questionnaire. Data on all patients undergoing TNE was collected prospectively and retrospectively analysed from the hospital computer records.

Results Since its introduction, 113 patients have been assessed as suitable for TNE. 67 females and 46 males (median age 62, IQR 52.5–70 years) underwent TNE. The first 17 patients were part of the pilot study. Of 96 subsequent patients, 66 were direct to test referrals on the cancer pathway, 10 other referrals on the cancer pathway, 13 routine, 3 planned surveillance, 1 urgent and 3 urgent inpatients. The most common indications were dysphagia (55 patients) and dyspepsia (36 patients). Endoscopy was completed trans-nasally in 92 patients (81.4%), trans-orally in 16 patients (14.1%) and failed in 5 patients (4.4%). Reasons for performing trans-orally were narrow nasal passages in 7 patients, 2 patients on warfarin with high INR, 2 patient choice and 7 didn't tolerate scope in nose. Duodenal intubation was successful in 107/113 (94.7%). There were no abnormal findings in 57 patients, inflammation was seen in 36 patients and 8 cancers of the oesophagus/oesophago-gastric junction were found. Biopsies were taken in 63 procedures and all were adequate for histology. Procedures were tolerated well with no immediate complications. Median (range) VAS was 9 (5–10) and of those who had had previous OGD, 71% expressed a preference for TNE and 29% preferred neither.

Conclusions TNE delivered in an outpatient clinic setting with immediate access to endoscopy unit is a safe and effective method of investigating upper gastrointestinal tract symptoms. This innovative service delivery has the potential to reduce traditional diagnostic gastroscopy and increase capacity.

PTH-063 ENDOSCOPIC RESECTION OF DYSPLASTIC LESIONS IN COLITIS

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Introduction Cumulative colon cancer risk is estimated at 2%–18% depending on duration of colitis. Management of flat neoplasia in colitis remains controversial. BSG guidelines recommend colectomy if complete endoscopic resection isn't guaranteed. Aim of this study was to assess need for surgery in the management of flat neoplasia in colitis.

Methods A multicentre cohort study of all flat neoplasia endoscopically resected in colitis in 5 tertiary European centres from 2008–2017.

Results 101 flat neoplasia were resected in 85 patients at 5 European centres. Mean age 61 years (range 28–82). Mean size of lesions 34 mm (range 8–120 mm).

Abstract PTH-063 Table 1 Lesion location

	KAR Colon (26)	KAR Rectum (13)	EMR Colon (54)	EMR Rectum (8)	Total (101)
Recurrence	2	0	5	0	7
Complications	5	0	2	0	7
En-bloc	14	11	33	5	63

Abstract PTH-063 Table 2 Fibrosis

	KAR Fibrosis (26)	KAR No fibrosis (13)	EMR Fibrosis (15)	EMR No fibrosis (47)	Total (101)
Recurrence	1	1	0	5	7
Complications	5	0	1	1	7
En-bloc	15	10	8	30	63

Abstract PTH-063 Table 3 Lesion size

	KAR 0– 20 mm	KAR >20 mm	EMR 0– 20 mm	EMR >20 mm	Total
Recurrence	0	2	3	2	7
Complications	0	5	1	1	7
En-bloc	4	21	37	1	63

40% of the lesions were treated by KAR. There was no difference in lesion location between EMR and KAR. Lesions >20 mm in size were removed more by KAR than EMR. More lesions removed by KAR (26) had fibrosis compared to EMR (15). 7 complications occurred in the cohort; 3 cases of bleeding and 4 perforations. Bleeding was controlled endoscopically. 3 perforations were managed endoscopically and 1 required surgery. 7/86 (8.1%) lesions with follow up data had recurrence.

Multi-variate regression analysis concluded;

- 33. EMR leads to higher recurrence rates, irrespective of size, location and fibrosis (p-value of 0.048)
- 34. KAR leads to higher complication rates in the colon as compared to rectum (p-value of 0.045)
- 35. KAR shows a trend towards better en-bloc resection (p-value 0.063).

5 lesions underwent surgery; 3 due to cancer; 1 due to perforation; 1 due to failure of endoscopic resection. Histology; 88 adenoma (low-grade dysplasia), 6 adenoma (high-grade dysplasia), 3 cancers and 4 sessile serrated polyps.

Conclusions This is the largest reported cohort of endoscopic resection of flat neoplasia in colitis. We demonstrate that both KAR and EMR are feasible in colitis with only 5% of patients requiring surgery. Fibrosis is very common in colitis. Recurrence is higher with EMR and complications higher with KAR. Our data shows that lesions with fibrosis are best treated by KAR, and those with fibrosis and <20 mm can be managed by EMR.

PTH-064 ANATOMICAL FEATURES OF THE ILEOCAECAL JUNCTION AND THEIR IMPLICATIONS FOR PROOF OF COLONOSCOPY COMPLETION

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Introduction A completion rate for colonoscopy in excess of 90% is a Joint Advisory Group quality assurance standard;

although images of the appendix orifice, tri-radiate fold and ileo-caecal junction (ICJ) are conventional markers for this, numerous studies have shown a lack of specificity confounded by variations in human anatomy. Terminal ileal intubation, with images of villiform mucosa, provides irrefutable evidence of completion but cannot always be achieved. We aimed to study the anatomy of the ICJ to determine the factors that may be relevant to documentation of proof of completion.

Methods The features of 69 embalmed cadaveric ICJ specimens were assessed, including gross morphology and the ileo-caecal angle. In addition, 100 consecutive colonoscopy videos performed by a single Bowel Cancer Screening colonoscopist showing ileal intubation were reviewed to determine ICJ morphology, time taken for ileal intubation and difficulties encountered.

Results The morphology of all cadaveric ICJs was categorised, with all except 2 being labial or papillary in type. The average angle of ileal entry into the caecum was 106 degrees (range 59–180). Both major ICJ types had on average a greater distance from the posterior caecal wall to the tip of the top lip compared to the distance to the lower lip, giving the ICJ an inferior tilt. In nearly half of the labial-type valves, the top lip overhung the bottom lip. On average, labial-type valves had thinner lips and a narrower vertical opening than papillary-type valves. These features could render a labial-type valve more difficult to visualise and intubate at colonoscopy.

In the colonoscopy videos, over a third of ICJs could not be fully visualised or categorised, with these having a lower rate of initial successful intubation than categorised valves. The median time taken for intubation was shorter for papillary compared to labial-type valves. Ileal intubation was faster in categorised valves when the appendix was visualised. It was also achieved more quickly in patients who were given buscopan pre-procedure.

Conclusions Appreciating the anatomical features of the ICJ should assist endoscopists to approach ICJs which can be difficult to navigate. Administering buscopan as pre-medication and visualising the appendix prior to attempting ileal intubation have both been shown to decrease the time taken for successful intubation.

PTH-065 SINGLE CENTRE EXPERIENCE OF SIMTOMAX, A POINT-OF-CARE TEST FOR COELIAC DISEASE, TO AVOID DUODENAL BIOPSIES

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Introduction The British Society of Gastroenterology (BSG) guidelines recommend screening for coeliac disease in patients with iron deficiency anaemia (IDA) with coeliac serology; but states that if it hasn't been carried out or if the result is unavailable, duodenal biopsies should be taken if the patient is undergoing a gastroscopy. As the prevalence of coeliac disease in the UK is around 1% and 5% in IDA, majority of duodenal biopsies are negative. As biopsies are costly we have been investigating ways to avoid doing them without missing the diagnosis of coeliac disease. Simtomax is a finger prick test for coeliac disease that provides immediate results, hence shown to be valuable as a negative predictive test.¹

The aim was to evaluate the value of Simtomax pre-endoscopy to reduce the number of duodenal biopsies without missing the diagnosis of coeliac disease in our local population.

Methods Between May–December 2016 we obtained informed consent and performed 106 Simtomax tests on patients attending for a gastroscopy (OGD) with an indication of anaemia/weight loss prior to their endoscopy. Using our databases, we collected the following: patient demographics, coeliac serology (anti tTG/EMA) if done, OGD findings and duodenal biopsy histology.

Results 106 patients (M=38, mean age 62, age range 34–91; F=68, mean age 62, age range 18–95) had both a Simtomax test and an OGD. 101/106 had duodenal biopsies (endoscopist's discretion) and 52 (49%) had coeliac serology (anti tTG). With histology as the gold standard for the diagnosis of coeliac disease, prevalence of the disease in these patients with IDA/weight loss was 3%. The negative predictive value (NPV) of a negative Simtomax test was 96% and the NPV of a negative Simtomax AND negative coeliac serology was 97%. The positive predictive values were 11% and 33% respectively for these 2 tests. The sensitivity and specificity of Simtomax were 33% and 96%.

Conclusions In the current NHS climate every saving is welcome as long as patient care isn't compromised. Our study shows that around 50% of patients attending for an OGD for IDA/weight loss didn't have coeliac serology available at the time of the procedure, therefore requiring duodenal biopsies as per BSG guidelines. Using a point of care test with a high negative predictive value would save more patients from having biopsies, save money¹ and valuable time of endoscopists, nurses and histopathologists. Our study confirms the high NPV of the point of care test Simtomax and would save biopsies in 96% of patients who haven't had coeliac serology prior to endoscopy (a saving of around £100 per set of duodenal biopsies).

REFERENCE

1. BMC Gastroenterol. doi:10.1186/s12876-016-0521537

PTH-066 ASPIRIN, NSAIDS, AND DYSPLASTIC COLONIC POLYPS – LESSONS FROM BOWEL CANCER SCREENING

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Introduction Studies on bowel cancer chemoprevention have been limited by the failure to distinguish between the activities of low-dose aspirin and standard non-steroidal anti-inflammatory drugs (NSAIDs). Also, little is known about the activities of these agents in bowel cancer screening programs. We, therefore, aimed to assess the numbers and sizes of polyps/cancers detected in bowel cancer screening of patients using low-dose aspirin (75-mg/day), NSAIDs, and controls.

Methods Guaiac peroxidase faecal occult blood test kits were sent to 71 026 local residents, aged 50–74 years, over the 12 calendar months of 2016: 38 799 subjects filled in and returned the kits. Those with positive kits (n=849) were interviewed and invited for colonoscopy. Their colonoscopic findings were classified according to their use of aspirin, NSAIDs, or neither. Only dysplastic or cancerous lesions were analysed. The Mann-Whitney test and Fisher's exact test were used as appropriate. Odds ratios were adjusted for age and sex by logistic regression.