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Quality Indicators: How Do You Compare? Part 2

Announcer:
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Dr. Rex:
This is CME on Reach MD. I'm Doug Rex, and with me is Dr. Dave Johnson.

Dave, quality indicators for colonoscopy, they are very important. Let's talk a bit more about them. Can you sort of extend our conversation about quality indicators?

Dr. Johnson:
Sure, Doug. The quality is what matters, right? So adenoma detection rate is what drives this whole discussion. There are clearly other indicators: adequacy of preparation, compliance with the surveillance intervals, and cecal intubation rates. That latter becomes somewhat, I think, too achievable. Let's talk about a couple significant ones as relates to adenoma detection. First, ADR, or adenoma detection rate, is about what drives interval cancer risk reduction, and there are some new things on adenoma detection that relates to adenoma per colonoscopy. And this is really that if you see one adenoma, you should see another. You've heard earlier, and you mentioned it earlier, about right-side detection, a second look. But an adenoma detection of a second adenoma, once you see one, should be apparent. The adenoma plus, if you will, of about 60% of times you'll see a second adenoma, has been ascribed as being a risk reduction for interval cancer. If you have a low adenoma per colonoscopy, that should be at least evaluated, at least for compliance. You're not seeing the level of detection that correlates that risk reduction. So adenoma per colonoscopy is something that becomes an issue because it also, then, may increases costs if you start to drive each polyp into an individual jar. So I'm not sure that that's going to really take traction yet.

As it relates to adenoma detection, a couple critical points. One, if you're doing a FIT [fecal immunochemical test] program – in particular, Kaiser, for example, does this – if you are FIT positive, you need to change the adenoma detection rate by 15%-20%. So an adenoma detection rate of 25% needs to be increased by 15%-20%, and in fact, the GIQuIC [GI Quality Improvement Consortium] data shows that the current adenoma detection rate, in standard mixed rates, is about 35%, and even high-level detection were in the target range of 40%-50%. So we can do better.

There are some other related possibilities. Sessile serrated lesion and detection rate is correlated, for the most part, with adenoma detection, but we're recognizing that some providers that are high-level adenoma detector are low-level serrated lesion detection, so we need to do better in that regard. And in particular, there are some other issues as relates to quality. Do not refer a patient to surgery with a 2 cm or greater polyp that's benign without at least a discussion of endoscopic resection. They should be referred if you can't do that. They should be referred to a center.

The other one is, in patients that are having diminutive polyps removed by cold biopsy, 2 mm, greater than 2 mm, the US Multi-Society

Task Force said that should be a cold snare, and the same for greater than 3 mm for the European Society. These have association with high residual polyp and they take longer, and there is less reimbursement, if you will. So the one-and-done, I think, is adenoma detection. We should not be doing just relative to one colonoscopy, one adenoma. We can do better. Polyp detection, there certainly are a number of ways we can increase this that relates to mucosal effacement, chromoendoscopy via electronic or by dye injection, dye infusion.

We clearly, Doug, can do better as it relates to the detection of lesions, as it relates to high-quality bowel prep, the complete inspection as relates to the colonoscopy, effacement of all folds, and high-level detection, but high-level endoscopic resection, which is really what drives colon cancer prevention. So there is, unfortunately, variable performance on all these things, and Doug, we can do better.

Dr. Rex:
Dave, I think you've made some fantastic points and covered a lot of the key quality indicators for colonoscopy. I want to emphasize the adenoma detection rate. The 25% is really a minimum threshold. And so that's one target, but we can think of an aspirational target, where we want to get up to 45%-50%. And in discussing the adenomas per colonoscopy and sessile serrated lesion detection rate, I think you're saying that the adenoma detection rate, while it's critical to measure, doesn't really tell the full story. And I think you've also hinted how we may see the quality movement move into areas involving polyp resection. So very exciting stuff. Exciting time as we try to improve the quality of colonoscopy.

Dr. Johnson:
Thanks, Doug. Great to be here.

Dr. Rex:
Thank you, Dave.

Announcer:
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