Sub-categorisation into interval and non-interval types was consistent in 21/35 cases, $k = .417$ (95% CI, .305 to .529), $p < 0.0005$.

Altering location of adenomas to adjacent segments did not affect assessment of most plausible explanation in any of the cases.

Abstract PTH-005 Table 1 Most Plausible Explanation

Most Plausible Explanation	Assessor 1	Assessor 2
Likely incomplete resection of previously identified lesion	2	0
Detected lesion, not resected	3	4
Possible missed lesion, prior examination adequate	21	21
Possible missed lesion, prior examination negative but inadequate	7	8
Likely new CRC	2	2

Conclusions The inter-rater agreement for most plausible explanation of PCCRC is almost perfect, indicating that the WEO algorithm is reproducible in a real-world setting. Inter-rater agreement for categorisation of PCCRC was moderate, most likely reflecting the fact that patient notes were not reviewed in higher detail in this study, making intended interval times not always available to assessors. Altering adenoma location did not affect results, but larger sample sizes are required to assess this further.

PTH-006 **COMPLEXITY OF POLYPS IDENTIFIED VIA BOWEL SCREENING PROGRAMME IN NHS GREATER GLASGOW AND CLYDE**

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10.1136/gutjnl-2019-BSGAbstracts.31

Introduction Colonic polyps are a common finding in the bowel screening colonoscopy program (BCSP). Standard practice is to remove at index colonoscopy if possible. The SMSA polyp scoring system is a method of scoring the difficulty of polypectomy and is not currently recorded in routine practice in our institution. We wished to prospectively audit the spread of SMSA scores in polyps identified in BCSP colonoscopy in NHS Greater Glasgow and Clyde (GGC). Knowledge of the frequency of higher SMSA scores will allow resource planning for the volume of cases which need to be undertaken by an expert endoscopist. We also anticipated the exercise would be formative to our cohort of BCSP colonoscopists when assessing adenoma complexity.

Methods NHS GGC features 8 endoscopy units with BCSP colonoscopy performed at all sites. Between 1st November 2017 and 28th February 2018 we prospectively audited the spread of complexity of adenomas detected on bowel screening colonoscopy. We recorded SMSA polyp characteristics, endoscopic techniques used and the deferral rate and reason.

Results 626 records of polyp assessment were returned. 149 were excluded (outwith date window, invalid CHI, non-BCSP colonoscopy indication). 477 polyps were therefore included in the audit, from a total of 207 BCSP endoscopies. This cohort comprised approximately 30% of bowel screening colonoscopies undertaken during that time period. 16

Colonoscopists performed BCSP colonoscopy in the studied time-frame: 1 nurse endoscopist, 2 gastroenterologists, 13 colorectal surgeons.

The range of SMSA Scores for polyps was 4–17 (Median 6). 174 (36.5%) were level 1 polyps, 259 (54.3%) were level 2 polyps, 32 (6.7%) were level 3 polyps and 7 (1.5%) were level 4 polyps.

457 Polyps were removed at index colonoscopy (96%). Polypectomy deferral rates varied by SMSA level: 42.9% (3 of 7) for SMSA Level 4 polyps, 18.8% (6 of 32) for SMSA level 3 polyps, 1.5% (2 of 259) for level 2 polyps, and 4% (7 of 174) for level 1 polyps. The commonest reason for deferring level 1 and 2 polyps was failure to stop the patient's anticoagulant or antiplatelet medication.

Conclusion 8.2% of polyps detected on bowel screening colonoscopy were SMSA level 3 and 4. The majority of these were removed at index colonoscopy. It is uncertain whether removal at index procedure was uniformly the correct approach in patients with level 3 and 4 polyps and we require to do further research looking at completeness of excision. This audit was undertaken when Guaic based faecal testing was being utilised by the bowel screening programme. Since the change to Faecal Immunochemical Test with a threshold of 80ug/g stool we have seen an increase in adenoma detection rates from 40% to 52% and therefore the spread of SMSA scores may have changed.

PTH-007 **ENDOSCOPIC REMOVAL OF ADENOMAS INVOLVING APPENDIX BASE IS TECHNICALLY FEASIBLE USING FULL THICKNESS RESECTION DEVICE**

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10.1136/gutjnl-2019-BSGAbstracts.32

Introduction Endoscopic resection of adenomas involving the appendiceal base is challenging and often technically impossible with resultant necessity for surgery. Endoscopic full thickness resection (eFTR) using the full thickness resection device (FTRD) is a novel technique for removing lesions in the colorectum unresectable by conventional methods. We report use of this technique and outcomes for adenomas involving the appendiceal base.

Methods Data was collected and analysed on patients who underwent eFTR of adenomas involving the appendix base in the UK from April 2015 – January 2019. Main outcome measures were technical success, procedural time, specimen size, R0 resection, endoscopic clearance, and adverse events including appendicitis, and need for surgery.

Results 10 cases were identified across 4 sites where eFTR was attempted for adenoma at the appendix base. Mean patient age was 68 years (range 57–78). 3/10 had previous attempts at EMR and 2/10 had prior appendicectomy.

In 9/10 patients the lesion was reached with the FTRD, with failure of insertion in 1/10 due to sigmoid diverticulosis. The procedure was technically successful in 9/9 patients. Median procedure time was 72 minutes (50–97) and median resection time 6 minutes (4–17). Antibiotics were given in all cases. Median hospital stay was 1 day (1–3).

Median specimen size was 26 mm (15–35), and full thickness resection was achieved in 7/9 and R0 resection in 6/9. In