(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.

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PTU-61 THE SAFE INTERVAL FROM INDEX COLONOSCOPY TO POLYPECTOMY

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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

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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%).

Abstract PTU-62 Figure 1 Biopsies taken in those diagnosed with MC

The diagnosis of MC was made in 20 cases. The age distribution was 30 to 80 (median 67.5) with male to female ratio 3:7. All had biopsies taken from both right and left colon amounting to 3 to 13 biopsies in total. The most common biopsy pattern in those diagnosed with MC were 5-6 biopsies taken as colonic series (25%) or 2-4 biopsies taken from both right and left colon (45%). Distribution in number of biopsies is shown in Table 1.

Conclusion There was a large variation in the sites and number of biopsies taken to investigate for MC reflecting the lack of established guidance on biopsy protocol. Excessive biopsy samples have negative impacts on our green footprint, increase workload for histopathology colleagues and potential risk in bleeding and perforation risk for patients.

We propose that the BSG should implement MC diagnostic biopsy protocol for standardisation of our practice. From the results of our data we advocate for either 5-6 biopsies as a colonic series or 2-4 biopsies to be taken from both right and left colon. Biopsies should not be taken from the rectum in a macroscopically normal colon.

*Multiple biopsies ordered from proximal to distal colon

PTU-63 SEMI-AUTOMATED ANNOTATION TOOL OUTPERFORMS MEDICAL STUDENTS AND IS COMPARABLE TO CLINICAL EXPERTS FOR POLYP DETECTION

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Introduction Expert labelling of each frame in a polyp video is the most robust way for constructing a training set for deep learning, but this is very time-consuming and currently represents a major barrier for widespread implementation of AI in endoscopy. In this study, two alternative approaches are evaluated, an innovative semi-automated labelling tool and trained medical students providing annotations.

Methods 20 unique polyp white light videos containing 6282 frames (14 adenomas and 6 sessile serrated lesions confirmed by histopathology, mean size 7mm, Olympus) were annotated with bounding boxes by a clinical expert. These annotations are used as the gold standard for comparison. Two cheaper annotation methods were then applied to evaluate their validity and relative performance: (1) a semi-automated labelling technique – this tool only requires 3 manually annotated

Abstract PTU-63 Table 1

	Sensitivity	PPV	Adjudicated PPV	Time (mins)
Student 1	74,38 ± 27,30	88,52 ± 30,51	89,92 ± 15,34	264
Student 2	63,08 ± 20,27	94,69 ± 22,30	95,00 ± 07,47	1208
Student 3	66,97 ± 27,37	94,77 ± 22,32	95,00 ± 12,30	234
Semi-automated	94,40 ± 06,22	97,17 ± 05,87	98,97 ± 14,04	25

video frames, from which a representation of the polyp is learned and transferred automatically to all the other frames in the video; (2) independent manual labelling of each video by three medical students – following a training module with polyp images and videos.

Results The mean and standard deviation of the frame-level sensitivity, positive predictive value (PPV) and adjudicated PPV (for borderline low-quality frames) over all videos are provided in table 1. The semi-automated method significantly outperforms all three students on sensitivity and annotation time (paired t-test, p-value < 0.05), while also achieving the highest value for PPV, both before and after adjudication.

Conclusions A semi-automated labelling tool is a faster, more efficient and valid approach for polyp detection. It outperforms three medical students, specifically trained for polyp recognition and is comparable to clinical expert performance.

PTU-64 SALINE IMMERSION THERAPEUTIC ENDOSCOPY FACILITATED ENDOSCOPIC SUBMUCOSAL DISSECTION OF AN ILEAL LIPOMA DURING ENTEROSCOPY

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Introduction Small bowel lipomas are benign, usually innocuous lesions which more frequently affect the terminal ileum (TI). They are usually asymptomatic but may give rise to obstructive symptoms and gastrointestinal bleeding, especially if ≥2cm in diameter. Although in such cases, surgery has been the mainstay of care, endoscopic resection is being increasingly employed. Endoscopic submucosal dissection (ESD) is emerging as a safe and definitive endotherapeutic, minimally invasive strategy for such lesions.

Methods A 69-year-old man with ischaemic heart disease and cerebrovascular disease was referred to our tertiary institution for endoscopic resection of a large, symptomatic, intussuscepting lipoma of the TI. At retrograde double-balloon enteroscopy (DBE), under conscious sedation, a 35mm semi-pedunculated submucosal lesion was identified within the TI, about 5cm proximal to the ileocecal valve.

Results Endoscopic morphology was pathognomonic of a lipoma. The lesion's size and its location within the narrow lumen of the TI precluded safe snare resection and we therefore proceeded with ESD. After injection of submucosal-lifting-solution (succinylated gelatin, indigo carmine (0.05%) and dilute epinephrine (1:100,000)), the stalk was dissected using