(n=104), Caecum 11.4% (n=57), Descending 7% (n=35), Hepatic flexure 4.4% (n=22), Rectosigmoid 3.8% (n=19), Splenic flexure 2.6% (n=13), Ileocaecal valve 0.2% (n=1) and Appendiceal orifice 0.2% (n=1).

Conclusions The prevalence of SLs as well as the number of polyps per individual was higher in the white group compared to Asian and much higher in men. Nevertheless, the number of colonoscopies in the Asian group was much lower; therefore, this might not fully reflect the demographic differences between the two groups.

SLs were higher in the left colon, particularly the sigmoid colon and were predominantly hyperplastic in nature.

Between the two groups, the prevalence of SSL and mixed type polyp was higher and was more prevalent in the white group.

Amongst the different types of SLs, the mixed type was more common.

REFERENCES

1. <https://en.wikipedia.org/wiki/Leicestershire>.
2. East JE, Atkin WS, Bateman AC, et al. British Society of Gastroenterology position statement on serrated polyps in the colon and rectum. *Gut* 2017;66:1181-1196.

PTU-61 THE SAFE INTERVAL FROM INDEX COLONOSCOPY TO POLYPECTOMY

¹Buraq Abdul-aema*, ^{1,2,3}Andrew Cole, ^{1,2,3}Said Din. ¹Royal Derby Hospital, UK; ²Consultant Gastroenterologist; ³Honorary Assistant Professor- University of Nottingham

10.1136/gutjnl-2021-BSG.134

There is no evidence about the safe timing of Polyp Endoscopic Mucosal Resection (EMR) after detection at diagnostic colonoscopy. The aim was to help identify a safe interval from the diagnostic colonoscopy to planned therapeutic polypectomy.

Methods All symptomatic and bowel cancer screening program (BCSP) patients referred for a planned therapeutic polypectomy at our centre in 2019 were retrospectively analysed. Data was collected on the time interval between polyp detection and removal, SMSA (site, morphology, size and access) level and differences in histology if the polyp was biopsied at detection and EMR specimen.

Results 120 patients were included; 57 in the BCSP (37 males, 20 females), median age 66 years and 63 in the symptomatic group (39 males, 24 females), median age of 70 years.

120 polypectomies were performed (mean size= 28.7 mm), 24 polyps had a biopsy taken prior to polypectomy. 53 (44%) polyps were classified as SMSA 2, 50 (42%) SMSA 3 and 17 (14%) SMSA 4 (Figure 1).

Median time interval for polypectomy was 9 days for BCSP and 13.5 days for symptomatic patients.

3 patients who had a polyp biopsy in the BCSP group (1 low grade dysplasia (LGD) and 2 high grade dysplasia (HGD), all SMSA 4 were found to have adenocarcinoma after polypectomy. The time interval from biopsy to polypectomy was 14 days for the LGD case and 19 and 26 days for the HGD cases.

2 patients who had a polyp biopsy in the symptomatic group (2 LGD, SMSA 3 and 4) were found to have adenocarcinoma after polypectomy. The time interval to polypectomy was 25 and 119 days respectively.

The patient with 119 days waiting time attended at 50 days from the index colonoscopy, but due to comorbidities

Abstract PTU-61 Figure 1 The number of the polyps presented by the SMSA level

and high INR was deferred. In the remaining 19 cases, there was no change in histology with a time interval of 6 -80 days to polypectomy.

SMSA level 2 or 3 polyps were removed in a mean time of 13.7 days (range 0-68 days). 4/17 (23.5%) polyps with SMSA level 4 were found to have adenocarcinoma after polypectomy, time interval to polypectomy was 14-25 days.

Conclusions These data show that a significant proportion of complex polyps may contain a cancer focus not recognised on prior endoscopy or biopsy. Polypectomy therefore should not be delayed.

PTU-62 MICROSCOPIC COLITIS: FINDING THE SWEET SPOT

Sun Mi Ha*, Flora Kokwaro, Nicola Grasso, Zillah Cargill, Olaolu Olabintan, Imogen Sutherland, Yazan Haddadin, Elizabeth Harrod. *Get Linked to KSS, Gastroenterology Trainee Network, UK*

10.1136/gutjnl-2021-BSG.135

Introduction Microscopic colitis (MC) is a prevalent and treatable cause of chronic, non-bloody, watery diarrhoea. In MC, the colon is usually macroscopically normal therefore the BSG and European guidance call for right and left colon biopsies to be taken for histological examination to make the diagnosis. There is no established guidance on biopsy protocol.

This retrospective, multi-centre study looked at our biopsy practice and whether there is a pattern that leads to higher diagnostic yield for diagnosis of MC.

Methods The endoscopy reporting systems in six trusts across Kent, Surrey, Sussex and Cambridge were searched for all colonoscopies in patients aged 18 or over with the indication chronic diarrhoea performed between 1 January 2020 and 31 March 2020. All diagnosis of cancer or macroscopic inflammatory disease were excluded. The endoscopy and histology reports were analysed to see how many biopsies were taken and their histological diagnosis.

Results 363 reports were analysed. The age range was 18 to 90. Male to female ratio was 1:1.8. Biopsies were taken from both the right and left colon in 83.5%. Biopsies of the rectum were taken in 10.5%.

The number of biopsies taken ranged from 0 to 17, most commonly taken as 4 right and 4 left colon biopsies (18.5%). The most common distribution was random right and left colon biopsies (22%) followed by colonic series biopsies* (9.6%).