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 SIGGER 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/

adrenaline/clips (27.5%), foreign body removal (0.4%), polypectomy (8.3%).

Only 4 (1.67%; 2 females) patients developed pancreatitis, all prior to implementation of indomethacin into the local protocol. They had a median age of $47.0 \pm SD3.20$ years, $11 \pm SD29.4$ passes, $90 \pm SD52.0$ min, $150 \text{ cm} \pm SD64.2$ cm of SB examined and median hospital stay of $14 \pm SD3.70$ days. 3 had polypectomies. 2 episodes occurred in the same patient. All had evidence of pancreatitis on CT scan. None of the patients received indomethacin before DBE.

Mean amylase ($51.6 \pm SD22.7$ vs $143.0 \pm SD143.9$ IU/L $p=0.0001$) and CRP ($13.0 \pm SD46.1$ vs $17.3 \pm SD81.7$ mg/L $p=0.0001$) after the procedure were significantly higher than before the procedure. Females had a significantly higher amylase than males post procedure (155.2 vs 130.7 IU/L $p=0.017$). Mean amylase 3 hours after DBE was significantly lower in patients who received indomethacin (114 vs 152) ($p=0.044$). 83.9% had a rise in amylase in the indomethacin group compared to 92.2% controls ($p=0.064$).

Whilst there was no correlation between post-procedure amylase ($p=0.552$), CRP ($p=0.058$) and duration of the procedure, there was a significant association between amylase post procedure and length of SB examined (Spearman's rho 0.186; $p=0.005$).

Conclusions This study identifies a role for rectal indomethacin in patients undergoing antegrade DBE. We have demonstrated that rectal indomethacin reduces amylase post DBE and no patients given indomethacin experienced pancreatitis. Larger studies are required to assess if this also transforms into lowering risk or severity of pancreatitis.

PTH-023 BARRETT'S SURVEILLANCE IN A DISTRICT GENERAL HOSPITAL: DO WE FOLLOW GUIDELINES FOR NON-DYSPLASTIC BARRETT'S?

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Introduction BSG 2013 guidelines for diagnosis and management of Barrett's oesophagus (BE) recommend surveillance intervals based on the length of BE, histology, and presence of intestinal metaplasia. Practice for BE surveillance varies nationally. East and North Hertfordshire NHS Trust is a district general hospital with a population of approx. 6 00 000. Since the 2013 guidelines most BE surveillance is done by 2 consultants and a specialist nurse.

Methods A retrospective review of all gastroscopies performed for the indication of BE surveillance from 1/1/16 – 31/12/16. These were audited against BSG 2013 guidelines specifically looking at use of Prague criteria (PC), histology and selection of surveillance intervals. All endoscopies were performed using high definition video-endoscopes.

Results 207 OGDs for BE surveillance were reviewed (median age 68 [29–90], 75% males). 144 (70%) recorded BE length using the PC. 23 (11%) had either no or minimal Barrett's (<1 cm), of whom 15 (65%) were discharged. In the remaining 40 OGDs (19%) length of BE was unclear in 11 reports, able to be partially deduced from the free text in 20 cases, and fully deduced in 9 cases.

Analysis of surveillance intervals was performed only on the 144 OGDs where length of BE was documented fully

using PC. Amongst these were 17 cases of dysplasia (12%: 6 indefinite for dysplasia, 7 low grade dysplasia, 4 high grade dysplasia). The remaining 127 cases (88%) were non-dysplastic. Distribution of length of BE is displayed in figure 1.

Of the non-dysplastic cases, 46 (36%) had a BE length of <3 cm of whom 20 (43%) had surveillance interval of 3–5 years, 18 (40%) were discharged and 8 (17%) had a surveillance interval of 2 years. 81 (64%) had a BE length of ≥ 3 cm, of whom 74 (92%) had surveillance interval of 2–3 years, 1 (1%) for 1 year, 4 (5%) for 4–5 years, 1 (1%) was discharged and 1 (1%) died.

Conclusions Whilst we reported 70% of our BE length using PC, a measure now recommended as a quality standard, a further 19% could have been reported this way. Our data show that only 10% (13) of our 127 non-dysplastic BE cases had an incorrect surveillance interval chosen, less than the figures suggested by JAG who estimate that 30% of patients undergo surveillance at incorrect intervals or where not indicated at all. Of the 207 OGDs analysed, 135 (65%) were carried out by one of our 2 consultants with specialist interest in BE or our BE specialist nurse endoscopist. We therefore support the advice that BE surveillance should be performed on dedicated lists in order to improve endoscopic quality reporting and choice of correct surveillance interval.

Abstract PTH-023 Figure 1 Non-dysplastic cases depicted by blue bars with number of cases as each length corresponding to height of the bar. Each individual case of dysplasia is depicted as illustrated in the key above

PTH-024 RISK FACTORS FOR BLEEDING DURING ENDOSCOPIC RESECTION FOR VISIBLE LESIONS IN BARRETT'S OEESOPHAGUS

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Introduction Endoscopic resection (ER) is the preferred initial treatment for early cancer and dysplasia with visible lesions arising in Barrett's oesophagus (BE). An intra-procedural bleeding risk of 10% is typically quoted, with most controlled by endoscopic intervention. There is little data on risk factors for bleeding during oesophageal piecemeal ER.

Studies on colonic polypectomy have shown older age and the presence of depressed lesions are associated with increased bleeding risk. Previous studies on gastric ESD have shown lesion size was the main risk factor. We sought to identify variables associated with an increased risk of bleeding.

Methods Data were collected retrospectively for patients who had undergone ER for BE at a tertiary endotherapy centre