High confidence optical diagnosis agreed with histopathology in 78.2% (366/468) of cases and disagreed in 21.8% (102/468). In cases of disagreement, the initial histopathology was reviewed and 7.8% (8/102) were due to histopathology error of which 3.9% (4/102) corrected on second review and 3.9% (4/102) corrected with deeper levels.

There were no polyp cancers and 1 case of high grade dysplasia.

Conclusions Although the majority of errors in optical diagnosis were related to incorrect high confidence calls a significant number were due to histopathology error. Change in practice to routinely perform additional deeper levels (ie 6 levels instead of 3) for small polyps appears to reduce this error rate by ~50%. Optical diagnosis errors may be reduced by increasing the threshold for assignment of high confidence.

HTU-4 COMPARISON OF POST COLONOSCOPY CANCER RATES IN SCREENING & SYMPTOMATIC SERVICES IN NHS GREATER GLASGOW

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Introduction The Post-Colonoscopy Cancer Rate at 3 years (PCCR-3yr) is a key indicator of quality of a service. The bowel screening programme (BCSP) in NHS England has reported PCCR-3 of 3.6%.¹ The bowel screening programme in Scotland has key differences to the English BCSP and does not rely on a specific accreditation programme with examination for screeners, although has concentrated investment in access by offering screening to age 50-74 years at outset. Our aim was to ascertain the PCCR in the bowel screening service in NHS Greater Glasgow and Clyde (the largest Scottish Health Board – population 1.14 million) during the period 2011-15, and compare with the rate in the symptomatic service for a similar age range (50-77yrs).

Method For each year within the study period, the total number of known cancer diagnoses was ascertained from cancer audit data submissions, identifying the 'true positive' colonoscopies. Cancer audit data was then linked to identify cases where a cancer was detected between 6 and 36 months after the index colonoscopy, giving the number of 'false negative' colonoscopies. Post colonoscopy cancer rate was then determined by expressing the number of 'false negative' colonoscopies as a percentage of the sum of 'true positive' and 'false negative' colonoscopies. The rates of post colonoscopy cancers between the screening and non-screening pathways were compared using the chi squared test.

Results There were 1909 true positive colonoscopies in the investigation period for the entire population. We found 102 cases of PCCR-3y, giving a rate of 5.2% (95% CI 4.6-5.6%). 678/2011 (34%) of all bowel cancers were screen detected. PCCR-3yr for the screening service was 4.4% (95% CI 3.6-5.2%), which was lower than 5.5% (95% CI 4.8-6.1%) for the symptomatic service but not statistically different.

Conclusion The overall PCCR-3yr for NHS GGC between 2011 and 2015 of 5.2% is similar to rates reported for England between 2015 and 2013. Post colonoscopy cancer rates for screening colonoscopy in NHS GGC were slightly lower than for the symptomatic service but not statistically different. Our rates were higher than rates reported for the English BCSP, but within the threshold of 5.5%¹ that has been

proposed by some investigators. This is the first report of PCCR-3yr in NHS Scotland and we believe that regular continuous audit of this important quality indicator should be replicated all Scottish boards. In our service, PCCR-3yr rates appear acceptable within NHS GGC and are slightly better for bowel screening compared with non-screening colonoscopy.

REFERENCE

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HTU-5 NATIONAL SERVICE EVALUATION OF THE TWO WEEK WAIT UPPER GI CANCER REFERRAL PATHWAY

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Introduction British Society of Gastroenterology (BSG) guidance on endoscopy during recovery from the COVID pandemic (April 2020) recommended that two week wait (2WW) referrals are triaged, with patients risk stratified for endoscopy or other investigation. We have prospectively evaluated the 2WW upper gastrointestinal (UGI) cancer pathway and its outcomes following this guidance.

Methods Data were collected at telephone triage by consultants and nurse endoscopists between May 2020 and February 2021 in 19 centres across the UK and recorded on a standardised data collection tool, which included recommendations on the timing of endoscopy based on the BSG recovery document. This project was supported by the BSG Clinical Services and Standards Committee.

Results Data for 1793 UGI 2WW referrals were received: median age 63 (IQR 51-74), 58% female. Dysphagia and odynophagia were the commonest reasons (83%) for referral. Other symptoms included dyspepsia (55%), weight loss (32%), globus (3%), and anaemia (3%). 15.8% of 2WW referrals were downgraded at triage to routine endoscopy (6.6%) or no investigation at all (9.2%). 56% were triaged to 2WW endoscopy; 19.6% to urgent (non-2WW) endoscopy; 4.7% to urgent CT scan; and 3.8% to barium swallow.

6.3% had UGI cancer (5.2% oesophageal, 1.1% gastric) and 0.9% had cancer at other sites (6 colorectal, 2 lung, 2 breast, 2 hypopharyngeal, 1 pancreatic and 2 unknown primary). Endoscopy results were available for 1387 patients (97.5% of all endoscopy pathways). The prevalence of UGI

Abstract HTU-5 Figure 1 The median interval from triage to endoscopy was: 12 days (IQR 8-18) for 2WW; 14 days (10-26) for urgent (non-2WW); and 17 days (9-38) for routine endoscopy