Conclusion In 138 colonoscopy procedures performed in a large Trust, 21% did not adhere to the minimal withdrawal time of 6 min as recommended in the best practice guidelines. If this finding were replicated across the UK, a significant amount of pathology may be missed, increasing risks to our patients.

PTH-046 DOUBLE-BALLOON ENTEROSCOPY ASSISTED CYANOACRYLATE INJECTION THERAPY OF SMALL-BOWEL VARICES: INTERNATIONAL EXPERIENCE FROM TWO EUROPEAN CENTRES

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Introduction Small bowel varices (SBV) are a rare consequence of portal hypertension and could lead to life-threatening mid-gut bleeding. Radiological intervention (RI) is usually considered first line management (e.g. Trans-jugular intrahepatic portosystemic shunting (TIPS), stenting of occluded mesenteric veins±embolisation of culprit varices). In cases where RI is impossible, management options become very limited.

This multicentre case series evaluated the usefulness of double-balloon enteroscopy (DBE) assisted cyanoacrylate injection of SBV.

Methods Retrospective review of DBE facilitated cyanoacrylate injection of SBV (December 2015 to October 2016). Demographic, clinical, endoscopic and radiological findings, interventions and follow-up data were analysed.

Results Ten DBEs were performed in 6 patients (4 women, median age: 68.5 years). Five patients had previous surgery (hemi-hepatectomy (n=2); SB resection (n=2); appendicitis with peritonitis (n=1)); one patient had a history of intra-abdominal sepsis in childhood causing portal vein thrombosis and one had cryptogenic thrombosis of the portal and the mesenteric vein. No radiological or surgical options were deemed feasible in any case. SBV were diagnosed at capsule endoscopy and triple phase CT mesenteric angiography. At DBE, a total of 13 nests of SBV were identified and injected with cyanoacrylate glue. There were no haemorrhagic or embolic complications but 1 patient developed an infection of a congenital urachal cyst, which was treated successfully with antibiotics. All patients underwent DBEs via the anterograde route, 2 patients required bi-directional DBE for treatment of both proximal and distal SBV and in total 2 patients required a repeat DBE for further treatment of SBV. At 30 day follow-up post-therapy, only 1 patient had experienced a mild recurrence of mid-gut bleeding treated conservatively. One patient presented with acute gastrointestinal bleeding 7 months later and a repeat DBE with cyanoacrylate injection therapy was successfully performed. One patient was lost to follow-up. The remaining patients had 12 months of follow-up without any recurrent gastrointestinal bleeding.

Conclusion Cyanoacrylate injection therapy of SBV at DBE appears to be a safe and effective management strategy for this condition when other first-line options are not feasible.

PTH-047 MICROSCOPIC COLITIS IN PATIENTS UNDERGOING TWO WEEK WAIT COLONOSCOPY FOR CHRONIC DIARRHOEA

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Introduction Chronic diarrhoea is an indication for referral on the Colorectal two week wait (TWW) pathway for suspected malignancy. Microscopic colitis (MC) characteristically presents with chronic watery diarrhoea. The frequency of MC diagnosed in TWW patients has not been systematically evaluated, but from available literature is diagnosed in 0.1%–2.8% of patients. We sought to define the incidence of MC in our cohort of patients who underwent colonoscopy for chronic diarrhoea on TWW pathway.

Methods All colonoscopies performed in a single NHS District General Hospital over a 4 year period (1/1/12 – 31/12/15) under the TWW pathway with one of the indications for investigation listed as chronic diarrhoea were identified from the electronic endoscopy database. Information on patient demographics, endoscopy reports and histological diagnoses were collected. For patients with histology definitive or suspicious for MC, the slides were re-reviewed by a single Histopathology Consultant with an interest in gastrointestinal disease. Further clinical information from case notes was obtained for definitive cases of MC.

Results Colonoscopy was performed in 533 patients in this time period, with a median age of 62 years, 55.2% were female. Out of these, 91.2% had colonic biopsies taken, and 84.2% had colonic biopsies from macroscopically normal mucosa, to exclude the diagnosis of MC. 21 patients (3.9% of all patients) were diagnosed with MC (6 with collagenous colitis, 15 with lymphocytic colitis). This subgroup had a median age of 76 years, 76.2% were female. 48% were on proton pump inhibitors, 19% had a diagnosis of hypothyroidism, 10% had a known malignancy (non colorectal).

Conclusions In our experience, random colonic biopsies were taken in the majority of patients referred on the TWW pathway with chronic diarrhoea in order to assess for MC. MC is a relatively common diagnosis and from our cohort of patients it was mainly seen in elderly females. MC should be considered in patients with chronic diarrhoea undergoing colonoscopy for suspected malignancy.

PTH-048 DIAGNOSTIC ERCP IN SPECIALIST CENTRES: SAFE AND EFFECTIVE FOR EVALUATING INDETERMINATE BILIARY CHANGES FOLLOWING MDT

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Introduction Indeterminate biliary strictures (BS) may be identified in symptomatic patients or incidentally on imaging. Patients need investigation to exclude cholangiocarcinoma or other significant pathology. The first line investigation is with Magnetic Resonance Cholangio-Pancreatography (MRCP) however this is not always diagnostic. Such cases are all reviewed

through our tertiary Multi-disciplinary team (MDT) meeting for further evaluation. Diagnostic Endoscopic Retrograde Cholangio-Pancreatography (ERCP) is often used to further investigate these abnormalities¹ but carries a risk of complications.

Methods A retrospective analysis was performed of patients reviewed through our regional HPB MDT from October 2014 to December 2016. Patients with indeterminate BS with no mass lesion were identified from our MDT database. Following MDT discussion, all patients were investigated with ERCP ± cholangioscopy (POC). Liver Function Tests (LFTs) and details of suspected BS were obtained from the medical records. Diagnoses were obtained from the endoscopy database and histopathology reports, where applicable.

Results 66 patients were identified with a mean age of 63.7 (SD 14.5). 47% were male. 82% of patients had abnormal LFTs, 35% had jaundice and 61% had upstream dilatation on radiological imaging. 31 (47%) required POC in addition to ERCP. 85% of patients (n=56) had an abnormal diagnosis. 8 (12.1%) had malignancy, 13 (19.7%) PSC or other cholangiopathy and 10 (15.2%) stone disease. In our centre, complications associated with these ERCPs were low: pancreatitis: 1 (1.6%); cholangitis: 1 (1.6%); bleeding: 1 (1.6%). There were 2 delayed bleeds (peptic ulcer and variceal). Upstream dilatation was shown to be a predictor of abnormal diagnosis on both univariate (p=0.004) and multivariate analysis (p=0.01) with a sensitivity of 72.5%, specificity of 72.7%, positive predictive value of 92.5% and negative predictive value of 36.4%.

Conclusions Of those with suspected BS on imaging, 85% had pathology demonstrated on direct cholangiography ± POC. 15.2% of those reviewed through a tertiary HPB MDT had stone disease evident at ERCP that was not diagnosed on review of MRCP and other imaging modalities. Diagnostic ERCP in appropriate centres still has a role to play in the evaluation of indeterminate biliary strictures following specialist MDT review when non-invasive imaging is inconclusive.

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PTH-049 CLINICAL OUTCOMES OF ENDOSCOPIC SUBMUCOSAL DISSECTION FOR COLORECTAL NEOPLASMS: A SINGLE UK REFERRAL CENTRE EXPERIENCE

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Introduction There is limited experience of endoscopic submucosal dissection (ESD) for resection of colorectal lesions in the West and outcome data tends to be worse than that reported from Japanese centres. We report the outcomes of ESD in a single, tertiary UK referral centre.

Methods A prospective database was analysed including 165 consecutive patients (mean age: 64.6±12.6 years, 62.4% males) with 173 colorectal neoplasms resected by ESD between 3/2012 and 12/2017. Two experienced colonoscopists performed all procedures.

Results The median (IQR) lesion size was 3.5 cm (2–5), and 140 (80.9%) were located in the rectum. Overall, 49.7% were granular-type laterally spreading tumours (LST), 19.7% were non-granular LST, and 30.6% were polypoid lesions. In 29 (16.7%) cases a flexible endosurgical platform was used to assist ESD of complex rectal polyps [median(IQR) size: 6 cm (5–8)] by dynamic trans-anal retraction (Trans-Anal Submucosal Endoscopic Resection; TASER). Histology showed low-grade adenoma/dysplasia in 83 (47.9%), high-grade adenoma/dysplasia in 52 (30%), T1 cancer (<1000 µm) in 17 (9.8%), and T1 cancer (<1000 µm) in 17 (9.8%) lesions. The en bloc, histological complete and curative (R0) resection rates were 97.7%, 80.3% and 76.3% respectively. Three (1.7%) cases of delayed bleeding occurred, with one case requiring transfusion. Perforation occurred in 2 (1.2%) cases: one was recognised and treated intraoperatively with endoclips; the other one was followed up and managed conservatively. Sixty (34.7%) patients were electively admitted to hospital post procedure, for a median duration of 1 day (range 1–5). Twenty patients (12.1%), at risk of lymph node metastasis, underwent additional radical surgery. Eighty-nine (51.4%) ESD cases had endoscopic follow-up data over a median duration of 12 months (range 3.4–51.3). The local recurrence rate was 4/89 (4.5%); all recurrent cases were managed endoscopically. The recurrence rate was lower in cases with en bloc compared with piecemeal resection (3.4% vs 50%, p=0.08), histologic complete compared with histologic incomplete resection (2.5% vs 22.2%, p=0.05), and R0 compared with non-R0 resection (2.5% vs 20%, p=0.06). After a median follow up of 14.6 months (range: 3–55.8), the overall and disease-specific survival in the study population was 98.8% and 100%, respectively.

Conclusions The current study demonstrates favourable clinical outcomes of selected colorectal ESD in a Western endoscopy setting. Further studies addressing the cost-effectiveness of ESD and comparing its long-term outcome with endoscopic mucosal resection in the West are needed.

PTH-050 RADIOFREQUENCY ABLATION AND ARGON PLASMA COAGULATION ENDOSCOPIC TREATMENT FOR SYMPTOMATIC RADIATION PROCTITIS TO IMPROVE ANAEMIA

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Introduction Radiation proctitis is a late effect of pelvic radiotherapy – which is commonly used to treat prostate cancer and female pelvic malignancy – and causes rectal bleeding, anaemia, diarrhoea and incontinence. Rectal bleeding post radiotherapy causes worry about bowel cancer and symptoms can force patients to become house bound with increased anxiety. Topical therapy with formaldehyde and argon plasma coagulation (APC) is time consuming and formaldehyde can damage healthy tissue (Andreyev HJN et al 2015). Radiofrequency ablation (RFA) can be used to treat large areas of neo-vascularisation (Zhou et. al. 2009). We treated a large cohort with symptomatic rectal bleeding to evaluate if ablative endotherapy is effective in treating anaemia in radiation induced proctitis.