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Results 56 VCE were performed on 27 patients. The mean age was 55.18 years. The majority of patients were male (62.96 %). The main indication was anemia in those aged ≥ 65 years and suspicion of IBD in those aged < 65, in addition to anemia and HDOO in men (▶ **Table 1** and **2**).

Table 3.1 we present the most relevant cases collected.

In 18.52 % of cases, the repeat VCE was prompted by an incomplete first examination; of these, all of them but one were complete (gastric by-pass). 92.6 % of repeat examinations took place in ≤ 24 months, and 48.14 % in ≤ 12 months. 55.55 % of patients received both VCEs for the same indication. Of these, when the indication was diagnostic (diarrhea, suspected IBD, anemia and obscure gastrointestinal bleeding, 66.66 % in total), 70 % turned out findings that were equivalent to the index examination. In 29.63 % of cases, findings in the first VCE did not prompt a change in management, and in 62.5 % of these patients, the repeat exploration did not return new relevant information. (▶ **Table 3**).

Conclusions A repeat VCE did not yield relevant information in a majority of cases, excepting those ordered for the follow-up of small bowel specific pathologies. Besides, in a high percentage of cases, the ordering of a second VCE did not prompt a change in clinical management. This should encourage reflection on the repeated ordering of this test, particularly considering its high cost and lack of practical impact on management in these particular cases.

Conflicts of Interest Authors do not have any conflict of interest to disclose.

eP222 Exploring the Interior: Indications and Diagnostic Yield of Capsule Endoscopy and Follow-Up Management of Its Findings

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Aims To define indications, DY and management of VCE findings.

Methods A descriptive retrospective study was performed analyzing all patients studied with the Medtronic SB3 model in our center between January 2019 and December 2023. Endoscopic, clinical and management parameters were analyzed.

Results 351 VCE were ordered, with 67 Patency capsules (PC) performed. 11 of the latter were deteriorated and a final number of 340 VCE were performed and analyzed for this study. The mean age was 54.07 years. 27 % of patients were ≥ 65 years of age, with a 55 % predominance of female patients. 96 % of VCEs were complete. Out of these, 52 % returned findings pertinent to the clinical question, with a 7 % rate of incidental findings in this group. Within the 48 % of VCEs without findings related to the indication, there was a 9 % rate of incidental findings. Figures 1, 2 and 3 reflect indications, management, and DY paired with the rate of cases in which management changes were motivated by VCE findings. 4 patients required surgical management: 1 ischemic anastomotic ulcers, 1 Meckel's diverticulum and 2 ulcerated submucosal lesions (1 lipoma and 1 pyloric gland adenoma). 3 cases were retained, with 2 of them underwent PC and came through the procedure intact, with a difference of 8 and 34 days between capsules. The 3 patients had IBD. 2 of these patients were successfully managed conservatively, while 1 required corticosteroid.

Conclusions Our study has an acceptable DY. Findings support prioritizing indications with a higher probability of positive findings, such as anemia or suspected IBD. On the other hand, DY was extremely low in VCEs ordered for the study of diarrhea without a firm suspicion for IBD. Even in cases when positive findings pertinent to the clinical question were found, did not exhibit a change in attitude. This observation prompts a critical evaluation of the utilization os this test. VCE is safe, even in patients with IBD who have the highest risk of retention, in which the time interval between PC and VCE should be optimized.

Conflicts of Interest Authors do not have any conflict of interest to disclose.

eP223 Impact of Capsule Endoscopy on the Assessment and Management of Inflammatory Bowel Disease

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Aims To define the indications, assessment and management changes prompted by IBD evaluation through VCE.

Methods Descriptive, retrospective study of all IBD patients evaluated through the SB3 type Medtronic VCE model in our center between January 2019 and December 2023. Endoscopic, clinical and management variables were included.

Results We assessed 33 VCE in a total of 31 patients. Mean age was 44.29 years, and a slight male predominance was observed (54.83 %). 35 % of these patients had had a colonoscopy in the previous 6 months. 7 of these showed active disease, 3 had been diagnosed of indeterminate IBD, 3 of them of ulcerative colitis (UC) and 1 of Crohn´s Disease (CD). 16 % of all patients had had a magnetic resonance enterography (MRE) in the same period, 2 of which had shown disease activity. 10 % of patients had had both tests (of which 1 patient had active disease in both of them), and 39 % had had none of these. Graph 1 summarizes indications for according to diagnostic tests and disease activity. ▶ **Table 1** summarizes treatment, disease behavior and location prior to the VCE. Before VCE, 14 patients were on maintenance mesalazine and 5 had no maintenance treament (both groups comprising 57 % of all patients). Of these, 79 % had a diagnosis of CD (6 L3, 4 L4 and 5 L1), 10.5 % of indeterminate IBD, and 10.5 % of ulcerative proctitis. 47 % of patients had not had a colonoscopy or an MRE in the previous 6 months. 32 % had had a colonoscopy, of which 3 had shown disease activity (2 cases of indeterminate IBD and 1 case of active proctitis), and 21 % had had an MRE, of which 2 had shown disease activity (L1 and L3, respectively). Through the VCE assessment, 85 % of patients keep the same Montreal classification, while 9 % switch from B1 to B2, 3 % from indeterminate IBD to UC, and 3 % from L1 to L3. Graph 3 shows all cases rated by disease activity, specifying ulterior management. In patients with a Lewis score (LS) of < 135, treatment was initiated in those presenting with colonic disease activity corroborated by another diagnostic test. Within the segment of patients with a LS of 135-790, no treatment was initiated in any patients < 500.

Conclusions In approximately a third of cases, a VCE was indicated without any recent colonoscopy or MRE. While it is true that VCE is the most sensitive test for detecting disease activity in the small bowel, it is not devoid of risks. This, as well as the costs involved, should elicit consideration on which should the best first-line test for each activity degree. Of note, the most frequent maintenance therapy prior to VCE was mesalazine, and several patients had been prescribe no maintenance treatment. Of these, almost half had not had a colonoscopy or MRE before the VCE; and in those that did and in which disease activity had been detected, VCE was nevertheless still ordered.

Conflicts of Interest Authors do not have any conflict of interest to disclose.

eP224 Assessing dysplasia/cancer in large granular mixed laterally spreading lesions: Endoscopic classifications versus forceps biopsy

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Aims Determine the most accurate endoscopic classification in comparison with forceps biopsy(FB) for granular mixed laterally spreading lesions(LSLs), by comparing them with histopathological findings [1–4].

Methods The study included 70 patients with granular mixed LSLs with a diameter ≥ 20mm, type 0-IIa, 0-Is or IIa + Is Paris Classification. Patients with deep invasive cancer were excluded. An expert endoscopist performed optical evaluations ac-

cording to Kudo, JNET, Modified Sano and Hiroshima classifications using chromoscopy and NBI, followed by target forceps biopsy and endoscopic resection. The findings were compared to specimen histopathology using Fisher's exact test, Wilson confidence intervals and descriptive statistics in Statistica 13.

Results Median age was 66 ± 9.9 year; median lesion size was 40 ± 16.7mm. 35.7 % of all LSLs were removed via piecemeal EMR, 32.9 % via ESD, 17.1 % by EMR en block and 14.3 % by hybrid ESD. Sensitivity was 67.39 % (95 %CI,53.8 %-80.9 %) for FB; 70.83 %(95 %CI,58 %-83.7 %) for JNET, 57.14 %(95 %CI,38.8 %-75.5 %) for Hiroshima and 89.58 %(95 %CI,80.9 %-98.2 %) for Modified Sano classification. Specificity was 95.83 % (95 %CI,87.8 %-100 %) for FB; 90.91 %(95 %CI,78.9 %-100 %) for JNET; 95.24 %(95 %CI,88.8 %-100 %) for Hiroshima and 54.55 %(95 %CI,33.7 %-75.4 %) for Modified Sano classification. P < 0.001 in all cases. In the analysis using the Kudo classification, the p-value was 0.103, indicating that the results were not statistically significant.

Conclusions Among the classifications tested, JNET has slightly higher sensitivity and slightly lower specificity compared to forceps biopsy. Given that the Sano classification demonstrates significantly higher sensitivity but lower specificity, it may be beneficial to combine both JNET and Sano classifications to enhance diagnostic accuracy. Comparable results between optical assessment and forceps biopsy indicate that forceps biopsy is unnecessary if endoscopic removal of the lesion is planned.

Conflicts of Interest Authors do not have any conflict of interest to disclose.

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eP225 No need to stay above the line: anorectal junction endoscopic submucosal dissection is comparable to other rectal locations

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Aims Evaluate the outcomes of rectal ESD and compare the resection of anorectal junction (ARJ) lesions with more proximal rectal (MPR) lesions, regarding feasibility, safety and efficacy.

Methods Retrospective unicentric study including consecutive patients submitted to rectal ESD. ARJ lesions were considered as those totally or partially located within 2 cm of the dentate line. ESD failure was determined whenever the target lesion was not removed. *En bloc* resection required that the target lesion be retrieved in one single specimen. R0 resection was achieved when pathological evaluation showed free horizontal and vertical margins in an *en bloc* resected specimen. Specimens with thermal effects at the margins preventing the pathologist from excluding abnormal cells were considered R1. Curative resection was considered low- (LGD) or high-grade dysplasia (HGD) with R0 resection or lesions harboring a well-differentiated adenocarcinoma with superficial submucosal invasion (< 1mm), with negative margins (> 1mm), without lymphatic/vascular invasion or tumor budding.

Results A total of 26 patients were included, 12 (46.2 %) had an ARJ lesion and 14 (53.8 %) had a MPR lesion. Most lesions were Paris 0-IIa + Is (61.5 %), followed by 0-IIa + b (15.4 %). Technical success was achieved in 25 patients (96.2 %), with no significant differences between those with an ARJ lesion and those with a MPR lesion (100.0 % *vs* 92.9 %, $p = 1.000$). There were also no significant differences in the rate of *en bloc* resection (91.7 % *vs* 92.9 %, $p = 1.000$). Most lesions harbored HGD (84.0 %), with no significant differences in histology between ARJ and MPR lesions: in ARJ lesions, LGD occurred in 16.7 % and HGD in 83.3 % *vs* in MPR lesions, HGD in 84.6 % and adenocarcinoma in 15.4 % ($p = 0.134$). The global R0 resection rate was 61.5 % and curative rate was 57.7 %, both without statistically significant differences between patients with ARJ lesions and MPR lesions (50.0 % *vs* 71.4 %, $p = 0.422$ and 50.0 % *vs* 64.3 %, $p = 0.462$). Regarding complications, there were no significant differences between patients with ARJ lesions and MPR lesions in the rate of significant intraprocedural bleeding (41.7 % *vs* 35.7 %, $p = 1.000$) and exposure/section of muscular fibers with the need of closure of the eschar (8.3 % *vs* 14.3 %, $p = 1.000$). The rate of postprocedural bacterial translocation and delayed bleeding were also similar between both groups (16.7 % *vs* 21.4 %, $p = 1.000$ and 8.3 % *vs* 7.1 %, $p = 1.000$, respectively). Only one (3.8 %) patient needed surgery due to a non-curative ESD, with no residual disease in the surgical specimen. Seventeen patients (65.4 %) underwent a surveillance colonoscopy 6 and 12 months after the ESD, with one (5.9 %) patient having residual tissue at 6 months with LGD and none with residual tissue at 12 months.

Conclusions ESD of rectal lesions in the ARJ is a feasible and safe procedure, with technical success and en bloc resection rate similar to MPR lesions, without differences in complication rates.

Conflicts of Interest Authors do not have any conflict of interest to disclose.

eP226 Primary colonic Lymphoma. Can endoscopic resection be a definitive therapeutic option?

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Introduction Primary colonic lymphoma (PCL) is a rare variety of non-Hodgkin lymphomas (NHL) and represents 0.2-1.2 % of all primary colon neoplasias. We present the case of a 61-year-old male who presented, during a colonoscopy performed within the colorectal cancer screening program, a giant non-granular lateral growth lesion Paris 0-IIa + IIb, occupying at least 3 haustras in anteroposterior diameter and 60 % of the circumference. A piece-meal underwater endoscopic mucosal resection was performed with complete resection of the lesion, enlarging healthy margins. No remains of the lesion or damage to the muscle layer were seen. The edges of the scar were treated with closed hot forceps/soft coag 80W. There were no immediate or delayed complications. Histologically, it was a low-grade B-cell lymphoma of the marginal zone. The extension study performed with PET CT, bone marrow biopsy and gastroscopy did not show extracolonic involvement. The control colonoscopy one year later showed no signs of endoscopic recurrence and the follow-up by Hematology ruled out extracolonic involvement.

Comment The endoscopic appearance of PCL lacks specificity. There is no uniformly agreed treatment for PCL and endoscopic treatment is anecdotal in the available reports. Our case was treated with a piece-meal endoscopic resection without presenting endoscopic or distant recurrence one year later. Therefore, in very localized and well-defined lesions it could be a therapeutic option to consider.

Conflicts of Interest Authors do not have any conflict of interest to disclose.