Abstract PTH-009 Table 1 Distribution of PCCRC origins

Category	No (%)
A likely incomplete resection	3 (11.1)
B lesion not resected	5 (18.5)
C possible missed lesion, exam adequate	7 (25.9)
D possible missed lesion, exam inadequate	12 (44.4)

Conclusions Although the WEO algorithm is a useful tool for PCCRC categorisation, a category for conservatively managed cases is missing. Further, a judgement is still required to conclude whether a PCCRC was avoidable or unavoidable. In this cohort, 70% of PCCRCs (19/27) were probably avoidable; 5 possibly avoidable and 3 likely unavoidable. The following are influencing factors and possible means of addressing them:

- PCCRC rates are high in patients with existing colon pathology. Rates would reduce in certain groups with greater vigilance and use of chromoendoscopy.
- Surveillance timeframes were often breached. Effective processes should reduce delays.
- Bowel preparation was often poor. If these colonoscopies are not repeated, the decision should be recorded.
- Some adenomas were overlooked while endoscopists focussed on large polyps. Early repeat colonoscopy should be considered after complicated procedures.
- Photodocumentation was adequate in 44.4% of cases. Inadequate photos may be a marker for other shortcomings and repeat colonoscopy considered if caecal documentation is incomplete.

These findings indicate that PCCRC rates could be reduced by up to 70% if avoidable factors are addressed. There is a need for quality improvement studies targeting these factors to quantify their impact on PCCRC rates.

REFERENCES

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PTH-010 CECAL WITHDRAWAL TIME: ASSESSING STANDARDS OF COLONOSCOPY IN DISTRICT GENERAL HOSPITAL

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Introduction The British Society of Gastroenterology, the UK Joint Advisory Group on GI Endoscopy, and the Association of Coloproctology of Great Britain and Ireland have developed quality assurance measures and key performance indicators for the delivery of colonoscopy within the UK. However, studies have suggested that high variations in the quality of colonoscopy among different endoscopists are reflected in surrogate measures such as adenoma detection, cecal intubation rates, withdrawal times, and incidence of complications. This documents identifies the unacceptable variation in practice and measures adopted to improve quality of care.

Method A prospective, observational colonoscopy practice audit was conducted of cecal withdrawal time at Glangwili General Hospital, Carmarthen for patients who presented for colonoscopy between August 2017 to January 2018.

Diagnostic procedures were included in the study comprising two cycles 8 months apart. Patients with history of colonic surgery were eliminated. Same endoscopy nurse manually collected the data from 5 different endoscopist using stopwatch without them knowing. Both the cycles were 3 months apart during which different measures were taken to improve withdrawal time including sending individual feedback to endoscopists, one to one discussions between endoscopy consultant lead and involved endoscopist and keeping a timer in endoscopy room to keep track of time.

Abstract PTH-010 Table 1

	Endoscopist A	Endoscopist B	Endoscopist C	Endoscopist D	Endoscopist E
1 st Cycle	13	10	4.2	11.6	2.4
2nd Cycle	8.9	8	8.2	11.5	6
Standard	6	6	6	6	6

Results We reviewed 10 colonoscopies performed by each endoscopist in each cycle of audit and mean cecal withdrawal time is shown below.

After taking appropriate measure to improve quality of care following results were obtained.

Following graph shows variation in mean withdrawal time between two cycles compared against set standards.

Below shows the comparison of 1 st and 2nd cycle showing rectal retroflexion performed and imaging of cecal landmarks recording done by each endoscopist

Abstract PTH-010 Table 2

	Endoscopist A	Endoscopist B	Endoscopist C	Endoscopist D	Endoscopist E
Retroflexion 1 st cycle	100	100	100	100	0
Picture Record 1 st cycle	100	100	100	100	20
Standard	100	100	100	100	100
Retroflexion 2nd cycle	100	100	100	100	20
Picture Record 2nd Cycle	100	100	100	100	30

Conclusion Practice among endoscopists varied with majority providing good standard of care. Weak points identified during 1 st stem of audit cycle and changes implemented lead to improvement in quality of care but still there is further room for improvement. Regular audits are important to make sure that colonoscopy practice meets key performance indicators outlined by JAG and BSG in order to increase polyp detection rate.

REFERENCES

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