

	No. of patients with polyps (n = 25)	No. of polyps Median (Range)	Size of polyps Median (Range) (mm)	No. of patients with Hyperplastic Polyps (n = 4)	Low grade adenoma (n)	Advanced adenoma (n)
Normal BMI	7	2 (1–4)	7 (3–15)	1	2	5
Obesity class I	8	2.5 (1–5)	6.5 (2–15)	0	3	2
Obesity class II	4	2 (1–3)	5.5 (2.5–25)	3	1	2
Obesity class III	4	2 (1–4)	7 (3–10)	0	2	2
Not recorded	2	1	12.5 (10–15)	0	0	2

Hot avulsion: a new technique for the non lifting polyp

SPIRO C RAFTOPOULOS, HARN CHIN CHEN,
DONALD ORMONDE, IAN YUSOFF

Gastroenterology & Hepatology, Sir Charles Gairdner Hospital, Perth, WA, Australia

Background Endoscopic management of non-lifting polyps poses a significant challenge. Traditionally laser and more recently argon plasma coagulation (APC) have been used with disappointing long term results.

Aims We aimed to describe our experience with a new hot avulsion (HA) technique for treatment of non-lifting polyps.

Methods Patients referred for management of colonic or gastric polyps were prospectively entered into an electronic database. Those cases where HA was used as part of the polypectomy technique for areas that elevated poorly were identified. All patients were contacted at 2 weeks following their procedure to establish any adverse events. Follow-up procedures were performed between 4 and 12 months and outcomes documented. Data collection is ongoing.

Results There were eighteen cases where HA was utilised in poorly lifting polyps. Seventeen patients (94%) had colonic polyps with the majority in the caecum (35%) and ascending colon (41%). The reason for non-lifting was: scarring/tethering from previous EMR attempt in 59% (10/17), previous biopsy of a flat polyp in 29% (5/17), presence of SPOT tattoo in 12% (2/17) and fibrosis NOS in 6% (1/17). In all cases attempts at polyp elevation (using Gelofusine) and removal with a number of different snares had failed prior to HA being used. At the index procedure HA was successful in removing macroscopic adenomatous tissue in all cases. To date 6 (38%) patients have had a follow up examination. There was no macroscopic recurrence in 4 patients (67%) and a small area of recurrence in 2 patients (33%) – both easily treated with repeat HA. There were no immediate or delayed complications.

Conclusion In this preliminary study HA appears to be a safe and highly effective technique for dealing with difficult non-lifting polyps. Further studies are required with direct comparison to established techniques.

Predictive factors for interval colorectal cancer

ARTI RATTAN
Gastroenterology, Lismore Base Hospital, Lismore, NSW, Australia

Background Colonoscopy is widely used for both colorectal cancer screening and surveillance. Miss rate for cancers and adenomatous polyps (benign tumours or adenomas) remains a concern. After a colonoscopy that is negative for cancer, a subset of patients may be diagnosed with

colorectal cancer, termed interval cancer. We defined interval cancer as a colorectal cancer occurring within the specified surveillance period. We evaluated various factors that would predict the occurrence of these colorectal interval cancers.

Aims To study various factors that would predict the incidence of interval colorectal cancers.

Methods Data was analysed from a total of 15,618 colonoscopies that were performed from January 2003 to March 2012 by two Gastroenterologists. Various patient-based factors (age at diagnosis, comorbidities, bowel preparation at the time of preceding colonoscopy, site and histology of previous relevant colonic lesions, location of the tumour,) waiting list based factors (difference between planned interval of follow up and actual interval) were looked at. Screening and surveillance intervals were as per the NHMRC published clinical guidelines.

Results Fifteen interval cancers were identified. The incidence rate of interval cancers was 1.6 per 1000 person-years. Three cases had a family history of colorectal cancer in a first degree relative diagnosed before the age of 55. Eight cases had diverticulosis. Three cases had a prior colorectal cancer and resection, and two had HGD in a tubulovillous adenoma. Adenomas had been present in the right colon in 11 of the cases. Only one patient had a normal index colonoscopy. The maximum time beyond the planned interval was 8 months. Six patients presented prior to their planned interval due to symptoms concerning of malignancy. Caecal intubation was documented in all cases, and the bowel preparation of the preceding colonoscopy was rated satisfactory in all. 10 interval cancers were in right colon and 5 in left colon. Three interval cancers were TNM-stage I, 4 were stage II, and 7 were stage III and one is being worked up. Fourteen patients were candidates for surgical management and one had palliative chemotherapy.

Conclusion A small number of patients had interval cancer after regular surveillance. Contributing factors included previous colon cancer or TVA in previous polyps, especially those with HGD, and prior right colonic adenomas. Even though patients developed interval cancers, almost all were amenable to surgical resection.

References

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Use of a gastroscope when conventional colonoscopy has failed in cases of significant sigmoid angulation or diverticular disease

MARCUS ROBERTSON, LAUREN BESWICK,
RAY BOYAPATI, LUKE CRANTOCK
Department of Gastroenterology, Southern Health, Clayton, VIC, Australia

Background Colorectal cancer is the third most common malignancy worldwide and the second leading cause of cancer death in Australia. Screening with colonoscopy has been demonstrated to reduce both the incidence and mortality of colorectal cancer. Critical to the success of colonoscopy is the ability to obtain good views throughout the entire colon. In cases where this is not possible with a colonoscope (conventional colonoscopy), alternatives have included the use of a paediatric colonoscope or CT colonography. We present a prospectively collected case series of 60 colonoscopies where a gastroscope was used to complete the procedure after an unsuccessful attempt at conventional colonoscopy.

Aims To determine rates of caecal intubation with a gastroscope in the setting of unsuccessful conventional colonoscopy

Methods We conducted a prospective study at a single endoscopy centre in Melbourne to determine rates of caecal intubation with a gastroscope