

different platforms with central updating. The application has been evaluated and tested through literature search, internal validation exercises, code testing, risk analysis, and usability assessments. Usability assessments (n=7) has shown mean user subjective satisfaction of 8.5 out of 10. A screenshot from the application. Plans for post-production maintenance and surveillance have been established. A technical file for the application has been written according to Medical Devices Directive (MDD) and all other relevant harmonised standards. The process of registering the application with the MHRA and for CE marking is underway.

**Conclusions** The application *Predict GI Cancer in IDA* generates an estimate of GI cancer risk (with 95% confidence interval), following the insertion of data for the four key variables. The whole process takes just a few seconds, which lends itself to use in busy clinical settings. Legal notices, contact system and all the supportive information for the application such as description of the population, intended users, safety information have been embedded within the application interface.

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#### IMPLEMENTATION OF SYSTEMATIC LYNCH SYNDROME TESTING IN COLORECTAL CANCER: OUTCOMES FROM A PILOT PATHWAY

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**Introduction** Lynch syndrome (LS) is an inherited genetic condition that accounts for 3.3% of colorectal tumours. Patients with LS are at risk of developing other cancers including cancer of the endometrium and urinary tract. The diagnosis of LS provides an opportunity to enrol affected patients into preventative surveillance programmes and also the opportunity to offer screening to relatives. Historically, targeted testing of patients with colorectal cancer (CRC) based on age (< 50 years) and family history has been widely adopted into common practice.

In 2017, NICE issued a recommendation for systematic testing for LS in all patients. Implementation of the guidelines poses some organisational challenges. Consent for genetic testing must be incorporated into patient pathways for those diagnosed with CRC. Co-ordinated communication between CRC MDTs and genetics laboratories is also required.

**Methods** A pilot pathway for LS testing was rolled out across two UK tertiary centres. Five CRC specialist nurses underwent training to consent patients for LS testing by members of the regional Clinical Genetics team. Consent was incorporated into their standard clinic review following the initial diagnosis of CRC.

LS testing was undertaken using an immunohistochemistry 4-panel test for MLH1, MSH2, MSH6 and PMS2, with sequential *BRAF* V600E and *MLH1* promotor hypermethylation testing in MLH1 IHC negative patients.

**Results** 189/196 (97%) patients consented to LS testing. 29/189 (15%) had abnormal IHC (potential LS patients). 6 cases of LS were confirmed on IHC alone (MSH2, n=1; MSH2 & MSH6, n=3; MSH6, n=1; PMS2, n=1). A further 6 cases were identified from the remaining patients.

Overall, 12 patients (6.3% of the tested cohort) had LS. 3 patients were <50 years old.

No adjustment to clinic numbers was required to accommodate consent for testing.

**Conclusion** Systematic LS testing can be incorporated into standard CRC pathways with minimal training required for existing teams to obtain consent for LS testing. There was a high uptake of LS testing among patients. Targeted testing for LS would have missed three quarters of cases, and by inference is a lost opportunity to discuss strategies to prevent cancer or detect cancer at an early stage with patients and their families.

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#### OUTCOME OF DIRECT ACCESS IBD PHYSICIAN DELIVERED ENDOSCOPY FOR GENERAL PRACTICE REFERRALS WITH SUSPECTED IBD

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**Introduction** Patients with suspected IBD referred by primary care (GP) are traditionally seen in gastroenterology outpatient clinics followed by endoscopic investigations. This 2 phase model leads to delay in diagnosis and treatment, increasing pressure on gastroenterology outpatient services while still requiring endoscopic intervention. Our novel pilot project compared outcomes between direct-access IBD physician-delivered endoscopy versus the traditional clinic model for patients with suspected IBD.

**Method** A prospective cohort of consecutive patients referred by GP with suspected IBD were triaged either direct to IBD endoscopy (n=50) or to outpatient IBD clinic followed by IBD endoscopy (n=50) at the discretion of 10 gastroenterology consultants grading GP referrals. Data on demographics, faecal calprotectin, C-reactive protein, endoscopy outcomes, treatment, and follow up was collected. (Group A = direct to IBD endoscopy and Group B = IBD endoscopy via IBD clinic).

**Results** Both groups were age and gender-matched. Group A had a higher mean calprotectin (1363 ug/g vs 302 ug/g) and a higher C-reactive protein (10.6 mg/l vs 4.5 mg/l). In Group A only 38% had a full colonoscopy versus 86% in Group B. Definitive diagnosis and treatment at time of IBD endoscopy took 27 days in Group A versus 212 days in Group B. Treatment with immunomodulators and biologics was similar in both groups but mesalazine and steroid use was higher in

Abstract 069 Table 1 Diagnostic breakdown

	Direct to endoscopy (Group A)	IBD endoscopy via IBD clinic (Group B)
Ulcerative colitis	44%	10%
Crohn's disease	18%	28%
IBDU	8%	4%
Diverticulosis/associated segmental colitis	6%	4%
IBS	24%	50%
Bile sale malabsorption	0%	4%