**Introduction:**
Colorectal cancer is common worldwide, and the elderly are disproportionately affected.
Increasing age is a risk factor for the development of precancerous adenomas and colorectal cancer.
BUT
Elderly patients are more likely to die of “natural” causes before adenoma develops into cancer.
Risks of colonoscopy and polypectomy are increased in elderly patients.

**Literature Review:**
Previous studies highlight the increased risks attendant with colonoscopy in the elderly population; Lin et al: NNT 140-227 in 80-84yo compared to 61-63 in 50-54yp.
Risk of colonoscopy complications higher than probability of preventing death.
Case reports and reviews also suggest avoidance of polypectomy; Baker et al: Recommendation that polyps <20 mm in size should be regarded as low-risk polyps and that polypectomy of low-risk polyps are not essential in patients aged 85 years and older.

**Aims:**
We aimed to assess the outcomes of polypectomy in patients ≥80 at our trust with five years of follow up.

**Areas to investigate:**
- Analyse polyp size and correlation with histology
- Analyse peri-procedural complication rates
- Analyse morbidity and mortality in patient cohort

**Method:**
Colonoscopy data analysed from the endoscopy reports.
Patients aged ≥80 in 2011 and 2012.
Histology reports and patient notes were also reviewed.
Mortality and cause of death within 5 years of the procedure date were also recorded from the Patient Mortality Coding Database.
Patients with a synchronous cancer at index procedure were excluded from 5 year mortality analysis.

**Results:**
Total Patients = 180
Overall total No of Polyps Removed = 313

<table>
<thead>
<tr>
<th>Size of Polyp</th>
<th>Total Known Sizes</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;10mm</td>
<td>224</td>
</tr>
<tr>
<td>10-19mm</td>
<td>58</td>
</tr>
<tr>
<td>&gt;20mm</td>
<td>20</td>
</tr>
<tr>
<td>unknown</td>
<td>11</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>&lt;10 mm histology</th>
<th>10-19mm histology</th>
<th>&gt;20mm histology</th>
</tr>
</thead>
<tbody>
<tr>
<td>LGD 183</td>
<td>LGD 44</td>
<td>LGD 13</td>
</tr>
<tr>
<td>HGD 2</td>
<td>HGD 8</td>
<td>HGD 6</td>
</tr>
<tr>
<td>Cancer 0</td>
<td>Cancer 3</td>
<td>Cancer 1</td>
</tr>
<tr>
<td>pseudo polyp 1</td>
<td>lost polyp 1</td>
<td>lost polyp 1</td>
</tr>
<tr>
<td>hyperplastic 19</td>
<td>serrated 1</td>
<td>serrated 1</td>
</tr>
<tr>
<td>normal 19</td>
<td>hyperplastic 1</td>
<td>hyperplastic 1</td>
</tr>
<tr>
<td>Total 224</td>
<td>Total 58</td>
<td>Total 20</td>
</tr>
</tbody>
</table>

**Peri-procedural complications:**
There were 3 (1.6%) peri-procedural complications identified (desaturation and bleeding post polypectomy) none requiring admission.
3 admissions within 8 days
17/180 inadequate bowel prep.

**Mortality:**
5 year mortality causes: 42 Deaths (23%) The Top 3 causes:
1. Pneumonia (11)
2. Heart Failure (6)
3. Stroke (5)
CRC was the cause of death in 1 patient (0.6%) and in this case the index polypectomy was a polyp cancer.

**Analysis:**
W day et al raised that completion rate and risk of complications will be higher in the elderly. From our study completion rate was very high (133/137) and complications very low (3/180).
For polyps <10mm there were 0 cancers and 0.9% HGD.
The 5 year mortality was 23%

**Our Recommendation:**
1. Polypectomy should be avoided for polyps <10mm in patients ≥80
2. Polypectomy of polyps >10mm should only be considered after documented deliberation with the patient.