Methods We performed a retrospective case notes review of patients referred to pelvic radiation disease clinic over a 16 month period (Sept 2018-Jan 2020) to identify those with endoscopic evidence of RP, determine the frequency of reported symptoms, primary cancer type and treatments used for RP following referral.

Results 102 patients were seen in pelvic radiation disease clinic during the 16 month period. 54 (53%) of these patients had endoscopic evidence of RP. Of these 54 patients, 34 (63%) were male. The median age was 70 years (31–86). RP was most common in patients following prostate radiotherapy (30, 56%), followed by radiotherapy for anorectal (8, 15%), cervical (5, 9%), endometrial (4, 7%), vaginal (3, 6%), bladder (1, 2%) and urothelial (1, 2%) cancers, along with pseudomyxoma (1, 2%) and Kaposi's sarcoma (1, 2%).

23 (43%) patients with RP didn't require any treatment. Of those requiring treatment, 19 (61%) had sucralfate enemas, 18 (58%) received endoscopically-delivered PuraStat, 1 (3%) had hyperbaric oxygen therapy and 2 (6%) were referred for radiofrequency ablation. 7 patients (23%) needed therapy with >1 modality after referral.

The most commonly reported symptom of RP was rectal bleeding (45, 83%). 8 (15%) had severe bleeding with anaemia, 28 (52%) had bleeding into the toilet bowl and/or incontinence of blood and 9 (17%) had bleeding on wiping. Most of the patients who developed anaemia (7, 88%) had prostate radiotherapy, 4 of whom underwent therapy with >1 treatment modality since re0ferral. Other commonly reported symptoms of RP included bowel urgency (17, 31%), faecal incontinence (18, 33%) and passage of rectal mucus (7, 13%).

Conclusions This case series suggests debilitating haemorrhagic RP is more common than previously reported. Over half of patients referred to tertiary clinic had endoscopic evidence of RP, with over half of them requiring treatment. Significant rectal haemorrhage was present in two thirds of patients and was more common following prostate radiotherapy. Those with severe rectal haemorrhage were also more likely to require >1 treatment modality to control their symptoms, suggesting further clinical trials are required to improve the management options for patients with haemorrhagic RP.

P290 OUTCOMES OF FAECAL IMMUNOCHEMICAL TESTING FOR RISK STRATIFICATION IN A TWO-WEEK-WAIT PATHWAY FOR COLORECTAL CANCER

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Introduction National guidelines on the investigation of cancer recommends patients with a 3% risk or greater are investigated on an urgent cancer pathway. A review of outcomes two years after the incorporation of FIT into a 2-week-wait (2WW) pathway for colorectal cancer (CRC) was undertaken.

Methods We introduced primary care access to FIT for stratification of symptomatic patients at risk of CRC in November 2017. A retrospective review of clinical outcomes at different FIT thresholds was undertaken. Outcomes were sourced from Cancer Outcomes and Service Dataset (COSD) to 31 December 2019.

Results 15589 FIT requests were made between November 2017 and October 2019. 90.4% of all FIT kits dispatched were returned for analysis (13361/14788). 0.3% of returned kits could not be analysed. FIT results ≥150 µg Hb/g faeces identified patients with a 24.1% risk of CRC diagnosis (132/547). FIT results 100–149.9 µg Hb/g faeces identified patients with a 12.6% risk of CRC (12.6%). FIT results 10–99.9 µg Hb/g faeces identified a 3.6% risk of CRC (65/1829) and 4–9.9 µg Hb/g faeces identified a 0.6% risk of CRC (10/1568). 8 CRCs were diagnosed in patients with FIT results <4 µg Hb/g faeces out of 8921 results (0.09% risk of CRC). Further stratification of results shows that FIT results 10–19.9 µg Hb/g faeces confers a 1.6% risk of CRC (11/711).

Conclusions FIT stratifies risk of CRC in a symptomatic population effectively. Risk falls below the NICE threshold for urgent investigation in some patients with >10 µg Hb/g faeces.

P291 COLORECTAL CANCER INCIDENCE AND MORTALITY IN EUROPE. ANY CHANGE WITH THE INTRODUCTION OF SCREENING?

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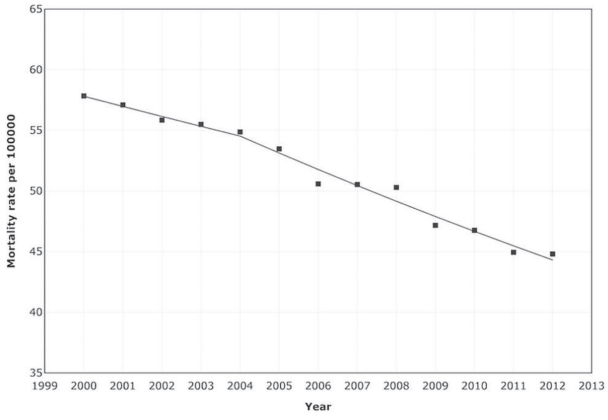
Introduction Though there is good clinical trials evidence of the efficacy of screening for colorectal cancer (CRC), how effective it is in the real world is less clear. For an effective screening programme one would expect an initial rise in incidence before a subsequent fall, and also a fall in mortality to be observed. We therefore aimed to examine changes in incidence and mortality from CRC across Europe during the period of the rollout of CRC screening.

Methods Age-standardised CRC incidence and mortality rates per 100,000 were obtained from the European Cancer Information System (ECIS) database for 6 European countries with a CRC screening programme instituted between 2000 and 2012 and complete data for this period. Joinpoint regression analysis was used to examine the annual percentage changes in these figures and to look for changes in these trends. Full details of methodology are available in, Kim HJ, Fay MP, Feuer EJ, Midthune DN. 'Permutation



Abstract 291 Figure 1

tests for joinpoint regression with applications to cancer rates' Statistics in Medicine 2000; 19:335–351: (correction: 2001;20:655).

Results Austria, Croatia, the Czech Republic, England, Scotland and Wales all met our inclusion criteria. Of these none experienced the hypothesised rise and subsequent fall in incidence after CRC screening introduction. England, Scotland, Wales and Croatia all experienced a rise and fall, but in each case the rise commenced before the programme was introduced. In all nations other than Croatia CRC mortality declined over the period, but in none of them did the decline become significantly steeper after the introduction of screening. Figure 1 illustrates as an example the changing mortality from CRC in England either side of the initiation of screening in 2006.

Conclusions Though CRC screening has been widely implemented in Europe, and CRC mortality is declining, the reductions in mortality began before screening started. We have not therefore been able to demonstrate a clear effect of screening at the population level.

P292 PROTON PUMP INHIBITORS AND FAECAL IMMUNOCHEMICAL TESTS FOR THE DETECTION OF COLORECTAL NEOPLASIA IN SYMPTOMATIC-PATIENTS

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Introduction The identification of the factors that are likely to influence the accuracy of the faecal immunochemical test (FIT) is of great importance for the colorectal cancer (CRC) screening programmes and for the screening of symptomatic patients. A study in Spanish cohort found that the proton pump inhibitors (PPI) therapy reduces the accuracy of FIT in detecting advanced neoplasia (AN) in symptomatic patients.[1] The aim of this study is to determine if these results can be reproduced in an independent population and can therefore be generalised.

Methods This is a prospective single centre study at the University Hospital of Coventry Warwickshire over a period of 14 months. Individuals who were referred for a diagnostic colonoscopy, on symptomatic pathway, were approached and were given a FIT prior to their colonoscopy. Their medication details were reviewed in-depth.

Results A total of 612 individuals were included in the study. The positivity threshold of FIT used was 10 µg Hb/g faeces and the main outcome was AN. AN was detected in 9% (55) of the patients. The accuracy of FIT for detecting AN in PPI users and non-PPI users were sensitivity 54% vs 81%, P = 0.05; specificity 91% vs 90%, P = 0.74; positive predictive value 29% vs 47%, P = 0.13; and negative predictive value 96% vs 98%, P = 0.41, respectively. The ROC curves for FIT for the detection of AN in PPI users and non-PPI users were 0.74 (CI 95% 0.58±0.91) and 0.92 (CI 95% 0.89 ±0.95) respectively.

Conclusions PPI therapy impairs the performance of FIT for the detection of AN in symptomatic patients. Given the widespread use of these drugs in the general population, the negative impact on the CRC screening programs could be substantial.

REFERENCE

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P293 EXTERNAL VALIDATION OF A FAECAL IMMUNOCHEMICAL TEST BASED-RISK SCORE FOR ADVANCED NEOPLASIA IN SYMPTOMATIC PATIENTS

[1]Subashini Chandrapalan*, [2]Lorena Rodriguez-Alonso, [1]Alexia Farrugia, [1]Monika Widlak, [2]Francisco Rodriguez-Moranta, [2]Jordi Guardiola, [1,3,4,5]Ramesh Arasaradnam. *[1]University Hospital Of Coventry And Warwickshire, Coventry, UK; [2]University Hospital of Bellvitge-IDIBELL, Barcelona, Spain; [3]Warwick Medical School, Warwick, UK; [4]Health, Biological and Experimental Sciences, University of Coventry, Coventry, UK; [5]School of Health Sciences, University of Leicester, Leicester, UK*

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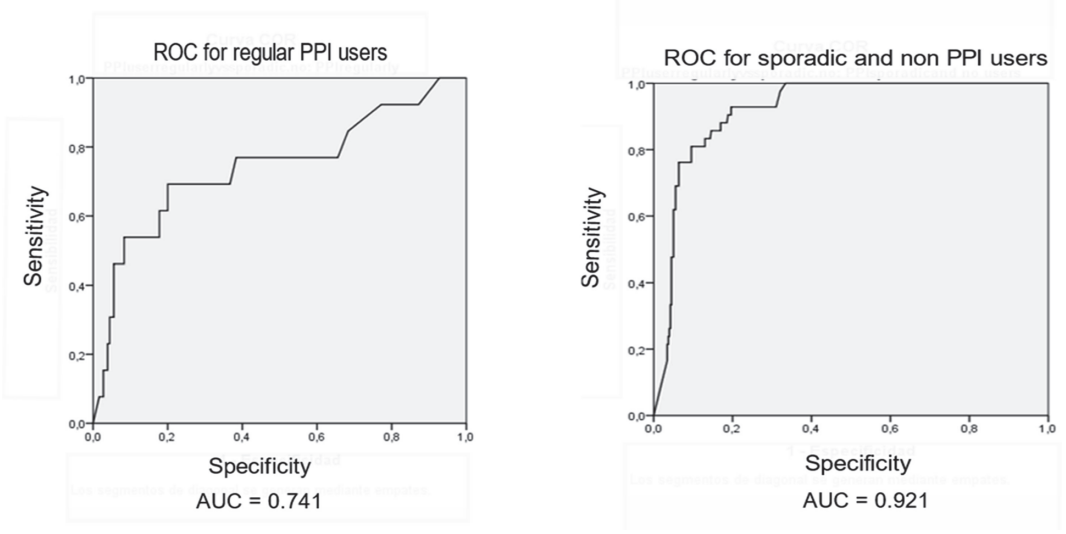

Abstract P292 Figure 1 ROC curves for PPI and non-PPI users