1 x caecal cancer. Presented with significant weight loss and diarrhoea.

So in our cohort, the sensitivity, specificity and NPV of FiT/C21 > 10 for colorectal cancer was 98%, 57% and 99.9% respectively.

Discussion & Conclusions There has been a reduction in the proportion of CWT referrals seen within 14 days between 2019 and 2020 in our institution. This study was to determine if we could use FiT to improve this proportion with the same resources. We have demonstrated that FiT/C21 > 10 has a very high NPV for colon cancer. A significant proportion of patients referred via the LGI CWT pathway have a FIT < 10.

Therefore, if triage by prioritising urgent investigation for only patients with FIT ≥ 10 or with concerning symptoms (eg palpable abdominal or rectal mass) were implemented this will free up LGI CWT slots and allow safe targeting of resources for urgent investigation to patients with higher likelihood of CRC.

REFERENCES
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Abstracts

PTH-108 THE USE OF QUANTITATIVE FAECAL IMMUNOCHEMICAL (FIT) TESTING IN THE STREAMLINING OF LOWER GASTROINTESTINAL INVESTIGATIONS

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10.1136/gutjnl-2021-BSG.311

Introduction The COVID-19 pandemic has resulted in a significant backlog of endoscopies, and challenges in achieving two-week-wait and eighteen-week-wait targets. Faecal Immunochemical Testing (FIT) offers a potential method to stratify the urgency of investigation by endoscopic or cross-sectional imaging. FIT scores are now used at Hillingdon Hospital during the referral triage process; patients with FIT > 50 μg/g being prioritised. This study aims to determine the impact of FIT testing on the post-COVID rationalisation of lower GI investigations in a real-world district general hospital setting.

Methods Data was collected prospectively from January 2020 to January 2021 for all patients referred to Hillingdon hospital with lower GI symptoms and a FIT score who were subsequently triaged to colonoscopy and/or a lower GI imaging modality (CT virtual colonoscopy or CT abdomen/pelvis with...
prolonged faecal tagging). We evaluated the diagnostic accuracy of FIT for colorectal cancer (CRC) and other significant bowel disease (SBD: inflammatory bowel disease, high-risk polyps as per 2020 BSG post-polypectomy guidelines) across a range of FIT thresholds (<10μg/g, 10-50μg/g, and >50μg/g). Multivariable logistic regression was performed to assess the predictive value of various demographic (age, gender) and clinical variables (lower GI symptoms, two-week vs non two-week referrals) in the prediction of CRC and SBD.

**Results**
481 patients (21-95 years, median 62 years) were included in the analysis. The prevalence of CRC in this cohort was 6.6%. The negative predictive values of FIT for CRC at three cut-offs (10μg/g, 50μg/g and 100μg/g) were 98.3% (95%CI 93.6-99.5%), 98.1% (95%CI 96.2-99.1%) and 96.7% (95%CI 94.9-97.9) respectively. The sensitivities at these cut-offs were 93.8% (95%CI 79.2-99.2%), 81.3% (95%CI 63.6-92.8%) and 62.5% (95%CI 43.7-78.9%) respectively. Based on a 10μg/g cut-off, two CRCs would have been missed, both of which arose in males over 75 years old. Multivariable regression analyses demonstrate that increasing age, male gender, and FIT>50μg/g are the sole of predictors of CRC (see table) and SBD.

**Conclusions**
A combination of age, male gender and FIT values are most predictive variables of future CRC and SBD risk. In the current post-COVID environment, FIT can play a role in streamlining lower GI investigations for two-week referrals, where FIT >50μg/g are prioritised as most urgent. Units with significant endoscopy backlogs could also consider de-escalating two-week referrals of younger patients with low FIT values (<10μg/g).

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**P-TH-109**

**THE BOTTOM LINE: REAL WORLD MANAGEMENT OF ACUTE LOWER GASTROINTESTINAL BLEEDING COMPARED TO BSG GUIDELINES**

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**Introduction**
Lower gastrointestinal bleeding (LGB) is a common hospital presentation, from self-limiting per-rectal bleeding to a life-threatening haemorrhage. British Society of Gastroenterology (BSG) acute LGB guidelines define a clear management approach including risk stratification for patient management. However, real-world management of LGB in relation to this guidance is currently unknown.

**Methods**
Patients aged ≥16 years presenting with LGB to 7 hospital trusts from June 1st-Aug 31st 2019 were included. Data on presentation, management and outcomes of patients were recorded. These were audited against BSG guidelines.

**Results**
407 patients were included. 51% were male with a mean age of 60 (SD = 22). Mean Shock Index (SI) at presentation was 0.69, with a SI ≥ 1 being rare (6.3%). 2.2% (9/407) of patients remained haemodynamically unstable (SI >1) after initial resuscitation. Of these, 22.2% underwent a computed tomogram angiography (CTA). Within the major bleed risk patients (Oakland Score >8), 284 (85%) were admitted and 50 (15%) were discharged from A&E. For minor bleed risk patients (Oakland Score ≤8), 67.9% and 32.1% were admitted and discharged respectively. Complete Oakland Score data was unavailable for 7 patients. Of admitted patients, colonoscopy and sigmoidoscopy was performed in 4.3% and 14.6% respectively, whilst 81.8% underwent no inpatient LGI endoscopy. A bleeding site was seen in 12 (20%) patients at endoscopy, for which 2 (10%) received endoscopic therapy. 7-day rebounding rates were higher in patients who underwent LGI endoscopy versus those conservatively managed (17.0% vs 7.5%, p=0.028). Inpatient mortality was low at 2.1%, with no difference in major vs minor bleed patients (2.1% vs 2.6%, p=1.0). Median length of stay was 5.5 days in patients who received LGI endoscopy and 2 days for those conservatively managed (p= < 0.00001). 15.3% of patients were managed in accordance with BSG guidance. The most common deviations being patients with an Oakland Score >8 being discharged and admitted patients not undergoing LGI endoscopy.

**Conclusions**
Real world practice of managing patients presenting with LGB is not in keeping with current BSG guidelines, with admission or discharge often not in keeping with Oakland Scores. The majority of admitted patients do not receive inpatient LGI endoscopy, in patients who do, endoscopic therapy is rarely indicated.