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Disclosure of Interest None Declared.

PWE-065 COLONOSCOPY PERFORMANCE IN A DISTRICT GENERAL HOSPITAL. HAS THE STANDARDISATION OF TRAINING STANDARDISED PERFORMANCE?

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Introduction Since the introduction of the JAG endoscopy training system (JETS) for trainees in 2003 there have been demonstrable improvements in the key performance indicators (KPIs) of colonoscopy performance. Caecal intubation, polyp detection and polyp retrieval rates are audited KPIs for departments. Terminal ileum (TI) intubation rates are also recorded. The national colonoscopy audit has shown a disparity between medical and surgical performance, but little has been studied to assess if this has improved over time.
Methods We retrospectively audited these KPIs between 2004 and 2012, analysing for variations in performance for all colonoscopists encompassing both trainees and Consultants. We compared the performance of medics and surgeons for each year, the performance in 2004 with 2012 and the overall performance for 9 years using the Chi-squared test.
Results 10055 colonoscopies were performed over 9 years: 8938 by medics and 1117 by surgeons. Completion rates improved significantly from 2004 to 2012 for all colonoscopists (80.3 to 92.0%, $p < 0.001$). A significant improvement in both specialties' completion rates was seen (medics: 84.1 to 93.0%, surgeons: 74.8 to 88.5%, $p < 0.001$). Over 9 years the overall completion rate for medics was higher (90.2 vs. 86.0%, $p < 0.001$). Between 2007 and 2011 there was no significant difference in completion rates. Both specialties' TI intubation rate improved between 2004 and 2012 (medics: 46.3 to 64.1%, surgeons: 10.41 to 42.0%, $p < 0.001$). Overall surgeons were better at polyp detection (28.5 vs. 24.8%, $p < 0.001$). Surgical performance has not improved since 2004 (29.02 to 23.2% in 2012), whereas medics improved from 14.4 to 29.7% ($p < 0.001$) to a standard in line with surgical colleagues. Over 9 years there was no significant difference in polyp retrieval rates between specialties (74.9 vs. 76.7% respectively, $p = 0.3$) and the performance of both improved from 2004 to 2012 (medics: 44.2 to 90.9%, surgeons: 57.6 to 80.2%, $p < 0.001$).
Conclusion There has been an overall improvement in colonoscopists' performance in all KPIs between 2004 and 2012. When performance is sub-divided into specialties, one can see that there were significant discrepancies in performance between physicians and surgeons in 2004. With the exception of TI intubation, performance has converged to a similar and higher standard in 2012. This coincides with the introduction of JETS and suggests standardised training may have served to normalise and improve the standard of colonoscopy across both specialties.

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PWE-066 ENDOSCOPIC VERSUS HISTOLOGICAL ASSESSMENT OF COLONIC POLYP SIZE

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Introduction Colonic polyp size is a factor in determining management and prognosis of patients. Polyp diameters greater than 9 mm require ongoing colonoscopic surveillance.[1] Accurate endoscopic estimation of polyp size can be affected by depth perception and parallax errors. We compared endoscopic versus histological size assessments to determine if accurate estimation was operator-dependent.
Methods Symptomatic and asymptomatic (bowel screening) patients were identified from hospital databases. Endoscopic and histological polyp diameters were reviewed. Agreement levels between these were analysed by deriving intraclass correlation coefficient (ICC) using SPSS software (Version 20).
Results Sixteen colonoscopists were included: 5 bowel screening, 7 non-bowel screening and 4 trainees. Five hundred and ten polyps ($n = 510$) were found among 299 patients (186 males, 104 females). Two hundred eighteen polyps were enbloc resected, retrieved whole and analysed. Overall accuracy of polyp size assessment was good (ICC > 0.70) with variability between skill levels (Table 1).

Accuracy was best among polyps ≥20 mm diameter (ICC 0.99, $p < 0.001$); all removed by bowel screening colonoscopists. Polyps between 8 to 12 mm demonstrated poor correlation (ICC (absolute agreement) 0.535, $P = 0.002$).
Conclusion While endoscopic estimation of polyp diameter is accurate, variability exists. Estimations are more accurate among bowel screening endoscopists suggesting experience and/or colonoscopy workload contribute to this skill. Poor diameter estimations among polyps 8–12 mm has implications for polyp surveillance intervals. Standardising diameter using against closed or open biopsy forceps (width 2.2 and 8 mm respectively) to optimise accuracy should be used.

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Abstract PWE-066 Table 1 Reliability analysis of polyp assessment according to aolonoscopist

	Intraclass correlation coefficient	p-value
All	0.95	p < 0.001
Bowel screening colonoscopists	0.96	p < 0.001
Non-bowel screening colonoscopists	0.74	p < 0.001
All trainees (consultant-supervised)	0.86	p < 0.001

PWE-067 DOES ENDOCUFF-VISION IMPROVE ADENOMA DETECTION

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