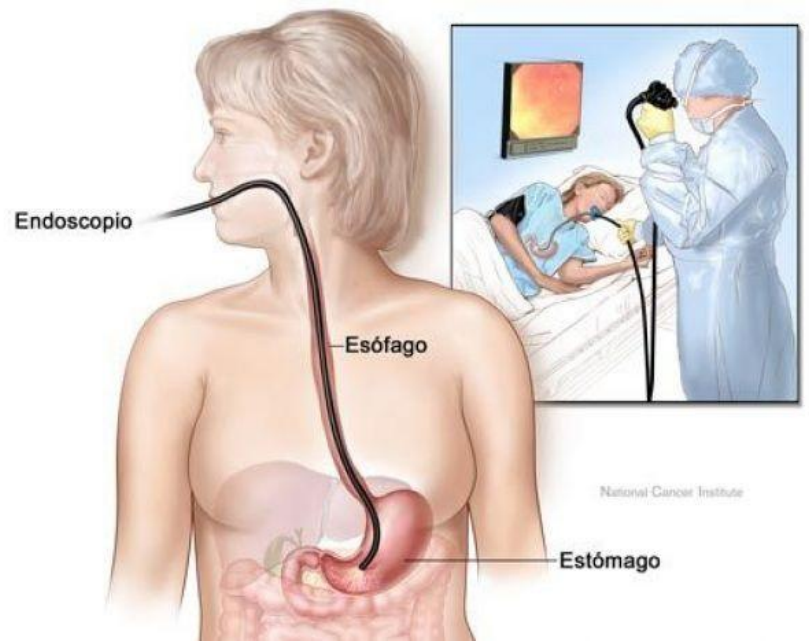
21 Convenciòn Internacional de Gastroenterologìa, AGAN Medellìn Nov 5, 6 2021

Calidad en Endoscopia digestiva superior



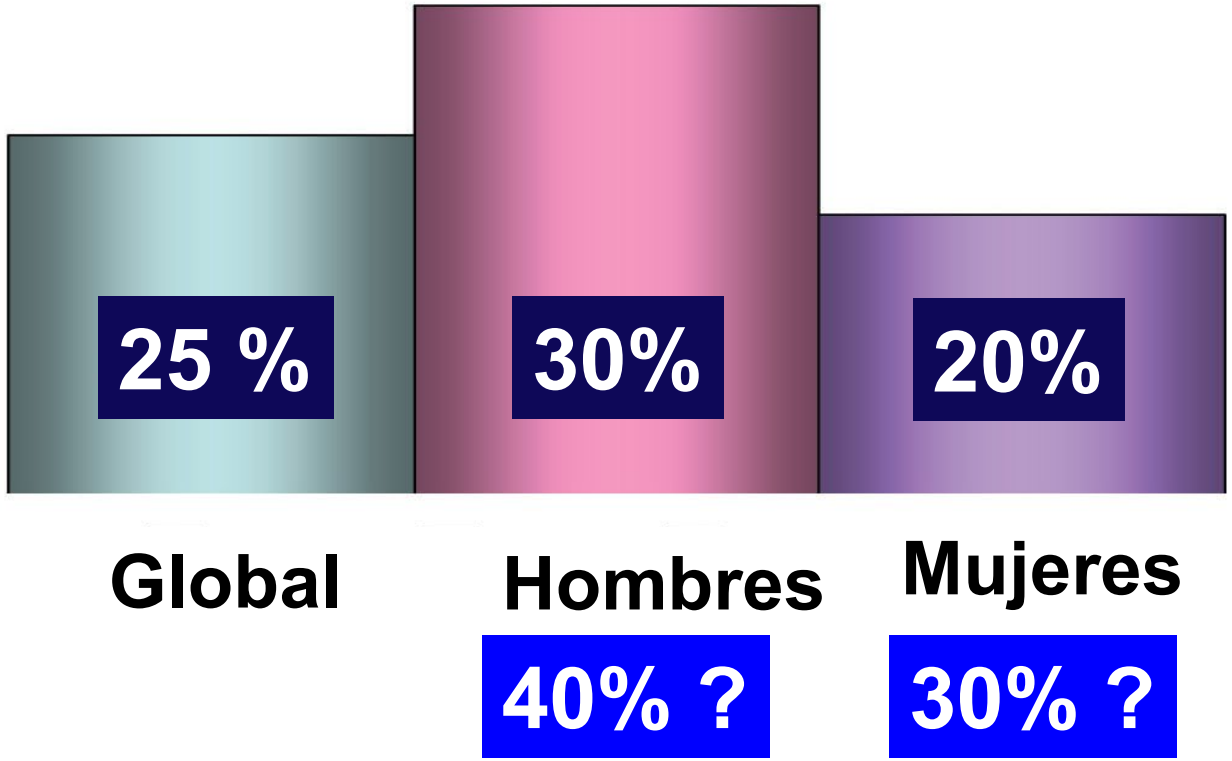
William Otero R MD, FAGA, FACP
Profesor Titular de Medicina
Director de Gastroenterología
Universidad Nacional de Colombia
Hospital Universitario Nacional de Colombia

Calidad en endoscopia alta

No había llamado La atención como Colonoscopia

Tasa de detección de adenomas

% pacientes > 50 años
Con adenomas identificados
Y documentados



ASGE 2015

ORIGINAL ARTICLE

Adenoma Detection Rate and Risk of Colorectal Cancer and Death

Douglas A. Corley, M.D., Ph.D., Christopher D. Jensen, Ph.D., Amy R. Marks, M.P.H., Wei K. Zhao, M.P.H., Jeffrey K. Lee, M.D., Chyke A. Doubeni, M.D., M.P.H., Ann G. Zauber, Ph.D., Jolanda de Boer, M.B., Bruce H. Fireman, Ph.D., Joanne E. Schottinger, M.D., Virginia P. Quinn, Ph.D., Nirupa R. Ghai, Ph.D., Theodore R. Levin, M.D., and Charles P. Quesenberry, Ph.D.

↓ Incidencia CCR

↓ Mortalidad por CCR

N Engl J Med 2014;370:1298-306

Endoscopia Digestiva Alta

“Pan diario de cada dìa”

Endoscopia Digestiva Alta

USA 6.1 millones de EVDA

↓

Cifras preocupantes

↓

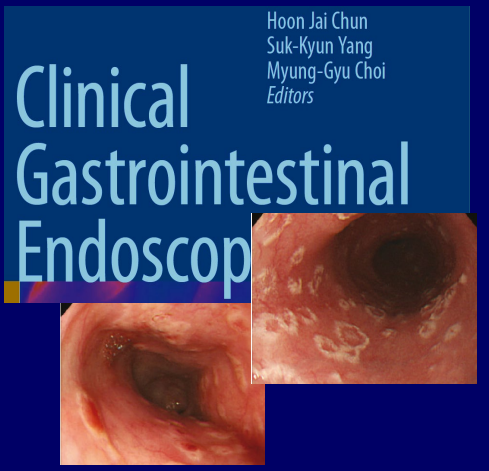
Tumores no identificados

↓

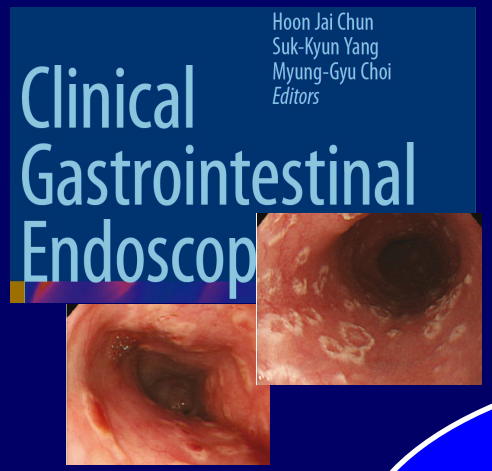
11.3% Canceres Digestivos altos 3 años antes
25% Càncer de esòfago 12 meses antes

Menon S, Endosc Int Open 2014;E46-50
Visrodia K, Gastroenterology 20216;150:599-607

Endoscopia Digestiva Alta



Errores en la Caracterización Reconocida Erróneamente Diagnosticada

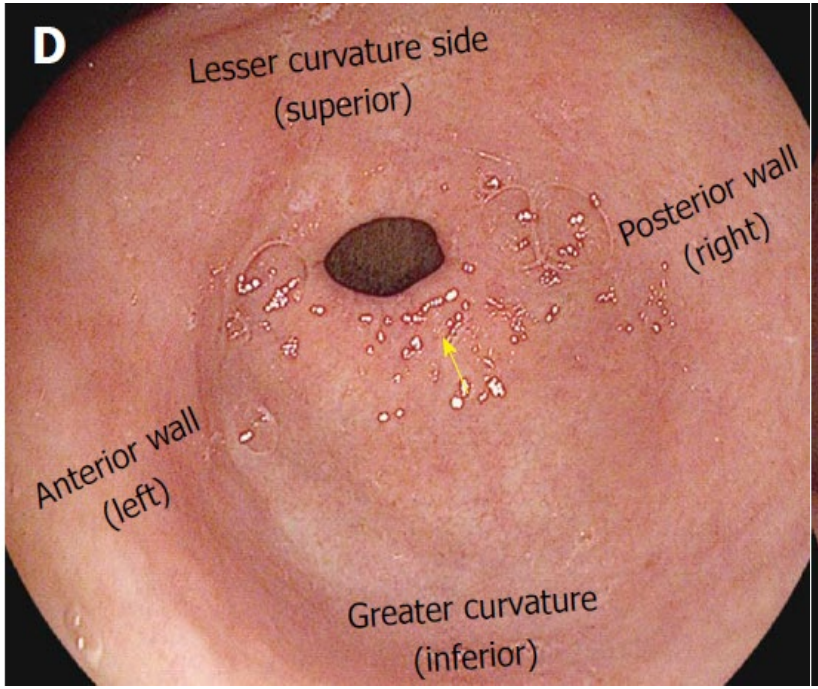


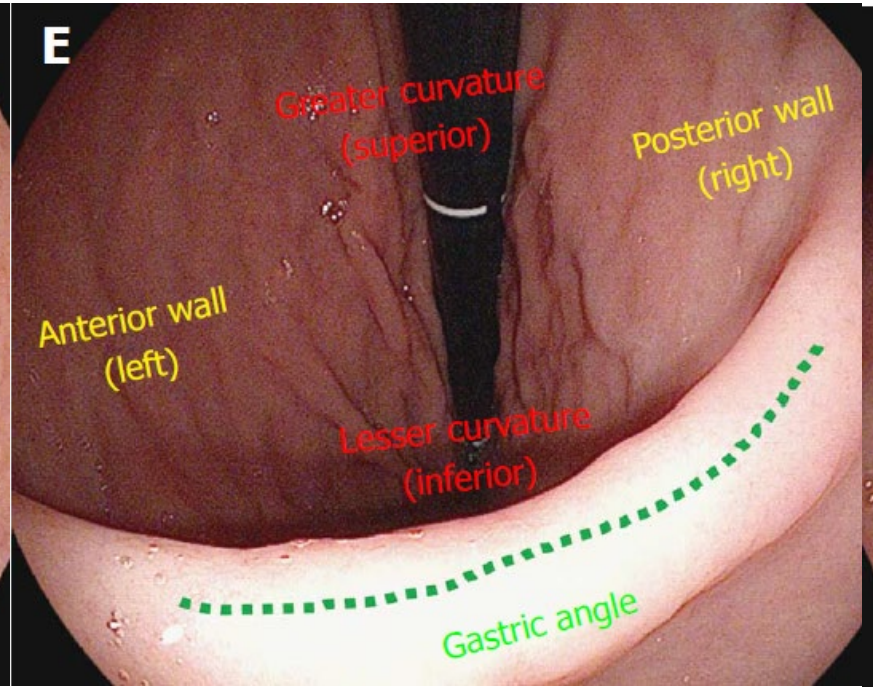
No Detección

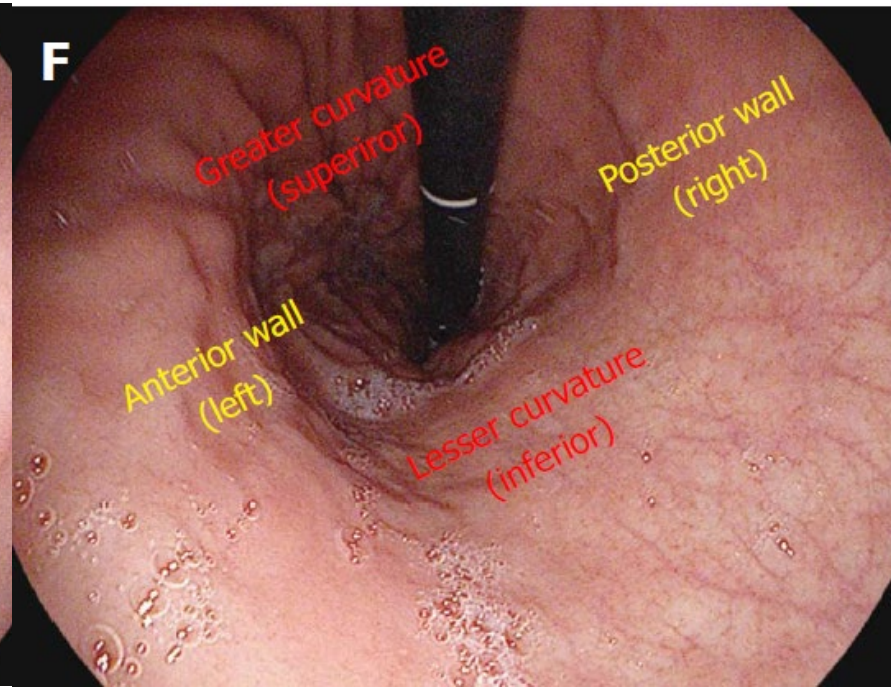
Errores en la Detección Lo ve, No reconoce

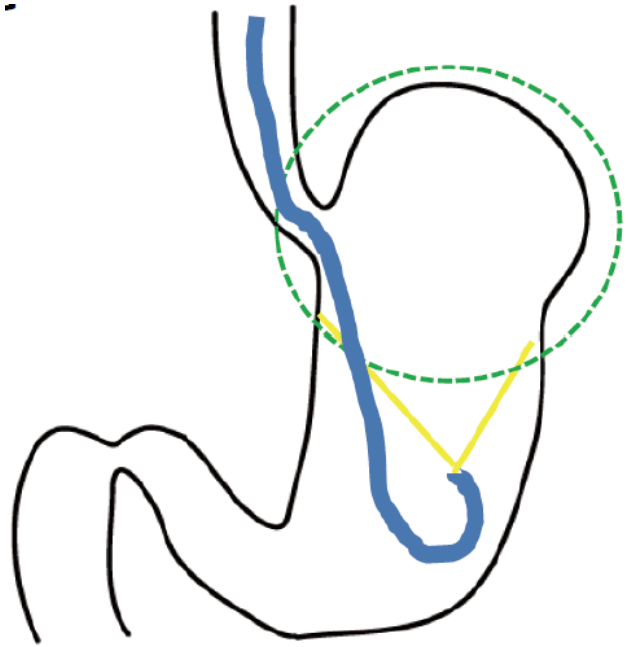
Errores en la Observación Áreas ciegas Difíciles de ver

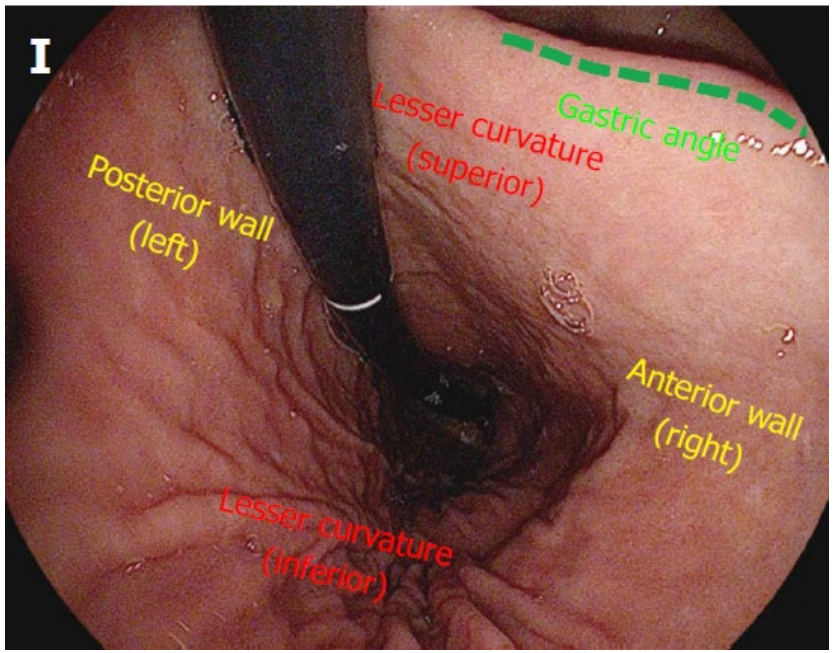
Tajiti H, Gastrointest Endosc 2019;89:1106-8



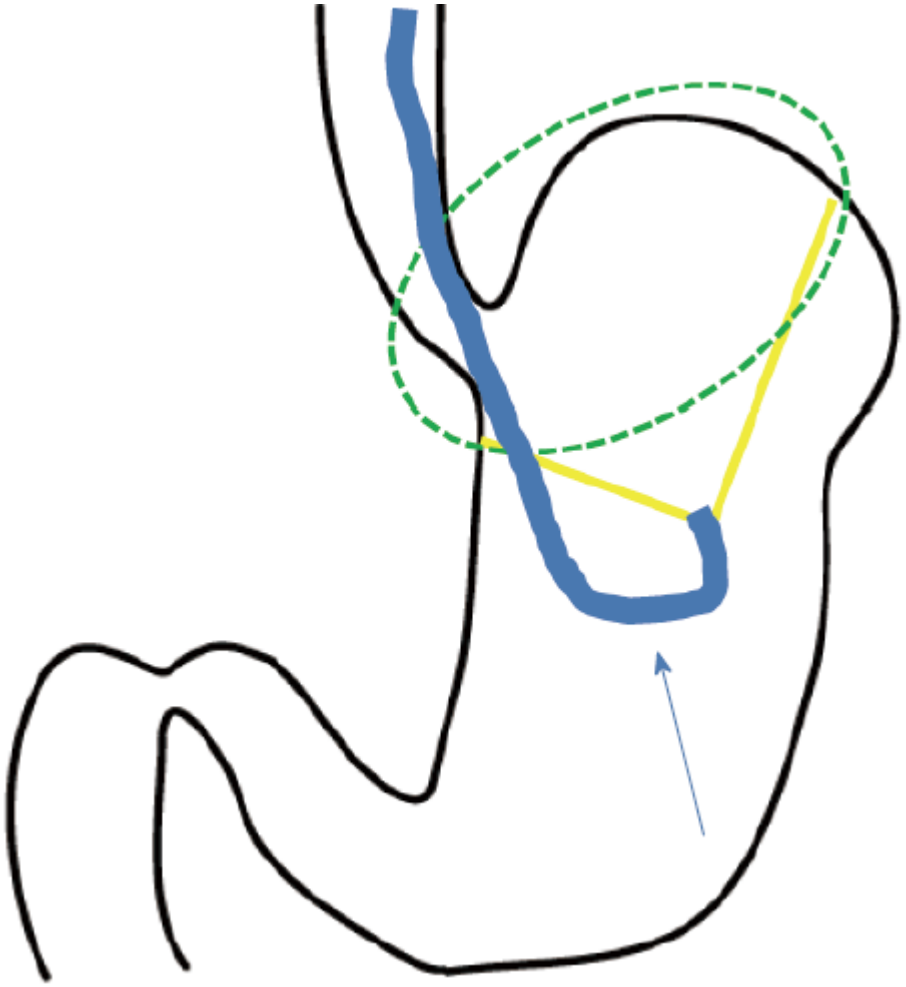


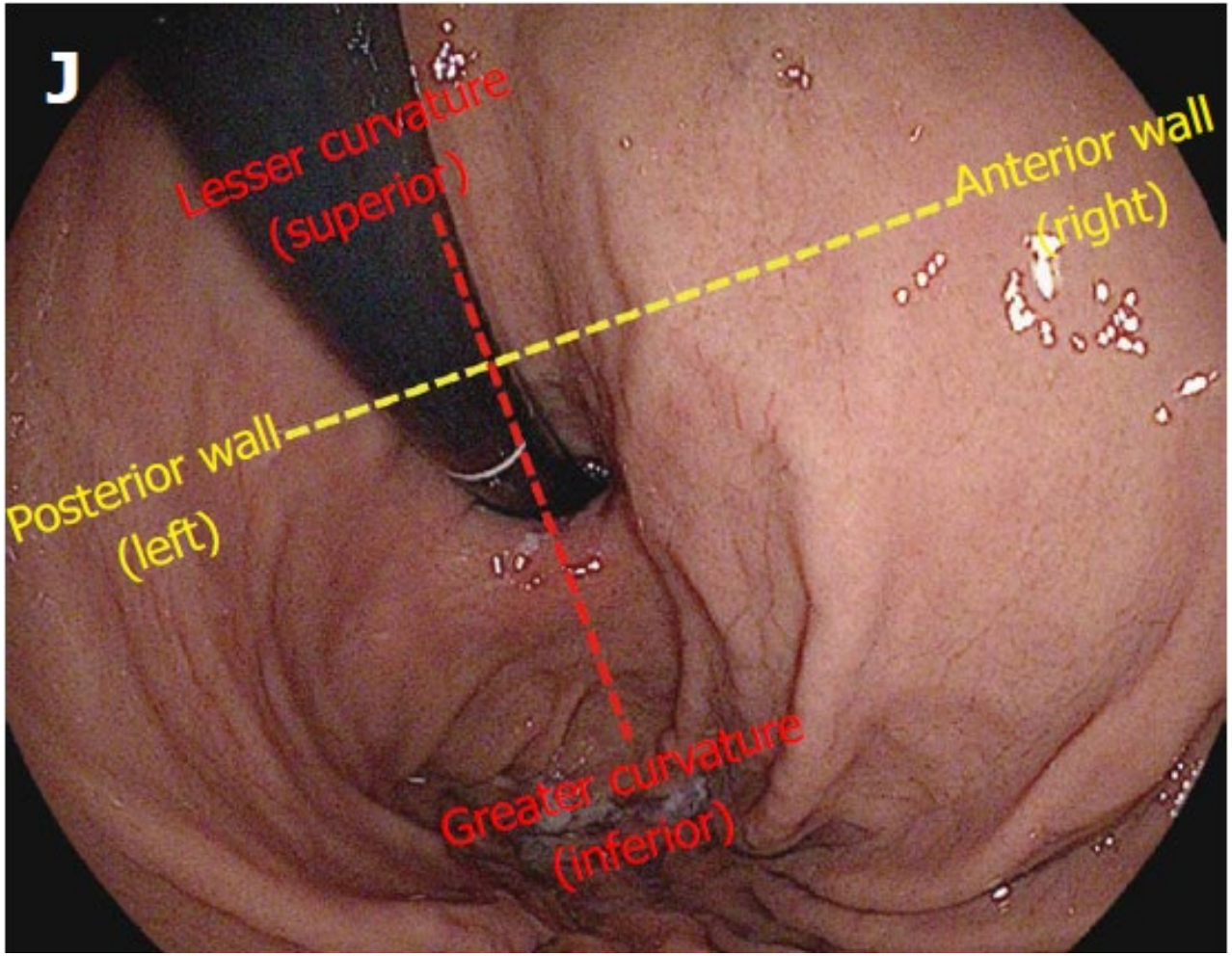




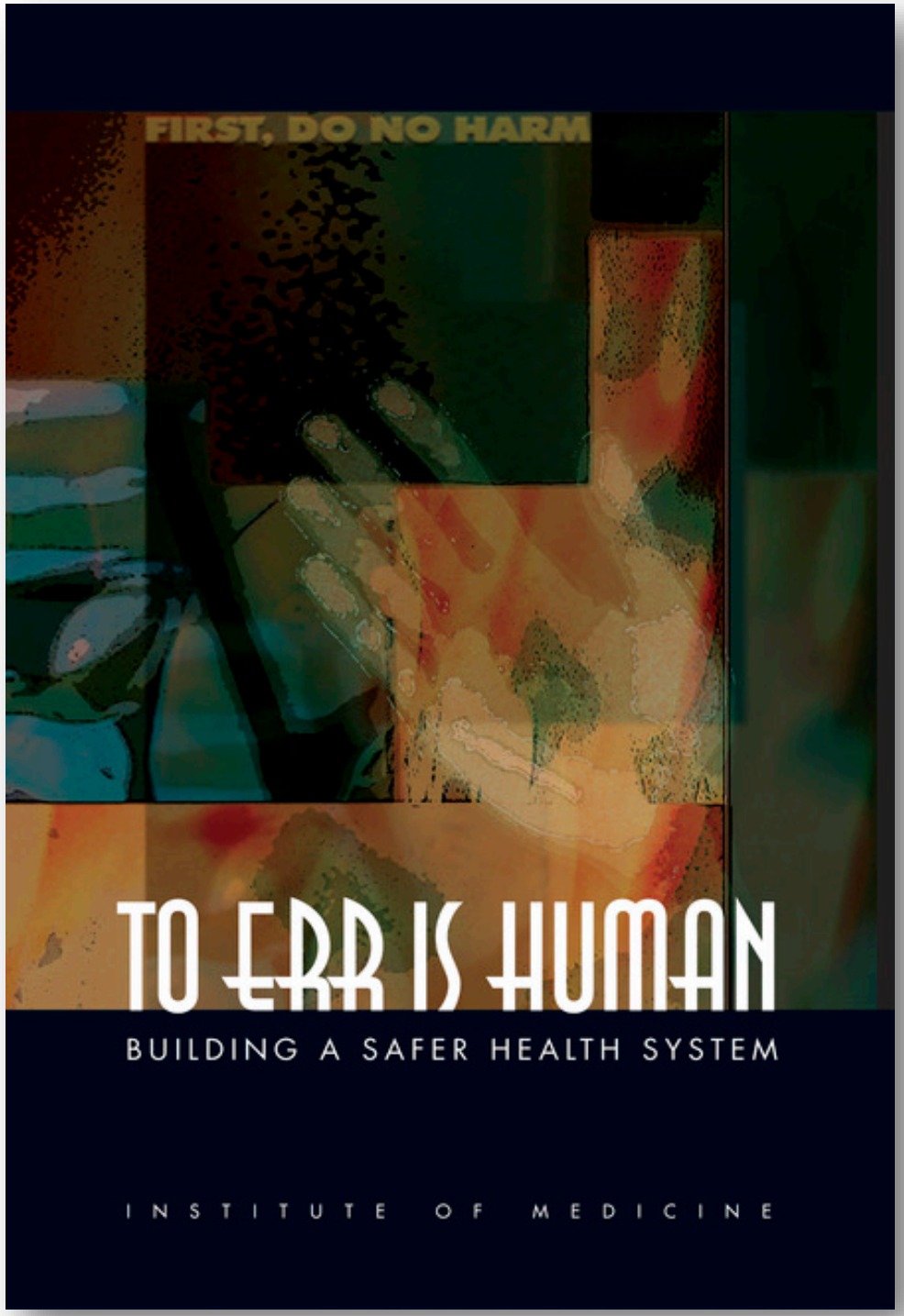


Lee SH, World J Gastroenterol 2015; 21: 759-85





Lee SH, World J Gastroenterol 2015; 21: 759-85



1999

TO ERR IS HUMAN

Building a Safer Health System

Identificar y entender el error se puede mejorar Inteligente!

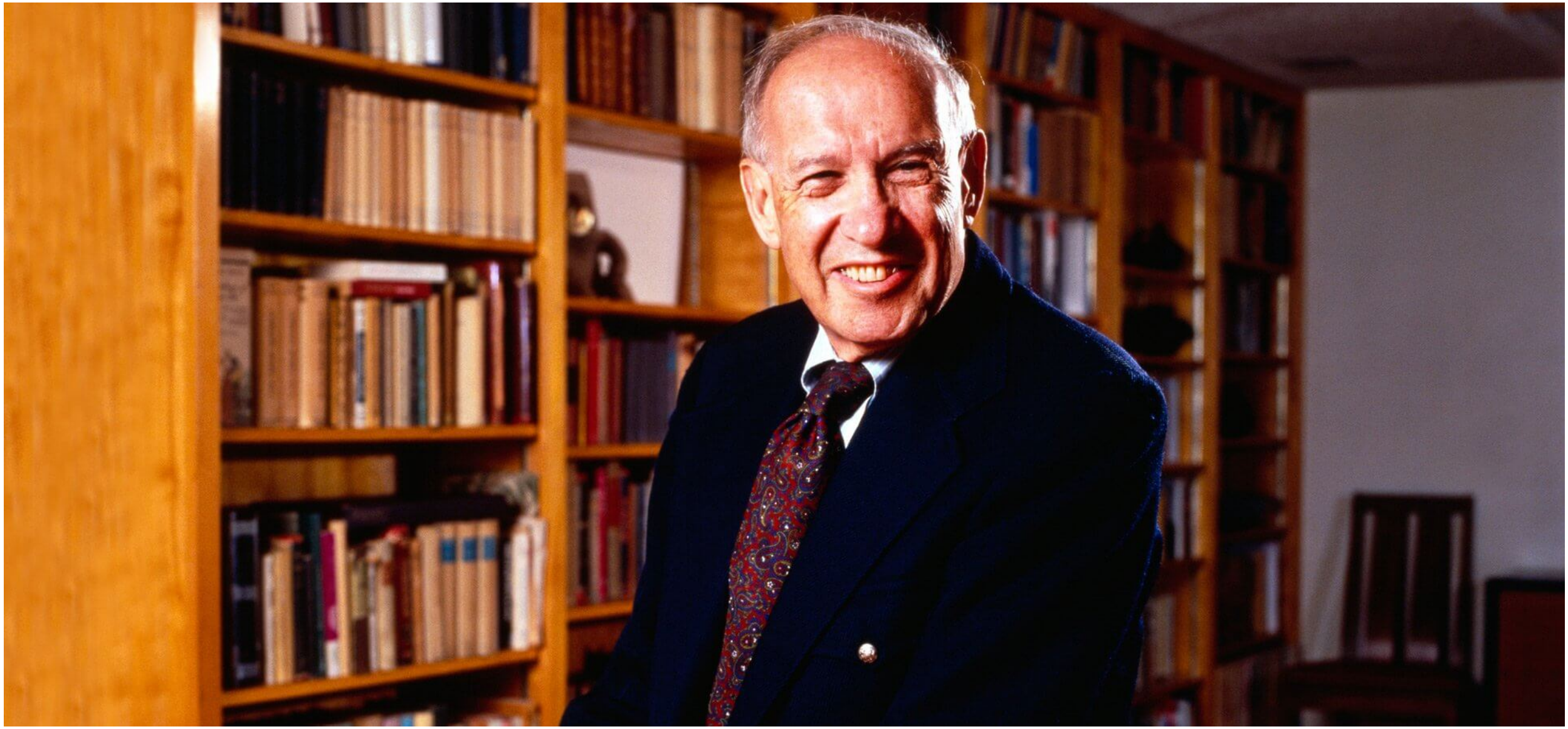
Linda T. Kohn, Janet M. Corrigan, and
Molla S. Donaldson, *Editors*

Committee on Quality of Health Care in America

INSTITUTE OF MEDICINE

NATIONAL ACADEMY PRESS
Washington, D.C.

Peter Druker “El padre de la administración” (Viena 1909-2005)



“Si no lo puedes medir, no lo puedes mejorar”

Colombia ?

No hay datos

En la práctica mucha variación en Los parámetros de calidad EVDA

Quality indicators in diagnostic upper gastrointestinal endoscopy

Wladyslaw Januszewicz and Michal F. Kaminski

Ther Adv Gastroenterol
2020, Vol. 13: 1–19
DOI: 10.1177/1756284820916693

Guidelines

OPEN ACCESS

An Asian consensus on standards of diagnostic upper endoscopy for neoplasia

Philip Wai Yan Chiu,[1] Noriya Uedo,[2] Rajvinder Singh,[3] Takuji Gotoda,[4] Enders Kwok Wai Ng,[1] Kenshi Yao,[5] Tiing Leong Ang,[6] Shiaw Hooi Ho,[7] Daisuke Kikuchi,[8] Fang Yao,[9] Rapat Pittayanon,[10] Kenichi Goda,[11] James Y W Lau,[1] Hisao Tajiri,[12] Haruhiro Inoue[13]

Chiu PWY, et al. Gut 2019;68:186–197

OPEN ACCESS

Quality standards in upper gastrointestinal endoscopy: a position statement of the British Society of Gastroenterology (BSG) and Association of Upper Gastrointestinal Surgeons of Great Britain and Ireland (AUGIS)

Sabina Beg,[1] Krish Ragunath,[1] Andrew Wyman,[2] Matthew Banks,[3] Nigel Trudgill,[4] Mark D Pritchard,[5] Stuart Riley,[6] John Anderson,[7] Helen Griffiths,[8] Pradeep Bhandari,[9] Phillip Kaye,[10] Andrew Veitch[11]

Beg S, et al. Gut 2017;66:1886–99

Communication from the ASGE Quality Assurance in Endoscopy Committee

QUALITY INDICATORS FOR GI ENDOSCOPIC PROCEDURES

Quality indicators for EGD

GIE 2015;81:17-30

REVIEW

Clin Endosc 2016;49:312-317
http://dx.doi.org/10.5946/ce.2016.084
Print ISSN 2234-2400 • On-line ISSN 2234-2443

CLINICAL ENDOSCOPY

Open Access

How to Improve the Quality of Screening Endoscopy in Korea: National Endoscopy Quality Improvement Program

Yu Kyung Cho

Review Article

UNITED EUROPEAN GASTROENTEROLOGY ueg journal

Performance measures for upper gastrointestinal endoscopy: A European Society of Gastrointestinal Endoscopy quality improvement initiative

United European Gastroenterology Journal
2016, Vol. 4(5) 629–656
This article is published simultaneously in the journals Endoscopy and the United European Gastroenterology Journal.

DOI: 10.1177/2050640616664843
ueg.sagepub.com
SAGE

Raf Bisschops[1], Miguel Areia[2,3], Emmanuel Coron[4], Daniela Dobru[5], Bernd Kaskas[6], Roman Kuvaev[7], Oliver Pech[8], Krish Ragunath[9], Bas Weusten[10], Pietro Familiari[11], Dirk Domagk[12], Roland Valori[13], Michal F Kaminski[14,15], Cristiano Spada[11], Michael Bretthauer[14,16], Cathy Bennett[17], Carlo Senore[18], Mário Dinis-Ribeiro[3,19] and Matthew D Rutter[20,21]

Developing Quality Metrics For Upper Endoscopy

Intense interest in health care quality has been raised worldwide after the Institute of Medicine published a book entitled *To Err Is Human,* which brought to light the

Sharma P, Gastroenterology 2020;158:9–13

QUALITY INDICATORS FOR
GI ENDOSCOPIC PROCEDURES

Quality indicators for EGD

22 Ítem

45 posibles indicadores

Gastrointest Endosc 2015;81:15-30

Developing Quality Metrics For Upper Endoscopy

Sharma P, Gastroenterology 2020;158:9–13

Indicadores de calidad en EVDA

- Pre-procedimiento
- Intra-procedimiento
- Post-procedimiento

ASGE, ESGE

Endoscopia digestiva alta

Evaluar siempre

Todas las marcas Anatómicas relevantes

Todas las Estaciones alto riesgo

Beg S, Gut 2017;66:1886-99

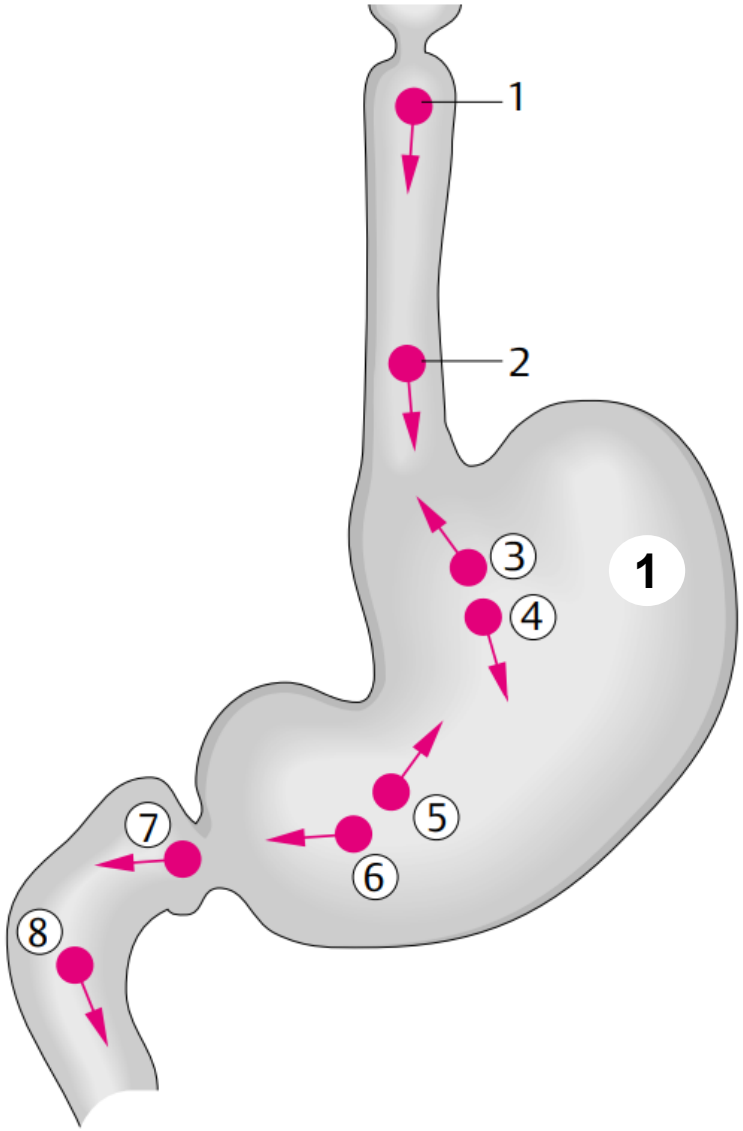
Foto documentación

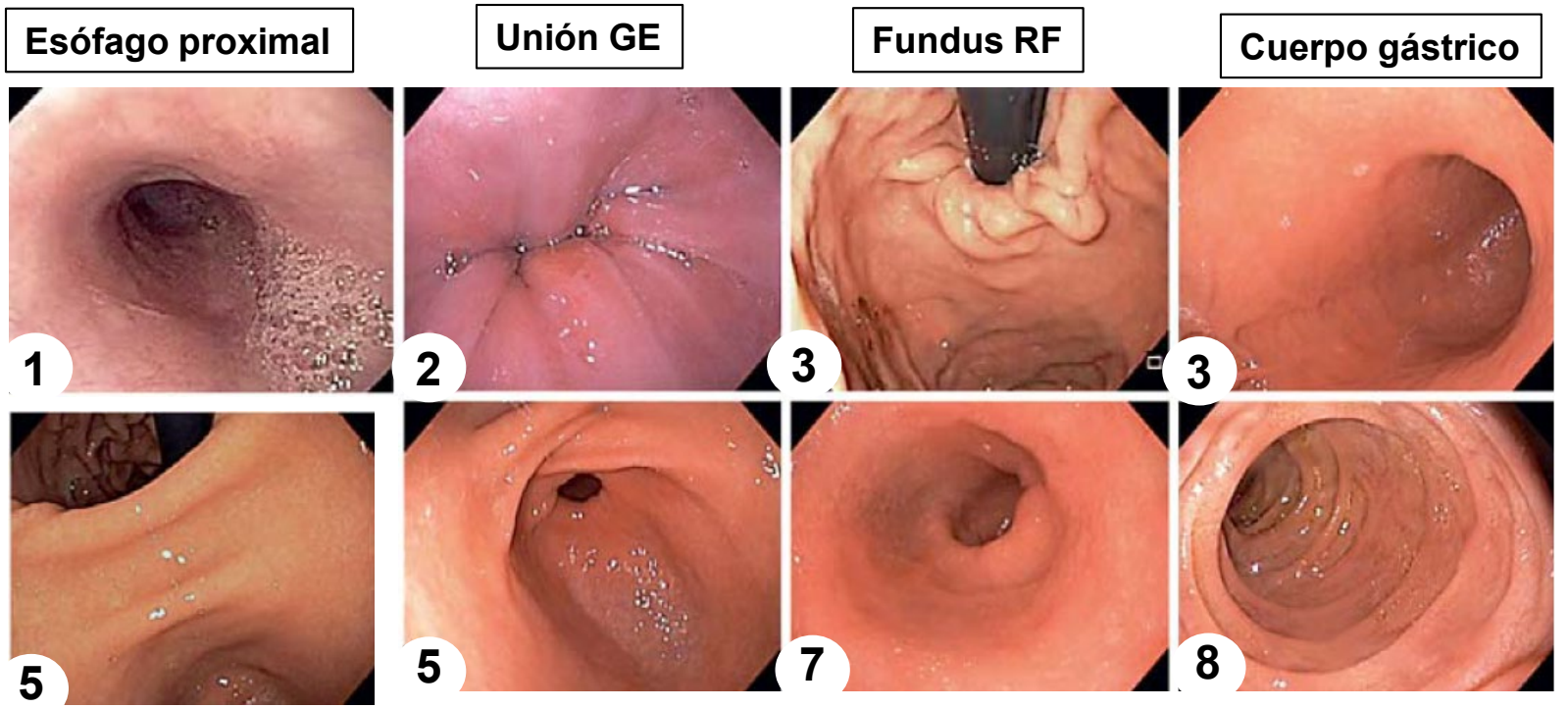
No hay evidencias

Facilita detallar áreas interés
Defensas legales
La limpieza mejor visibilidad

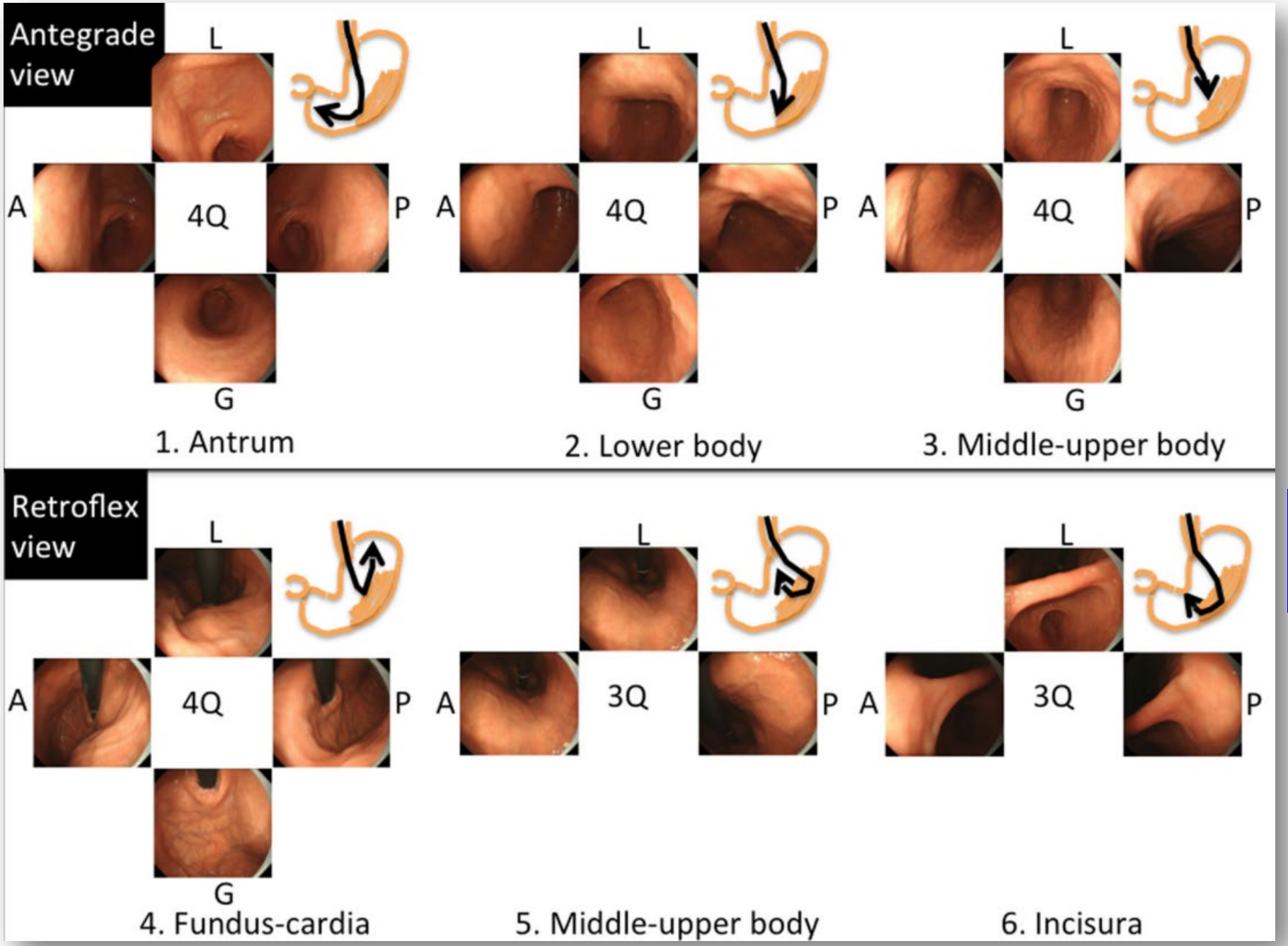
Bisschops R, Endoscopy 2016;48:843-64
Beg S, Gut 2017;66:1886-99

Estaciones recomendadas para fotodocumentación





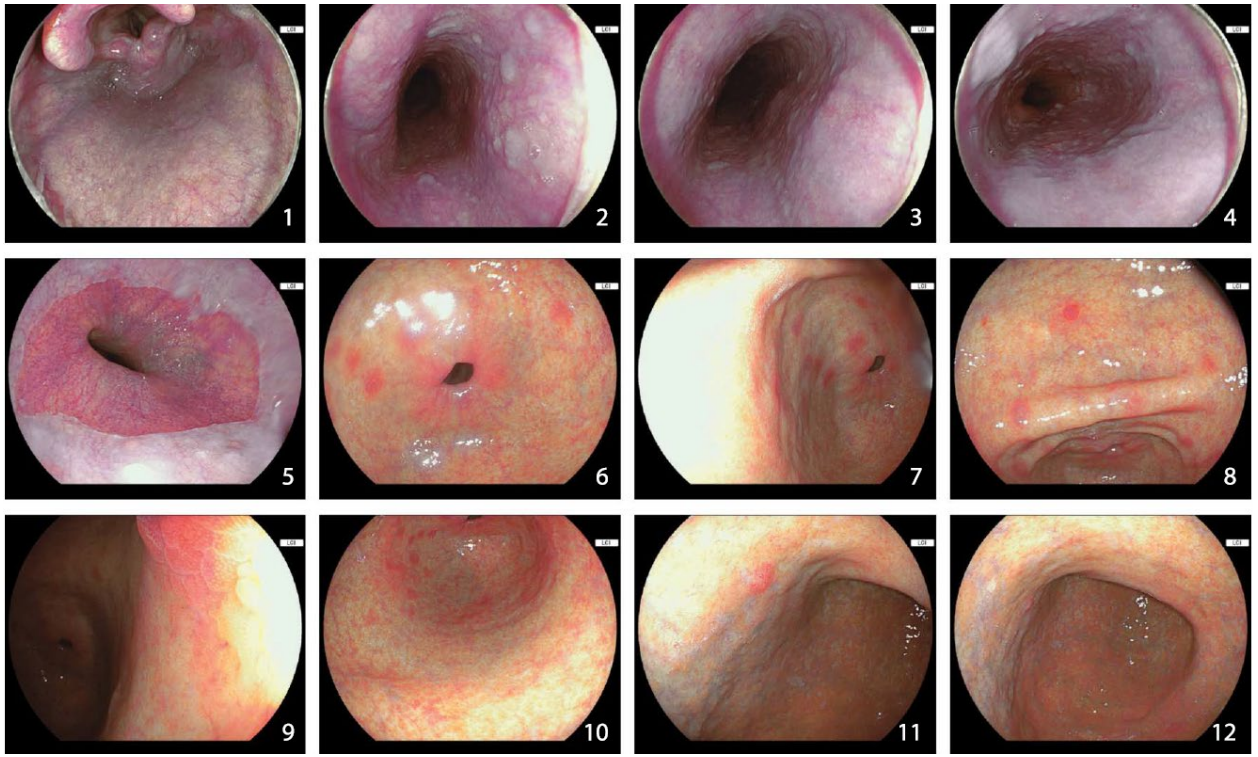
Rey JF, (ESGE) Endoscopy 2001;33:901-3

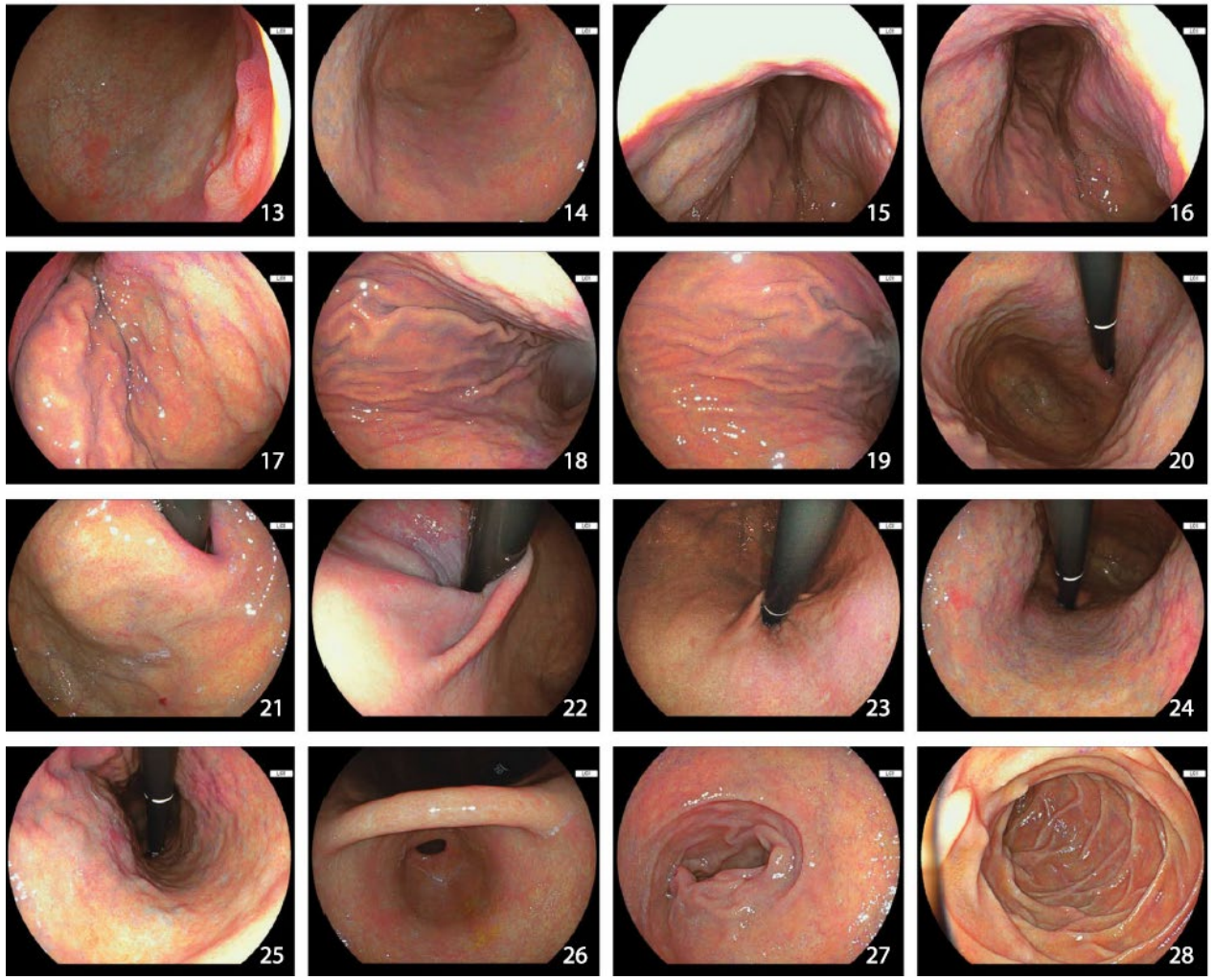


22 Estaciones

Yao K, Ann Gastroenterol 2012;26:11

Endoscopia sistemática alfa numérica 28 estaciones





Emura F, Am J Gastroenterol 2019;114:841-45.

Calidad de la visualización

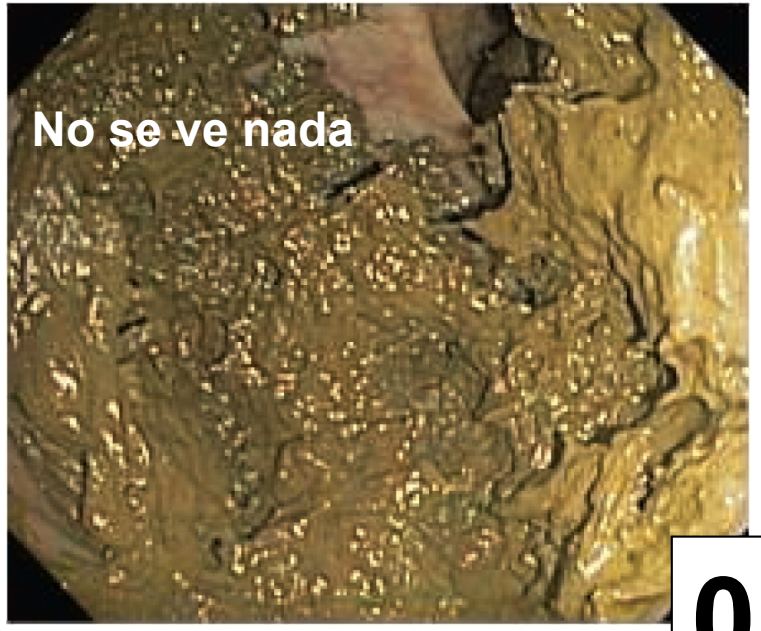
Debe reportarse

No hay escalas

Beg S, Gut 2017;66:1886-99
Bisschops R, Endoscopy 2016;48: 843-64

Boston

0-9



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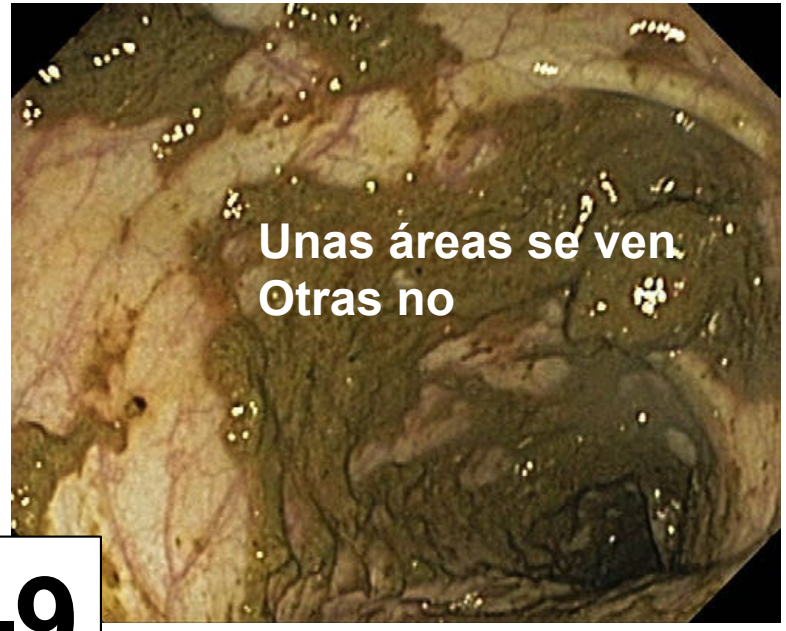
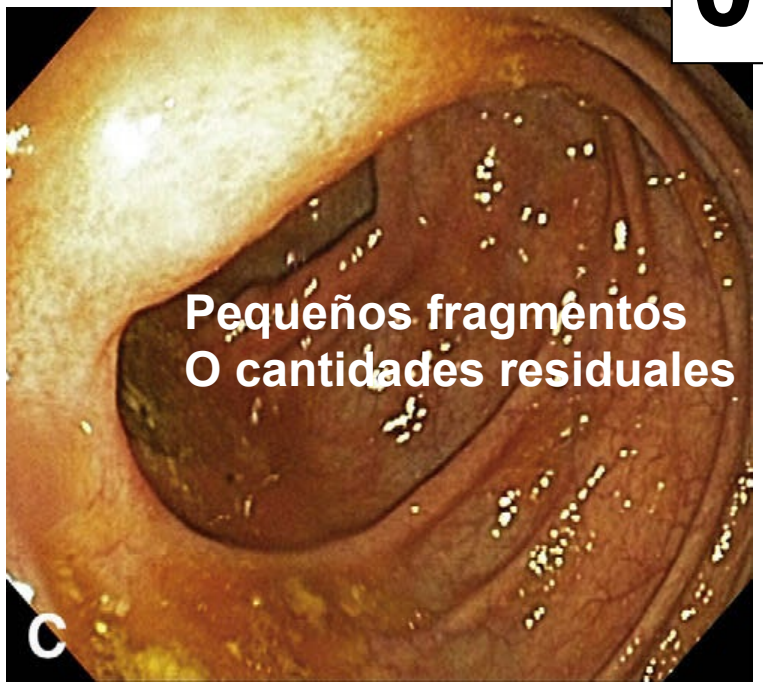
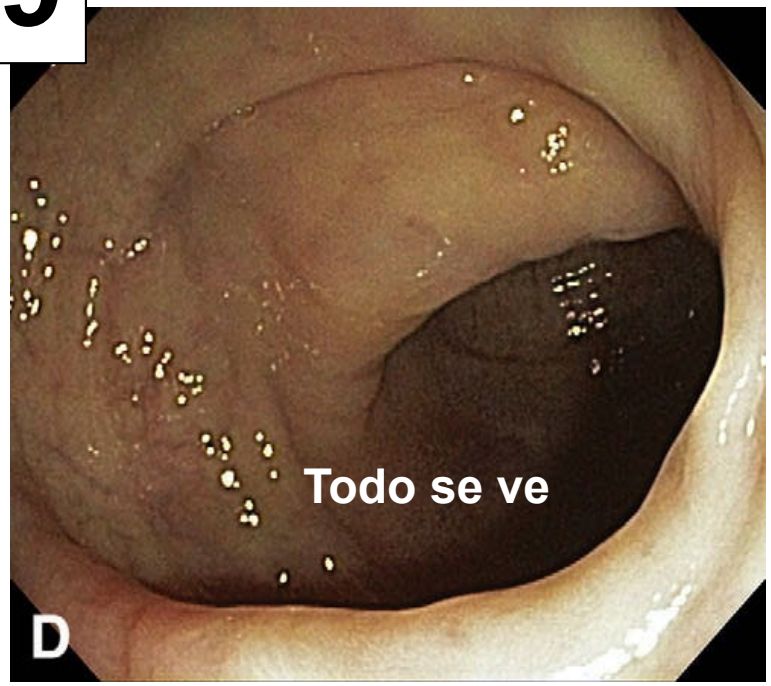


1

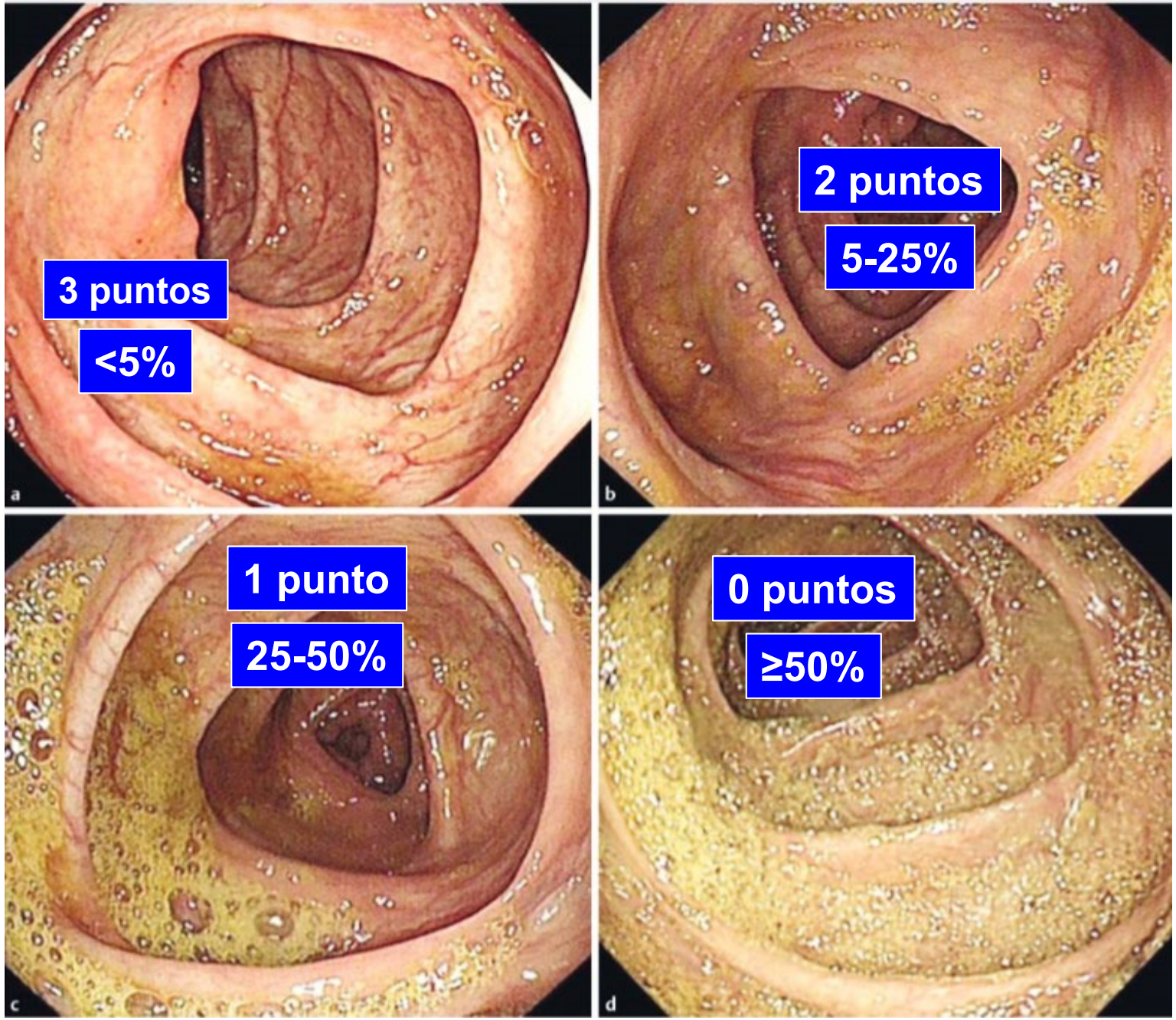


2



3

Puntaje de Burbujas



Zhang S, et al. Endoscopy 2018;50:412-422.

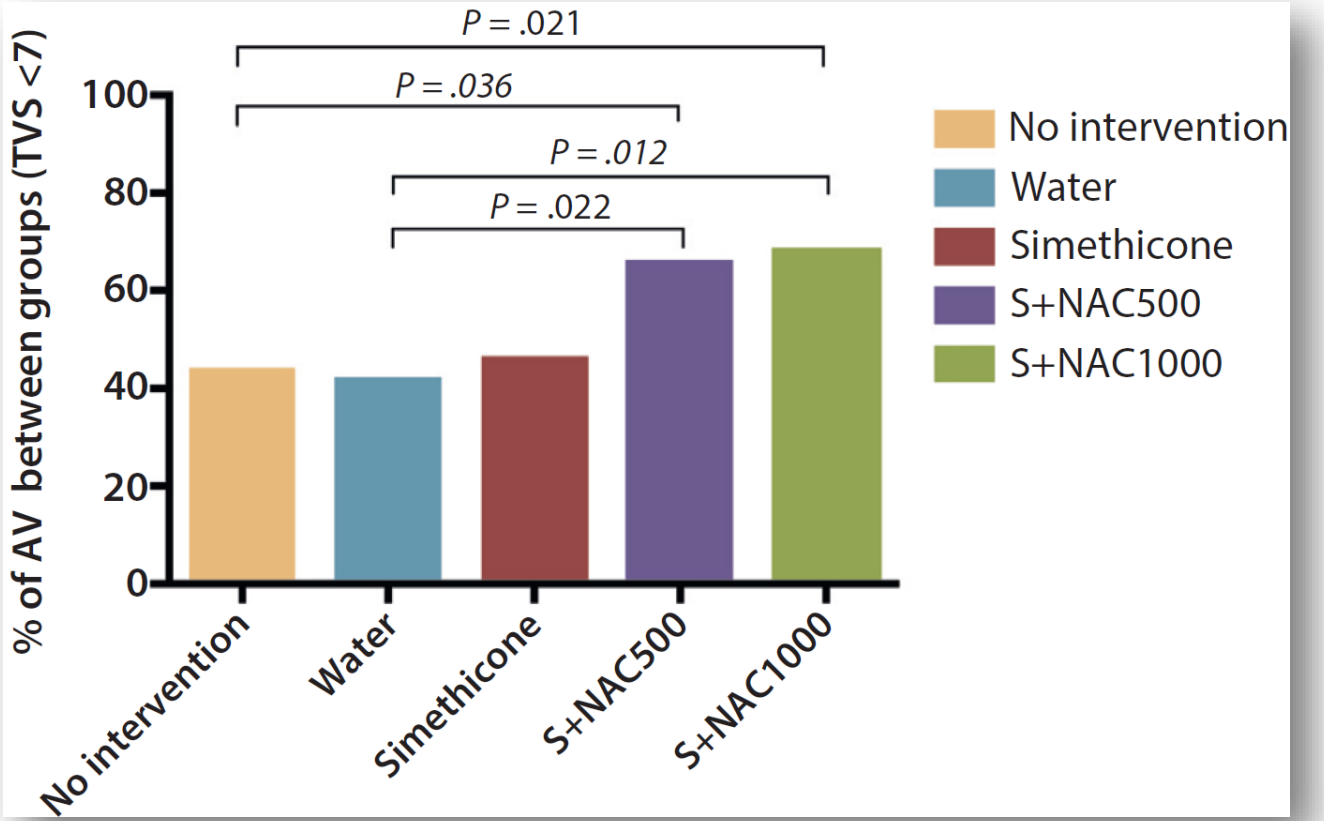
Adecuada visualización

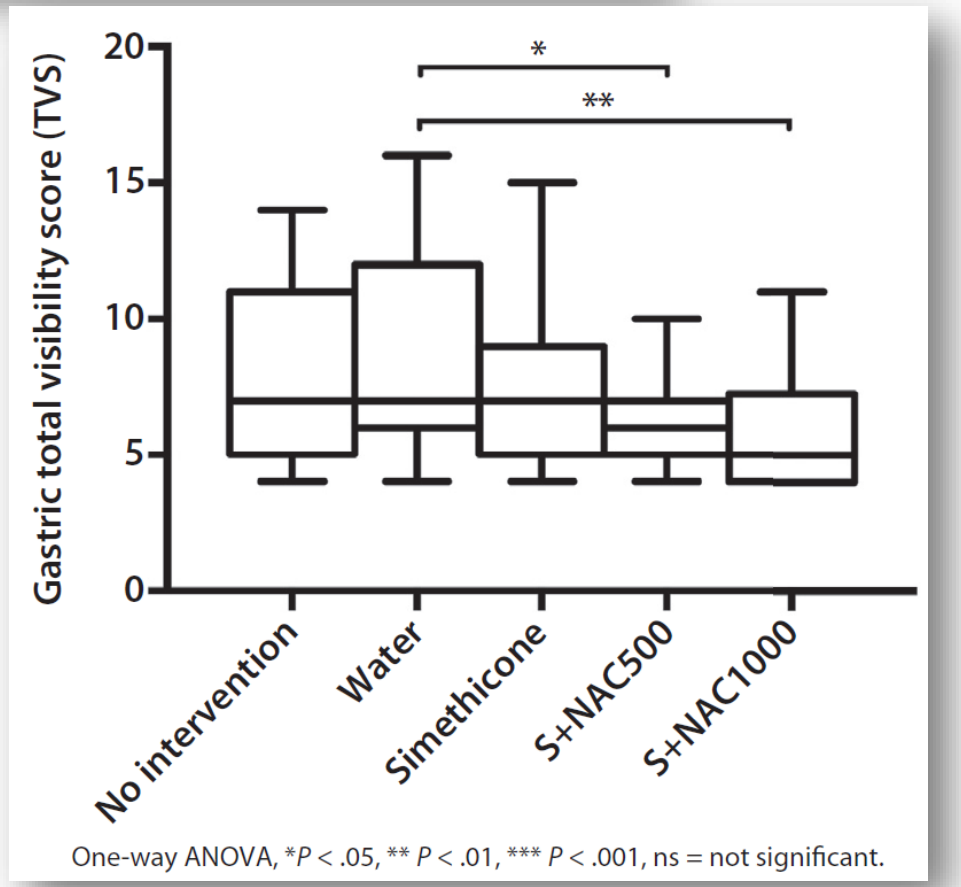
Insuflación
Aspiración
Agentes “limpieza” 10 -30 min antes
Mucolíticos: *N acetil cisteína, pronasa*
Anti espumante: *simeticona*
Mejor visibilidad

Beg S, Gut 2017;66:1886-99
Woo JG, J Clin Gastroenterol 2007;2013;47:389-92

Use of N-acetylcysteine plus simethicone to improve mucosal visibility during upper GI endoscopy: a double-blind, randomized controlled trial

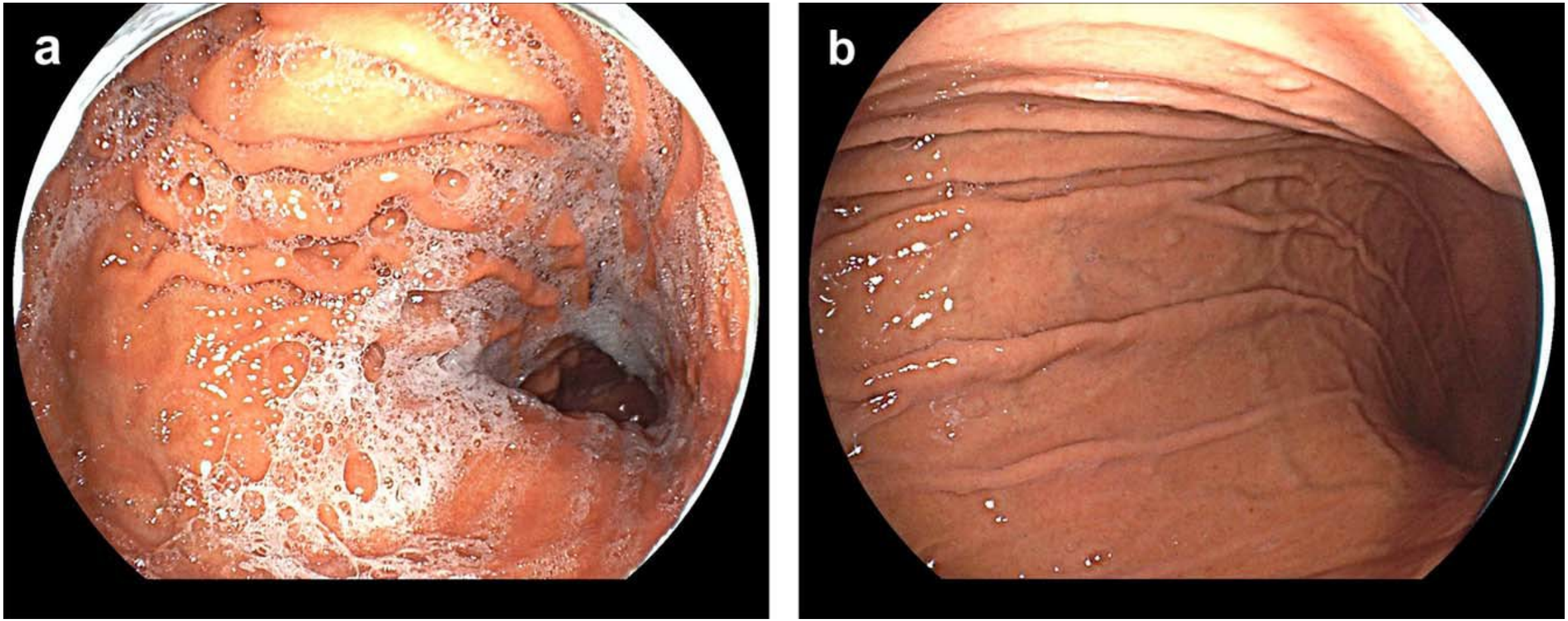
Hugo Monrroy, MD,[*,1,2,3] Jose Ignacio Vargas, MD,[*,1,2,3] Esteban Glasinovic, MD,[4] Roberto Candia, MD, Emilio Azúa, MD,[2] Camila Gálvez, MD,[2] Camila Rojas, MD,[2] Natalia Cabrera,[2] Josefa Vidaurre,[2] Natalia Álvarez,[3] Jessica González,[3] Alberto Espino, MD,[1,2,3] Robinson González, MD,[1,2,3] Adolfo Parra-Blanco, MD, PhD[1,3,5,6]





Monroy H, Gastrointest Endosc 2018;87:986-93

Visualización sin y con adecuada preparación, N acetilcisteína



Emura F, Am J Gastroenterol 2019;114:841-45.

Duración

Examination time as a quality indicator of screening upper gastrointestinal endoscopy for asymptomatic examinees

Takuji Kawamura,[1] Hironori Wada,[1] Naokuni Sakiyama,[1] Yuki Ueda,[1] Atsushi Shirakawa,[1] Yusuke Okada,[1] Kasumi Sanada,[1] Kojiro Nakase,[1] Koichiro Mandai,[1] Azumi Suzuki,[1] Mai Kamaguchi,[2] Atsuhiro Morita,[1] Kenichi Nishioji,[2] Kiyohito Tanaka,[1] Naomi Mochizuki,[2] Koji Uno,[1] Isao Yokota,[3] Masao Kobayashi[2] and Kenjiro Yasuda[1]

Rápidos	**4.4 ± 1 minuto**
Moderados	**6.1 ± 1.4minutos**
Lento	**7.8 ± 1.9 minutos**

Detección Lesión neoplásica
OR 1.90 (IC95%1.06-3.40

Digestive Endoscopy 2017; 29: 569-75

Longer Examination Time Improves Detection of Gastric Cancer During Diagnostic Upper Gastrointestinal Endoscopy

Jun Liang Teh,* Jin Rong Tan,‡ Linus Jian Fa Lau,‡ Nakul Saxena,§,|| Agus Salim,¶ Amy Tay,* Asim Shabbir,* Sydney Chung,*,‡ Mikael Hartman,*,||,# and Jimmy Bok-Yan So*,‡

224 pacientes
Punto de corte 7 minutos
Endoscopistas
Rápidos 5.5 ± 2.1 min
Lentos 8.6 ± 4.2 min
Lesiones alto riesgo OR 2.5 (IC95%1.52-4.12)
Cáncer OR 3.42 (IC95% 1,25-10,38)

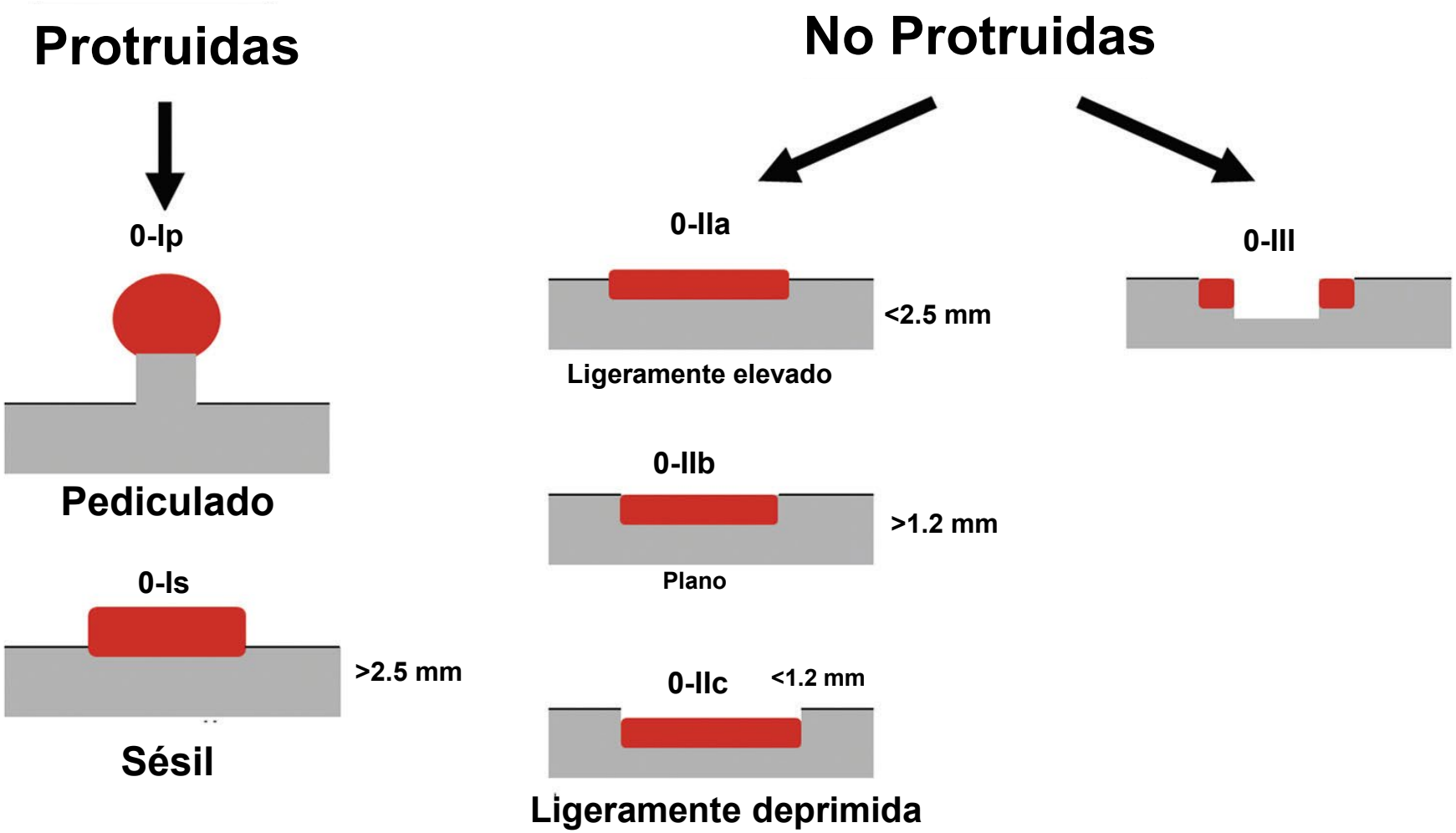
ESGE: Al menos 7 minutos por EVDA

Independiente de experticia!

Teh JL, Clin Gastroenterol Hepatol 2015;13:480–7

Clasificaciones estandarizadas

Alteraciones morfológicas



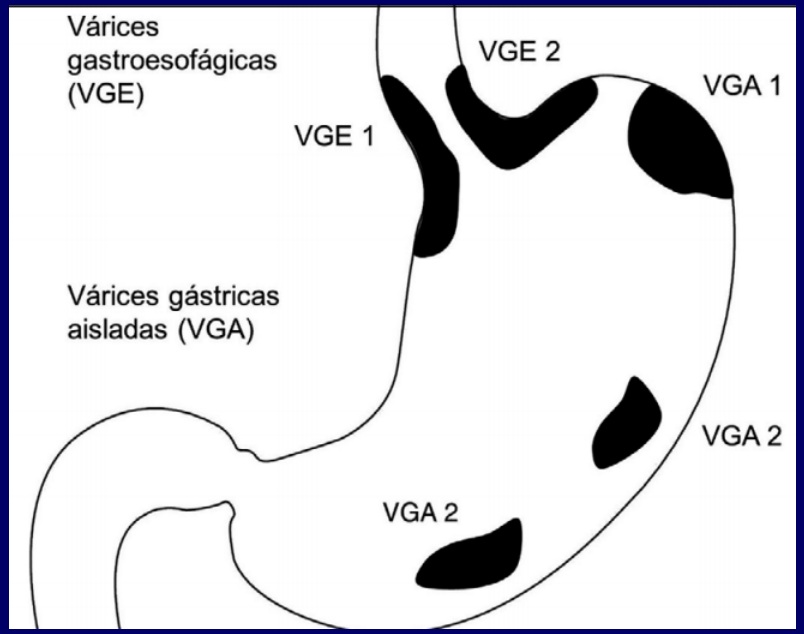
París. Endoscopy 2005;37:570-8

Várices, describirlas, según nomeclatura

Esofágicas

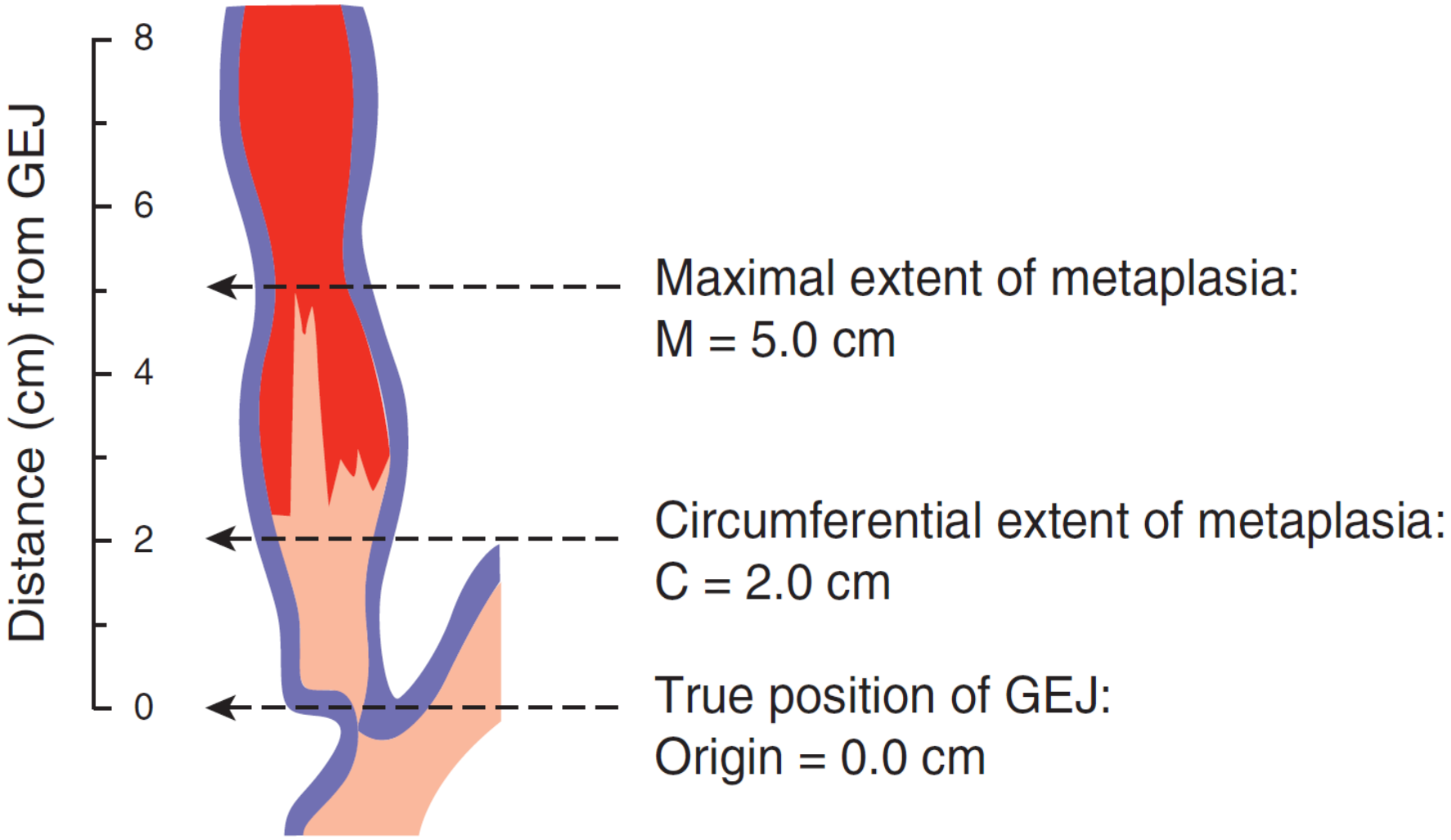
± 5mm o > 5 mm

Gástricas



Esófago de Barrett

Esófago de Barrett, clasificación de Praga



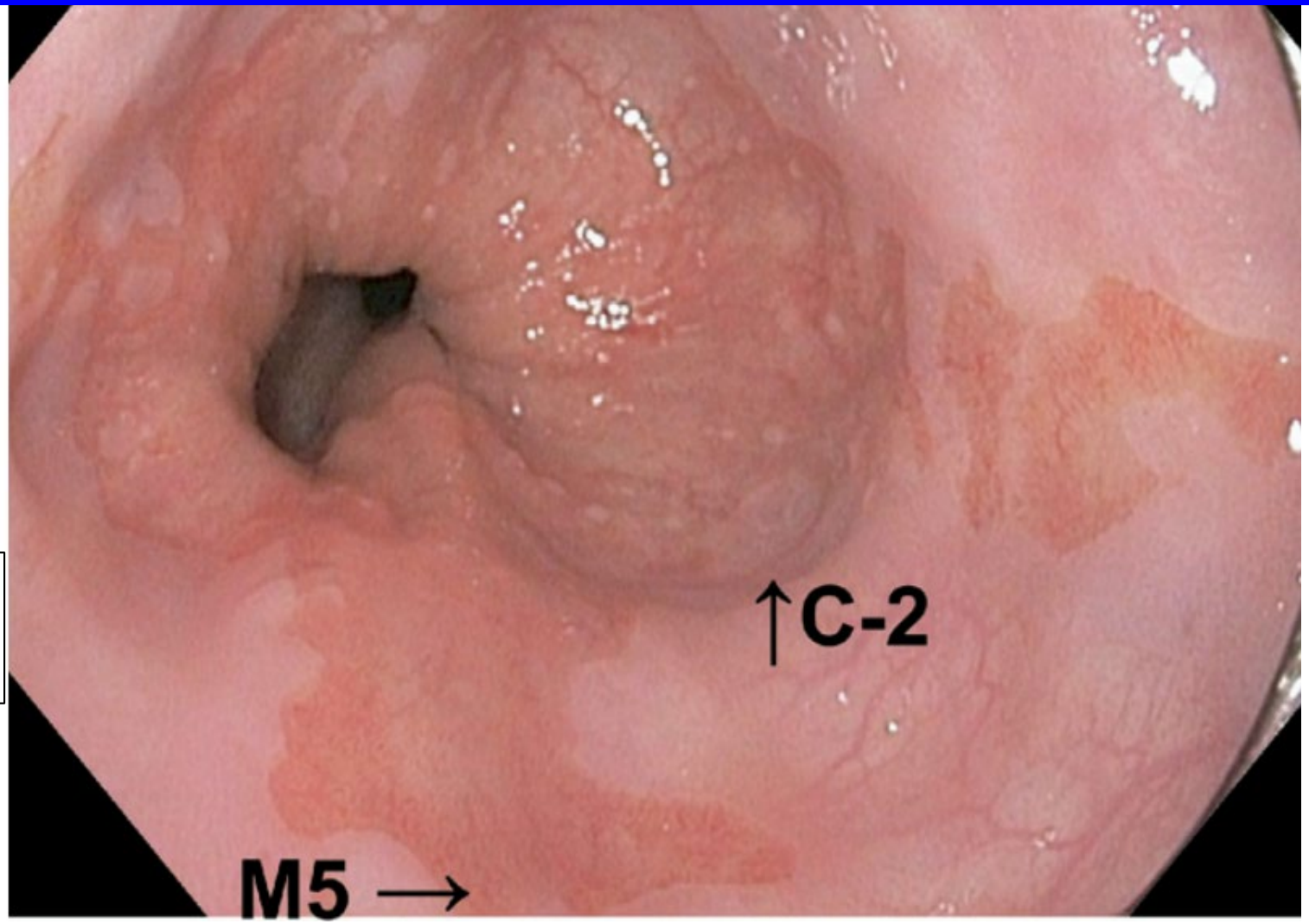
Sharma P , Gastroenterology 2006 ; 131 : 1392 – 9

Mejor herramienta disponible para evaluar la longitud endoscópica del esófago Barrett

Bennett C, Gastroenterology 2012; 143: 336

Clasificación De Praga

Todas las guías y Expertos



Durante Retirada

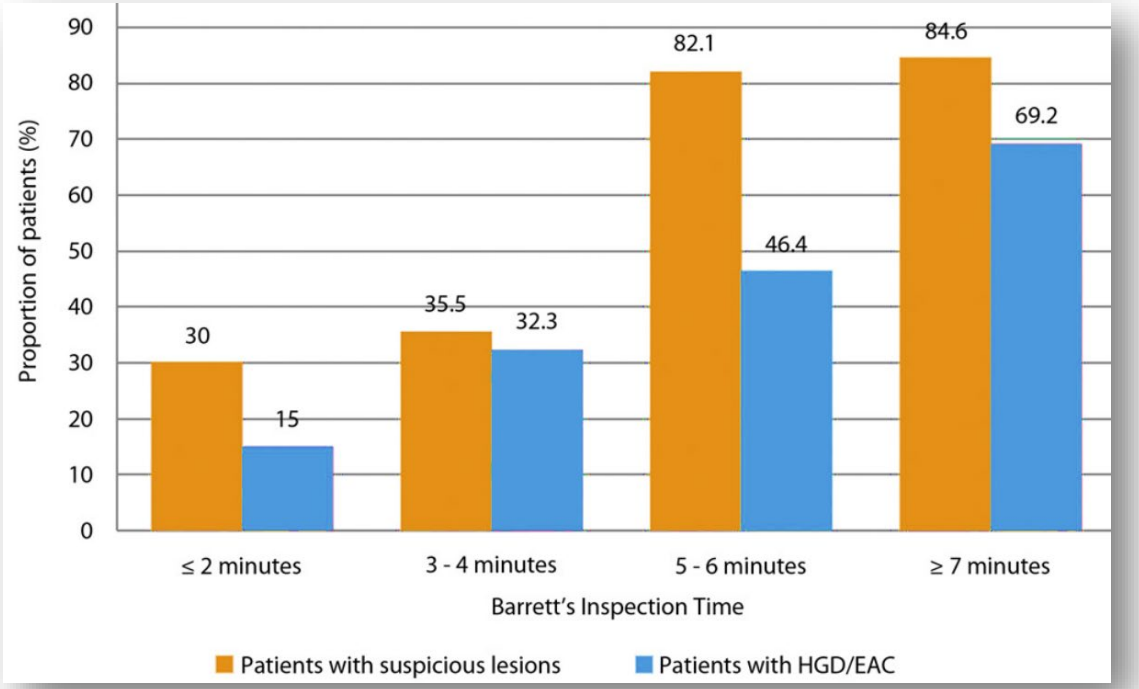
Sharma P, Gastroenterology 2006;131:1392-9

Longer inspection time is associated with increased detection of high-grade dysplasia and esophageal adenocarcinoma in Barrett's esophagus CME

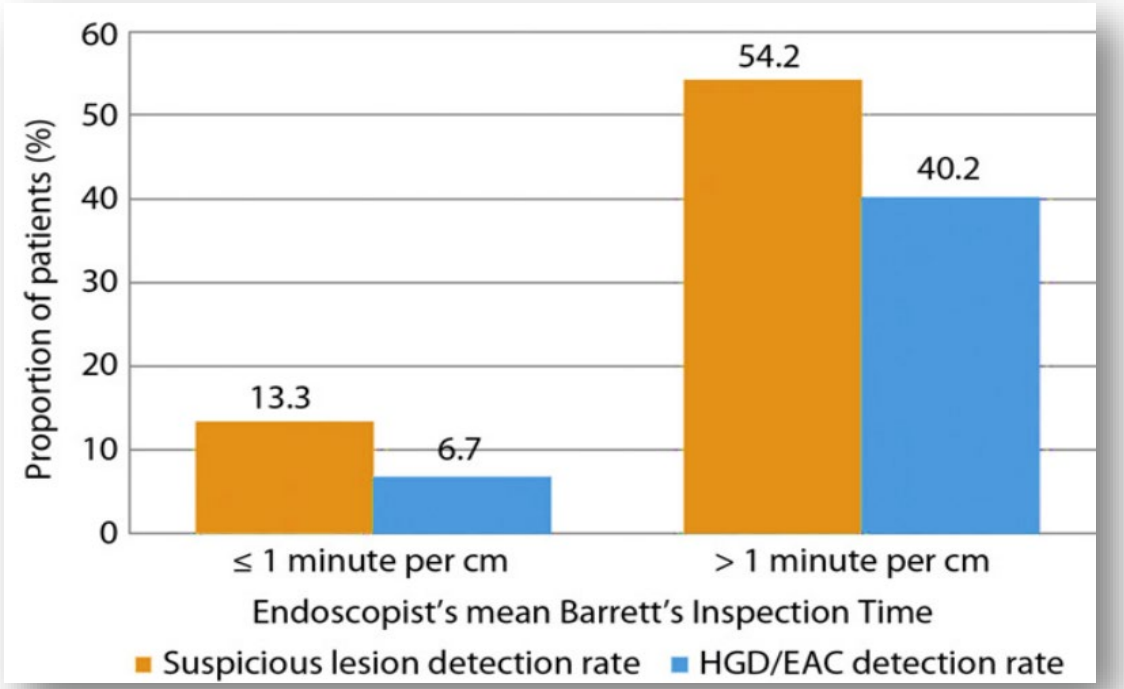
Neil Gupta, MD, MPH,[1,2] Srinivas Gaddam, MD, MPH,[1] Sachin B. Wani, MD,[1,2] Ajay Bansal, MD,[1,2] Amit Rastogi, MD,[1,2] Prateek Sharma, MD[1,2]

Gastrointest Endosc 2012;76:531-8.

Más tiempo de observación del Barrett
Más lesiones sospechosas y más
Cáncer o displasia de alto grado



>1min por cada cm de Barrett
>Más lesiones sospechosas



Estudio histológico del esófago de Barrett

Protocolo Seattle

4 biopsias Cada 2 cm

Todas las guías

Alteraciones morfolóficas en E. Barrett

Clasificación de parís

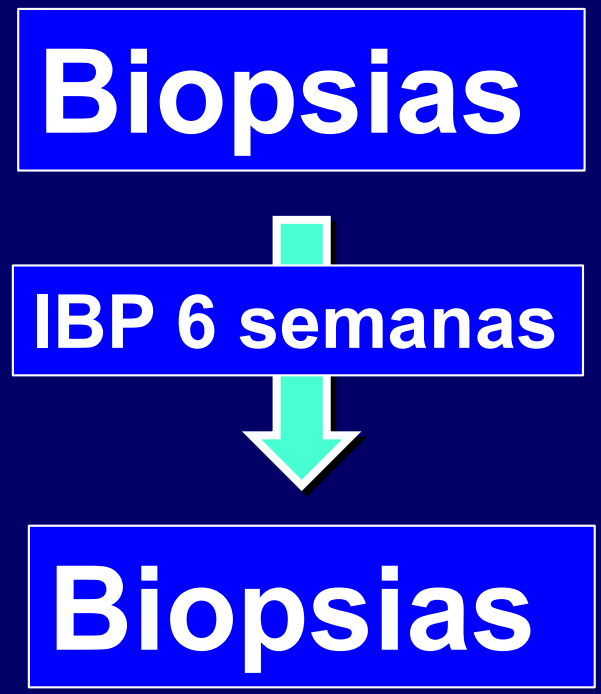
Todas las guías

Esofagitis

Clasificación de Los Ángeles

Todas las Guías
Todos los expertos

Esofagitis grado D, ulceras
Apariencia atípica



Beg S, Gut 2017;66:1866-99

Estenosis esofágica

Biopsias antes de la dilatación

Todas las guías

Mucosa gástrica heterotópica esófago cervical

3-12%

Sahin G, et al Int J Biomed Sci 2014;10:129
Poyrazoglu OK, Int J Clin Pract 2009;63:287–91.

THE AMERICAN JOURNAL OF GASTROENTEROLOGY
© 2003 by Am. Coll. of Gastroenterology
Published by Elsevier Inc.

2003

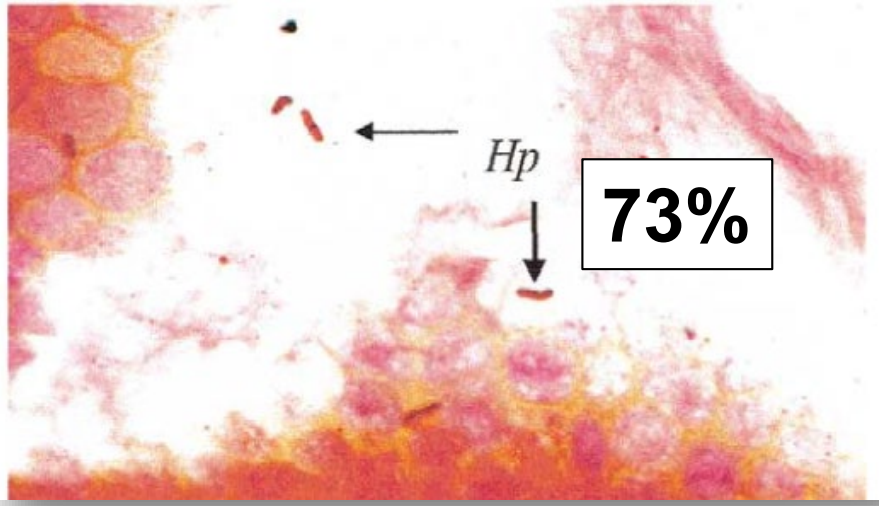
Vol. 98, No. 6, 2003
ISSN 0002-9270/03/$30.00
doi:10.1016/S0002-9270(03)00267-3

Helicobacter pylori and Hetertopic Gastric Mucosa in the Upper Esophagus (the Inlet Patch)

Oscar Gutierrez, M.D., Taiji Akamatsu, M.D., Hector Cardona, M.D., David Y. Graham, M.D., and Hala M.T. El-Zimaity, M.D.

Gastrointestinal Mucosa Pathology Laboratory, Department of Medicine, Department of Pathology, Veterans Affairs Medical Center and Baylor College of Medicine, Houston, Texas, USA; Department of Endoscopy, Shinshu University Hospital, Matsumoto, Japan; and Department of Gastroenterology, National University of Colombia, Bogota, Colombia

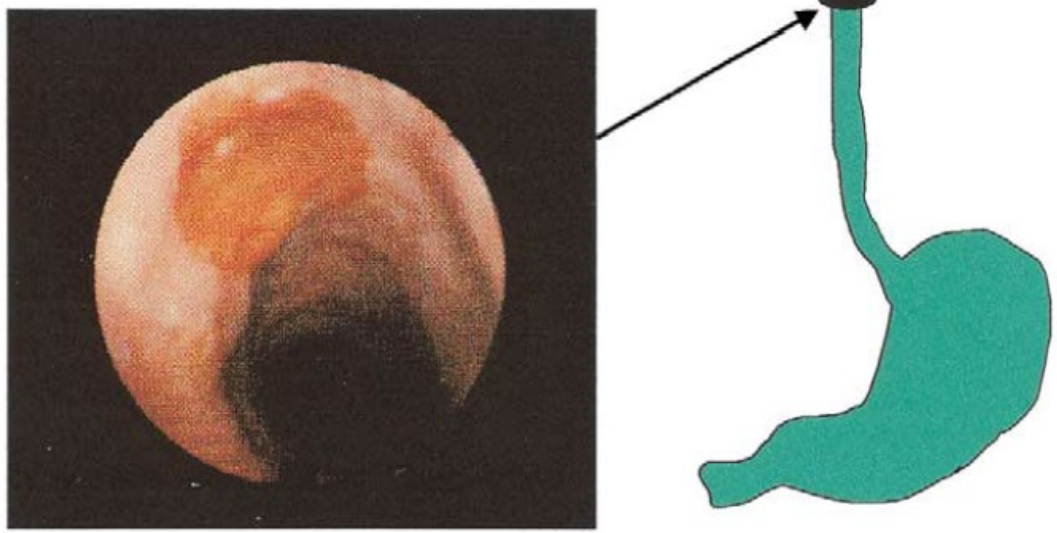
Inlet Patch - Dual Stain



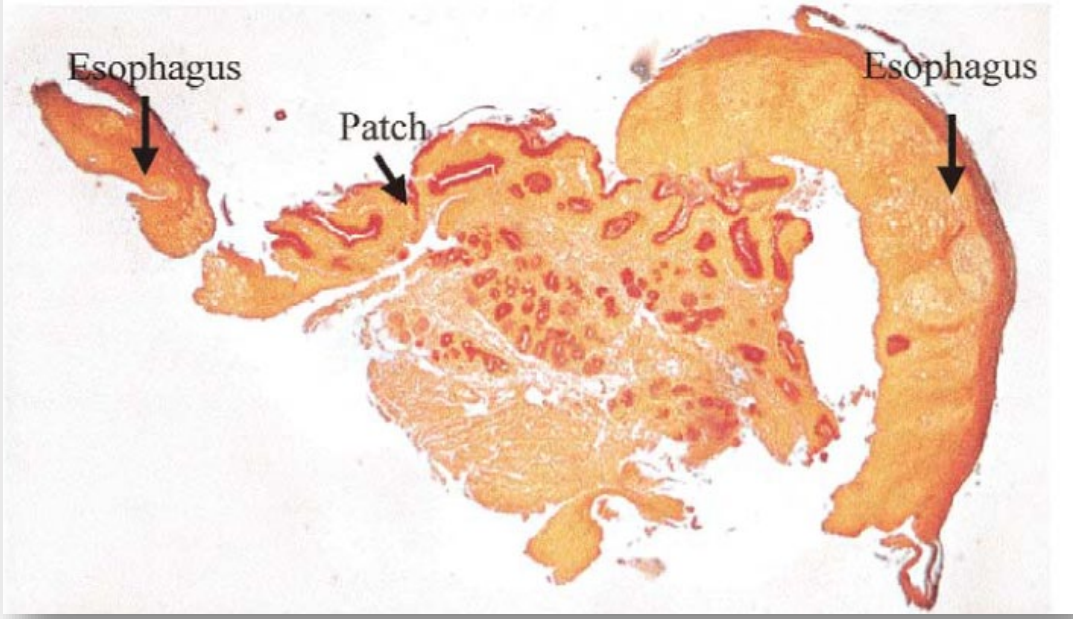
73%

Inlet Patch

3.8% (57/1495 un año)

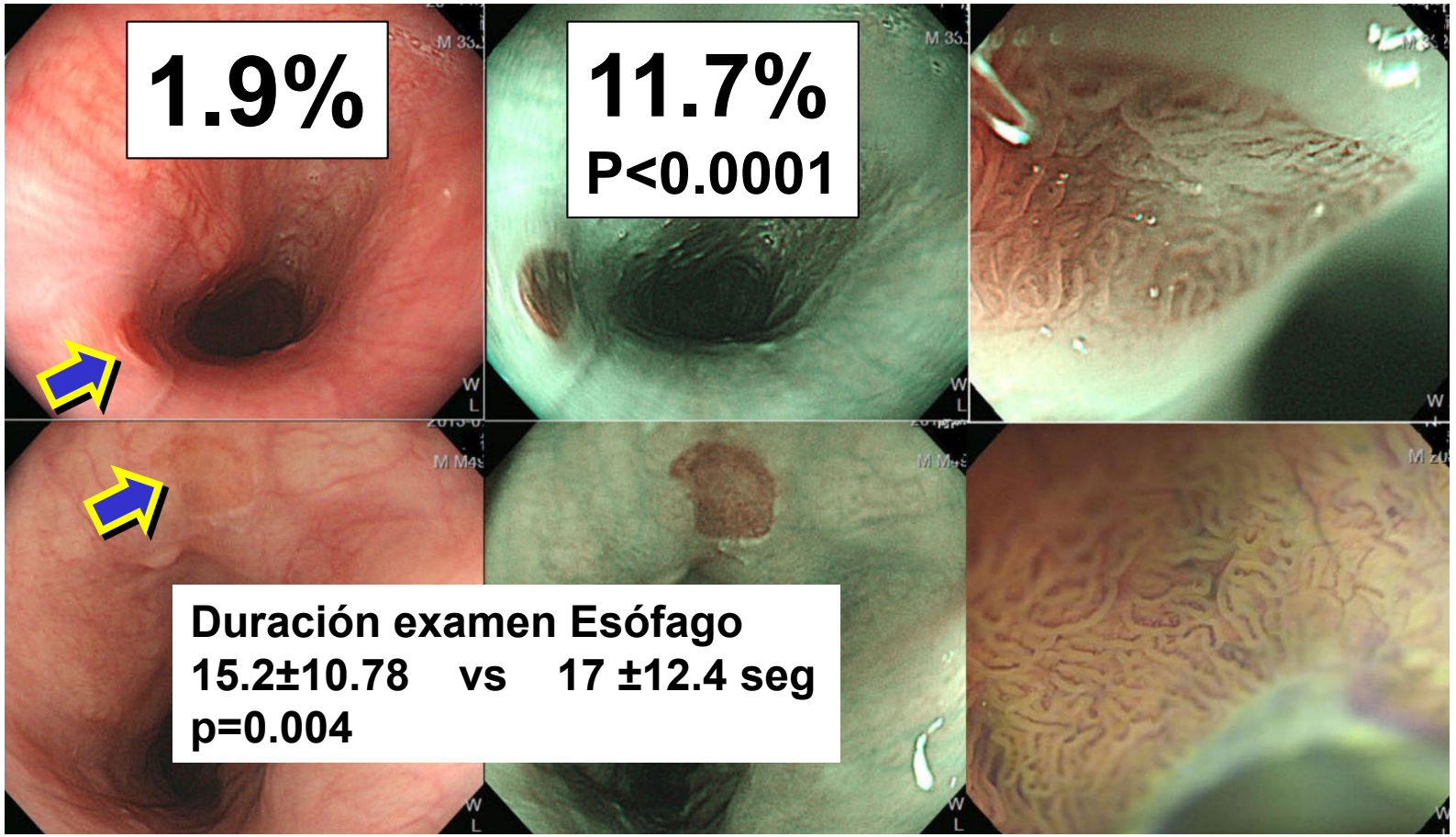


Inlet Patch - Antral Type Mucosa



Intentional examination of esophagus by narrow-band imaging endoscopy increases detection rate of cervical inlet patch

C.-S. Chung,[1,2] C.-K. Lin,[1] C.-C. Liang,[1] W.-F. Hsu,[1] T.-H. Lee[1]



Chung CS, Dis Es 2015;28:666-72

Mucosa gástrica ectópica

Marcador (“subrogado”) de examen completo Del esófago

British Society Gastroenterology
Gut 2017;66:1886-99

Esofagitis eosinofílica

Clinica

Adolescentes Adultos

Disfagia, Impactación, Alimentos
Pirosis refractaria

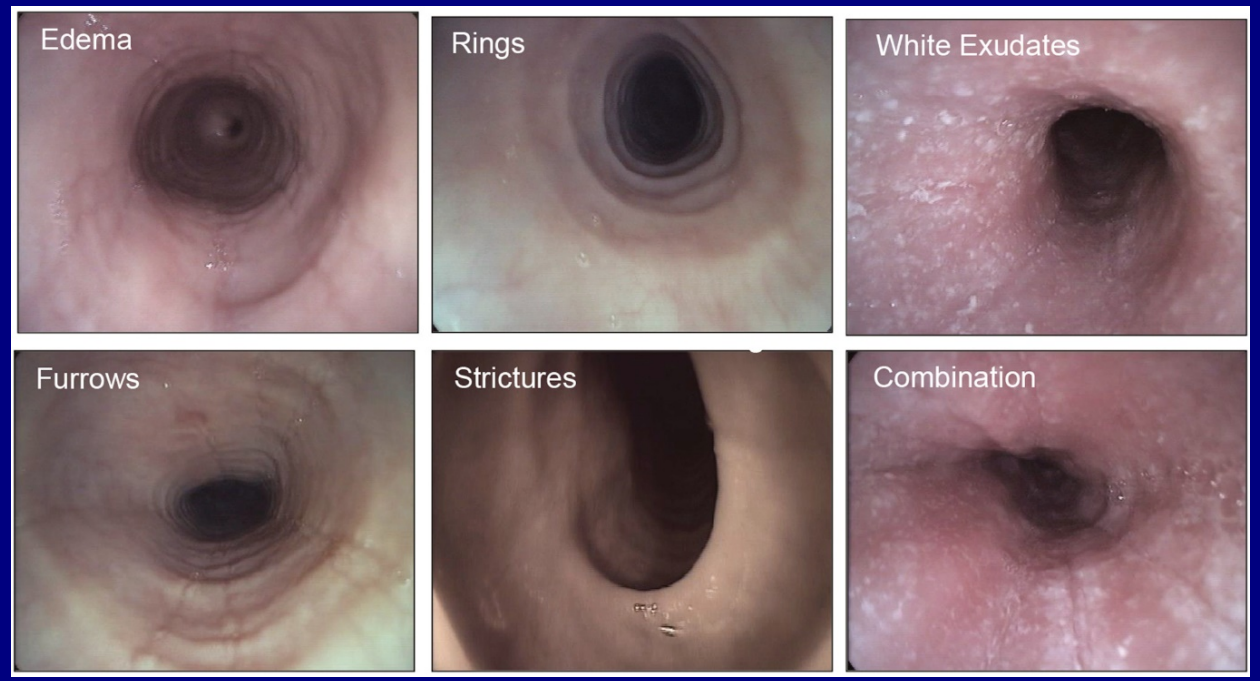
Niños

<Crecimiento, Vómito, pirosis
Malestar abdominal

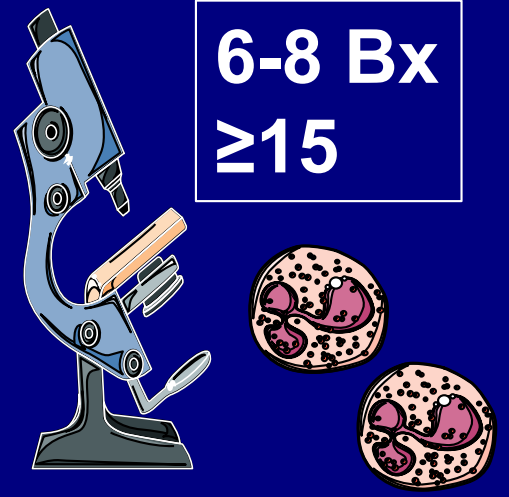
3D

Drogas
Dieta
Dilatación

Endoscopia



Histología



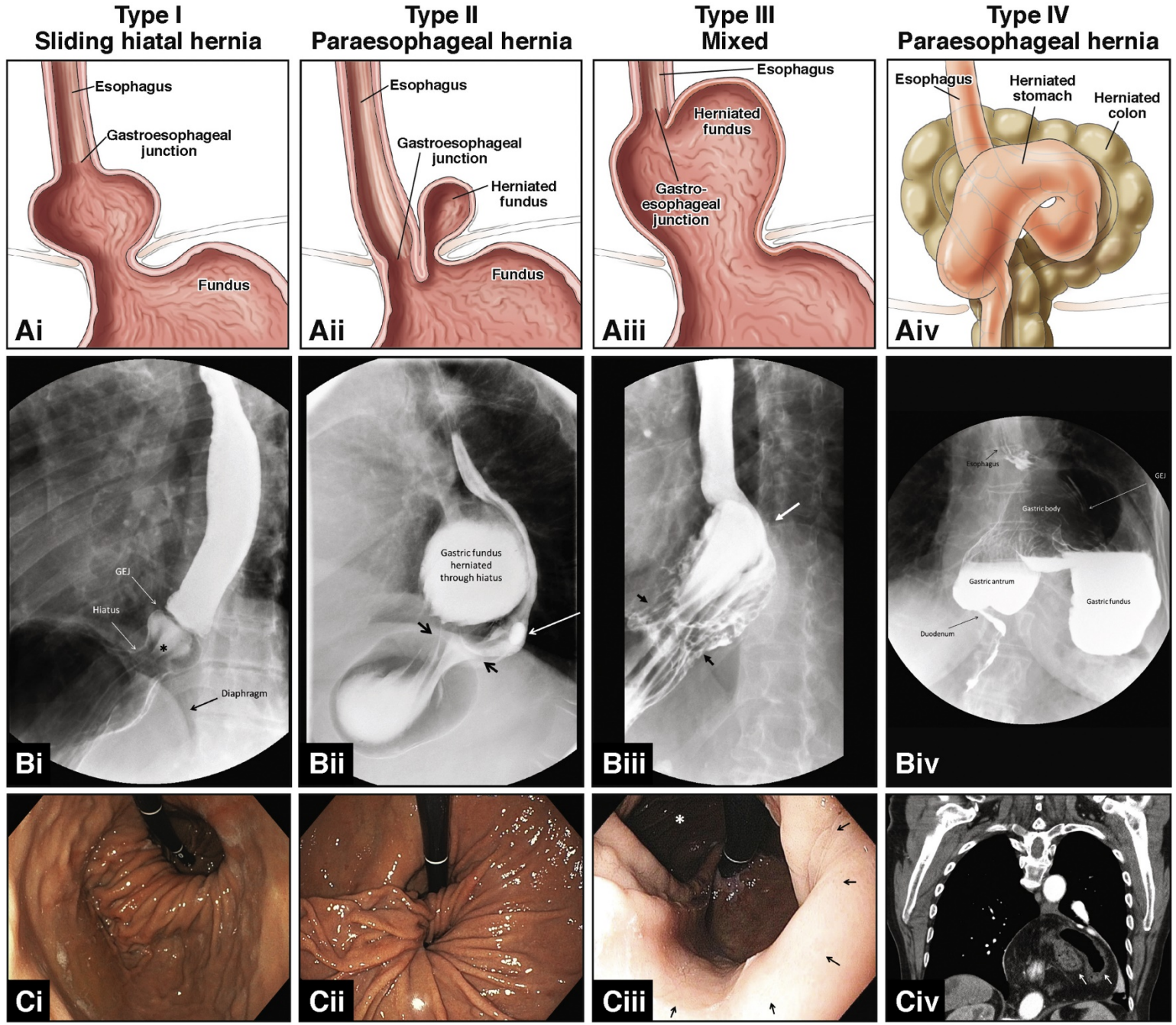
6-8 Bx
≥15

Strauman A, Gastroenterology 2018;154:346–59

Hernia hiatal

Debe ser documentada y medida

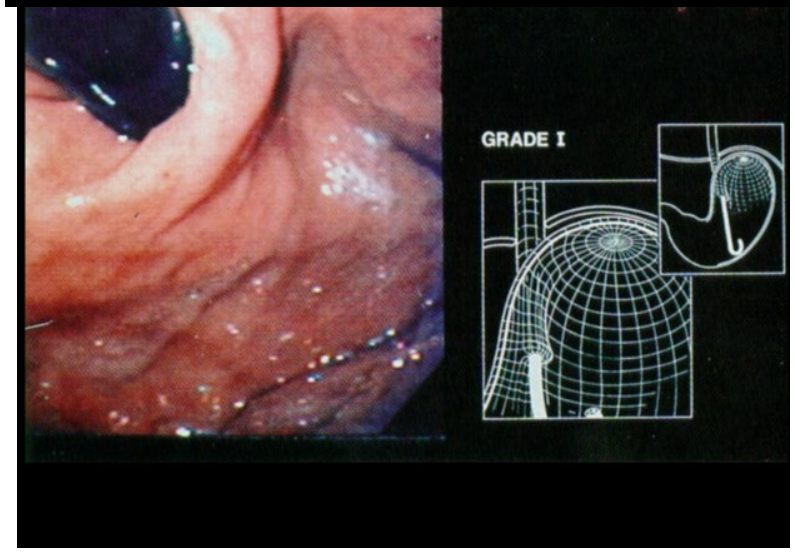
Todas las guías



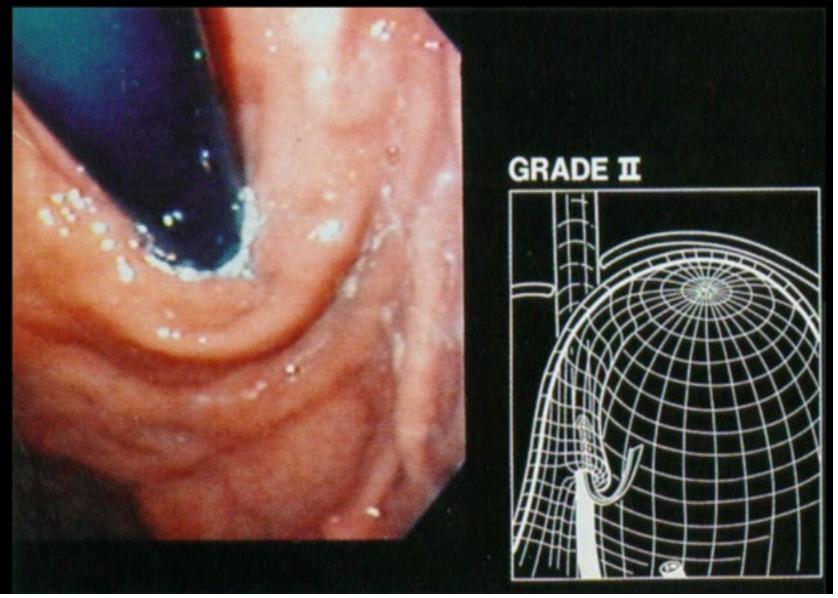
Callaway JP, Clin Gastroenterol Hepatol 2018;16:810-13

Evaluación endoscópica de la barrera anti-reflujo, Sistema de Hill

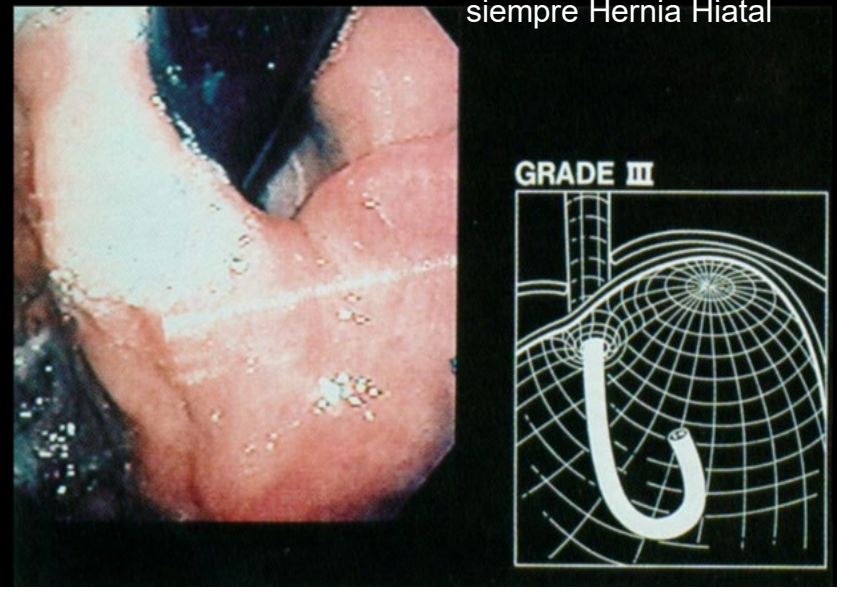
Grado I. La solapa de la válvula. Cresta en estrecho contacto con el endoscopio. Se extiende 3-4 cm hacia curva menor



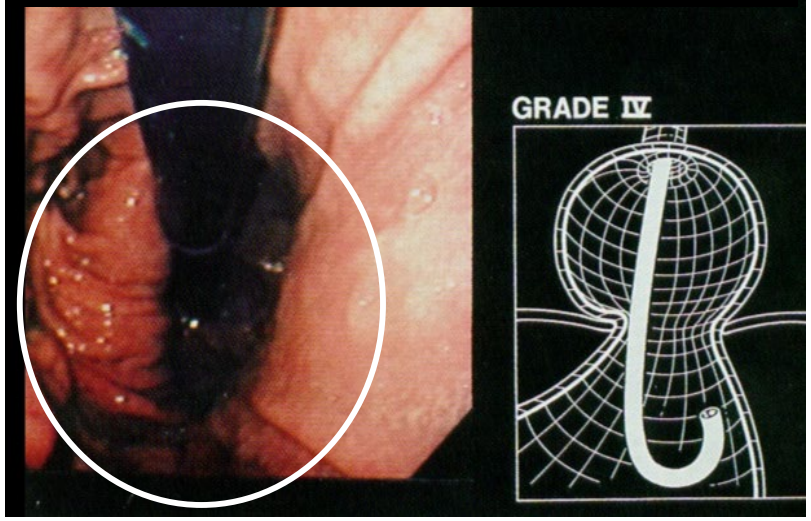
Grado II. La solapa de la válvula. La Cresta es menos definida, se abre con la respiración y se cierra enseguida



Grado III. La solapa de la válvula. La Cresta apenas Se nota. No hay cierre alrededor del endoscopio. Casi siempre Hernia Hiatal



Grado IV. La solapa de la válvula. No hay anillo muscular El área gastroesofágica permanece abierta, se ve el Epitelio escamoso. Hay hernia hiatal siempre



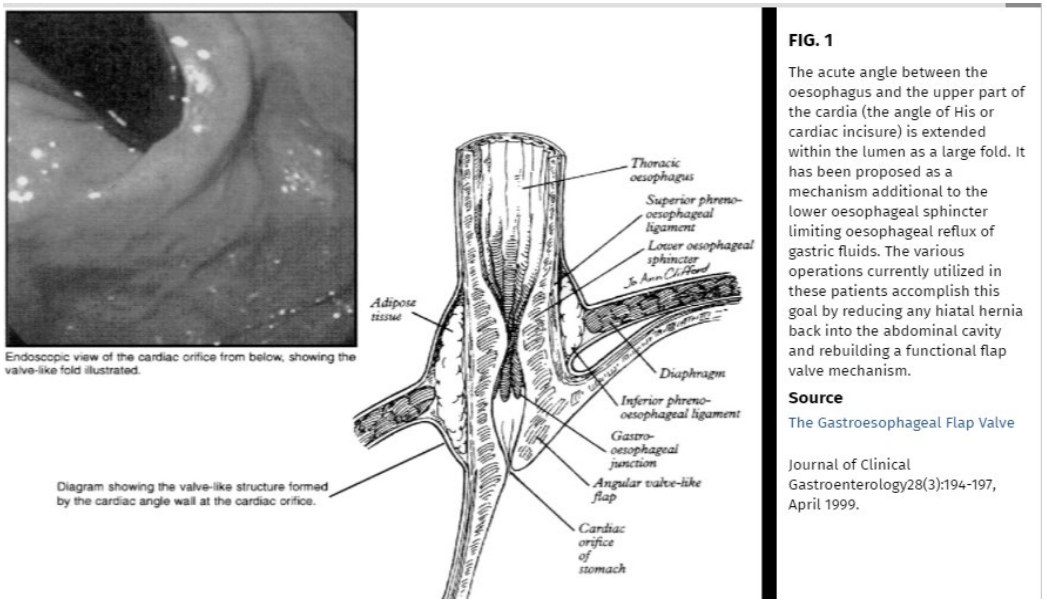


FIG. 1

The acute angle between the oesophagus and the upper part of the cardia (the angle of His or cardiac incisure) is extended within the lumen as a large fold. It has been proposed as a mechanism additional to the lower oesophageal sphincter limiting oesophageal reflux of gastric fluids. The various operations currently utilized in these patients accomplish this goal by reducing any hiatal hernia back into the abdominal cavity and rebuilding a functional flap valve mechanism.

Source

The Gastroesophageal Flap Valve

Journal of Clinical Gastroenterology28(3):194-197, April 1999.

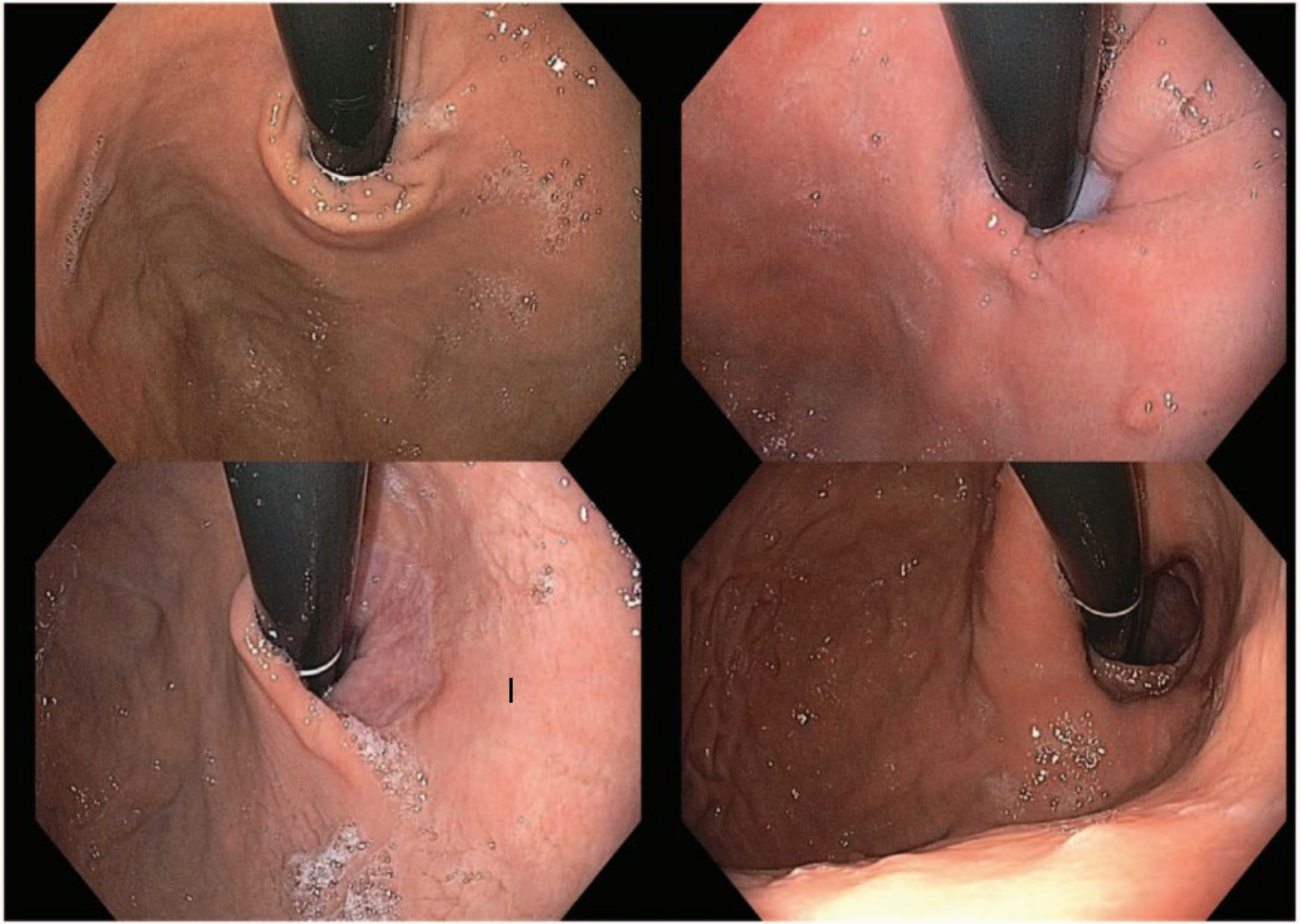
Hill LD, AJG 1999;28:194-7

I

II

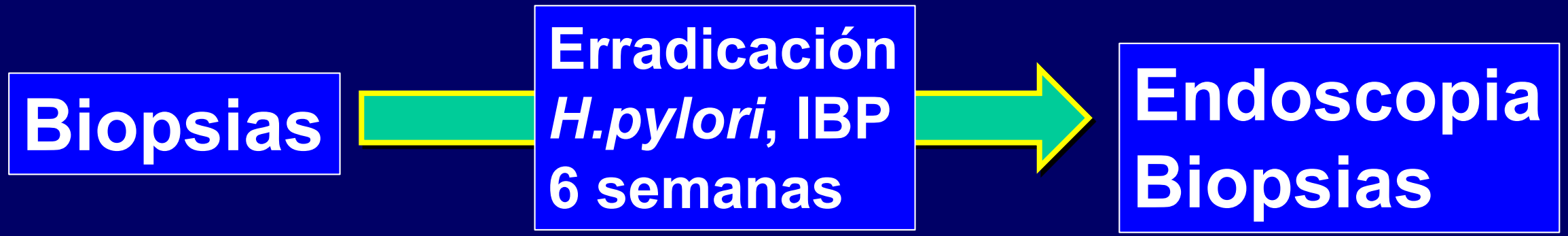
III

IV



60 Segundos

Ulceras gástricas



Todas las guías

Ulcera Gástrica/Duodenal

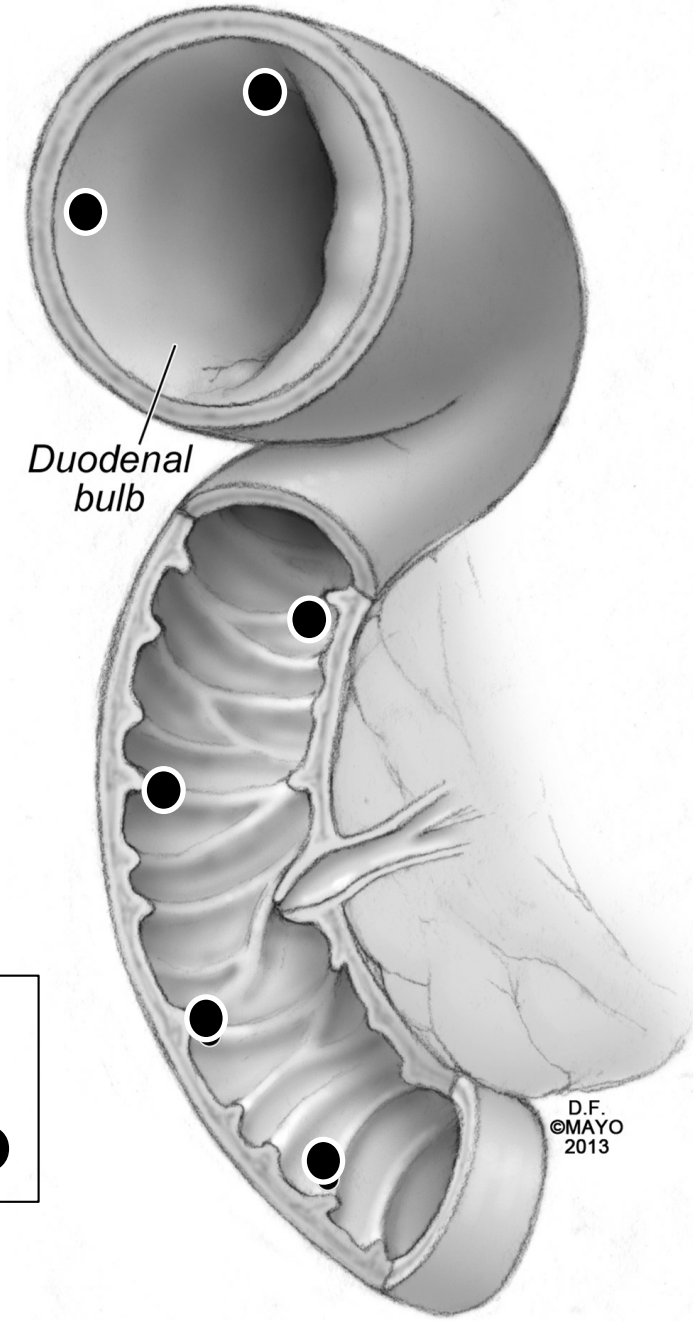
Investigar y tratar *H.pylori* si es (+)

Todas las guías

Anemia Ferropénica

Enfermedad Celíaca

Serología (+)
No se ha estudiado



Frascos Diferentes Estómago

Oxentenko AS, et al. Clin Gastroenterol Hepatol 2015;13:1396–1404

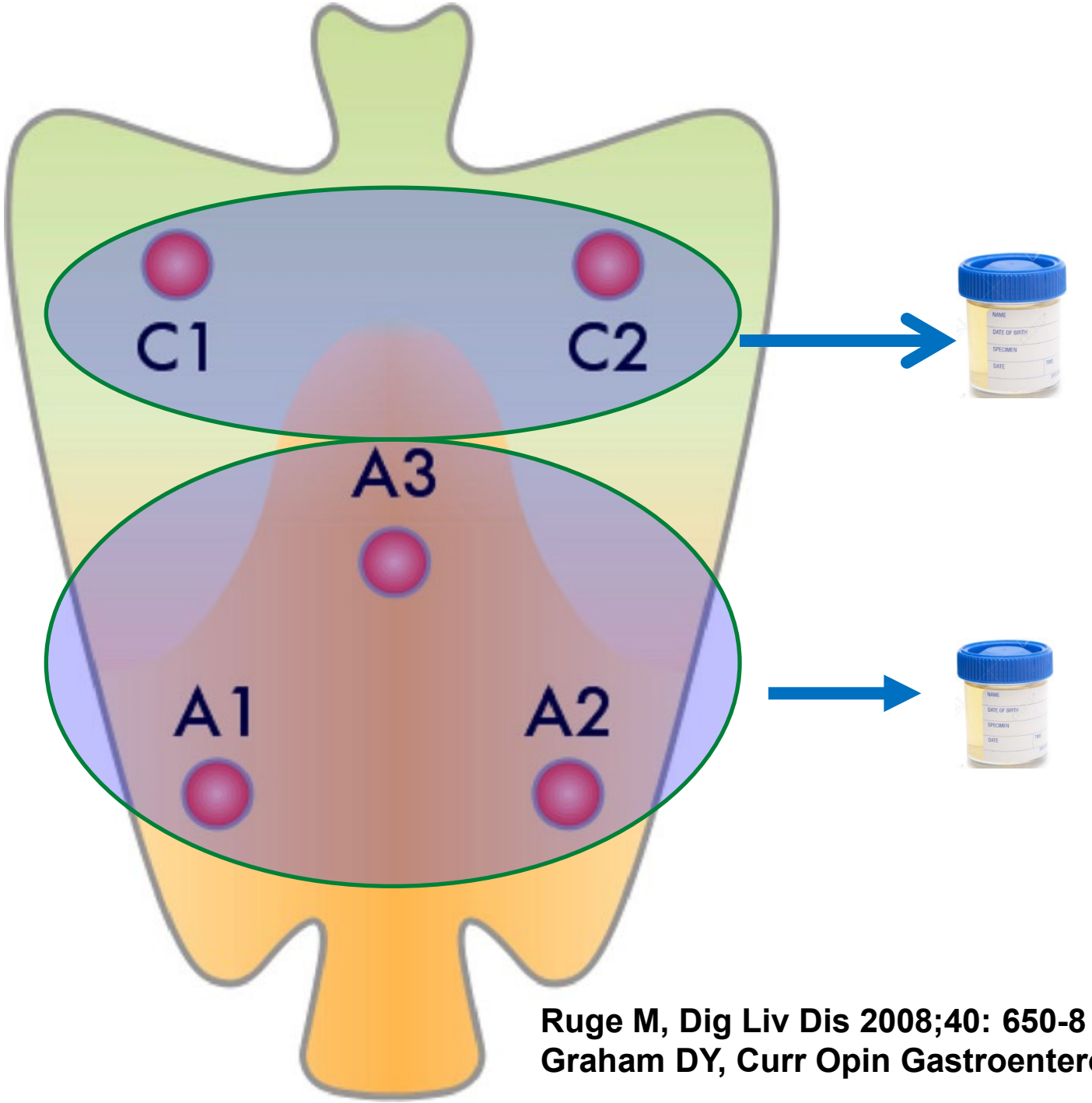
Estàndar bàsico en Estómago

Helicobacter pylori
Estratificaciòn riesgo de càncer gàstrico
Severidad de atrofia (OLGA)
Metaplasia intestinal(OLGIM)

!!!!!!!

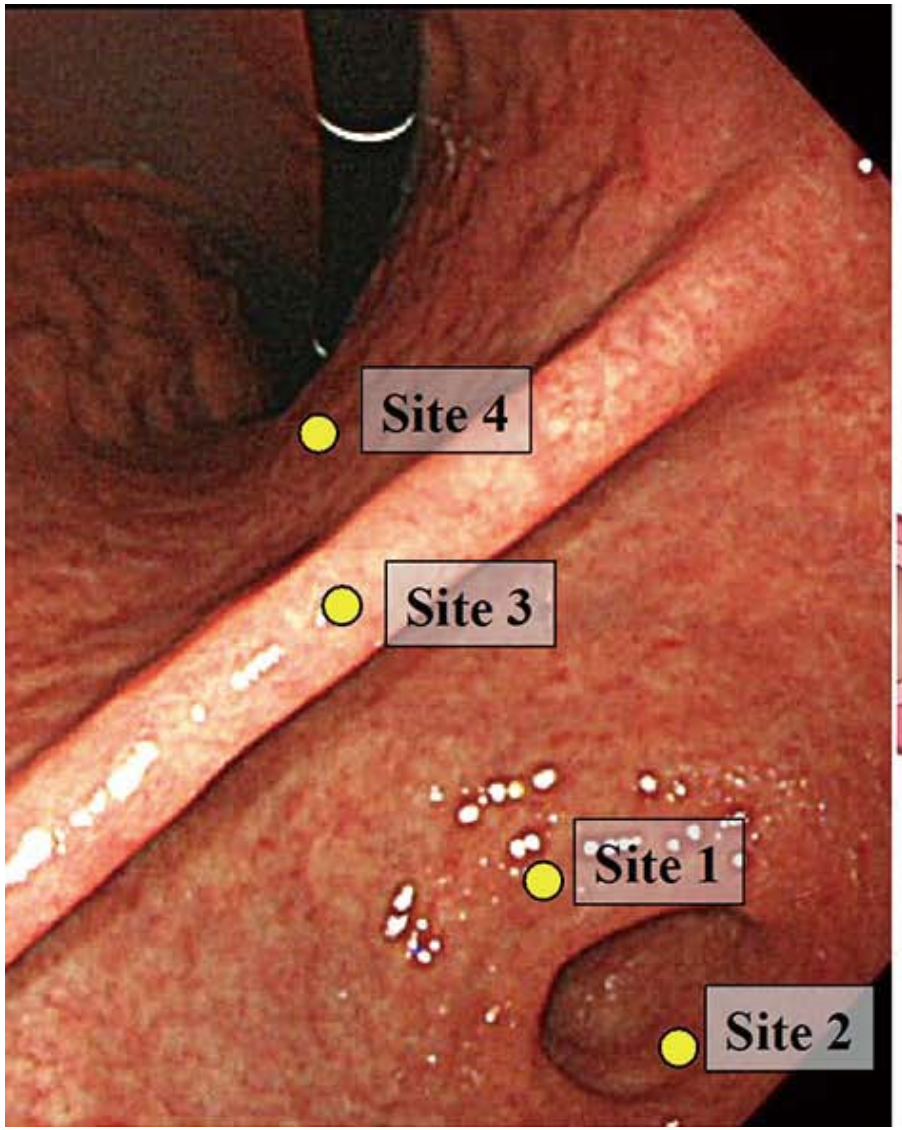
Mkioto 2015
Maastricht 2017

Biopsias Protocolo Sídney

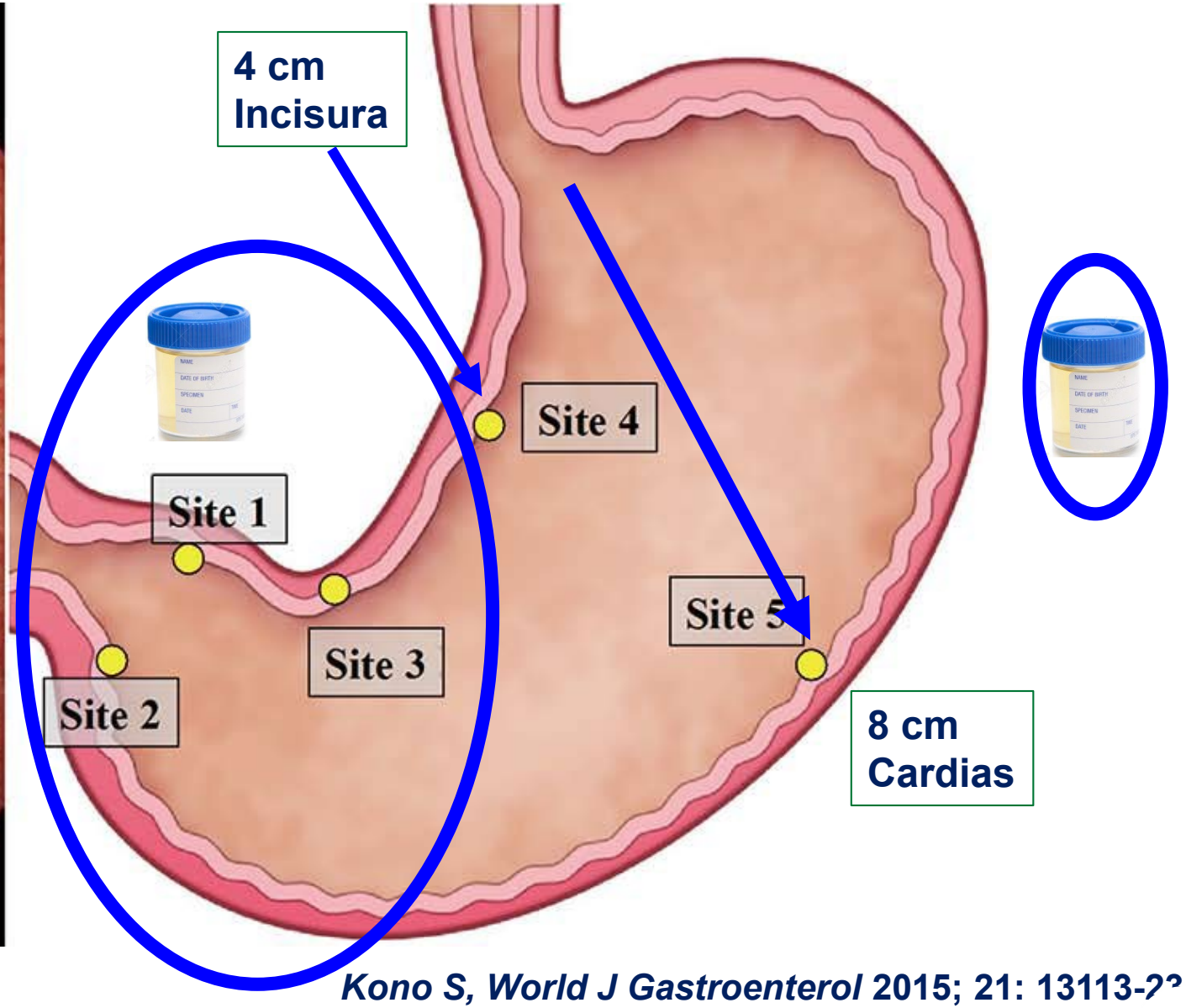


Ruge M, Dig Liv Dis 2008;40: 650-8
Graham DY, Curr Opin Gastroenterol 2019;35:535–43

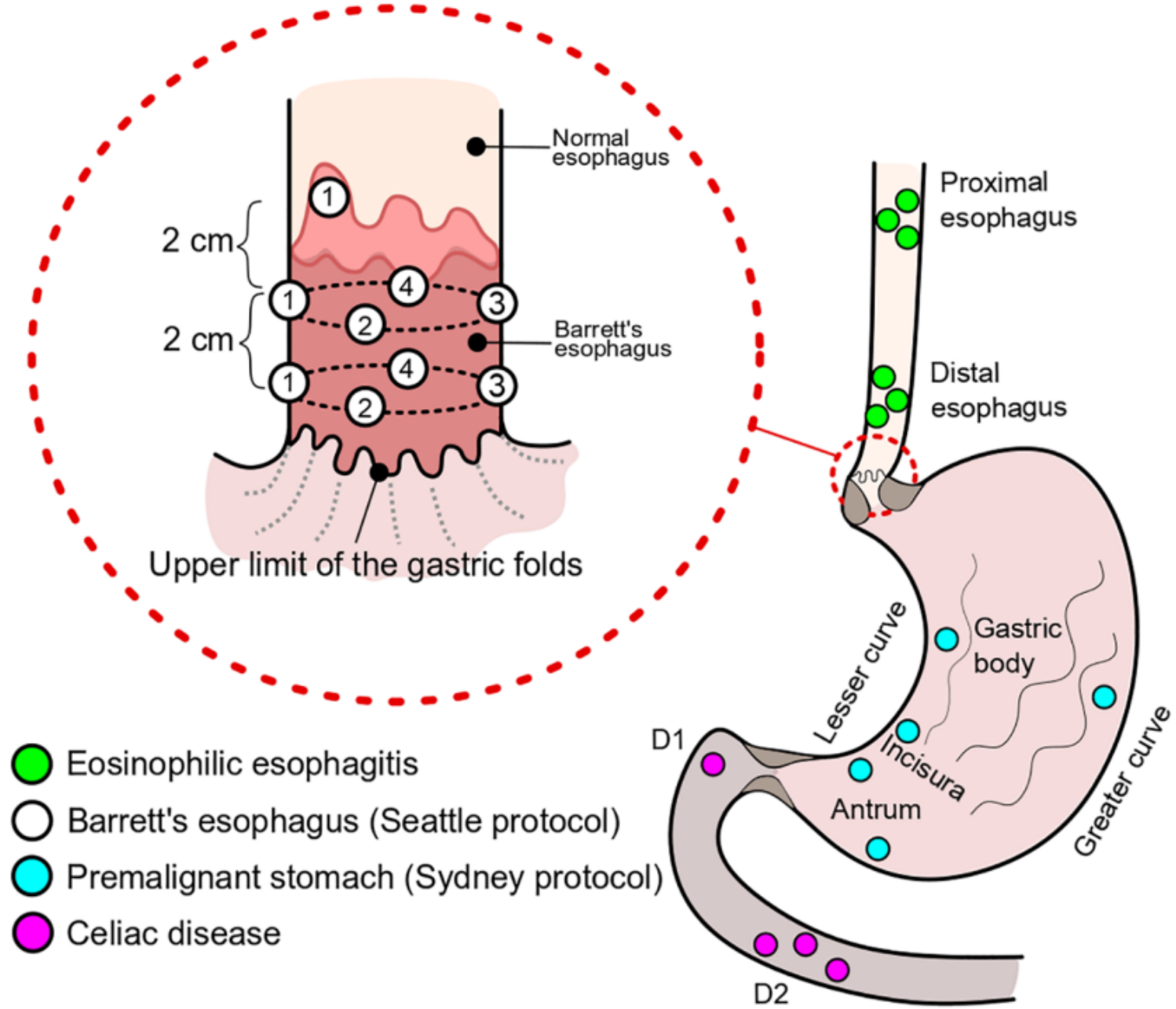
Biopsias sistema Sídney



Biopsias No dirigidas



Kono S, World J Gastroenterol 2015; 21: 13113-2?



Januszewicz M, et al. Ther Adv Gastroenterol 2020;13:1-19

EVDA

Pos procedimiento

Informe escrito completo
Con recomendaciones

Para el paciente
Para el patólogo

Todas las guías

Solicitud de patología

Debe incluir el informe Del procedimiento con todos los detalles

Especìmenes para patología Intactos, no fragmentados

El clínico y el patólogo son amigos indisociables
Trabajan con la mejor evidencia publicada

Estar atentos a las quejas pos procedimiento Complicaciones

Sharma P, Gastrointest Endosc 2021;94:989-94

Top 10 tips for performing a high-quality upper endoscopy (with videos)

Prateek Sharma, MD, FASGE

TABLE 1. Top 10 tips for performing a high-quality upper endoscopy

1. Collect the patient's medical history, obtain informed consent, confirm the indication for the procedure, and review the risks, benefits, and alternatives to the procedure.
2. Stand comfortably, follow appropriate intubation technique, use torque effectively, go slow, and reduce the gastric loop in the descending duodenum.
3. Clean the surface mucosa.
4. Take your time and inspect carefully.
5. Follow guidelines for biopsy sample removal.
6. Perform retroflexion and carefully inspect the cardia and fundus.
7. Obtain high-quality images of key landmarks and abnormal findings.
8. Use standardized classification systems for abnormal findings.
9. Do not ignore the signs and symptoms of possible adverse events.
10. Set an appropriate endoscopy surveillance schedule and do not overuse endoscopy.

Sharma P, Gastrointest Endosc 2021;94:989-94

Endoscopias de control

Vigilancia

No abusar de los controles

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Sharma P, Gastrointest Endosc 2021;94:989-94

Digestive findings that do not require endoscopic surveillance – Reducing the burden of care: European Society of Gastrointestinal Endoscopy (ESGE) Position Statement

Enrique Rodríguez-de-Santiago[*1], Leonardo Frazzoni[*2], Lorenzo Fuccio[2], Jeanin E van Hooft[3], Thierry Ponchon[4], Cesare Hassan[5], Mário Dinis-Ribeiro[6,7]

Rodríguez-de-Santiago E, Endoscopy 2020, Mayo 20

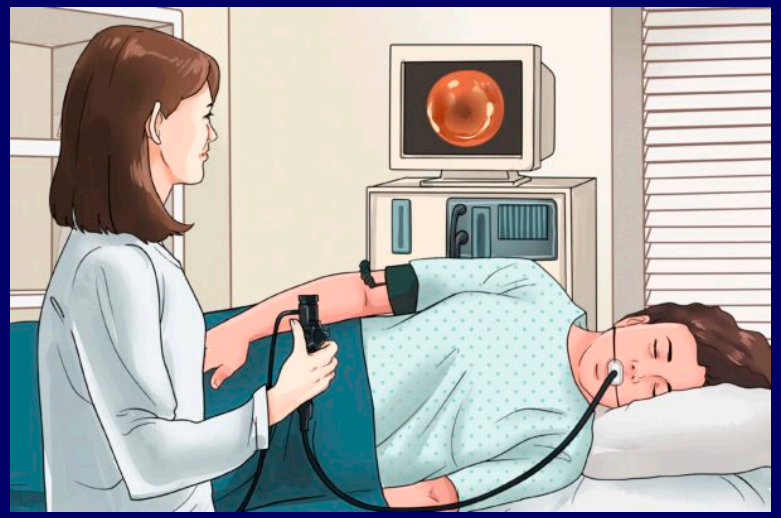
TABLE 2. European Society for Gastrointestinal Endoscopy recommendations against endoscopic surveillance

Endoscopic surveillance should not be used in patients with the following:

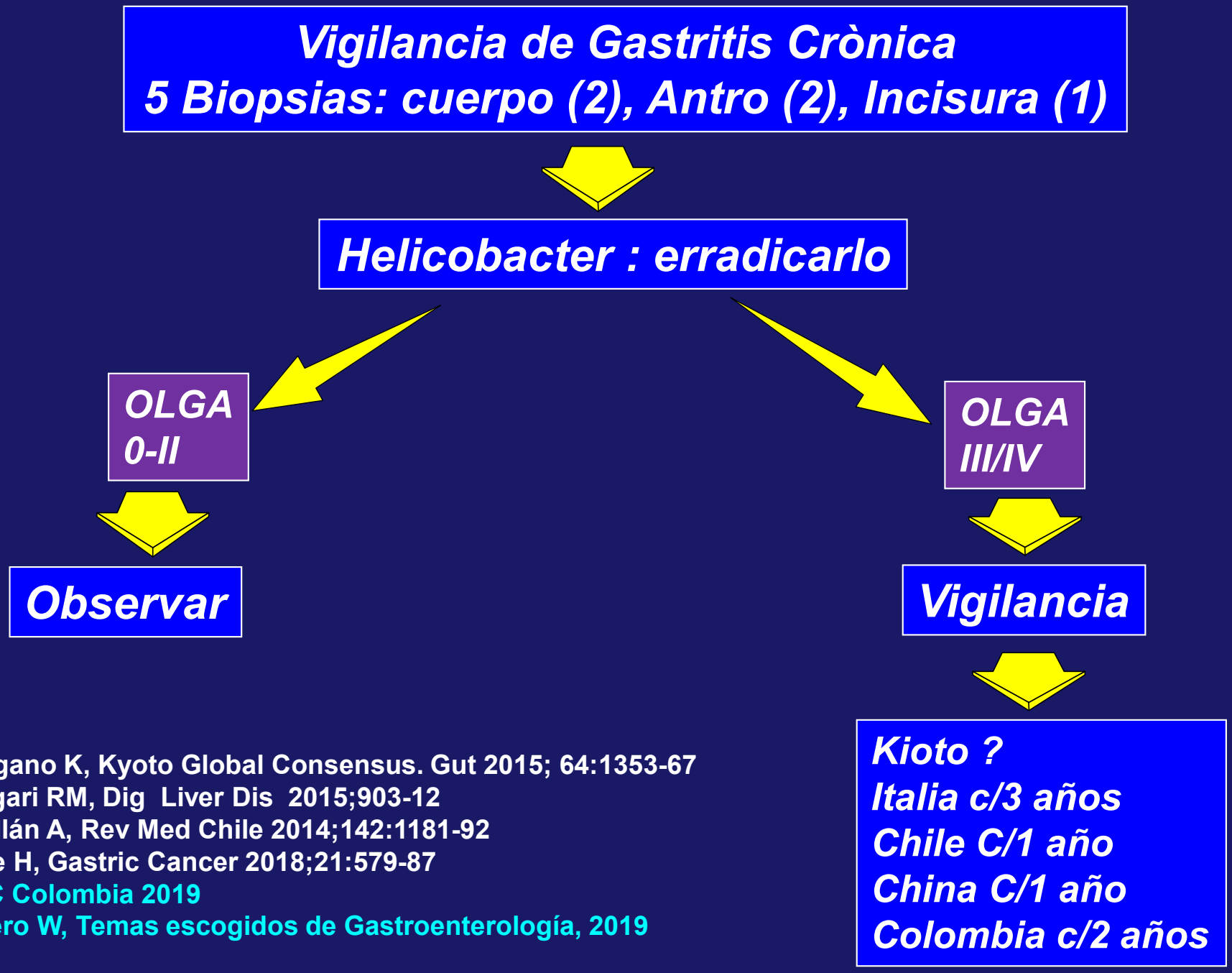
- An inlet esophageal patch
- Los Angeles grade A or B erosive esophagitis or <1-cm columnar-lined esophagus
- Intestinal metaplasia limited to the antrum, with exceptions
- Fundic gland polyps in the absence of suspicious endoscopic features or hereditary syndromes
- GI leiomyomas, lipomas, and antral pancreatic rests, provided that these lesions have typical ultrasonographic features
- Duodenal peptic ulcer, unless symptoms persist despite adequate therapy
- GI conditions when the individual is over 80 years old, has less than 10 years of life expectancy, and is in poor general health

Diagnostico de patologìa

“Gastritis crónica con metaplasia Intestinal”



Endoscopia cada año



Sugano K, Kyoto Global Consensus. Gut 2015; 64:1353-67
Zagari RM, Dig Liver Dis 2015;903-12
Rollán A, Rev Med Chile 2014;142:1181-92
Yue H, Gastric Cancer 2018;21:579-87
INC Colombia 2019
Otero W, Temas escogidos de Gastroenterología, 2019

Esófago de Barrett sin displasia
Cada 3-5 años

Sharma P, GIE 2021;94:989-94

Medidas de calidad propuestas

Variable	Medida	Razón Fundamental
Tiempo examen E de Barrett	1 minuto por cada 1cm de longitud	Más tiempo de inspección, mejor análisis, mas detección neoplasia
Tasa detección Neoplasia en Barrett (NDR)	% detección displasia en endoscopia inicial para tamización Barrett	NDR reflejaría adecuada inspección del Barrett
Adecuado número de biopsias para cáncer gástrico	%EVDA para metaplasia intestinal con ≥ 5 biopsias	Tasa de biopsias adecuadas que se toman
Tiempo de inspección	% de EVDA para metaplasia intestinal > 7 minutos (Igualmente Cáncer temprano)	A mayor tiempo inspección, mejor mayor tasa de detección de neoplasia
Tasa de investigación y erradicación *H.pylori*	% de EVDA que documenta investigación H.pylori cuando hay ulceras pépticas	A todos los pacientes con úlceras pépticas se les debe investigar *H.pylori*
Número biopsias sospecha Enfermedad celíaca	≥4 Biopsias duodenales deben tomarse	Al menos cuatro biopsias se necesitan diagnosticar enfermedad celíaca
Esofagitis eosinofílica biopsias proximales y distales	% EVDA por sospecha de EE en que tomaron biopsias proximales y distales	2-4 biopsias proximales y distales aumentan diagnóstico EE

Sharma P, Barasa , Shaheen N, Gastroenterology 2020;158:9-13. ;

Mensajes para la casa

1999

TO ERR IS HUMAN

Building a Safer Health System

“Si no lo puedes medir, no lo puedes mejorar”

Linda T. Kohn, Janet M. Corrigan, and
Molla S. Donaldson, *Editors*

Committee on Quality of Health Care in America

INSTITUTE OF MEDICINE

NATIONAL ACADEMY PRESS
Washington, D.C.

Es urgente implementar La calidad endoscopia ALTA Seguir las guías sobre el Tema!

Muchas gracias!