67% used visual estimation to size polyps and 30% used the open forceps technique. There was a discrepancy in how respondents would position the scope and forceps to size the polyp with no statistical significance. 22% admitted they would not know which forceps were used in their department. Only 22% correctly identified the size of the OF (range 2 mm–8 mm).

Of those endoscopists who perform >500 LGI endoscopies/year, 50% used OF and 50% VE. This group were more likely to correctly size OF. Trainee endoscopists performing only 50–100 LGI endoscopies mostly used VE which raises the question of whether they correctly size polyps given their limited experience.

Conclusion This small observational survey shows that the majority of endoscopists are likely to be incorrectly sizing polyps at LGI endoscopy. The majority of our respondents use VE which has been previously shown to be inferior to the OF technique. However, as demonstrated in this survey, our endoscopy staff do not know the correct size of the OF. Incorrect polyp sizing at LGI endoscopy could have far-reaching consequences on CRC prevention. Further work should be considered to develop a standardized technique for polyp sizing at the time of LGI endoscopy and to determine if training should focus more on this important skill.

PTH-004 EFFICACY AND SAFETY OF ARGON PLASMA COAGULATION FOR THE TREATMENT OF RADIATION PROCTOPATHY

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Introduction Argon plasma coagulation (APC) is probably the most commonly used endoscopic treatment utilised for rectal bleeding due to radiation proctopathy (RP) but there are concerns about its efficacy and safety

Method Patients treated with APC for RP were identified from the endoscopy unit software database (Unisoft) over a 6 year period from 2011–2016. The case notes of each patient were obtained and the electronic patient record was also scrutinised in regard to symptoms, response to treatment and any complications.

Results 31 patients were identified that had APC for RP (median age 72, range 49–82) with all the 27 male patients having had radiotherapy for prostate cancer. There were four women that had APC for RP, 3 having had radiotherapy for cervical cancer and one having had radiotherapy for anal cancer. 28 of the 31 patients were referred for lower GI endoscopy primarily because of rectal bleeding. The number of APC treatments ranged from 1 to 7 (see figure 1) but only 10/31 (32%) required more than 3 sessions. Rectal bleeding was documented to have resolved in 28/31. In 2 patients it was unclear if rectal bleeding had resolved but the endoscopy report stated for both patients that there were only minimal RP changes and there was no need for further APC. One patient did have some persistent minor rectal bleeding but this was not thought to relate to the residual RP and APC was not given. There was only one minor endoscopic complication with small rectal ulcers noted after APC but this was not symptomatic and resolved spontaneously by the time of repeat endoscopy. APC was

provided at a flow rate of 0.6L/min and a power setting of 30W for all patients.

Abstract PTH-004 Figure 1 Number of APC treatments

Conclusions This long-term retrospective study has shown that only 10/31 (32%) patients required more than 3 APC sessions for symptom resolution and that treatment was efficacious with symptom resolution documented in nearly all patients. There was only one minor complication of small ulcers in the rectum after APC but this was not symptomatic and resolved spontaneously. In summary, APC is an effective and safe treatment for RP but may need multiple sessions to provide symptom resolution. APC could be considered as an alternative to medical treatments such as Sucralfate enemas.

PTH-005 RELIABILITY OF POST-COLONOSCOPY COLORECTAL CANCER ALGORITHMS

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Introduction Post-colonoscopy colorectal cancer (PCCRC) rate is an important metric of colonoscopy quality. The World Endoscopy Organisation (WEO) recently published a consensus statement advising review of PCCRC cases, to facilitate categorisation of PCCRCs into interval or non-interval cancers and determine their most plausible explanation. However, it is still unclear if the relevant algorithms are reproducible in real life practice, or how the respective plausible explanations are affected by factors such as reported adenoma location.

This study aims to test the inter-rater reliability for both categorisation of PCCRC and most plausible explanation of cause; it will also test whether altering the location of previously seen adenomas to neighbouring segments of the colon impacts on most plausible explanation categorisation.

Methods Colorectal cancer (CRC) cases diagnosed from January 2015 to December 2016 in a single trust were identified and each case was cross-referenced with online endoscopy and pathology databases to analyse cases of PCCRC. PCCRC definition was as per WEO consensus statement. Two assessors independently reviewed each PCCRC case, and agreement was measured using Cohen's kappa (k).

Results Among 527 patients with CRC, 35 cases of PCCRC were identified; mean age was 71 years (range 48–87) and 21 (60%) of cases were males.

Categorisation of most plausible explanations is seen in table 1. Consistent most plausible explanation was found in 33/35 cases, k = .903 (95% CI, .839 to .967), p < 0.0005.