112 (17.0%), inadequate photo for NICE in 59/112 (52.7%) and histology processing error in 3/112 (2.7%).

Conclusions Adequacy of polyp photo is critical to quality assurance of OD. In this study a significant proportion of OD errors had corresponding inadequate photodocumentation with incorrect focal distance the main photographic issue. This may affect application of the NICE criteria. In cases where photos were adequate, understandable error occurred where lesions had a mixture of NICE 1 and 2 features.

PTU-13 LEARNING CURVE OF OPTICAL DIAGNOSIS WITH A RESECT AND DISCARD STRATEGY FOR SCREENING COLONOSCOPY

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Introduction Advanced endoscopic imaging allows optical diagnosis of diminutive polyps. Performance thresholds for optical diagnosis have been set to allow a 'resect and discard strategy' which may streamline patient care and reduce histopathology need. Aim: to assess early implementation and quality assurance of this strategy in a bowel cancer screening unit setting (1.1 million population).

Methods In this prospective feasibility study, 8 bowel cancer screening colonoscopists completed a validated optical diagnosis training module and performed all procedures during Feb-Oct 2020. All ≤ 5 mm polyps had white-light and narrow-band images. Endoscopists classified the optical diagnosis as high or low confidence. All polyps had standard histopathology.

Performance was analysed in 2 month time periods with active feedback given. There was repeat histology review of inaccurate high confidence optical diagnoses.

Results In the 8 months to date, 639 polyps were optically diagnosed (468 high confidence and 171 low confidence) from 283 patients who were divided into 4 time periods.

The proportion of low confidence diagnoses increased from 15% in periods 1-2 to 29% in period 4.

In periods 1-2, 1/8 endoscopists achieved the 90% accuracy threshold. In periods 3 and 4, 2/8 and 4/8 endoscopists achieved the threshold respectively. Overall, accurate diagnoses increased from 81% to 86% (period 1 to 4). Of those who reached the threshold by period 4 the mean number of high confidence calls was 60 (range 41-99).

For periods 1-4, the positive and negative predictive values for optical diagnosis of an adenoma were 89.3% and 64.4% respectively.

Abstract PTU-13 Table 1

		Histology		Total
		Adenoma	Non-adenoma	
Optical diagnosis	Adenoma	275	57	332
	Non-adenoma	33	103	136
Total		308	160	468

Conclusions The learning curve for optical diagnosis in a bowel cancer screening setting varies between individual operators. Over time, and with feedback, there is a gradual increase in optical diagnosis accuracy and in the number of colonoscopists achieving the 90% threshold accuracy target, with a corresponding decrease in the percentage of high confidence calls.

PTU-14 PATIENT ACCEPTABILITY OF DIMINUTIVE POLYP OPTICAL DIAGNOSIS WITH RESECT AND DISCARD STRATEGY IN SCREENING COLONOSCOPY

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Introduction Colonoscopy with polypectomy reduces the rate of subsequent colorectal cancer and associated mortality. Most polyps resected are diminutive and have a low cancer risk. Currently, these diminutive polyps are resected and examined histologically. Using advanced imaging technologies some studies show we can distinguish adenomas from non-adenomas optically. This could potentially avoid unnecessary polypectomies and associated histology costs in cases where there is high confidence in the diagnosis of the polyps allowing polyps to be resected and discarded. The aim of this study is to assess the acceptability of such a strategy for patients in real life clinical practice.

Methods Two hundred and fifty patients undergoing a bowel cancer screening colonoscopy procedure, where optical diagnosis was used as part of the DISCARD3 study, were invited to participate in a patient experience survey. This was carried out over February - October 2020 at a London bowel cancer screening centre (screening population 1.1 million) with 209 patients included (41 patients excluded: 33 did not complete, 8 did not consent).

Patients were asked to rate the following questions (responses: 5 point scale from strongly disagree to strongly agree):

2. My colonoscopy was comfortable

1. I would be happy for any polyps found during my colonoscopy to be assessed by the person carrying out the procedure at the time (rather than to wait for laboratory results to get the diagnosis)
2. If a future colonoscopy is advised I would prefer to be informed immediately after the initial procedure rather than wait to be told later by telephone or in the outpatient department
3. I feel confident that the person carrying out the procedure could accurately diagnose polyps without sending them to the laboratory
4. I felt highly satisfied with the procedure today Patients were also asked about their previous experience (responses: Yes, No or N/A):
5. If you have had a previous colonoscopy, did you notice any difference in the procedure today compared with previously?

Results Most patients found their procedure comfortable (85.2%; 178/209) and were satisfied with their procedure (97.6%; 204/209). Most agreed or strongly agreed that they would be happy for polyps to be assessed optically (78.9%;

165/209) and felt confident in the ability of the endoscopist to do this (90.9%; 190/209). 85.2% (178/209) would be happy to be informed of their colonoscopy surveillance interval immediately after the procedure.

Conclusions In this small but representative sample, optical diagnosis of diminutive polyps using a resect and discard strategy appears to be an acceptable approach for patients within a bowel cancer screening programme. To achieve similar levels of acceptability in standard clinical practice patients may require additional and enhanced information about the concept and application of a resect and discard strategy.

PTU-15 PCCRCs IDENTIFIED FROM POPULATION-BASED DATA MAY BE RE-CLASSIFIED AS DETECTED CANCERS FOLLOWING LOCAL DATA ANALYSIS

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Introduction A recent population-based cohort study showed variation in post-colonoscopy colorectal cancer (PCCRC) rates across providers. Aim: to analyse PCCRC cases using local data in order to determine the cause and evaluate whether clinician and/or patient factors are primarily responsible.

Methods A retrospective root cause analysis was performed, in accordance with World Endoscopy Organisation recommendations, on a sample of 52 cases reported as PCCRCs from a national dataset (CORECT-R) during 2005-2013. 6 cases were excluded (3 missing data, 3 duplicates).

First, we confirmed if the case was a true PCCRC and if so, the most plausible explanation. We then evaluated whether responsibility for the PCCRC was primarily due to clinician and/or patient factors.

Results Of 46 included cases, 35 were confirmed as PCCRCs. 11 cases did not meet the PCCRC definition (8 detected cancers, 3 data errors).

The mean age for PCCRCs was 68 years old (range 39-93). The primary endoscopist was an independent non-consultant endoscopist, consultant, or nurse endoscopist in 51.4%

(18/35), 45.7% (16/35), and 2.9% (1/35) of cases respectively. Caecal intubation was reported in 94.3% (33/35) of cases with adequate caecal photodocumentation in 54.3% (19/35) of cases (reviewed by two blinded endoscopists). Rectal retroflexion was performed in 42.9% (15/35) of cases.

Primary responsibility for the PCCRC cases was in 74.3% (26/35) the clinician, 11.4% (4/35) the patient (surgery refused) and 14.3% (5/35) both clinician and patient (see Table 1).

Conclusions Local data helps confirm and evaluate PCCRC cases identified from national datasets. Clinician-factors were responsible for the majority of PCCRC cases. Lack of caecal and rectal retroflexion photodocumentation occurred frequently in PCCRC cases and may be a marker of suboptimal examination. In a significant proportion of cases where a lesion was detected patients refused surgery which ultimately led to the PCCRC.

PTU-16 UTILITY OF NASOBILIARY DRAINAGE IN CHOLESTASIS; A TERTIARY CENTRE EXPERIENCE

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Introduction Nasobiliary drainage (NBD) is a technique that has been successfully used to manage intrahepatic cholestasis, bile leak and obstructive cholangitis. It involves placing a catheter via Endoscopic Retrograde Cholangio-pancreatography (ERCP) to allow continuous external drainage of bile thereby bypassing the ileum where bile salts would be reabsorbed. We sought to assess the efficacy of placement on markers of cholestasis and patient symptoms.

Methods Consecutive patients with undergoing NBD over a ten-year period were retrospectively analysed. Recorded variables included patient demographics, procedural characteristics and response to therapy. Wilcoxon signed-rank test was used for paired samples.

Results 25 patients (14 male) underwent 31 procedures. The mean age was 31 years old (range 2-67 years old). One procedure was carried out in 21 patients, with two having 2 and one having 5. The most common aetiologies were hereditary cholestatic disease (n=9, 36%) followed by drug induced cholestasis (n=4, 16%), idiopathic cholestasis (n=4, 16%) and post-surgical (n=2, 8%). The indications for drainage were: cholestasis (n=20, 80%), bile leak (n=3, 12%), cholangitis (n=2, 8%) and cholangiocarcinoma (n=1, 4%).

Sphincterotomy was performed in 11 (35.48%). Normal biliary anatomy was encountered in 15 (48.39%) patients. In the patients with a bile leak, ileus was also present. Intravenous antibiotics were administered to 24 (77.42%) patients. Median hospital stay was 18 days (range 1-91).

Duration of NBD was available for 22 (70.9%) cases. They remained sited for a median of 8.5 days (range 1-54 days). There was an overall improvement in bilirubin (17% improvement, 5.77% SD, p=0.0344), and ALP (12% improvement, SD 4.38%, p=0.0465). All patients with pruritis as their primary symptom had symptomatic improvement. Clinically significant pancreatitis occurred in 2 (6.45%) patients. The majority tolerated placement of the drainage catheters (n= 29, 94%).

Abstract PTU-15 Table 1 Breakdown of most plausible explanation for confirmed PCCRC cases and primary responsibility

Most plausible explanation	Primary responsibility			Total
	Clinician	Clinician and Patient	Patient	
Possible missed lesion, prior examination adequate	4	0	0	4 (11.4%)
Possible missed lesion, prior examination negative but inadequate	12	1	0	13 (37.1%)
Detected lesion, not resected	4	4	4	12 (34.3%)
Likely incomplete resection of previously identified lesion	6	0	0	6 (17.1%)
Likely new cancer	0	0	0	0 (0%)
Total	26 (74.3%)	5 (14.3%)	4 (11.4%)	