PTH-014

THE ERCP QUALITY NETWORK BENCHMARKING PRACTICE AND PERFORMANCE; A COMPARISON OF UK AND USA

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Introduction There is increasing interest in documenting the performance of individual Endoscopists, for their own education and to ensure quality standards. What has been lacking hitherto is an infrastructure to facilitate collection and analyses of data to allow practitioners to easily compile a 'report card' of their own practice or benchmark themselves against their peers. The ERCP Quality Network is a web based tool started in the USA.[1]

Methods Anonymised key data points (indications, sedation/anaesthesia, therapies, successes and adverse events), on each case are uploaded through a web based interface onto a central server hosted by Olympus America. This analysis is limited to the 51 endoscopists based in USA and the 12 in the UK who have each entered more than 30 cases. The results were evaluated in aggregate.

Results The table 1 shows some of the areas where practice differed between countries. Those Endoscopists reporting their data in Britain are clearly doing less complex procedures as judged by the accepted complexity grade[2] with lower (but acceptable) technical success rates. The differences were maintained when the comparison was restricted to cases performed with conscious sedation. The proportion of complex 'grade 3' cases was significantly higher in USA. The other striking difference is in the use of anaesthesia, that is, 3% versus 62%.

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	UK (N)	%	USA (N)	%	p Value
Endoscopists	12	–	51	–	
Less experience	5	42	29	57	0.02
ERCPs	1624	–	13 459	–	–
Grade 1	999	62	5542	41	<0.0001
Grade 3	151	9	4839	36	<0.0001
Anaesthesia	56	3	8434	63	<0.0001
Biliary cannulation	1543	93.1	12 437	97.4	<0.0001
Stone <10 mm	447	94.9	2429	99.4	<0.0001
Procedure time	–	29.8 min	–	27.8 min	0.02

Conclusion These data do not purport to reflect average UK and US practice, since the participants are self-selected, and not necessarily representative. The UK data compares favourably with the BSG ERCP audit in which only 77% of trained endoscopists achieved a cannulation rate of greater than 80%.[3] The collection of this level of data about ones own practice is likely to become mandatory in the near future. In the UK the driver for collection of quality data is likely to be revalidation. The ERCP Quality Network is available to use and is a practical tool for self monitoring of quality outcomes and benchmarking against peers.

Competing interests None.

Keywords biostatistics, ERCP.

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