20–50). Snare polypectomy was performed for all pedunculated polyps. The colonoscopists were able to remove the polyp enbloc in 87.7% of patient (n=43) while in the rest polyps were removed piecemeal (n=6). There was no reported perforation or major bleeding requiring blood transfusion. Only 4 (8.1%) patients had minor bleeding which was successfully controlled during the procedure and no further intervention was required. Histologically, pedunculated polyps were 93.9 % villous or tubulvillous (n=46), 4.1% hamartomatous (n=2) and 2% benign leimyoma (n=1). In the group of patient who had sessile polyp, 10 were male while rest were female. There mean age was 71.93 years. The average size of the polyp was 33.67 mm (range: 20–55). Endoscopic mucosal resection was performed in all of them. The polyp was removed enbloc in only three cases (20%) while in rest it was removed piecemeal (n=12). There was no reported perforation or blood loss requiring blood transfusion. Only 1 (6.66%) of the patient had a minor bleeding which was controlled during the procedure. All 15 of sessile polyp were histological either villous or tubulovillous.

Conclusion The complication rates of colonoscopic removal of large pedunculated and sessile polyps in a district general hospital are very low as evident from the data presented. Hence these procedures when performed by skilled colonoscopists are safe and can save the patient from major surgical procedures.

Competing interests None declared.

PMO-187 A MULTI-CENTRE AUDIT OF 16 064 COLONOSCOPIES LOOKING AT CAECAL INTUBATION RATES, OVER A 2-YEAR PERIOD. NON-GI OPERATORS AND THOSE DOING <100 P.A. NEED TO IMPROVE OR STOP PERFORMING COLONOSCOPY

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Introduction Colonoscopy is the gold standard assessment for large bowel mucosal pathology, but a complete examination is an essential requirement. The first national colonoscopy audit carried out in 1999 demonstrated caecal intubation rates (CIRs) of 56.9%, which the authors described as "unacceptably low". As a result the Joint Advisory Group on Gastrointestinal endoscopy (JAG) launched a programme of continuous quality improvement by standardising training, peer review and audit. JAG recommends practitioners undertake at least 100 procedures per annum with target CIRs of 90%. This current audit provides an assessment of performance against these quality standards.

Methods Data were collected from all procedures undertaken in 2008–2009 from six hospitals across three English regions. The data included grade and specialism of operator, number of procedures and CIRs. Caecal intubation was recorded if reports positively documented reaching defined landmarks.

Results 16 064 colonoscopies performed with a CIR of 90.57% (95% CI 90.11% to 91.01%). Operators doing 100+ procedures per annum. CIR=91.76% (95% CI 91.24% to 92.25%). **Operators doing <100 procedures per annum=87.77% (95% CI 86.82% to 88.67%)**. Gastroenterologists=91.01% (95% CI 90.32% to 91.70%). Surgeons=91.03% (95% CI 90.27% to 91.79%). **Others practitioners=81.51% (95% CI 78.79% to 84.22%)**. Bowel cancer screening colonoscopies=97.71% (95% CI 97.07% to 98.34%). Non-screening colonoscopies=88.31% (95% CI 87.68% to 88.94%).

Conclusion This audit of 16 064 colonoscopies over three regions demonstrates aggregated achievement of the CIR quality standard, which is evidence of the effects of improvements in training and the implementation of standards Introduced by JAG since the 1999 national audit of colonoscopy. There is however a significant performance gap when comparing BCSP colonoscopists with non-screening colonoscopists and the CIR of >90% is supported by the volume of BCS colonoscopy work load (BCSP colonoscopies should be considered the new "gold standard"). Endoscopists performing low volume colonoscopy (<100 procedures per annum) and non-GI practitioners have a CIR (including the 95% CIs) of <90%. Endoscopists and/or non-GI practitioners with low volume practice who does not meet the quality standards should engage in skills augmentation plus further training and increase the numbers of procedures performed with local mentorship, **or stop performing colonoscopy**.

Competing interests None declared.

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PMO-188 GENDER DIFFERENCES: ANALYSIS OF 5162 COLONOSCOPIES OVER 4 YEARS REVEALS HIGHER CAECAL INTUBATION RATES IN MALE PATIENTS

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Introduction Colonoscopy is the gold standard assessment for large bowel mucosal pathology, but a complete examination is an essential requirement. Higher caecal intubation rates in male patients vs female patients have been shown in the literature.[1–3] Several theories are mooted for this difference such as female patients undergoing previous hysterectomy,[1] low BMI[2] and the suggestion that female patients have longer colons.[3] The published papers on this subject are mostly over 10 years old and colonoscopy practice has changed dramatically over the last decade in the UK. The Joint Advisory Group on Gastrointestinal endoscopy (JAG) has run a programme of continuous quality improvement by standardising training, peer review and audit. The Bowel Cancer Screening Programme (BCSP) has been rolled out since 2006. This large audit revisits this subject to see if the improvements in colonoscopic practice have evened out the differences.

Methods Data were collected from all colonoscopies undertaken (symptomatic, surveillance and BCSP procedures) at Kettering General Hospital between 1 July 2007 and 30 June 2011.

Results

	Number of colonoscopies	Reached caecum/ TI/anastomosis	Failed	CIR (%)	95% CI
Females	2440	2138	302	**87.62**	86.26 to 88.87
Males	2772	2524	198	**92.73**	91.69 to 93.64
Total	5162	4662	500	90.31	89.48 to 91.09

Conclusion Analysis of the data reveals significant differences in CIR between female and male patients (87.62% vs 92.73% (p≤0.0001) NNT 19.57). This large retrospective audit shows despite the improvements in training and practice overseen by JAG and the introduction of BCSP, significant gender differences remain in CIR. Perhaps it would be prudent for endoscopy units to delineate these differences in gender and the potential ramifications (missed polyps etc) when giving information and consenting patients for