PTH-96

COLORECTAL CANCER DIAGNOSED AT SIGMOIDOSCOPY, IS COLONOSCOPY NECESSARY TO ASSESS FOR SYNCHRONOUS CANCER?

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Introduction The Association of Coloproctology of Great Britain & Ireland (ACGBI) 2017 colorectal cancer (CRC) guidelines reaffirmed the longstanding practice of assessing for synchronous cancer in patients diagnosed with CRC at sigmoidoscopy (f-sig). Ideally by colonoscopy in addition to CT staging of chest, abdomen & pelvis (CT CAP), or alternatively CT colonography (CTC) and CT thorax if complete colonoscopy not possible.

In the literature, approximately 3.5% of patients had synchronous CRC. Scheduling colonoscopy may delay treatment and be onerous for patients. Access to prompt colonoscopy can be challenging due to capacity issues, especially in the COVID-19 pandemic era.

Methods Data were retrospectively analysed from electronic endoscopy, radiology and pathology records from patients diagnosed with CRC at f-sig and colonoscopy over 11 years (2010-2020 inclusive).

Results Analysis 1: 680 patients who had CRC diagnosed at f-sig: 230 underwent pre-treatment colonoscopy (33.8%).

Interval between f-sig and colonoscopy; mean 17.5 days/median 15.0 days.

Two synchronous cancers identified at colonoscopy; 0.9%

1. 57 years old man with primary rectal cancer and synchronous transverse colon cancer – both lesions reported on staging imaging scans.

• 69 years old woman with a primary rectal cancer and synchronous sigmoid colon cancer (not seen at f-sig due to poor preparation) – both lesions reported on staging imaging scans.

Analysis 2: 796 patients who had CRC diagnosed at colonoscopy:

48/796 have a significant 2nd finding (6.0%)

• 24 had synchronous CRC (3.0%)/24 had a significant polyp >20 mm (3.0%)

In these 48 cases, if F-sig was performed instead of colon, what would have been the outcome?

• Only in one case would a significant lesion be missed. 72 years old man with a primary rectal cancer and a 30 mm ascending colon polyp (not seen on staging CT scan).

• In the other 47 cases; staging CT scans pick up lesions or metastases, or lesions are all left sided and would be seen at F-sig, or lesions are all right sided and would not be seen at f-sig, or missed lesion was a benign polyp.

Conclusions This is a large analysis of 1476 patients diagnosed with CRC. Of the 796 diagnosed at colonoscopy, 6.0% had a synchronous lesion (48 patients), 3.0% had a synchronous CRC, only 1 patient would have had a missed lesion if they'd had a f-sig alone. Of the 680 patients diagnosed with CRC at f-sig, 230 had a colonoscopy (33.5%), the rest were precluded due to advanced disease/obstruction or weren't fit due to advanced age/co-morbidity. Colonoscopy was undertaken at a median of 15.0 days. The yield of identifying a synchronous cancer at colonoscopy in this cohort is < 1%, in both cases these lesions were reported on staging imaging scans.

British Society of Gastroenterology and ACPGBI guidelines from 2019 suggest that in patients who are fit/suitable they

Abstract PTH-96 Table 1

Colonoscopy after f-sig	Number (n)	Female (n)	Male (n)	Mean age (years)	Median age (years)
No	450	193	257 (57.1%)	73.2	75.5
Yes	230	77	153 (66.5%)	66.8	67.8
Colonoscopy only	796	320	476 (59.8%)	69.1	69.1

should undergo a surveillance colonoscopy at 12 months post CRC diagnosis. Given the capacity issues affecting colonoscopy services in the pandemic era, a proposed pathway for patients diagnosed with CRC at sigmoidoscopy; if staging imaging scans shows resectable CRC without synchronous lesion, is to consider undergoing surgery and to utilise 12-month colonoscopy to clear any adenomas. Alternatively CTC and CT thorax could be utilised though capacity issues may limit this approach. This data supports the consideration of alternative approaches as the likelihood of a synchronous cancer not seen at sigmoidoscopy and staging imaging scan appears to be very low.

PTH-97

FIT IN THE POST-COVID-19 COLORECTAL PATHWAY – ARE WE DOING IT RIGHT?

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Introduction During COVID-19 pandemic, national guidance updated NG12 colorectal cancer (CRC) referral criteria to incorporate Faecal Immunochemical Testing (FIT), previously reserved only for patients on the low risk DG30 pathway. Positive FIT results ($\geq 10\mu\text{g/g}$ of faeces) in patients with colorectal symptoms would trigger a two week wait (2ww) referral for urgent investigations. Otherwise, patients with 'negative FIT' were expected to be safety-netted but not investigated. Patients with high-risk symptoms (i.e. NG12 compliant) could be referred in the absence of FIT result. We wished to explore how this change has affected referral patterns and whether the new guidance was adhered to.

Methods We extracted 2ww colorectal referrals to University College London Hospital from August to October 2020. Demographics, reason for referral, symptoms, investigations and outcome were recorded. These values were compared between patients who had FIT (FIT group) to those who did not (no FIT group). Two-tailed t-test and Chi-squared test were used to assess for significant difference between the two groups.

Results 522 referrals were received in the period examined, 92 were excluded as they were either repeat referrals or contained insufficient clinical information. Of the remaining 420, 315 underwent FIT, although 37% of results were negative. Of those with a positive FIT, 73% were NG12 compliant and 27% had neither NG12 nor DG30 symptoms. In the FIT negative group, 77% were NG12 compliant. 105 patients were referred without FIT, of these 90% were NG12 compliant. There was no significant difference in mean age (FIT 62 v no