ABS-0081 Table 4), iceA (57/91,62.6%) (Table 7) and iceA1 (50/91, 55%) (IDDF2021-ABS-0081 Table 5), iceA2 (10/91, 11%) (IDDF2021-ABS-0081 Table 6) strains in patients with gastric cancer. The odds of gastric cancer in *H. pylori* with iceA was 4.245 higher than those who did not carry iceA (IDDF2021-ABS-0081 Table 7). The odds of gastric cancer in *H. pylori* with iceA1 was 4.685 higher than those who did not carry iceA1 (IDDF2021-ABS-0081 Table 5).

Conclusions VacA s1, m2, and iceA are predominant in patients with gastric cancer. As compared with those in non-cancer patients, patients with gastric cancer have less vacA s1 and more m1 subtypes. The odds of gastric cancer in *H. pylori* with iceA was 4.245 higher than those who did not carry iceA. The odds of gastric cancer in *H. pylori* with iceA1 was 4.685 higher than those who did not carry iceA1.

IDDF2021-ABS-0082 APPLICATION AND LEARNING CURVE OF NICE CLASSIFICATION FOR COLORECTAL POLYPS UNDER NON-MAGNIFYING ENDOSCOPY

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Background To study the application value of narrow-band image international colorectal endoscopic (NICE) classification under non-magnifying endoscopy in the accuracy of

colorectal polyp judgment and clarify the learning curve of NICE classification application of endoscopes with different experiences

Methods 1674 pictures of colorectal polyps from the Sixth Affiliated Hospital of Sun Yat-sen University from December 2019 to April 2020 were collected. Three junior physicians and one senior physician were respectively used for NICE classification. Pathological diagnosis was taken as the gold standard, and the accuracy rate was calculated and the learning curve was drawn

Results The accuracy of NICE classification was 88% and 95.6%, respectively, for primary and senior physicians. The accuracy rates of primary and senior physicians in the diagnosis of inflammatory hyperplasia and invasive cancer were 87.4% and 84%, 99.2%, and 100%, respectively, with no statistically significant difference ($P > 0.05$). The accuracy of adenoma and early cancer was 63.2% and 90.7%, respectively, with a statistically significant difference ($P < 0.05$) (IDDF2021-ABS-0082 Table 1). The Kappa values of the preliminary and senior physicians for the detection of the consistency between NICE typing and pathological results were 0.8 and 0.93, respectively. After 900 and 350 images of colorectal polyps were observed by primary and senior physicians, the accuracy of judgment was nearly 100% and the fluctuation was reduced (IDDF2021-ABS-0082 Figure 1. Learning curve of NICE for primary and senior doctors)

Conclusions The overall accuracy of NICE classification for colorectal polyps under non-magnifying endoscopy is high, and endoscopists can achieve high accuracy after learning and accumulating a certain number of endoscopic images, which is easy for clinical promotion

Abstract IDDF2021-ABS-0082 Figure 1

Abstract IDDF2021-ABS-0082 Table 1 Accuracy of NICE for primary and senior doctors

Type	Primary doctor			Senior doctor			χ^2	P
	Correct Number	Wrong number	accuracy	Correct number	Wrong number	accuracy		
Normal	933	50	0.949	982	1	0.999	48.332	0 ¹
Type1	208	30	0.874	200	38	0.840	1.098	0.295 ¹
Type2	204	119	0.632	293	30	0.907	69.099	0 ¹
Type3	129	1	0.992	130	0	1.000	\	1 ²
Total	1474	200	0.880	1605	69	0.958	69.369	0 ¹

(¹Pearson's chi-square test; ²Continuity correction for chi-square test)