**SURVEILLANCE GUIDELINES: LONG-TERM ADENOMA SIMULATION TRAINING FOR ENDOSCOPY ASSISTANTS**

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**Introduction** 1 in 10 people in the UK have a detectable colorectal adenoma. Most adenomas are asymptomatic and detected incidentally during national screening and surveillance programmes. Post-polypectomy, these patients are considered to be at an increased risk of colorectal cancer (CRC), with calculations primarily based on polyp size and multiplicity.

To investigate the outcomes of endoscopic surveillance and compare the British Society of Gastroenterology (BSG) 2012 guidelines with the recently revised 2019 guidelines. The primary outcome was to determine the incidence of advanced adenomas on repeat investigations following the complete guideline for polyp surveillance reduces the burden of colonoscopy to patients and the healthcare system, without compromising the identification of significant pathology or CRC.

**Methods** Post-polypectomy patients under surveillance at a single large tertiary referral centre serving a secondary care population of approximately 1 million were identified. Patients with a familial hereditary condition, polyposis syndrome, inflammatory bowel disease (IBD), previous CRC diagnosis with a familial hereditary condition, polyposis syndrome, or large non-pedunculated colorectal polyp (LNPCP), or discharge during surveillance was detected in n=46(9.5%), n=7 (1.7%) patients in high, intermediate and low risk patients respectively, as per 2012 guidelines; high risk vs intermediate risk (p=0.0017), intermediate risk vs low risk (p=0.146). On re-stratification to 2019 guidelines, API ≥1 was determined in LNPCP (n=177), high risk (n=296) and discharge (n=717), as n=15 (8.5%), n=34 (11%) and n=18 (2.5%) respectively.

**Conclusions** Using 2019 revised guidelines, 717 (60.1%) patients would have been discharged following the index procedure and no CRC would have missed. 18 (2.5%) patients with an API ≥1 would have been missed, however this was not significant (Fisher’s Exact Test; p=0.42). The revised BSG guideline for polyp surveillance reduces the burden of colonoscopy to patients and the healthcare system, without compromising the identification of significant pathology or CRC.

**REFERENCES**


**Introduction** Bowel Scope screening (BoSS) was launched in 2013 for individuals aged 55 after a landmark study showed that sigmoidoscopy based colorectal cancer (CRC) screening reduced cancer incidence by 23%.\(^1\) Longer term follow up in this study showed that the protection given by sigmoidoscopy based screening from colorectal cancer lasted at least 17 years.\(^2\)

What is not known is how subjects who underwent BoSS at age 55, would interact with the home faecal occult blood/ immunochemical test (FOBt/FIT) based screening offered at age 60, compared to non-BoSS screened subjects engaging who engage with FOBt/FIT.

**Methods** 429 Northamptonshire subjects who underwent BoSS in 2014 had their interaction with the FOBt/FIT screening in 2019 recorded and analysed, benchmarked against non-BoSS screened subjects’ data (from Exeter database dashboard; 2017 & 2018).

**Results** 429 subjects’ data analysed, 205 females (47.8%), 412 subjects attended a BoSS examination. 30/412 had the benefits shown in the original studies.\(^1\)\(^,\)\(^2\) this trend for lower positivity is established when looking a sample size is too small to reach statistical significance, but if the BoSS cohort than the non-BoSS screened population. The and older.

Much more likely to engage with FOBt/FIT at the age of 60

**Conclusion** The cohort of subjects who underwent BoSS in 2014 were significantly more likely to return FOBt/FIT kits when compared to a non-BoSS screened population (benchmarked with data from 2017 & 2018), Even considering the switch to FIT from FOBt during 2019, the marked improvement in returns suggests that the majority of subjects who underwent BoSS found it a positive experience making them much more likely to engage with FOBt/FIT at the age of 60 and older.

Despite the higher uptake, the positivity rate is lower for the BoSS cohort than the non-BoSS screened population. The sample size is too small to reach statistical significance, but if this trend for lower positivity is established when looking a bigger sample (eg; all the regions of England), this may represent the benefits shown in the original studies.\(^1\)\(^,\)\(^2\)

**Abstract P78 Table 1**

<table>
<thead>
<tr>
<th></th>
<th>BoSS cohort 2019</th>
<th>FOBt data 2017</th>
<th>FOBt data 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Uptake</strong></td>
<td>304/412, 73.8%</td>
<td>45869/75082, 61.1%</td>
<td>51600/82185, 62.8%</td>
</tr>
<tr>
<td><strong>Positivity</strong></td>
<td>5/304, 1.6%</td>
<td>953/45869, 2.1%</td>
<td>97451600, 1.9%</td>
</tr>
</tbody>
</table>

† For Boss cohort vs FOBt 2017, and for Boss cohort vs FOBt 2018; p < 0.0001

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