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.

REFERENCE

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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.