



Screening colonoscopy performed by colorectal surgeons: High-quality regardless of specialty[☆]



DR. ANTHONY SENAGORE (Kalamazoo, Michigan): The authors should be congratulated on a timely assessment of a topic which represents a combination of clinical quality, public health, and, fortunately, to some degree, a discussion over clinical turf.

This issue has potential impact on graduate medical education and, therefore, future clinical workforce decisions. Unfortunately, some of the prior discussions in the literature may also negatively impact hospital and health care credentialing. You should recall, however, that these measures had their origins in CMS payment policy, not truly a desire for quality. Additionally, there is limited data that these measures (especially high rates of polypectomy) reduce either the overall rate of colon cancer or “missed” cancers without complex hazard modeling and inclusion of incomplete scopes, which no one could advocate for. Interestingly, incomplete polypectomy, especially with the increasing use of non-energy polypectomy has not been evaluated consistently, and, therefore, that data is not relevant to the outcomes. I have the following questions and comments:

What percentage of each specialty's scopes were performed by trainees. As one would expect, longer procedures for a novice versus an expert? This would impact both insertion time as well as total time.

The important withdrawal time, which by the way, is meant to be an average time, not necessarily minimum base time, is also only calculated for negative exams, as that is how the metric was originally devised. Do you have those times by specialty?

It is important to note that the overall complications both related to technical issues and sedation related, and I assume you had anesthesia providers involved, were similar for both teams. This implies that the current training paradigms, a trainee who spends three years of graded experience in endoscopy, i.e., GI, versus a trainee who undergoes a structured curriculum, i.e., FES, over five years and there were more rigorous/concentrated training of one year of practical experience as a colorectal residency suggest equipoise in training between these two groups of individuals.

Finally, did the authors have thoughts on how adenoma detection rate can be so much higher than colon cancer rates in un-screened population. It's about threefold. This is further confused by the fact that a significant proportion of interval cancers after a negative scope appear to be associated with either a BRAF or CIMP pathway which implies a completely different pathophysiology.

DR. SAPCI: For your first question about the training environment, thank you, this is an excellent question. And the particular database we used did not capture residential moment, and we

agree that it may have an effect on insertion time and total time and also adenoma detection rate, and we are currently reviewing this for a future project.

For your second question, we have that information, but it was not included in the presentation. When we looked at only negative scopes, both specialties exceeded 6 minutes for withdrawal time and colorectal surgery was significantly longer and to be specific, gastroenterology was 9.3 and colorectal surgery was ten minutes.

And for your third question, anesthesia providers weren't involved in the scopes. In fact, we included only scopes done under conscious sedation and excluded those done under anesthesia. And we don't think we can conclude any effect that training can have, because we included scopes done by multiple colorectal surgeons and also by multiple gastroenterologists. So considering the differences in training, we can conclude from our study that training is the reasoning behind the differences or equality of quality.

And for your last question, the question of why adenoma detection rate is higher than colon cancer rate, it's very interesting, which was not addressed in our paper.

DR. THOMAS A. STELLATO (Cleveland, Ohio): Since the only real reason for doing a colonoscopy is to either detect polyps or to detect cancer, how would you address the criticism that this paper were being presented by gastroenterologists and they said, well, we should be doing colonoscopies since our adenoma detection rate is so much higher? How would you address that criticism?

DR. SAPCI: Like I said, we included 19 colorectal surgeons and 73 gastroenterologists, so there are multiple individuals involved even if we have the same specialty, so we cannot conclude that one is better than another. But we just presented our results.

DR. PETER HALLOWELL (Charlottesville, Virginia): Did you stratify your data by the number of procedures done by each provider and in each group?

DR. SAPCI: We did not stratify by the number of procedures, but when we excluded colonoscopists that did under 50 scopes, our results were the same.

DR. ABDELKADER HAWASLI (Detroit, Michigan): Withdrawal time has to do with the physician doing the polypectomy at the time of insertion and removal. As mentioned before, the six minutes was where somebody had a negative score. Have you looked these polypectomies that were done at insertion or done under retrieval between the two groups?

DR. SAPCI: We did not compare that based on the polypectomies performed, but for the negative scopes, the withdrawal time, as I mentioned earlier, was still longer for the colorectal surgery.

DR. SUKAMAL SAHA (Flint, Michigan): Let me ask you about the subject question. Any general surgeons, actively local docs that has privilege for colonoscopy? Within the regular community, a lot of

[☆] (Presentation given by Ipek Sapci, M.D.).

general surgeons are doing colonoscopies, that's number one.

Number two, did you check the Fellows more than the GI and the colorectal Fellow? Are they included when they are doing it with or without separation?

DR. SAPCI: No, we did not have if the Fellows were included. We are looking for that for a future project. And general surgeons are not included. It's only colorectal surgeons for our data set.

DR. SAAD SHEBRAIN (Kalamazoo, Michigan): So you included patient age 50 and above in this study. And now recommendation that screening should include patient 40 and above. It will be interesting to go back and see how many patients including age of 40 and 50 who underwent colonoscopy by both colorectal surgeon and gastroenterologist just for screening, because we see this most of the time?

DR. SAPCI: This is a great point that will be very interesting to look in the future.

DR. CARLOS RODRIGUEZ (Grand Rapids, Michigan): I'm not trying to be funny here, but was there a standard definition of what an adenoma is, because they may find – you may have found that different colonoscopists have different perspective of what an adenoma is. Gastroenterologists may find that they call something an adenoma that other people don't. It's obvious when you see an obvious one, but sometimes there are some borderline structures that we look at. Did you have a standard definition for what an adenoma was?

DR. SAPCI: That's a great point. We included all the adenomas that were done as adenoma, yes, group for histopathologically confirmed adenomas.