[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

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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

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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.

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.

Although 9 patients had a minor rise in faecal calprotectin of >200. None of these patients had other significant pathology such as inflammatory bowel disease or colonic cancer. Patients reported watery diarrhoea in 54 of 55 cases with weight loss and abdominal pain being described in 16 and 19 patients respectively. Average length of symptoms at time of diagnosis was 4.8 months. 43 patients were on at least one medication which is known to be associated with MC and of these medications were reviewed in 31 cases (72%) with culprit medications being stopped or changed in 16 patients (37%). In total 32 patients were commenced on therapy for their MC with 19 (59%) receiving a reducing course of Budesonide, 7 (22%) receiving a fixed dose of Budesonide and 6 (19%) receiving 5-ASA. All 55 patients were triaged to have 'direct-to-test' colonoscopy, however, only 12 patients (22%) were referred directly to gastroenterology from GP. In total 42 patients were referred to surgical specialties with 30 of these patients receiving onwards referral to gastroenterology, often via their GP which resulted in a delay of up to 12 months in some patients. Only 5 patients had recurrent disease, with 2 patients undergoing active investigation at the time of data analysis.

Conclusion Our data set is in keeping with other published data on MC. There is a variation in both referral pathway and management of these patients in FVRH. There exists no common pathway and time taken to see a gastroenterologist is often lengthy and arduous. Review of culprit medications appears to be often overlooked and this may result in ongoing symptoms or recurrent disease. Within FVRH we are currently undertaking a service change with an aim to streamline the referral process, standardise management and improve the patient journey.

PWE-042 PREDICTING THE RISK OF GASTRO-INTESTINAL CANCER IN IRON DEFICIENCY ANAEMIA

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Introduction Iron deficiency anaemia (IDA) is a common clinical presentation, and in a significant minority of cases (~0%) is the first indication of an underlying cancer in the gastrointestinal (GI) tract. IDA is therefore considered an indication for fast-track endoscopic investigation, though the majority of cases will not actually have cancer. This study explores whether cancer risk in IDA can be predicted on the basis of simple and objective clinical variables.

Method A study of the predictive value of sex, age, haemoglobin concentration (Hb), mean red cell volume (MCV) and iron studies for the risk of GI malignancy on subsequent investigation in adults with confirmed IDA attending a single IDA clinic. The study population comprised a training dataset (n = 2295) and a validation dataset (n = 602). The analysis was undertaken using logistic regression, and an App to predict the probability of GI cancer in IDA was developed as a clinical tool using R Shiny programming language.

Results Using the training data, the best model showed that the risk of GI malignancy was strongly associated with sex (OR for males: 2.83, P<0.001) age, (OR: 1.05 for each added year, and Hb (OR: 0.975 for each g/l fall, P<0.001) – see figure 1 for the combined effects with their confidence intervals. GI cancer risk was less strongly associated with

Abstract PWE-042 Figure 1

MCV (OR: 0.971 for each fl fall, P<0.05), with a complex relationship largely due to an increased cancer risk in those with more severe anaemia, particularly in younger age-groups.

The model was tested on the validation data and produced similar results. It allowed stratification of 13% of the study population into a sub-group at high risk of cancer (arbitrarily defined as >15%), 28% into a sub-group at low risk (~%), and 16% into a sub-group at very low risk (<1%).

Conclusion This study confirms that a simple clinical scoring system can effectively stratify patients with IDA according to GI cancer risk, allowing stretched investigational resources to be targeted at the high-risk group, whilst perhaps avoiding invasive investigation altogether in those predicted to be at extremely low risk. The App developed has the potential to provide a quick estimate of GI cancer risk in clinical settings, and so facilitate patient counselling.

PWE-043 BURDEN OF CLOSTRIDIUM DIFFICILE INFECTION ON HOSPITALIZATION AND ITS IMPACT ON SPECIFIC MAJOR DIAGNOSTIC CATEGORIES

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Introduction *Clostridium difficile* infection (CDI) has emerged as a major healthcare-associated infection, with an important