Methods 80 datasets of clinical images were reviewed by 3 assessors yielding a median RIQI score from 30 observations for 8 independently practising colonoscopists. This was correlated against annual KPI data for each colonoscopist – including CIR (%), PDR (%) and median WDT (mins). Pearson Rank correlation was performed.

Results Median RIQI scores for the 8 colonoscopists ranged from 2 to 10 (<5=poor; 6–8=moderate, 9–10=high image quality). Unadjusted CIR ranged from 81.6% to 95.0%; PDR from 24.2% to 64.5% and median WDT from 7 to 19 min. Median RIQI scores had a moderate to good positive correlation with existing KPIs – correlation values: CIR $r=0.59$; PDR $r=0.53$; WDT=0.54.

Conclusions The RIQI score is a novel KPI assessing the recording of image quality. This is a surrogate marker of both tip control and ability to identify, wash and assess lesions. We have demonstrated that the RIQI score shows positive correlation with other commonly used KPIs in colonoscopy and further work is anticipated in exploring its role in upper GI endoscopy aligned to the BSG Quality Standards.¹

REFERENCE

1. Beg S, Ragunath K, Wyman A, et al. Quality standards in upper gastrointestinal endoscopy: a position statement of the British Society of Gastroenterology (BSG) and Association of Upper Gastrointestinal Surgeons of Great Britain and Ireland (AUGIS). *Gut* 2017 Sep 13;gutjnl-2017.

PTH-071 OUTCOMES OF ENDOSCOPIC RESECTION OF LARGE COLORECTAL LESIONS IN VERY ELDERLY (≥ 85 YEARS) PATIENTS

Andrew Emmanuel*, Shraddha Gulati, Margaret Burt, Bu Hayee, Aryn Haji. *King's College Hospital, London, UK*

10.1136/gutjnl-2018-BSGAbstracts.92

Background Endoscopic resection (ER) provides organ conserving treatment for large colorectal superficial neoplastic lesions (CSNL), allowing many patients to avoid surgery. Although ER is widely practised, little is known about outcomes in very elderly patients who may benefit the most from avoiding major surgery. The few studies examining outcomes in the elderly originate from eastern expert centres using ESD or use a relatively young definition of elderly. We aimed to compare outcomes of ER in very elderly compared to younger patients.

Methods Colorectal ERs of large (≥ 2 cm) CSNL performed at a tertiary institution were included. ER was performed for all lesions without overt invasive cancer regardless of size or location. Surveillance colonoscopy was performed at 3 months (SC1) and 12 months (SC2). Very elderly was defined as age ≥ 85 years. Outcomes were compared between patients aged ≥ 85 years and those <85 years.

Results 570 ERs of lesions ≥ 2 cm were included. Very elderly patients ($n=57$) had a mean age of 88 years *vs* 70 years for younger patients. There were no significant differences in mean lesion size (61 mm *vs* 52 mm, $p=0.19$) or location ($p=0.74$). The proportion of ERs using ESD/Hybrid ESD was similar (25% *versus* 26%, $p=0.81$). More patients ≥ 85 years had covert invasive adenocarcinoma, although this was not significant (12% *vs* 7%, $p=0.13$).

More patients ≥ 85 years experienced post procedure bleeding (8% *vs* 1%, $p<0.001$), but there was no difference in perforation rates (3% *vs* 3%, $p=0.83$) and no patients ≥ 85 years

required surgery for a complication. Recurrence was similar (15% *vs* 13%, $p=0.79$). Similar proportions underwent surgery for covert invasive adenocarcinoma (3.5% *vs* 2.9%, $p=0.79$) and for recurrence (2.4% *vs* 1.3%, $p=0.55$). Although they were equally likely to complete SC1 ($p=0.42$), patients ≥ 85 years were significantly less likely to complete SC2 (OR 0.43, $p=0.013$), probably because of a lack of medical fitness or unwillingness to undergo further surveillance (OR 24.3, $p<0.001$) but not necessarily due to death (OR 1.13, $p=0.87$).

Conclusions ER for large CSNL is safe and effective in very elderly patients, who can be treated using similar techniques to younger patients with similar short term recurrence. Serious complications are rare. If surgery is indicated for covert adenocarcinoma or recurrence, it appears very elderly patients are equally likely to undergo surgery. However, significantly fewer very elderly patients are eligible for long-term follow up and therefore treatment should be tailored according to each patient's specific lesion characteristics, symptoms and physiological fitness.

PTH-072 TRAINING FUTURE INTERVENTIONAL ENDOSCOPISTS: OUTCOMES OF TRAINEE PERFORMED COLORECTAL COMPLEX EMR/PEMR IN A TERTIARY CENTRE

Andrew Emmanuel*, Shraddha Gulati, Margaret Burt, Bu Hayee, Aryn Haji. *King's College Hospital, London, UK*

10.1136/gutjnl-2018-BSGAbstracts.93

Introduction Despite the widespread use of endoscopic mucosal resection (EMR) and piecemeal EMR (pEMR) to treat large colorectal superficial neoplastic lesions, training and competence in complex endoscopic resection (ER) in western centres takes place almost exclusively during specialist practice after the completion of residency. There are no accredited western training programs in advanced ER and no reports of outcomes of complex EMR performed by trainees. However, as the use of advanced ER to treat CSNL increases, it is conceivable that training in complex EMR takes place during residency for selected trainees. Our tertiary referral unit has been training 2 residents in advanced colorectal lesion assessment and EMR since January 2016. We evaluated the outcomes of complex EMR performed by trainees during this period.

Methods All EMR and pEMR of large (≥ 2 cm) CSNL performed from January 2016 to October 2017 were included. Lesions resected using ESD were excluded. ER were performed by 2 specialist interventional endoscopist trainers and 2 residents. The residents were already accredited for independent practice for diagnostic colonoscopy and polypectomy <2 cm. Patient and lesion characteristics were described and outcomes including failed ER, complications and recurrence for EMR performed by residents and trainers were compared.

Results 238 ER of colorectal lesions ≥ 2 cm were performed during the study period. After excluding procedures for recurrent lesions ($n=16$) and procedures using ESD/Hybrid ESD ($n=78$), 144 lesions resected using EMR/pEMR were included. 60 ER were performed by residents (42%). The mean patient age was 69.5 years (male=40). The mean size of resident performed EMR was 34.3 mm ± 10.7 mm (range 20 mm–60 mm) *versus* 52.6 mm ± 32.3 mm for ER performed by trainers ($p<0.001$). Lesions were located in the right colon ($n=33$),