Introduction Numerous studies have questioned the value of taking biopsies in endoscopic macroscopically normal mucosa. Inappropriate biopsies increase financial and time strains on NHS endoscopy and pathology services. Taking a biopsy adds to each procedure a cost of £56 for gastroscopy and £66 for colonoscopy. With 4.5% yearly increase in demand for histopathology services and only 1.2–3% per year increase recruitment of cellular pathologists, number of patients waiting longer than 6 weeks for diagnostic results has increased by 17% per year since 2010–11.

Methods We did a retrospective study of diagnostic gastroscopies and colonoscopies performed across 3 district-general hospitals (January-November 2018) in United Lincolnshire Hospitals NHS Trust. Endoscopic reports were examined for age, sex, indication, endoscopic diagnosis, biopsies taken (yes/no), and operator (gastroenterologist/surgeon/nurse endoscopists (NE)). We classified ‘biopsy not indicated’ when mucosa was described as ‘normal’ for indications of anaemia, rectal bleeding, weight-loss in colonoscopies, and dyspepsia, vomiting and abdominal pain in gastroscopies.

Results A total of 326 gastroscopies and 355 colonoscopies were included. 170 procedures fulfilled the ‘biopsy not indicated’ criterion, of which 59% had multiple biopsies (at least 5 specimens) taken. Biopsy rates among gastroenterologists, surgeons, and NEs in ‘biopsy not indicated’ were 53% (39/73), 60% (42/70) and 70% (19/27) respectively. Using Chi-square, there was no statistically significant difference between various groups: surgeons and NEs (p = 0.34), surgeons and gastroenterologists (p = 0.42), and gastroenterologists and NEs (p = 0.12).

Conclusions Our study showed that a significant number of biopsies are performed without good indication. Further, no significant inter-operator variability was seen. Both British Society of Gastroenterology and National Institute for Health and Care Excellence have published guidance on when biopsy is indicated, but there are few high-level recommendations on when not to biopsy. Taking a biopsy cost of £103 a potential of £10330 could have been saved during our study period. Findings from our study mandate development of such guidance, followed by training of all endoscopists and UK-wide audit of local practice to ensure compliance with guidelines. The implementation of such strategies has been proven effective at a local level, and if adopted nationally can significantly optimise financial burden on the NHS and reduce waiting times.

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P355 DESIGN AND IMPLEMENTATION OF THE FIRST ONE-STOP MULTIDISCIPLINARY CLINIC FOR LYNCH SYNDROME IN THE UK

Intervention The clinical benefit of a multidisciplinary clinic (MDC) model has been well documented for a variety of medical conditions. We designed and implemented a novel MDC for Lynch syndrome (LS) patients, which aims to improve treatment outcomes, participation in research trials, and patient satisfaction.

Methods From January 2019, LS patients in our region were invited to attend a bimonthly MDC offering gene-specific evidence-based cancer risk management. Patients could choose to see the gastroenterology, colorectal, gynaecology, medical oncology, research, and clinical psychology teams. Clinical outcomes and patient satisfaction were evaluated over 12 months.

Results Thirty-eight LS patients were seen (8 MLHI1, 18 MSH2, 8 MSH6, 4 PMS2); mean age was 46y (range: 20–
STRAIGHT-TO-TEST REFERRALS OF IRON DEFICIENCY ANAEMIA: RESULTS FROM A TRAINEE-LED, PAN-YORKSHIRE MULTI-SITE AUDIT

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Introduction
Iron deficiency anaemia (IDA) is a common reason for gastroenterology referral. We aimed to see whether straight-to-test (STT) endoscopy referrals enable more rapid diagnosis in patients with cancer or improve chances of treatment success.

Methods
Retrospective audit across 10 sites in Yorkshire, by a newly formed trainee research network. We included patients referred on a suspected cancer pathway with IDA in November 2018. Data on referral criteria, initial review, investigations, time to diagnosis and outcome were collected. Anonymised data was pooled for comparative analysis.

Results
508 patients included: median age 72 years (range 24–97); 55% female. 93 (18%) patients underwent STT investigations, varying significantly across 8 sites (1.4–78.2% referrals). Patients were more often seen in surgical (42%) or gastroenterology (23%) clinic. Cancer was diagnosed in 41 (8%) patients: 5% colorectal, 1% upper gastrointestinal (GI) and 2% other cancers.

The STT group were younger and had a significantly reduced time to first investigation/cancer diagnosis, than those not referred STT (non-STT). However, patients were no more likely to receive curative treatment (table 1).

Conclusion
STT investigations removed the need for initial (but not follow-up) review in 1 of 5 patients with IDA and reduced time to diagnosis, than did not increase likelihood of treatment success. Patient choice was the main reason for incomplete investigation. We plan to re-audit after introduction of formal STT pathways in the region, to see if better patient selection can improve outcomes.