

Quality in Gastrointestinal Endoscopy: A Myth or Reality?

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Endoscopy is a powerful and pivotal tool in the diagnosis and management of gastrointestinal pathology. Ensuring that endoscopy is of high quality is fundamental to providing the best care and experience for our patients. High quality endoscopy delivers better health outcomes, better patient experience, and fewer repeat procedures [1]. Although intuitive, it is only in recent years that the evidence base to support the value of quality has grown, primarily in colonoscopy [1]. The quality of endoscopy being delivered in endoscopy units is known to vary considerably [1]. We are unlikely to change or improve unless we are aware of our performance and how it compares with peers and quality standards. The American Society of Gastrointestinal Endoscopy (ASGE) and the British Society of Gastroenterology (BSG) have each published quality and safety indicators in endoscopy that were updated in 2015 [2-5]. Selected performance targets were recommended for each quality indicator to serve as specific goals for measuring quality improvement [2-5]. In the United Kingdom, following a decade of quality improvement initiatives, colonoscopy crude completion rate improved nationally from 76.9% to 92.3% [6].

The question we need to answer is whether quality monitoring in endoscopy is practicable in routine practice and if so does it improve patient outcome? In 2003 an Egyptian secondary care government hospital endoscopy team successfully introduced a quality assurance and improvement program into routine endoscopic practice [7]. Initially it involved setting standards of practice and designing an approved training program. Quality indicators developed by the ASGE and BSG were applied to patients, procedures, endoscopists, equipment and assistant staff. Process and outcome indicators were used to evaluate and monitor the quality of endoscopic procedures with benchmarking to detect shortcomings and deviation from the standards set. A quality improvement process was then introduced. Assessment of esophagogastroduodenoscopy practice in 2004 complied with published standards but colonoscopy was sub-optimal [7]. The initial crude completion rate was only 50%. 50% of patients reported moderate to severe pain. Complete polyp removal rate was only 41% and their retrieval was not documented. Biopsies were taken in only 40% of patients with chronic diarrhea and normal looking mucosa, and ileoscopy was not performed. Changes were instituted and by 2009 crude completion rate had improved to 94% (adjusted completion 100%) [8]. Patients experiencing moderate or severe pain had fallen to 27% [8]. By 2011 complete polyp removal had risen to 86% and retrieval to 92% [9]. Tissue sampling and ileoscopy was achieved in all patients with chronic diarrhea and normal mucosa by 2009 [10]. The detection of microscopic colitis increased from 18% 2004 – 2006 to 63% 2007 – 2009 [10]. Measures were taken to improve infection control and the safety of personnel exposed to disinfectants [11-13]. These studies show that quality assurance and continual improvement in routine practice can be successfully applied in Egyptian endoscopy units and can achieve dramatic improvements in the quality of endoscopy and outcomes.

Unless practice is regularly monitored for quality, outcomes are likely be compromised. Quality evaluation in the health care system is at present optional; but sooner or later it will become mandatory. Quality assessment and improvement are dynamic processes requiring continuous monitoring and benchmarking against local and national standards [14]. Change is usually best implemented as an evolution rather than a revolution [1]. Nevertheless, evolution involves continual change and improvement and we, as endoscopists, should embrace a constant drive towards higher quality for our patients [1].

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