Abstracts of Distinction

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

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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 0.9–5.7). 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 2.1–6.0).

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**

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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 ‘reset 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 0.7–7.8).

89 cancers were found in the left colon and rectum compared with 15 cancers in the right colon (85.5% vs 14.5%)
Conclusions This study demonstrates that the prevalence of covert cancer in colorectal lesions between 0-0 mm is very low. Cancer risk, however, increased more than 20 fold in polyps greater than 1 cm (3.6%) [OR 21, 95%CI 7.8–31.75, 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.

Abstract PWE-040 Table 1

<table>
<thead>
<tr>
<th>Size</th>
<th>Proportion %</th>
<th>Morphology (%)</th>
<th>Dysplasia (%)</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5mm</td>
<td>67.74</td>
<td>Pedunculated.</td>
<td>No dysplasia. LGD. HGD.</td>
<td>3.7 96.3 0.0</td>
</tr>
<tr>
<td>(N=10775)</td>
<td></td>
<td>Nonpedunculated</td>
<td>Cancer 34.0, 65.40, 0.60.</td>
<td>21.33 74.44 4.06 0.17</td>
</tr>
<tr>
<td>0mm</td>
<td>14.87</td>
<td></td>
<td></td>
<td>41.5</td>
</tr>
<tr>
<td>(N=2365)</td>
<td></td>
<td></td>
<td></td>
<td>(p&lt;0.001)</td>
</tr>
<tr>
<td>1-0mm</td>
<td>11.27</td>
<td></td>
<td></td>
<td>813</td>
</tr>
<tr>
<td>(N=1793)</td>
<td></td>
<td></td>
<td></td>
<td>(p&lt;0.0001)</td>
</tr>
<tr>
<td>&gt;10mm</td>
<td>6.12</td>
<td></td>
<td></td>
<td>952</td>
</tr>
<tr>
<td>(N=973)</td>
<td></td>
<td></td>
<td></td>
<td>(p&lt;0.0001)</td>
</tr>
</tbody>
</table>

*OR calculated using <5mm size group as control

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 -0 mm 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**

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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.

Methods We performed a retrospective analysis of all patients with histologically proven MC from December 2016-December 2017 in FVRH. Data was obtained from patholgy 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.