ISSUE 8

The Bottom Line

Vaughan Endoscopy Clinic (VEC) is a **state of the art** out-of-hospital endoscopy clinic providing **Screening colonoscopy and endoscopy** for the work up of mild gastrointestinal disorders. It is staffed by gastroenterologists**.**

In addition to the endoscopic services, they will provide all the necessary **GI follow-up** and make all the appropriate referrals required due to findings at the endoscopy.

The Medical Director has been an active participant at the CPSO in the development of **standards for out-of-hospital clinics**, all of which VEC adheres to.

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In addition to high quality and convenient access to endoscopy, the Doctors at VEC will provide you with supplemental practical GI advice through this periodic newsletter. This article on Quality Endoscopy is written by Dr. Jonathon Springer (a gastroenterologist from St. Joseph's Health Centre).

What Makes a Quality Screening Colonoscopy?

Colorectal cancer (CRC) occurs in 6% of the population and is the second most common cause of cancer related deaths in north America. Colonoscopy is considered the gold standard for detection and removal of adenomatous polyps, the precursors to CRC. The removal of these polyps has been associated with up to a 75-90% risk reduction in the incidence of colorectal cancer. Additionally, it is generally thought that the risk of CRC after a normal colonoscopy is reduced for at least 10 years compared to the normal population.

Yet, 5% of colorectal cancers develop within 3 years of a negative colonoscopy and more recently some studies have suggested that the risk reduction benefits of colonoscopy might not be as great for the prevention of tumours on the right side of the colon.

Several factors that might explain these findings include the endoscopist missing lesions during the index colonoscopy as a result of either poor bowel preparation, or poor endoscopic technique, or (less likely) the development of new lesions that don't follow the usual expected timeframe or pathopysiology.

It has become clear that a *high quality* examination by colonoscopy that ensures the detection and appropriate removal of all neoplastic lesions is the key to effective screening. If colonoscopies are missing cancers think of what stool for occult blood may be missing.

Evaluating Screening Colonoscopy Options:

Primary care clinicians initiate and oversee the delivery of CRC screening for their patients but the consultants perform the colonoscopy. It is well established that the accuracy and safety of colonoscopy varies among endoscopists. So it's up to the primary care physician to choose the best available colonoscopy services.

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So what is the proper endoscopic technique and what makes a quality colonoscopy and quality screening process?

Recently, several task forces and professional societies have proposed the use of various quality assessment indicators for colonoscopy as part of colon cancer screening and have established appropriate reporting criteria for the documentation and dissemination of the findings.

The endoscopist performing the colonoscopy should be able to achieve a 95% cecal intubation rate for screening colonoscopies without obvious hindrances. The endoscopist should have at least a 25% adenoma detection rate in men and 15% in women over age 50. The complication rate should be within the expected range with a < 1/1000 rate of perforation for screening colonoscopy and 1% bleeding rate for removal of polyps.

The indication, sedation, quality of bowel preparation, findings (including number, size and location of polyps), interventions, and subsequent management plan and follow up should all be documented in the report and forwarded to the primary care physician. Recommendations for follow-up surveillance colonoscopy intervals should be evidence based.

Three recent large studies (two in Canada) have looked at these quality indicators and concluded that procedures done by non-gastroenterologists were associated with a higher risk of developing new or interval CRC after a normal colonoscopy. An Ontario study showed an almost 40% increase in the subsequent development of CRC if the colonoscopy was done by a general surgeon compared to a gastroenterologist. Interestingly, there was no association between whether it was in a rural, urban, hospital based, or ambulatory clinic based setting.

I am proud that all the endoscopists offering services for VEC are practicing gastroenterologists with greater than 10 years experience. Our endoscopists meet or exceed the quality assessment and reporting criteria and these standards are regularly reviewed. Our polyp detection rate is greater than 35% of patients referred to the VEC for screening colonoscopy. As gastroenterologists, we also deal with any GI symptoms and follow-up with any findings as appropriate. Please feel free to visit our website or drop by the clinic to see for yourself what makes a quality screening colonoscopy.

References:

- Fletcher R. et al. The Quality of Colonoscopy Services. Responsibility of Referring Clinicians. A Consensus Statement of the Quality Assurance Task Group, National Colorectal Cancer Roundtable. J Gen Intern Med 2010 25(11):1230-4.
- Rabeneck L. et al. Endoscopist Specialty is Associated with Incident Colorectal Cancer After Negative Colonoscopy. Clin Gastroenterol and Hepatol 2010;8:275-279.
- Singh H. et al. Predictors of Colorectal Cancer After Negative Colonoscopy: A Population Based Study. Am J Gastroenterol 2010 Mar;105:663-673.

The bottom line is:

Screening colonoscopy saves lives when done well. There are quality indicators to assess adequacy of technique and process and it has been shown that large variations exist between different physicians and clinics. Primary care physicians should be aware of and enquire as to how their consultants and the various clinics perform when referring patients for colonoscopy.

Our newsletters are posted on our website (www.vaughanendoscopy.com) thus your patients are able to download a copy for reference. Other GI topics of interest are published periodically.