Screening Modalities	Number of studies	I ²	Pooled ASMRs (95%CI)
gFOBT	8	90.5%	0.894 (0.835, 0.958)
6-10 years	6	61.4%	0.936 (0.884, 0.991)
FIT	18	82.5%	0.879 (0.847, 0.913)
1-5 years	6	37.0%	0.987 (0.934, 1.043)
6-10 years	6	0.0%	0.853 (0.806, 0.902)
11-20 years	4	19.2%	0.818 (0.793, 0.843)
gFOBT or FIT (6-10 years)	10	88.9%	0.882 (0.835, 0.932)
Faecal test or FS (11-20 years and >20 years)	4	94.3%	0.840 (0.786, 0.898)
Faecal tests or colonoscopy (11-20 years)	4	87.7%	0.619 (0.549, 0.698)

ASMR: age-standardised mortality ratio, gFOBT: guaiac faecal occult blood test, FIT: faecal immunochemical tests, FS: flexible sigmoidoscopy. *Each country had two studies (male and female), and this table only showed subgroups with at least two countries or areas (four studies).

Abstract IDDF2021-ABS-0179 Figure 1

Results CRC screening programmes have been conducted in 58 countries/regions. After matching with the IARC database, we recorded >2.5 million CRC-related deaths from 22 countries where rollout screening programmes were performed. The screening modality with a provision of choice between faecal tests and colonoscopy as the primary screening test was associated with a 38.1% reduction in CRC mortality (ASMR=0.619, 95%CI: 0.549-0.698), which was higher than programmes that offered guaiac faecal occult blood test (gFOBT) (0.894, 0.835-0.958), faecal immunochemical tests (FIT) (0.879, 0.847-0.913), gFOBT or FIT (0.882, 0.835-0.932), and faecal tests or flexible sigmoidoscopy (0.840, 0.786-0.898). The longer duration of screening was associated with a higher reduction in the pooled ASMR. In particular, the pooled ASMR became non-significant (0.987, 0.934-1.043) when the FIT screening was implemented for less than 5 years (IDDF2021-ABS-0179 Figure 1. The pooled age-standardised colorectal cancer-related mortality ratio by screening modalities and screening duration). The LMM result also showed a 0.172 decrease in ASMR ($P<0.001$) among the screening strategy with faecal test or colonoscopy as a primary screening tool when compared with gFOBT.

Conclusions A CRC screening programme running for >5 years was associated with a reduction of CRC-related mortality. Countries with a heavy burden of CRC should implement sustainable, organised CRC screening providing a choice between faecal tests and colonoscopy as a preferred primary screening test.

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CHALLENGES IN MOTORISED POWER SPIRUS ENTEROSCOPY- INITIAL EXPERIENCE

Viswanath Reddy Donapati*, Rakesh Kumar Adi, Ravi Shankar Bagepally, Srinivas Rao Guduru R, Bharani Immaneni, Vamsidhar Reddy Vempalli. *Yashoda Hospital, Secunderabad, Telangana, India*

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Background The novel Motorised Power Spirus Enteroscopy is a valuable tool in our armamentarium for small bowel evaluation and therapy. But, there are some challenges in performing it. **Aim** Challenges faced during the performance of the power spirus enteroscopy were analysed and what are the measures to overcome them.

Methods We performed 22 cases of small bowel evaluation using the motorised power spirus enteroscope. Eighteen were

performed antegrade manner and four were from the retrograde route. Ten cases were done for GI Bleeding, Six for evaluation of pain abdomen and three for small bowel lesions like thickening on imaging. One was a case of intestinal obstruction due to a polyp in Ileum.

The procedure went on successfully in 20 cases. Two cases could not be done due to difficulty in intubation of Esophagus, which we could complete using a Balloon Enteroscope. Two cases had a Total Enteroscopy from the proximal route. In eight cases, there was difficulty in negotiating Pyloric channel but ultimately succeeded on repeated attempts. In five cases, there was some difficulty in negotiating the Duodenojejunal flexure, but it could be maneuvered across. There was difficulty in the evaluation of deeper Ileum, but it could be completed by an abdominal massage using lesser air, like switching of insufflation and using water for visualisation.

Results Twenty cases of attempted 22 cases(91%) could be done successfully using Motorised power spirus Enteroscopy. Eighteen of them were done from the antegrade route. Two cases had Total Enteroscopy done(10%). Difficulties were noted during Esophageal intubation which could be overcome by prior dilatation with 18mm dilator, then crossing of Pylorus by straightening the scope. Negotiating Duodenal Jejunal Flexure could be possible by switching off CO₂ and gentle maneuvering. The challenge of deeper intubation of the Ileum could be possible by abdominal massaging and reducing CO₂ usage and infusing more water.

Conclusions Motorised Power Spiral Enteroscopy is a very good modality in the evaluation of the small bowel with its own challenges. The challenges while performing it can be overcome with certain maneuvers.

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INCIDENCE AND RISK FACTORS FOR EARLY-ONSET COLORECTAL CANCER: A GLOBAL DATA ANALYSIS

¹Junjie Huang*, ¹Alfonse Ngai, ²Veeleah Lok, ³Xianjing Liu, ⁴Lin Zhang, ⁵Jinqiu Yuan, ⁶Wanghong Xu, ⁷Zhi-Jie Zheng, ¹Martin CS Wong. ¹Jockey Club School of Public Health and Primary Care, Faculty of Medicine, Chinese University of Hong Kong, Hong Kong; ²Department of Global Public Health, Karolinska Institute, Karolinska University Hospital, Stockholm, Sweden; ³Department of Radiology and Medical Informatics, Erasmus University Medical Centre, Rotterdam, Netherlands; ⁴Centre of Cancer Research, Victorian Comprehensive Cancer Centre, Melbourne, Austria; ⁵Clinical Research Centre, The Seventh Affiliated Hospital, Sun Yat-sen University, Guangdong, China; ⁶School of Public Health, Fudan University, Shanghai, China; ⁷Department of Global Health, School of Public Health, Peking University, Beijing, China

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