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Quality Outcomes for Endoscopy

QUALITY OUTCOMES FOR ENDOSCOPY

You are listening to ReachMD XM157, the Channel for Medical Professionals. Welcome to GI Insights where we cover the latest clinical issues, trends, and technologies in gastroenterological practice. GI Insights is brought to you by AGA Institute and sponsored by Takeda Pharmaceuticals North America. Your host for GI Insights is Professor of Medicine and Director of the Digestive Disease Center at the Medical University of South Carolina, Dr. Mark DeLegge.

Endoscopy has revolutionized gastroenterology, but the procedure presents many challenges in its application meaning what is an endoscopy at one place may be not an endoscopy or a similar endoscopy at a separate center. Joining us to discuss quality outcomes for endoscopy is Dr. Peter Cotton, Professor of Medicine at the Digestive Disease Center at the Medical University of South Carolina in beautiful Charleston, South Carolina.

DR. MARK DELEGGE:

Welcome Dr. Cotton.

DR. PETER COTTON:

Hi.

DR. MARK DELEGGE:

Peter, I am getting right to the meat of this, we hear about risks with endoscopy meaning that there can be some, well lets say bad outcomes. What specific risk are we talking about?

DR. PETER COTTON:

Well, there are some risks of having any sort of a procedure related to sedation, anesthesia, but the more dramatic ones are things like perforation. That is the most feared complication of colonoscopy, which is the most popular, most common GI endoscopy procedure that is performed and being performed in even greater numbers over the last few years as the screening initiatives have taken place in the

United States and around the world and if you are feeling well, then being persuaded by your wife to have a colonoscopy because you had your fiftieth birthday and you end up with a perforated colon, that is really very bad news. The risk of that in good hands is probably in the region of 1 in 2 out of 5000, but it is a devastating experience when it occurs. It is recognized quickly that of course it could usually be managed pretty quickly, but it still involves an operation. If it is not recognized quickly, then it can have the devastating consequences and then there are other complications like bleeding, which can occur when any therapeutic procedure is done.

DR. MARK DELEGGE:

Peter, like, any other procedural area, there is great controversy about what sorts of training an endoscopist may require to do a procedure. My question is, are there types of training that minimize the risk and maximize the benefits? Is there a way we should be doing this to ensure good quality outcomes?

DR. PETER COTTON:

We certainly should and the standard training for gastroenterologists as you well know, Mark, is 3 years of GI after internal medicine training, which includes very substantial training in at least the standard endoscopic procedures, operative procedures, colonoscopy, and in some cases in the more advanced procedures like endoscopic gallstone and ERCP, and the people coming out of those fellowship programs are pretty competent in the routine procedures and the therapeutic aspects, some of them like managing bleeding, taking out polyps, and that type of thing. But, we are talking there in terms of several hundred procedures that they have done under supervision before they are allowed to fly free as it were. Surgeons also, many of them are trained in endoscopy, but by and large don't get that same sort of volume and there are very few training programs that actually provide that sort of experience for internists and family practitioners. The issue really is training is only a means to an end. What we are trying to end up with is people who are competent and the struggle that has been to define and recognize competence, so that over the years the main professional societies in United States like ASGE, ACG, AGA, SAGES have been struggling to define what they mean by high-quality procedures and perhaps more important what things can be measured to prove that people are reaching those levels of quality. What has been missing has been any real measurement of that quality. There is no certification of endoscopists in the United States as there is in some other countries. There is no exam you can take, put out a diploma on your wall that says somebody has looked at me and my training and my experience and my data and has given me a star and that has been a big issue because as I said, training may have come through, legitimately come through a number of different routes, what we would want to end up with is some sort of mechanism that shows people are actually achieving what they think they can achieve.

DR. MARK DELEGGE:

Peter, on the economic front, there has been a tremendous push amongst endoscopists to do more procedures meaning what I call throughput in the endoscopy suite and that includes colonoscopy, and some of the questions I have regarding that is, I read some data regarding taking your time, especially on withdrawal looking for adenomatous polyps or polyps in general and that the thoroughness of the examination actually can be correlated with people who spend longer withdrawing. You know that there are some practices where the hope is to get you in, do the colonoscopy, turn over the patient, and move on to the next. Do you believe this data? Is that an important concept?

DR. PETER COTTON:

Without question. It has been validated several times. The first seminal paper was produced by, in fact, by a practice group and was presented to a national meeting published in The New England Journal of Medicine, which very clearly correlates that the withdrawal time, the length of time that the endoscopist was looking what they were finding and these are old people with a huge amount of experience, so doing colonoscopy, may be not every day, but certainly many times a week and they showed that the people who took

the longest on withdrawal compared with the people who took the shortest found twice as many lesions, not just tiny little tinsels of polyps, they found twice as many what we call advanced adenomas, which are large adenomas or ones with significant dysplasia or even cancer. It is a really rather shocking data actually and along with other data from other centers looking at quality of colonoscopy show that it is not just a quick look-see and if you get there and back, it is done and patient is safe for 5 or 10 years. It has to be done very carefully and in deed the more you look and the more adjunctive techniques you look, the more you find.

DR. MARK DELEGGE:

There are a lot of physicians and a lot of practices will say, I will pick on cardiovascular surgery where a lot of their outcomes data is published. With regards to, we will say an endoscopist perforation rate or his or her withdrawal times. Do you see these becoming publishable items?

DR. PETER COTTON:

I certainly hope so. I have been advocating it for close on 10 years. At the moment, there is no obligation on anybody to produce any data of any sort. There may be the occasional forward-thinking hospital that's credentialing people who is actually asking for data, but I am not aware of them. The only things that have been done in the United States is that these have been purely on a voluntary basis and some high quality gastroenterology practices have it as part of their contract that they have to collect data or they are helped to collect data and they are able to look at their performance in various ways, incidents of sedation for instance or perforation rates or bleeding if you want and compare them with their own colleagues. What we don't have is the data from the bad people, because they don't collect and publish their data for obvious reasons. I have been pushing very hard for voluntary report cards for endoscopists over the years and most people thought that was ridiculous for a few years, but now it is actually official policy from the ASGE and the ACG at least and they have spent a lot of time with impressive committees pulling together the sorts of matrix that are required, withdrawal time being one of them and adverse outcome events being another. This of course has had some stimulus from the Medicare efforts and pay-for-performance, suggestions that we should be paid a little bit more according to our outcomes. As far as I am aware, there are only 2 larger initiatives going on at the present time to collect and compare data; one is a colonoscopy exercise that was started by Ewing Pike up in Virginia, where he has got may be 40 or 50 colonoscopists around the country entering data on to a website, so that the individual endoscopists can look at their performance every few months or whatever and compare it with everybody else who is providing data without knowing who those other people are. So, that is called benchmarking and that has got may be 15,000 colonoscopies in it at the moment. It is giving very powerful data on what people are proud of what they do are actually achieving. The other project is one of my own that I have been running for the last year on ERCP, which as you know is more complex and dangerous procedure. It is also done less often and therefore it is kind of easier to keep track of it. We have got 50 odd ERCP doctors collecting data and putting them in to the central data bank that is supported by the Olympus Corporation and we have something like 7000 cases in there right now so that I can look at my matrix, for instance how often I fail to get in to the bile duct or the pancreatic duct or how often I fail to remove a stone that I am trying to take out and compare my performance with everybody else in the system again, anonymously, as far as they are concerned and the ASGE and the ACG have bought in to that concept and are formally discussing a joint national system to do exactly that. Of course, all of this should be made easier and will eventually be made easier by the electronic reporting systems that most endoscopists use. Now, well we don't anymore dictate reports, we put them in to computer databases that generate a report. Now, it should be possible to extract automatically those quality data from those data sets and whoosh them up on the internet automatically to be crunched and sent back down again for benchmarking. The problem there is providing the central data storage and analysis system, which is going to be pretty expensive. Again, that is going to start off being voluntary, but they will become a tipping point where most people doing it and everyone else will begin to feel that they ought to be doing it not least if the payers suddenly catch on and realize that there are some people who can provide data and there are others who cannot. I personally think this will have a very substantial practice advantage down the road.

DR. MARK DELEGGE:

I would like to thank my guest, Dr. Peter Cotton, Professor of Medicine at The Digestive Disease Center at the Medical University of

South Carolina. Dr. Cotton, thank you very much for being our guest this week on GI Insights.

DR. PETER COTTON:

My pleasure.

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