3 years and the review confirmed normal looking mucosa at the anatomical area concerned. (50%).

Conclusion Our study shows, incidence of the oesophageal cancer was high in comparison to gastric or junctional tumours for those who had gastroscopy within 3 years prior to the diagnosis. The normal endoscopic photo documentation in 50% of the patients, suggests interval cancers rather than 'missed' cancers. This raises suspicion on whether we are increasingly dealing with rapidly progressing tumours as suggested by emerging evidence that many cancers develop rapidly by punctuated and catastrophic genome evolution (2). Serial photographic documentation of important anatomical landmarks in accordance with latest BSG guidance (3) and further studies on interval cancers are important for future cancer interception.

PTH-020 ENDOSCOPIC MUCOSAL RESECTION: EVALUATION OF A SINGLE CENTRE OUTCOME

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Background EMR has been well accepted as one of the management options for superficial colorectal tumours requiring minimal invasion, better patient tolerance and significantly lower morbidity compared to surgery. However, lesions ≥ 20 mm can be tricky.

Method Retrospective medical record analysis was performed for a period of 24 months between Jan 2015 – Dec 2016. The data was collected on patient demographics, polyp characteristics, complications and follow up endoscopy at the 3 months and 12 months intervals where applicable.

Results A total of 212 patients had 264 procedures. The mean age of the population was 68. All of the procedures were performed by experienced endoscopists using hot/cold snare and Methylene blue/Volplex solution. 22 (8%) of all polypectomies were ≥ 40 mm in size. The rate of complications in accordance with polyp size and colonic sites are illustrated below (table 1 and 2).

The perforation was managed with endoclips and required a day of admission. The immediate bleeding had been managed with clipping $\pm$ adrenaline injection. The overall 30 days mortality was zero. 9 (4%) patients had prophylactic endoclips.

Abstract PTH-020 Table 1 Complications for different sizes of the polyps

Complications	Polyp size <20 mm (n,%)	Polyp size 20–39 mm (n,%)	Polyp size ≥ 40 mm (n,%)	Total (Percentage) (n,%)
Immediate bleeding	8 (206, 4%)	1 (36, 3%)	2 (22, 9%)	11 (264, 5%)
Delayed bleeding	0	0	0	0
Perforation	0	1 (36, 3%)	0	1 (264, 0.4%)
Recurrence at 3/12	0	0	3 (22, 14%)	3 (264, 1%)
Recurrence 12/12	0	0	1 (12, 8%)	1 (109, 0.9%)

The adenocarcinoma detection rate was 2.8% (6) and all of them had had either repeat scope at the 3 and 12 months intervals or had surgery. 12 (5.6%) had tubular/tubulovillous adenoma with high grade dysplasia. 8 (66%) of these patients had repeat scope at 3 months, whilst 1 (8%) underwent surgery and 3 (25%) made an informed choice to not have further colonoscopic examination.

Abstract PTH-020 Table 2 Complications at different sites of the colon for all the polyp sizes.

Complications	Caecum	Ascending colon	Transverse colon	Descending colon	Sigmoid colon	Rectum
Immediate bleeding	3	0	2	0	2	4
Delayed bleeding	0	0	0	0	0	0
Perforation	0	1	0	0	0	0
Recurrence at 3/12	0	0	0	0	0	3

Our rescope rate for the polyp size ≥ 20 mm at 3 months and 12 months was 69% and 78% respectively. The main reasons for not having the scope were either patient choice or having surgery/other forms of cancer treatment.

Conclusions EMR is an effective and safe approach in the expert hands for the management of colonic polyps. The role of prophylactic endoclips is still unclear in reducing the risk of post-procedural bleeding and it is highly dependent on the operator's preference and experience.

Total character count 2817.

PTH-021 CANCER AND ADENOMA DETECTION RATE IN 2-WEEK WAIT COLONOSCOPY AND CT COLONOGRAPHY-TERTIARY CENTRE EXPERIENCE

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Introduction Computed Tomography Colonoscopy (CTC) is increasingly being used as an alternative to optical colonoscopy (OC). The SIGGAR trial and COCOS study have shown CTC to be an accurate and safe alternative to OC for diagnosis of colorectal cancer (CRC) and large polyps. Our aim was to compare various performance indicators between CTC and OC in the lower GI straight to test (STT) 2 week wait (2 WW) pathway.

Methods The investigation of choice for the lower GI 2 WW STT cohort between Nov 2014 and Oct 2015 was OC with CTC being the first-line test between Jan 2016 and Dec 2016. We retrospectively analysed 12 months' data for both cohorts. Outcomes included completion rate, polyp detection rate (PDR), adenoma detection rate (ADR) and CRC detection rates.

Results 1135 patients attended for OC versus 1829 for CTC. Significantly more OC were cancelled on the day compared to CTC (6.5% v 2% $p=0.0001$). OC had a completion rate measured by caecal intubation of 86% versus 100% of CTC ($p=0.0001$). The diagnostic study rate measured by adequate

bowel preparation/faecal tagging and distension was 89.3% at OC (adequate preparation) versus 98.4% for CTC ($p=0.0001$).

CRC detection rate was 4.5% (95% CI 3.43% to 5.95%) in the OC group versus 4.9% (95% CI 3.97% to 5.95%) in the CTC group ($p=>0.005$).

The PDR was significantly higher in the OC group compared to the CTC group (25.1% (95% CI 22.95% to 27.32%) v 13.5% (95% CI 11.95% to 15.11%) $p=0.0001$). However, 61.7% of the polyps detected at OC were ≤ 5 mm which are not routinely reported on CTC. PDR for polyps > 5 mm at OC was 9.6% (95% CI 7.98% to 11.54%) versus 13.5% at CTC ($p=0.0024$).

The ADR at OC was significantly higher than in the CTC (16.5% (95% CI 14.38% to 18.85%) versus 9.8% (95% CI 8.53% to 11.29%) $p=0.0001$).

The non-CRC detection rate in the CTC group was 4.3%. **Conclusions** CTC and OC have comparable CRC detection rates for patients referred via the 2 WW STT lower GI pathway. However, the PDR and ADR are higher with OC, this data is skewed by the number of diminutive polyps identified at OC that are not routinely reported at CTC. Also, a number of cases with 5–10 mm polyps at CTC did not progress to OC. Long term follow up data is required to compare interval cancer detection rates in these cohorts to assess the impact of not reporting/identifying sub 5 mm polyps.

From a service delivery perspective, the on the day cancellation rate, completion rate and diagnostic study rate for CTC were significantly better than OC in the STT patient.

An additional benefit of CTC is the diagnosis of non-colonic cancers, the rate of which was comparable to the CRC rate.

PTH-022 HYPERAMYLASAEMIA POST ANTEGRADE DOUBLE BALLOON ENTEROSCOPY – DOES INDOMETHACIN MAKE A DIFFERENCE?

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Introduction High amylase does not always signify acute pancreatitis and it can occur due to focal areas of ischaemia in the pancreas due to mechanical stress during double balloon enteroscopy (DBE). The use of rectal NSAIDs to prevent post DBE pancreatitis has never been explored unlike in ERCP where patients receiving rectal NSAIDs have a lower incidence of pancreatitis.

Methods Patients who received rectal indomethacin (100 mg) 30 min prior to antegrade DBE were compared to a control group who did not receive indomethacin before the above protocol was implemented. Serum amylase and CRP 3 hours before and after DBE were compared.

Results 240 patients (56 indomethacin, 184 controls; 50% males; mean age $58.5 \pm SD14.0$) were included.

Indications included IDA (37.5%), obscure overt gastrointestinal bleeding (17.1%), suspected crohn's disease and strictures (17.9%), complication of coeliac disease (1.3%), small bowel (SB) tumours/polyps (17.9%), others (8.3%).

Patients had a median of $13.0 \pm SD13.0$ passes, $65.0 \pm SD25.0$ min, $170 \pm SD52.0$ cm of SB examined. 36.3% underwent a therapeutic procedure during DBE: APC/