Of the 8 PICRCs, 3 were detected at subsequent BCSP procedures, one at 1 year surveillance, and 2 following re-invitation for screening at 2 years. Five were detected outside the BCSP.

Conclusions

1. The PICRC-3y in the BCSP is higher than the rate in the published literature (4.4%)(2) and the corresponding rate for Post Colonoscopy Colorectal Cancer (PCCRC) over the same period (2.5%).
2. CTC is commonly reserved for patients who are either deemed unsuitable for colonoscopy, or in whom colonoscopy has failed, meaning that there are likely to be substantial differences between the populations undergoing each examination.
3. Because CTC and colonoscopy are performed in different populations, those having CTC more likely to be frailer with greater co-morbidity, the higher rate of PICRC when compared to PCCRC has to be interpreted with caution and may relate to the difficulty of investigating such patients, who may not be fit enough for, or refuse an intervention even if a lesion is found.

REFERENCES

1. Beintaris I, et al. *United European Gastroenterology Journal* Vol 5 Issue 5_Suppl P0436
2. Obaro AE, et al. *Lancet Gastroenterol Hepatol* 3(5) 32–36

Abstracts of Distinction

AWE-08 WHY ARE WE MISSING COLORECTAL CANCER? A STUDY INVESTIGATING THE CAUSE OF DELAYS IN DIAGNOSIS

B Hayes, I Bjarnason, R Logan, B Hayee, P Dubois, A Haji, Lindsey Barker, G Chung-Faye, R Srirajaskanthan, AJ Kent. *King's College Hospital, London, UK*

10.1136/gutjnl-2019-BSGAbstracts.362

Introduction Delay in diagnosis of colorectal cancer (CRC) is associated with worse outcomes. Although studies have shown the incidence of CRC missed at endoscopy to be 2.5%–7.7% (Morris et al., 2014), there are additional non-endoscopic factors that may lead to delays. This study aimed to identify all factors leading to a delayed diagnosis, including endoscopic “misses”.

Methods All patients diagnosed with CRC at Kings College Hospital, London between 2011 – 2018 were included. We identified patients seen in an outpatient clinic or underwent endoscopy within 36 months preceding diagnosis. ‘Delayed’ cancers were grouped into ‘clinical factors’ and ‘technical factors’. ‘Clinical factors’ included the subset of post-colonoscopy colorectal cancers (PCCRC). The Joint Advisory Group on GI endoscopy (JAG) have defined PCCRC as being cancers diagnosed within 36 months of an endoscopy.

Results 797 cases of CRC were diagnosed in the study period and 60(7.5%) were seen in the preceding 36 months. 46 patients (5.8%) were determined to have a delayed diagnosis, of which 24(52.2%) were diagnosed within 1 year of initial investigation. 38 delayed diagnoses were due to clinical factors: PCCRC (n=23), incomplete endoscopy (n=2), inadequate investigation (n=7), missed on rigid sigmoidoscopy (n=1) and incomplete bowel preparation (n=5) with an average delay of 172 days. 8 delays were caused by technical

factors: Incomplete follow up (n=4), delayed investigation (n=2), histology not reviewed (n=1), missed on CT (n=1).

The rate of missed cancer in the 2WW, Bowel Cancer Screening and Routine referral pathways was 4.8% (n=14), 5.1% (n=8), 7.3% (n=28) respectively. The incidence of missed cancer in the right colon was significantly higher (p=0.068, 95% CI 0.9–.57). Further interrogation showed the highest incidence in the hepatic flexure (10.5%), splenic flexure (9.4%), caecum (7.5%), and anal canal (6.5%).

91.3% of PCCRCs versus 47.8% of other missed cancers identified another pathology at the initial endoscopy which was documented on the report (p=0.003, 95% Confidence interval 2.1–0.6).

A delay in diagnosis was not associated with more advanced TNM staging or K-ras mutations.

Conclusions Our rate of missed cancers is equivalent to that published in the literature, with the majority of missed cancers due to PCCRC. Delays in diagnosis are related to avoidable factors, such as improving the quality of bowel prep or ensuring further investigations in patients with incomplete endoscopies. Endoscopists should also be aware of the increased miss rate in specific locations. Non-cancer pathology identified at endoscopy is also associated with missed cancer, so endoscopists should be careful to maintain a careful examination for concomitant cancers.

Posters

PWE-039 INDICATORS OF RECURRENCE IN COMPLEX COLORECTAL POLYPS AT RESECTION

¹Ejaz Hossain*, ²Sreedhari Thayalasekaran, ³Asma Alkandari, ⁴Sophie Amdtz, ⁵Mohamed Abdelrahim, ⁶Pradeep Bhandari. ¹Queen Alexandra Hospital, Portsmouth, UK; ²QA Hospital, Portsmouth; ³QA Hospital, Portsmouth; ⁴QA Hospital, Portsmouth; ⁵QA Hospital, Portsmouth; ⁶QA Hospital, Portsmouth

10.1136/gutjnl-2019-BSGAbstracts.363

Cancer incidence in –0mm endoscopically detected colorectal lesions

Introduction Recent data has shown the risk of cancer in colorectal lesions <5mm is less than previously reported. This has led to a ‘resect and discard’ strategy for diminutive polyps. Few studies have been done to demonstrate cancer incidence in lesions between –0 mm and formulating a treatment strategy for these lesions.

Methods We analysed outcomes of all patients who underwent colonoscopy from January 2007 to December 2018 and were found to have colorectal polyps. Data was prospectively collected on an online endoscopy reporting system and pathology reporting system. A chart review was then carried out analysing the site, size, morphology and histological diagnoses of each polyp.

Results A total of 15906 polyps were removed at colonoscopy over the specified period, size of the polyps ranging from 1 mm to 120 mm and a mean size of 7.3 mm.

A histopathological diagnosis of 104 cancers was made (0.65% of all polyps), of which 94 cancers (90.25%) were associated with non pedunculated polyps [OR 1.45, 95%CI 0.7–.78].

89 cancers were found in the left colon and rectum compared with 15 cancers in the right colon (85.5% vs 14.5%)

[OR 4.31, 95%CI 2.–7, $p < 0.0001$]. Of the 2365 (14.87%) polyps –0mm in size, 4 (0.17%) had adenocarcinoma [OR 41.5, 95%CI 2.2–71, $p=0.01$]

Abstract PWE-039 Table 1 A further analysis of the polyps based on size is depicted.

Size	Proportion %	Morphology(%)	Dysplasia (%)	Odds Ratio
<5mm (N=10775)	67.74	Pedunculated. Nonpedunculated 3.7 96.3	No dysplasia. LGD. HGD. Cancer 34.0. 65.40. 0.60. 0.0	
–0mm (N= 2365)	14.87	31.75 68.25	21.33 74.44 4.06 0.17	41.5 ($p=0.01$)
1–0mm (N=1793)	11.27	46.9 53.1	12.2 68.89 15.67 3.25	813 ($p<0.0001$)
>30mm (N=973)	6.12	14.08 85.92	10.1 69.50 16.10. 4.30	952 ($p<0.0001$)

*OR calculated using <5mm size group as control

Conclusions This study demonstrates that the prevalence of covert cancer in colorectal lesions between –0mm is very low. Cancer risk, however, increased more than 20 fold in polyps greater than 1 cm (3.6%) [OR 21, 95%CI 7.8–8.15 $p<0.0001$] Based on the above data, we can conclude that the ‘resect and discard’ strategy can be extended to colorectal lesions –0 mm in size.

PWE-040 CANCERS IN COLONIC POLYPS: SIZE MATTERS

¹E Hossain*, ²P Bhandari, ³S Amdtz, ²M Abdelrahim. ¹Queen Alexandra Hospital, Portsmouth, UK; ²QA Hospital, Portsmouth

10.1136/gutjnl-2019-BSGAbstracts.364

Introduction Colorectal polyps with overt endoscopic features of invasive cancer are referred for surgery. However, polyps without overt features might still harbour cancer. We aim to identify incidence of such covert cancers in colorectal polyps to see if the ‘resect and discard’ strategy could be extended beyond diminutive polyps.

Methods We analysed outcomes of all patients who were colonoscoped by 5 expert (BCSP) endoscopists between January 2007 to December 2018 and were found to have polyps. Data was prospectively collected on an online endoscopy reporting system and pathology reporting system. A chart review was then carried out analysing the site, size, morphology and histological diagnoses of each polyp.

Results A total of 15906 polyps were removed at colonoscopy over the specified period. Mean size was 7.3 mm (range: 1 to 120 mm). 86.6% of all polyps were non pedunculated and 56.3% polyps were located in the left colon and rectum. The size, site, morphology and histology of these polyps is shown in table 1.

A histopathological diagnosis of polyp cancer was made in 104/15906 polyps (0.65%). 94/104 polyp cancers (90.25%) were associated with non pedunculated morphology [OR 1.45, 95%CI 0.7–78].

No cancer was found in polyps < 5 mm in size. However, the cancer incidence was 4/2365 (0.17%) in polyps –0mm,

58/1793 (3.25%), in polyps 1–0 mm and 42/973 (4.30%) in polyps > 30 mm in size.

89 cancers were found in the left colon and rectum compared with 15 cancers in the right colon (85.5% vs 14.5%) [OR 4.31, 95%CI 2.–7]. All 4 cancers found in the –0 mm category were non-pedunculated polyps in left colon.

Abstract PWE-040 Table 1

Size	Proportion %	Morphology (%)	Location (%)	Dysplasia (%)
<5mm (N=10775)	67.74	P* NP* 3.7 96.3	Right Left colon colon 50.3. 49.7	None LGD. HGD. Cancer 34.0. 65.40. 0.60 0.0
–0mm (N= 2365)	14.87	31.75 68.25	30.8 69.2	21.33 74.44 4.06 0.17
1–0mm (N=1793)	11.27	46.9 53.1	31.0 69.0	12.2 68.89 15.67 3.25
>30mm (N=973)	6.12	14.08 5.92	24.0 76.0	10.1 69.50 16.10. 4.30

*P- Pedunculated

*NP- Non Pedunculated

Conclusion We have demonstrated that the prevalence of covert cancer in colorectal lesions <5mm is negligible and that of polyps –0 mm is very low (0.17%). All these cancers were in non-pedunculated polyps in left colon. This will be a very important information in consideration of Resect & Discard strategy for polyps –0mm in size.

Cancer risk, however, increased more than 20 fold in polyps between – cm (3.25%) and 25 fold in polyps > 3 cm (4.3%). This calls for careful resection (preferably en-bloc) and retrieval of these polyps to obtain all prognostic information.

PWE-041 RETROSPECTIVE STUDY OF PATIENTS WITH MICROSCOPIC COLITIS

Ruridh Allen*, Gordon Reid, Santosh Salunke. NHS Forth Valley, Larbert, UK

10.1136/gutjnl-2019-BSGAbstracts.365

Background Microscopic colitis (MC) in its 2 histologically distinct patterns - Lymphocytic Colitis (LC) and Collagenous Colitis (CC)- is an increasingly common cause of non-bloody diarrhoea. There appears to be an association with other autoimmune conditions and a number of culprit medications such as selective serotonin reuptake inhibitors (SSRI) and proton pump inhibitors (PPI). There appears to be a variability in patient journey from referral to treatment.

Aim We looked to assess the current referral process, demographics and management of patients with MC within Forth Valley Royal Hospital (FVRH).

Method We performed a retrospective analysis of all patients with histologically proven MC from December 2016–December 2017 in FVRH. Data was obtained from pathology reports and patient details, including all clinical data was collected using ‘clinical portal’.

Findings In total data was collected from 55 patients, 41 of these were female, with a median age of 65. 36 patients had LC, 15 CC and 4 patients had a mixed or unclear diagnosis.