Our data show that that with regimented training and a protocolised and standardized approach we can improve the pickup recurrent disease in patients post EET on dedicated sessions in order to offer retreatment.

Our aim is to introduce this across the country by supporting and monitoring other CNEs and specialist units to follow our model to provide a standardized model which is easy to follow and provide a national training programme for both therapeutic and diagnostic procedures.

Education & training

074 EXPERIENCE OF A PILOT TRAINING THE COLONOSCOPY TRAINERS COURSE IN INDIA

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Introduction Training the Colonoscopy Trainers (TCT) courses have become a key resource in improving colonoscopy training in the UK and elsewhere around the globe. To our knowledge, such courses have never taken place in India. Endoscopy in India is believed to be of a high standard but the training of endoscopists is variable with little structure or standardisation. Indian and UK colleagues were keen to explore whether TCT courses would be effective and well received in the Indian endoscopic setting.

Methods A team of three UK based experienced TCT faculty visited the Dr Rela Institute and Medical Centre (DRIMC) in Chennai, India in January 2020. Over the course of 4 days, two 2 day TCTs were delivered to a total of 12 delegates. All of the delegates were independent consultant colonoscopists with a training role in their base hospital. Years of independent colonoscopy median 3 years (range 1 - 9). Number of colonoscopies performed independently median 800 (range 100 - >5000). Each delegate had been nominated to attend by their home unit in an area encompassing much of South India. The courses delivered were slightly modified standard UK courses. Day 1: educational theory, role play; Day 2: hands on training of peers. Delegates were asked to retrospectively evaluate the impact the course had on their training style and techniques using a pre- and post-course 1–10 scale in the following specific areas: applying structured training interventions; segmenting training; SMART (Specific, measurable, Achievable, Realistic, Timely) objective setting; understanding conscious competence; avoiding dual task interference;

using performance enhancing feedback; critical self-reflection on teaching.

Results

Conclusions This is an account of the first ever TCT courses, to our knowledge, delivered in India. The courses were very positively and enthusiastically received. Delegates knowledge of and ability to deliver effective colonoscopy training were significantly improved across a range of measures. We plan to deliver further courses with an eventual aim to enable Indian colleagues to become effective TCT faculty to deliver their own courses.

075 TRAINING IN CLINICAL RESEARCH FOR THE ANY, NOT THE FEW: A PILOT PROGRAMME IN HEPATOLOGY

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Introduction Everyone working in frontline NHS services is trained to deliver clinical care, but few are trained to conduct research. To ensure research remains accessible to all patients, there is a need to train future generations in the skills required to deliver it. The NIHR hepatology National Specialty Group (NSG) developed a national programme to empower trainees to use, conduct, design and lead clinical research as an NHS Consultant. Through participation in a year-long programme, trainees learn core competencies against a curriculum comprising: Good Clinical Practice (GCP), Evidence-Based Medicine (EBM), Clinical Research Methodology, Research Governance, and Conduct of Clinical Research.

Methods We established a team of trainers and trainees to develop the programme. It is based on the principles of EBM and delivered through a mix of residential learning, on-line materials, and supervised participation in clinical research. The programme begins with a 2-day residential course and is completed at work and on-line. Online materials - developed in collaboration with NIHR Learn - include: GCP training, Evidence-based hepatology videos, critical appraisal worksheets and a forum for networking and giving feedback. Assessment is via completion of Workplace Based Assessments, coursework and a satisfactory educational supervisors report. From the outset we worked with specialty societies and the Hepatology NSG. We engaged the Specialist Advisory Committee at the Royal College of Physicians, and the NIHR Academy and CRN during development to ensure that they were fully aware of the initiative.

Results The first cohort of 27 trainees recently completed the course, and a second similar-sized group began in September 2019. Feedback was sought from the year 1 cohort. The majority felt more robust research training was important and necessary. Everyone said the course was extremely useful or useful. Participants were empowered to be research active, and to build it into their clinical work: most were on a trial delegation log and had been involved with more than one aspect of the study. Some have also continued to recruit into studies in their current placement. Crucially, several registrars are now leading research. One obtained funding and opened a portfolio study which has recruited over 300 participants; one is a co-applicant on an NIHR grant; and another leads an industry funded study and is a co-applicant on grants from the Academy of Medical Sciences and NIHR.

Abstract 074 Table 1

	Pre-course score [median and (range)]	Post-course score [median and (range)]	p-value (Wilcoxon)
Structured interventions	3 (1–5)	8 (6–9)	<0.01
Segmenting	3 (1–6)	8 (7–9)	<0.01
SMART objectives	1 (1–4)	8 (7–9)	<0.01
Conscious competence	2 (1–5)	8 (7–9)	<0.01
Dual task interference	2 (1–7)	9 (1–7)	<0.01
Effective feedback	3 (1–5)	8 (8–9)	<0.01
Reflection	3 (1–4)	8 (7–9)	<0.01

Conclusions The programme has delivered competency-based training in clinical research and generated excellent feedback and evidence of increased research engagement in the first cohort. Although the programme to date has focused on hepatology doctors, the skills taught are generic and it is our hope that it is adapted for all specialties and healthcare professions, to help build the next generation of research-ready NHS staff.

Posters

Endoscopy

P1 EARLY EVALUATION OF A COMPUTER ASSISTED POLYP DETECTION SYSTEM IN BOWEL CANCER SCREENING

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Introduction Polyp detection during colonoscopy is critical for reduction of colorectal cancer associated morbidity and mortality. Computer-aided detection (CAD) systems are now available but have had limited evaluation in clinical practice. Our aim is to evaluate the effectiveness of, and clinician acceptability of, a polyp detection system in the bowel cancer screening programme (BCSP).

Methods We evaluated polyp detection rate (PDR) and adenoma detection rate (ADR) over a 2 month period on bowel cancer screening lists. In the first month, there was no change in usual practice. In the second month, all colonoscopies were performed with the addition of GI Genius (Medtronic Ltd), a computer aided polyp detection system.

Analysis of all CAD-assisted polyp detections (for greater than 1 second) was assessed alongside the endoscopist interpretation of the area of mucosa highlighted by the CAD.

Endoscopist's completed an evaluation form after the procedure.

Results The PDR and ADR for standard versus CAD-assisted colonoscopies are shown in table 1.

A sub-group analysis of 6 cases showed 149 episodes of CAD-assisted 'polyp detections' of which 36 were considered true polyps (24.3%) by the endoscopist. The 112 false positive detections (75.8%) consisted of folds (46), normal mucosa (35), stool (17), bubbles (5), ileocaecal valve (4), suction polyps (4), and Endocuff arms (2).

The endoscopist evaluation of 11 clinicians revealed that 45% found the system was helpful in identifying polyps and

90% of clinicians felt that it did not adversely affect the procedure. 70% were unsure if the CAD system should be used in clinical practice.

Conclusions This early evaluation found no significant difference in polyp and adenoma detection rate when using a polyp detection system in the BCSP with high performing operators. The false positive rate is a significant issue. However, endoscopists did not feel the CAD adversely affected the procedure and further studies are required to evaluate the impact of CAD in clinical practice.

P2 RECTAL GASTRIC HETEROTOPIA ASSOCIATED WITH HELICOBACTER PYLORI; A CASE REPORT

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Introduction Lower GI tract gastric heterotopic mucosa (GHT) is rare and the aetiology remains unclear. GHT is a condition in which the gastric mucosa is discovered elsewhere. GHT in lower GI tract is uncommon and literature review shows that predominant locations include oesophagus, and duodenum; it can rarely present like a Meckel's diverticulum.

Rectal GHT is rare and literature search has shown around 50 case reports. Only a few have shown colonisation of *Helicobacter pylori*, which can be associated with the usual associations of *Helicobacter pylori* such as inflammatory change, ulceration and potential neoplasia, such as MALT lymphoma and colorectal cancer; the latter can sometimes lead to intermittent rectal bleeding.

Case Presentation We present a case of 56 year old lady who attended for a flexible-sigmoidoscopy as part of the Bowel Scope programme. Her sigmoidoscopy, revealed a 10 mm raised area in the rectum, near the anal verge, with an unusual pit pattern appearance.

She was subsequently referred for a completion colonoscopy and potential EMR polypectomy; the Bowel Cancer Screening colonoscopist took biopsies from the lower rectal polyp as he felt that this was not an adenomatous polyp; the histopathological analysis showed a mixture of normal large bowel mucosa and gastric phenotype contiguous with each other; there was mild patchy chronic inflammation with no evidence of dysplasia or malignancy; there were a small number of curvilinear rod shaped organisms seen trapped in the surface suggestive of *Helicobacter pylori*. These findings were confirmed with the aid of immunohistochemistry.

Discussion *Helicobacter pylori* can pass from the stomach to colonise other areas such as gallbladder, ears, nose, skin and areas as far as intestinal tract and to the rectum. *Helicobacter pylori* is associated with adenocarcinoma.¹ There are studies showing increased risk of both colon polyps and colon cancer in *H. pylori*-infected patients.^{1 2} We present the first case of GHT, in the literature, within the national Bowel Scope programme.

REFERENCES

1. Beyond the stomach: An updated view of *Helicobacter pylori* pathogenesis, diagnosis, and treatment. *Digestive Disease and Sciences*, 2012 Aug; **57**(8): 2184–94
2. *Helicobacter pylori* is a risk factor for colonic neoplasms. *American Journal of Gastroenterology*, 2013 Feb; **108**(2): 208–15.

Abstract P1 Table 1 The effect of a polyp detection system on PDR and ADR in BCSP Colonoscopy and Bowel Scope lists

	BCSP Colonoscopy			BCSP Bowel Scope		
	Standard	CAD	P value	Standard	CAD	P value
Procedures	86	82		565	408	
Polyps seen	208	202		251	150	
PDR (%)	58.1	62.2	0.59	26.9	24.3	0.35
ADR (%)	46.5	48.8	0.77	12.6	9.8	0.18