PTH-086 REGIONAL IBD SURVEILLANCE ENDOSCOPY NORTH-WEST (RISE NOW): A PROSPECTIVE AUDIT OF PRACTICE IN NORTH-WEST ENGLAND

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Introduction Interval surveillance colonoscopy plays a crucial role in identifying and managing colitis related dysplasia to reduce the risk of colorectal cancer. Dye based or image enhanced chromoendoscopy has been endorsed by multiple organisations as the preferred means of detecting dysplasia since 2015. We aimed to assess the methods of surveillance utilised within the North West of England using the established trainee research network, Gastroenterology Trainee Research and Improvement Network North West (GasTRIN NoW).

Methods GasTRIN NoW investigators prospectively collected data from 10 hospitals in North West England to assess surveillance practice between June and October 2018. All IBD interval surveillance colonoscopies were included. SCENIC consensus guidelines were used as the standard for adequate surveillance while BSG standards were used for the interval surveillance standard.^{1 2}

Results 226 patients underwent IBD surveillance endoscopy (143 UC, 66 CD, 17 IBDU) with a median disease duration of 12 years (IQR9-20). There were 122 males and the median age was 54 years (range 20–86). A total of 46 (20%) procedures did not adhere to guidelines and 21 (46%) were delayed (>6 months). Dye spray was used in 22% (n=49) of procedures while the remaining had random colonic biopsies. Image enhanced chromoendoscopy was not used in our cohort. There was more visible dysplasia identified in the dye spray cohort 913 dye spray vs. 8 non dye spray, chi sq $p=7\times10^{-6}$). Adenocarcinoma was confirmed in the dye spray group while no cancers were identified in the non dye spray group. There were no differences in histological dysplasia between these groups (5 vs. 6 respectively, $p=0.11$). Where withdrawal time was recorded (n=139), median times were significantly different between both groups (dye spray 16 min (IQR 12–25) vs. no dye spray 10 min (8–14 min); Wilcoxon test, $p=3.7\times10^{-4}$).

Conclusions Our data demonstrates that there are delays to elective IBD surveillance in clinical practice. Dye spray colonoscopy is not widely practised across North west England. Dye spray colonoscopy identified more visible dysplasia and was associated with longer withdrawal time, a recognised surrogate marker for colonoscopy quality. Our data will inform future work in optimising IBD surveillance in England.

REFERENCES

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PTH-087 REGIONAL IBD SURVEILLANCE ENDOSCOPY NORTH-WEST (RISE NOW): A SURVEY OF CURRENT ENDOSCOPY PRACTITIONERS

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Introduction Patients with longstanding ulcerative or Crohn's colitis are at an increased risk of developing colorectal cancer (CRC). Colitis related dysplasia appears to confer the greatest risk, prompting national societies to advocate colonoscopic surveillance. The SCENIC consensus recommends chromoendoscopy (CE) with high definition white light endoscopy (HDWLE) as the preferred technique followed by HDWLE without CE for dysplasia detection replacing traditional random biopsy sampling.¹ Our aim was to explore practice, perceptions and barriers towards current 'gold standard' surveillance among endoscopists in North West England.

Method GasTRIN NoW investigators conducted a paper based survey of all colonoscopists in 13 hospitals in North West England to assess IBD colonoscopic practice between June and September 2018.

Results Forty two of 88 respondents (47.7%) were consultant gastroenterologists. Seventy one respondents (81%) performed IBD surveillance colonoscopy of which 5 (7%) were surgeons. Of the endoscopists performing interval surveillance, 39% (n=28) had a specialist interest in IBD although 62% (n=40) felt that IBD surveillance endoscopy comprised less than a quarter of their endoscopic practice. Sixty six of the 71 colonoscopists (93%) reported having access to CE but only 7% (4 of 60 responses) used CE in more than 50% of surveillance cases. Fifty seven percent of dye based CE users felt confident using this technique. Those with prior training in CE felt more confident performing CE than those without training (31 compared with 3, $p<0.05$). Despite this, many colonoscopists still perform random biopsies (Figure 1). Among the 66 endoscopists with access to CE, 40 (61%) and 27 (42%) reported financial constraints and inadequate bowel preparation as barriers to CE surveillance respectively. Fifty nine percent of those performing surveillance endoscopy felt that their institution was open to training in new surveillance modalities.

Abstract PTH-087 Figure 1 Percentage of cases with random biopsies

Conclusion IBD surveillance is predominantly delivered by consultant gastroenterologists with CE access being widely available. Despite this, WLE with random biopsy sampling is still widely practiced even by gastroenterologists. Lack of confidence from perceived lack of training, financial constraints and poor bowel preparation were cited as main reasons for not performing CE. Overcoming operational barriers may positively impact on quality of surveillance in IBD patients.