colonic contractions. The influence of melatonin on feacal 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 artifical 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.

P315 MEASURES TO REDUCE POST-POLYPECTOMY BLEEDING IN PEDUNCULATED POLYPS – DOES A CLIP HELP?

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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 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.

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

P316 HOW IS FIT BEING USED IN THE COLORECTAL TWO WEEK WAIT PATHWAY?

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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

was 44gHb/gF. None of the FIT negative group had CRC, only one had a single 3 mm adenoma.
Conclusions FIT is providing significant numbers to the 2ww referral population, although half of the FIT referrals received were on patients who would have met symptomatic criteria stipulated in NG12. Despite the age of patients with FIT referrals being significantly younger as one would expect from the referral criteria, there is no significant difference between CRC and polyp detection rates in our population studied. Nonetheless, the number of cancers were small, suggesting that referring patients who are FIT negative is unlikely to result in the finding of significant pathology.

P317 DIFFERENCES IN NORMAL MUCOSA AND COLORECTAL TUMOUR MICROBIOTA BETWEEN RIGHT AND LEFT COLON

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Introduction Colorectal cancer (CRC) is categorised by colonic location of the primary tumour. Right-sided colon cancers (RCC) are found in the ascending and transverse colon. Whereas, left-sided colorectal cancers (LCC) are found in the descending colon, sigmoid colon and the rectum. The right and left colon have many distinctive developmental and physiological differences, which may explain the variations in outcomes, prognosis and response to therapy between RCC and LCC. In addition, the variability also observed in genetic mutations and oncogenic signalling pathways between RCC and LCC has led to stratifying CRC patients to right or left for treatment and clinical trials. However, the differences in mucosal adherent microbiota between the right and left colon and RCC and LCC has not been fully categorised.
Methods Normal and tumour biopsies were obtained post-surgery from 15 patients with RCC and 7 patients with LCC and were analysed for mucosal adherent gut microbiota using 16S rRNA profiling. Bacterial α-diversity was assed using the Shannon diversity index. All patients had either T3 or T4 stage tumours, had iron deficiency anaemia and were treated with intravenous ferric carboxymaltose prior to surgery.
Results Species α-diversity in the right colon was significantly greater than the left colon ($p=0.045$). However, the species α-diversity between RCC and LCC showed no difference. To assess whether this was due to a decrease in RCC α-diversity or an increase in LCC α-diversity, we compared the right colon to the RCC and the left colon to the LCC. Species α-diversity was consistent between RCC and adjacent right colon, whereas, the LCC had significantly higher bacterial α-diversity than the adjacent left colon ($p=0.015$).
Conclusion These results suggest that under normal physiological conditions the right and left colon have different bacterial diversities. However, in CRC the tumour associated bacteria show similar diversities regardless of location. This may suggest that the LCC has acquired a mechanism to increase bacterial populations, potentially to support tumour growth. Ongoing work will determine the individual bacterial species associated with this increase in LCC α-diversity. The outcome is potentially beneficial when stratifying CRC patients, due to the development of probiotic therapies and biological drugs.

P318 COLORECTAL CANCER (CRC) IN THE YOUNG: A COMPARATIVE STUDY OF CRC IN YOUNG VS OLD

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Introduction Incidence of CRC in the young are increasing and it is defined when a diagnosis is made in individuals younger than 50 years of age. There is plethora of data on incidence and tumour characteristics in young. However, there is limited literature available regarding clinical presentation and tumour behaviour in young CRC. Aim is to assess the clinical presentation, tumour characteristics, management and mortality in young and to compare between older individuals.
Methodology It is a retrospective review of prospectively collected data. We reviewed all CRC diagnosed at our hospital between 2014 – June 2019. Data were retrieved from trust cancer database, endoscopy reports, electronic clinical records and pathology reporting systems.

Abstract P318 Table 1

	Young No (%)	Old No (%)
Number	48(8.7)	499(91.3)
Clinical Presentation		
Change in bowel habits	06(12.5)	96(19.2)
Abdominal pain	05(10.4)	54(10.8)
Rectal bleeding	19(39.6)	105(21)
Abnormal imaging	05(10.4)	79(15.8)
Anaemia	19(40)	110(22)
Complications related to CRC	1(2.1)	17(3.4)
Laboratory findings		
Iron deficiency anaemia	29(60.4)	338(75.3)
Thrombocytosis	11(22.9)	69(13.8)
Location of CRC		
Rectum	16(33.3)	149(23.5)
Sigmoid colon	16(33.3)	141(28.2)
Descending colon	04(8.3)	23(4.6)
Transverse colon	01(2.2)	40(8)
Caecum/appendix/ascending colon	11(22.9)	146(35.7)
Staging at the time of diagnosis		
1	2(2.1)	25(5)
2	3(4.2)	45(9)
3	18(37.5)	178(35.7)
4	15(31.2)	90(18)
Not specified	10(25)	209(32.3)
Survival		
1 year	42(87.5)	405(81)
2 years	41(85.4)	377(75.4)
3 years	39(81.2)	359(71.8)
4 years	37(77.1)	349(69.8)
5 years	37(77.1)	346(69.2)