Gut

Leading article

Improving the standards of endoscopy

It is now more than two decades since fiberoptic endoscopy with biopsy of the gastrointestinal tract became routinely available and its impact on gastrointestinal practice and knowledge has been enormous. Improvement in instrumentation and method, better nursing support, and the development of therapeutic techniques have firmly established endoscopy as essential for every district general hospital. Until recently, however, there have been a number of drawbacks when endoscopy is compared with contrast radiology.¹ There is often, for example, no permanent record of the endoscopic procedure. The use of videoendoscopy with large capacity hard discs will change all that when it will be possible to record the relevant parts of each endoscopy for replaying to colleagues and as part of a case presentation.² The availability of radiographs was a great advantage for barium studies, but now that endoscopy is moving into the era of recording examinations (slowly in underresourced health care systems such as in Britain) and exposure to radiation has come under critical scrutiny³ the use of upper gastrointestinal endoscopy is bound to increase as the first line investigation for dyspepsia. Endoscopy is more accurate⁴ and so unnecessary duplication is avoided, but it is invasive, unpleasant for the patient, and with potential for hazard. However, now that equipment and endoscopic skills have developed so much, patients have a right to expect safe endoscopy of good quality.

This issue of *Gut* contains a recommended set of standards for sedation and monitoring during endoscopy from a working group of the British Society of Gastroenterology Endoscopy Committee.⁵ It is a more detailed report, following the wider perspective given in *Provision of Gastrointestinal and Related Services for a District General Hospital* published in 1990.⁶ In the Western world about 90% of patients prefer sedation, and the use of benzodiazepines is widespread.⁷ However, in the Eastern world endoscopy is done with pharyngeal anaesthesia without sedation. Perhaps we should be encouraging endoscopy without sedation for routine oesophagogastroduodenoscopy, but it will take a major change in public attitudes – the increasing use of informative leaflets would help here.

As the accompanying report outlines, sedation has its own problems both for the patient and endoscopist. Sedation requires continuous monitoring to ensure that the patient is not being exposed to avoidable risk. The passage of an endoscope and the use of sedation will lower oxygenation, particularly if an opiate is added to a benzodiazepine. The report highlights the primary responsibility of the endoscopist. For safe endoscopy the endoscopist must be supported by a nurse assistant who ensures a clear airway and monitors

the patient's pulse and respiration. Extra precautions need to be taken, including venous access and continuous oxygenation particularly in prolonged procedures or routine examinations in high risk patients. The use of an oximeter to provide early detection of hypoxia and potential problems is strongly advocated. At the cost of about one fifth of an endoscope, it is an essential piece of equipment for any busy unit.

Nowadays, when every new item of equipment needs to be justified, this report in a balanced way provides powerful evidence as to why each department should be equipped to a safe and effective level, and with adequate staff who are well trained.

Audit of clinical activity is central to clinical care and, as the working party indicates,⁵ each department needs to be developing its own system for monitoring not only the workload but especially any complications. While the use of computerised systems for reporting makes review of the workload easy, follow up of complications is often difficult to coordinate but needs to be undertaken to ensure that standards continue to improve. The medicolegal aspects of this report are, sadly, all too clear, but it has been written to advance the practice of endoscopy rather than advocating defensive practice – every gastrointestinal unit needs to examine the report carefully and in a constructive way.

Sedation is just one aspect of endoscopy. Good equipment and cleansing of instruments, skilled nursing support, satisfactory facilities, and careful endoscopic technique are all essential if standards of safety and quality are to be achieved. Interpretation of findings is a combination of both visual appearance and biopsy, and must be linked to clinical signs and symptoms. It is an area which has been underresearched. The absence of any overt lesion does not exclude the possibility that the symptoms originate in the upper gastrointestinal tract – for example, gastro-oesophageal reflux disease may occur without any visible mucosal change and yet needs treatment with antireflux measures. Equally, many patients with gastritis and erythematous duodenitis have symptoms from another cause.⁸ To complicate matters further, biopsy of a lesion may not confirm an expected area of malignancy which is submucosal, and so appearances alone may be taken into account when planning patient management.⁹ The endoscopist needs to take the greatest care when interpreting for the non-specialist, as inappropriate interpretation seriously reduces the value of endoscopy.

It is a pleasure to see the practice of our specialty advance steadily, not only in its achievements, but also with real emphasis on standards of care and safety. Tackling the problem of training and experience in endoscopy is another

crucial factor and is being reviewed by a joint working group of the royal colleges and the British Society of Gastroenterology. Documenting training facilities in endoscopy units and trainees recording their experiences are likely to be recommended. The next generation of endoscopists and nurses should be well trained and will regard the standards being aimed at today as normal practice. Hopefully, we can implement the proposals contained in this report⁵ sooner rather than later for the benefit of both our patients and our specialty.

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