

colonic contractions. The influence of melatonin on faecal pellet was explored.

Results Melatonin release was shown to 2-fold greater than serotonin, when released from the colon (n=6). Melatonin release occurred on demand during mechanical stimulation but was not released by a chemical stimulus, the bile salt deoxycholic acid. EFS of isolated colon segments caused contraction at lower frequencies but relaxation at higher frequencies. In the proximal colon, 5 µM melatonin facilitated contraction at all EFS frequencies (p<0.05, n=6), however this was not altered in the distal colon. In the presence of tetrodotoxin (TTX), melatonin did not alter KCl stimulated muscle contraction. Melatonin caused a reduction in CMMC amplitude in the proximal colon (p<0.01, n=5) but did not influence the distal colon. Melatonin did not influence the velocity of CMMCs (n=5). Melatonin significantly decreased colonic transit times of an artificial faecal pellet (p<0.001, n=5), however luzindole significantly increased colonic transit times (p<0.01, n=5).

Conclusions Our findings highlight that melatonin is present and released from the colonic mucosa and has an important functional role in influencing muscle contraction. Therefore, melatonin signalling pathways may serve to be important targets to direct therapeutic development.

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MEASURES TO REDUCE POST-POLYPECTOMY BLEEDING IN PEDUNCULATED POLYPS – DOES A CLIP HELP?

Rajan N Patel*, Saadiq Moledina, Rigers Cama, Richard Hall, Kalpesh Besherdas. *Barnet Hospital, Royal Free London NHS Foundation Trust, London, UK*

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Introduction Immediate and delayed post-polypectomy bleeding (PPB) are serious complications after endoscopic removal of large pedunculated polyps. Options to decrease the risk of bleeding include injecting the stalk with adrenaline, placing endoscopic clips across the stalk (before or after the polypectomy) and placement of a nylon loop around the stalk. The principle of closing a defect to reduce complications is well established but the cost effectiveness of prophylactic clipping remains controversial. There are currently no consensus guidelines.

Methods We aimed to investigate the use of endoscopic clips during polypectomy of pedunculated polyps >10 mm and assess its association with PPB. We performed a large retrospective study across two sites at a tertiary London-based hospital Trust. Endoscopy software (Unisoft GI reporting tool) was used to identify pedunculated polyps >10 mm in size during a 5 year period (January 2014 to March 2019). Patients that did not undergo polypectomy were excluded.

Results 657 polypectomies were performed for pedunculated polyps during the study period (mean age 65.2 (range 22 - 94), Female 240 (36.5%)). Mean pedunculated polyp size 16.4 mm (10 - 60 mm). 431 (65.6%) in sigmoid colon. 636 (96.8%) hot snare polypectomy; 264 (40.2%) injected with adrenaline. Endoscopic clip used in 191 (29%). Total immediate (< 6 hrs) and delayed bleeding (6 hrs to 2 weeks) events were 11 (1.7%) and 14 (2.1%), respectively.

Conclusion Endoscopic clip use was associated with more immediate bleeding events suggesting that it is being used as a treatment strategy (not prophylactically) to achieve haemostasis in high risk patients. Endoscopic clips are being deployed

Abstract P315 Table 1 Bleeding complications according to use of endoscopic clip

	Endoscopic Clip (n = 191)	No Endoscopic Clip (n = 466)	p value*
Size (mm)	18.1	15.7	0.0002
Hot Snare (%)	183 (95.8)	453 (97.2)	0.35
Adrenaline injection (%)	115 (60.2)	149 (32.0)	<0.0001
Immediate bleeding (%)	9 (4.7)	2 (0.4)	0.0001
Delayed bleeding (%)	4 (2.1)	10 (2.1)	0.97

more often with larger polyps and in combination with adrenaline injection. Overall PPB rates in our cohort remain low. There remains considerable variation in practice and the type/size of clip to use and the method of clipping remain unanswered questions. Whilst there is clear guidance from national and international bodies on how to remove sessile polyps, the optimal technique for resection of pedunculated polyp is less clear and this may account for the variability in clinical practice.

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HOW IS FIT BEING USED IN THE COLORECTAL TWO WEEK WAIT PATHWAY?

¹Preena Patel*, ¹Kristie Leung, ¹Deborah Alawode, ²Edward Seward. ¹UCL Medical School, London, UK; ²Endoscopy Department, University College London Hospital, London, UK

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Introduction Faecal Immunochemical Testing (FIT) has been proposed by NICE to be used in patients fulfilling DG30 criteria ('low risk but not no risk' of colorectal cancer, i.e. 0.1-3% colorectal cancer risk). A positive FIT test result necessitates a 2 week wait (2ww) referral. FIT is not currently supported by NICE for NG12 patients, in other words those individuals with >3% risk of colorectal cancer (CRC) are referred based on symptoms. FIT testing was introduced in our referral population in mid-2019. We would like to explore how FIT has affected referral patterns and whether it was being used in accordance with NICE guidance.

Methods We extracted the 2ww colorectal referrals from November 2019 to February 2020 and compared demographic and clinical data for those patients referred as FIT positive (FIT group) to those referred based on symptoms alone (symptoms alone group). Outcomes for CRC and presence of polyps were recorded. Two-tailed t-test and Fisher's exact test were used to assess for a significant difference between the two groups.

Results 502 referrals were received in the three month period, of which 22 were excluded as no information regarding FIT could be found. 72 patients (15%) were referred on the basis of their FIT result, 22 of whom have negative FIT results. 39 patients from the FIT group (54%) had NG12 compliant symptoms, rendering a FIT unnecessary. Mean age in the FIT group was lower than the symptoms alone group (58.2 vs 62.2, p = 0.03). There was no significant difference between the FIT and symptoms alone groups in CRC rate (3.2% vs 1.9%) or polyp detection rate (27.1% vs 24.2%), but there are fewer cancer diagnoses in the FIT group (n = 2 in FIT group, n = 6 in symptoms alone group). Mean FIT value