Of patients treated for volvulus (median follow up 10 months), 5 (55%) had PEC removal after 3 months without recurrence to date, whilst 2 (22%) had recurrent volvulus following PEC removal requiring further intervention (surgery 1, further PEC 1). One patient required regular venting from the PEC, hence tube not removed.

Two patients with pseudo-obstruction have ongoing venting via their PEC tube, whereas one patient removed their PEC 3 weeks post insertion. Despite forcible removal, there was no observed faecal peritonitis.

Conclusions Sigmoidopexy-assisted PEC appears to be a safe and effective technique, with no significant post-procedural complications in this case series. Two patients developed recurrent sigmoid volvulus after tube removal, suggesting a need to leave tubes in situ for longer than the 3 months used in our initial protocol.

PTH-106 PATIENT PERCEPTION OF FIT IN THE DIAGNOSTIC PATHWAY FOR COLORECTAL CANCER: A MIXED METHOD STUDY

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Introduction The faecal immunochemical test (FIT) is a non-invasive, quantitative immunoassay detecting haemoglobin in faeces. FIT is used in bowel cancer screening in the UK for the asymptomatic population. There is mounting evidence of the high diagnostic accuracy of FIT in patients with suspected colorectal cancer (CRC) symptoms. To date, there is no research on usability and perception of FIT in these patients. The aim of the study was to better understand variation in patient perception and acceptability of FIT for patients with suspected CRC symptoms.

Methods A questionnaire was co-developed with patients and included 21 statements covering four themes: FIT feasibility, faecal aversion, patient knowledge and future intentions. Questionnaires were sent to patients with suspected CRC symptoms participating in the NICE FIT study, a multicentre study determining FIT sensitivity for CRC in symptomatic patients. Logistic regression analysis explored differences in patients' test perception by demographic factors. In addition, semi-structed interviews were conducted with patients who had experienced suspected CRC symptoms and used FIT.

Results 1151 questionnaires (31% response rate) were analysed; 90.1% of patients found faecal collection straightforward, (95% CI 88.3% - 91.8%), 76.3% disagreed FIT was unhygienic (95% CI 73.7% - 78.6%), 78.0% would prefer FIT to colonoscopy (95% CI 75.6% - 80.4%). Preference for FIT over colonoscopy increased with age (OR 1.02; 95% CI 1.01 - 1.03). Intention to use FIT again was stronger in patients who successfully used FIT than those who did not (OR 11.19; 95% CI 2.75 - 45.52) and people of white compared to other ethnicities (OR 3.17; 95% CI 1.31 - 7.68). 15 patient interviews were completed. Patient interviews identified that patients' perception of GP workload could influence test return preferences with patients concerned that returning FIT directly to GPs could add to GP workload. Patients' perception of missing CRC using FIT, and their personal perception of acceptable risk of missed cancer was variable with evidence that patients' personal experience of cancer risk could influence future behaviour in investigation preference.

Conclusions While most patients found FIT practical and hygienic, perception differences were found. Developing strategies to engage patients with more negative FIT perception should be part of symptomatic FIT pathways. FIT recommendation from GPs should trigger a simple patient pathway with rapid secondary care input.

PTH-107 MANDATORY USE OF FAECAL IMMUNOCHEMICAL TEST WILL IMPROVE TRIAGE FOR LOWER GI CANCER REFERRALS

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Prior to the coronavirus pandemic data from our hospital showed a 39% increase in referrals through lower GI (LGI) cancer pathway (CWT) from 2018 to 2019 with 30% having 1st contact in 14 days.[1]

We structure endoscopy lists and outpatient clinics so that some appointment 'slots' are kept exclusively for LGI CWT. After restart of services post COVID 'lockdown' in April 2020 we attempted to send all patients referred via LGI CWT a FIT kit. We wanted to look at local data to assess the following:

a) Proportion of patients referred via LGI CWT with final cancer diagnosis ie the conversion rate (c-rate).[2]

b) Proportion with first hospital contact within 14 days.

c) Impact of triage using FiT $\geq$10 as standard for urgent investigation in the absence of alarm symptoms e.g. palpable abdo/rectal mass or weight loss on colorectal cancer (CRC) diagnosis – assessed by calculating negative predictive value (NPV) of a FIT$\geq$10 for CRC in this cohort.

Method We prospectively collected the following from LGI CWT referrals from 1/4/20 to 31/12/20: Patient demographics, referral 'symptom', dates patients referred and first hospital contact ('seen'), FIT result and final diagnosis of cancer.

Results 1591 patients were referred in the period. 1404 (88.2%) had a FIT result.

Monthly referral numbers shown in figure 1.

The unadjusted (for choice) median time to first seen was 25 days (0 – 92); only 17% seen within 14 days

51 cancers diagnosed in this cohort (includes 1 patient with pancreatic and 1 with possible gallbladder cancer) i.e. a c-rate of 3.2% for all cancer (3.1% for CRC). All apart from one of the patients with a final diagnosis of CRC referred via CWT had FiT $\geq$10. So when considering those with a FiT result, c-rate was 7.8% for patients with FIT$\geq$ 10 and 0.1% for FIT<10

Table 1 below shows the main presenting symptom with cancer proportion and FiT level

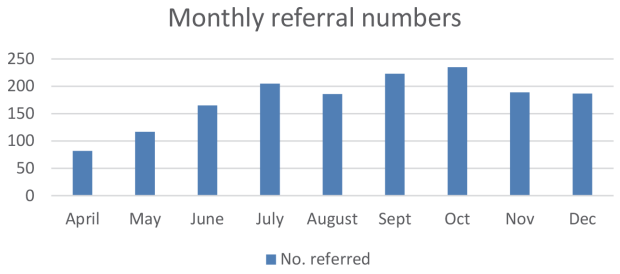
773 patients (55.1%) had a FIT <10 and 2 of them had final diagnosis of cancer:

- 1 x metastatic pancreas cancer. Presented with abdominal pain and weight loss

Abstract PTH-107 Table 1

Main symptom	Number	% Cancer	FiT range
IDA	329	3.9	11 - 214
Alt bowels	70	7.1**	40 - >400
Diarrhoea	578	3.8	36 - >400
PR bleed	313	2.9	30 - >400
Wt loss	84	4.8	110 - >400
Abdo pain	118	1.7	75
Rectal mass	32	9.4	Not done
Abdo mass	20	5	Not done

**1 x possible gall bladder cancer



Abstract PTH-107 Figure 1

• 1 x caecal cancer. Presented with significant weight loss and diarrhoea.

So in our cohort, the sensitivity, specificity and NPV of FiT≥10 for colorectal cancer was 98%, 57% and 99.9% respectively.

Discussion & Conclusions There has been a reduction in the proportion of CWT referrals seen within 14 days between 2019 and 2020 in our institution. This study was to determine if we could use FiT to improve this proportion with the same resources. We have demonstrated that FiT ≥10 has a very high NPV for colon cancer. A significant proportion of patients referred via the LGI CWT pathway have a FIT <10.

Therefore, if triage by prioritising urgent investigation for only patients with FIT ≥10 or with concerning symptoms (eg palpable abdominal or rectal mass) were implemented this will free up LGI CWT slots and allow safe targeting of resources for urgent investigation to patients with higher likelihood of CRC.

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PTH-108 THE USE OF QUANTITATIVE FAECAL IMMUNOCHEMICAL (FIT) TESTING IN THE STREAMLINING OF LOWER GASTROINTESTINAL INVESTIGATIONS

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Introduction The COVID-19 pandemic has resulted in a significant backlog of endoscopies, and challenges in achieving two-week-wait and eighteen-week-wait targets. Faecal Immunochemical Testing (FIT) offers a potential method to stratify the urgency of investigation by endoscopic or cross-sectional imaging. FIT scores are now used at Hillingdon Hospital during the referral triage process; patients with FIT >50µg/g being prioritised. This study aims to determine the impact of FIT testing on the post-COVID rationalisation of lower GI investigations in a real-world district general hospital setting,

Methods Data was collected prospectively from January 2020 to January 2021 for all patients referred to Hillingdon hospital with lower GI symptoms and a FIT score, who were subsequently triaged to colonoscopy and/or an lower GI imaging modality (CT virtual colonoscopy or CT abdomen/pelvis with

Variable		N	Odds ratio		p
Age (range 21 - 95, median 62)		481		1.02 (1.00, 1.04)	0.046
Gender	Female	237		Reference	
	Male	244		2.08 (1.27, 3.45)	0.004
Rectal Bleeding	No	285		Reference	
	Yes	196		1.17 (0.61, 2.22)	0.635
Iron Deficiency Anaemia	No	326		Reference	
	Yes	155		1.14 (0.59, 2.18)	0.694
Change in Bowel Habit	No	276		Reference	
	Yes	205		1.29 (0.74, 2.26)	0.370
Weight Loss	No	406		Reference	
	Yes	75		0.50 (0.22, 1.08)	0.090
Abdominal Pain or Bloating	No	395		Reference	
	Yes	86		1.05 (0.53, 2.02)	0.880
Two Week Wait Referral	No	136		Reference	
	Yes	345		0.88 (0.42, 1.88)	0.746
FIT value (µg/g)	0 - 9	115		Reference	
	10 - 50	204		1.47 (0.67, 3.51)	0.358
	50 +	162		8.03 (3.82, 18.70)	<0.001

Abstract PTH-108 Figure 1