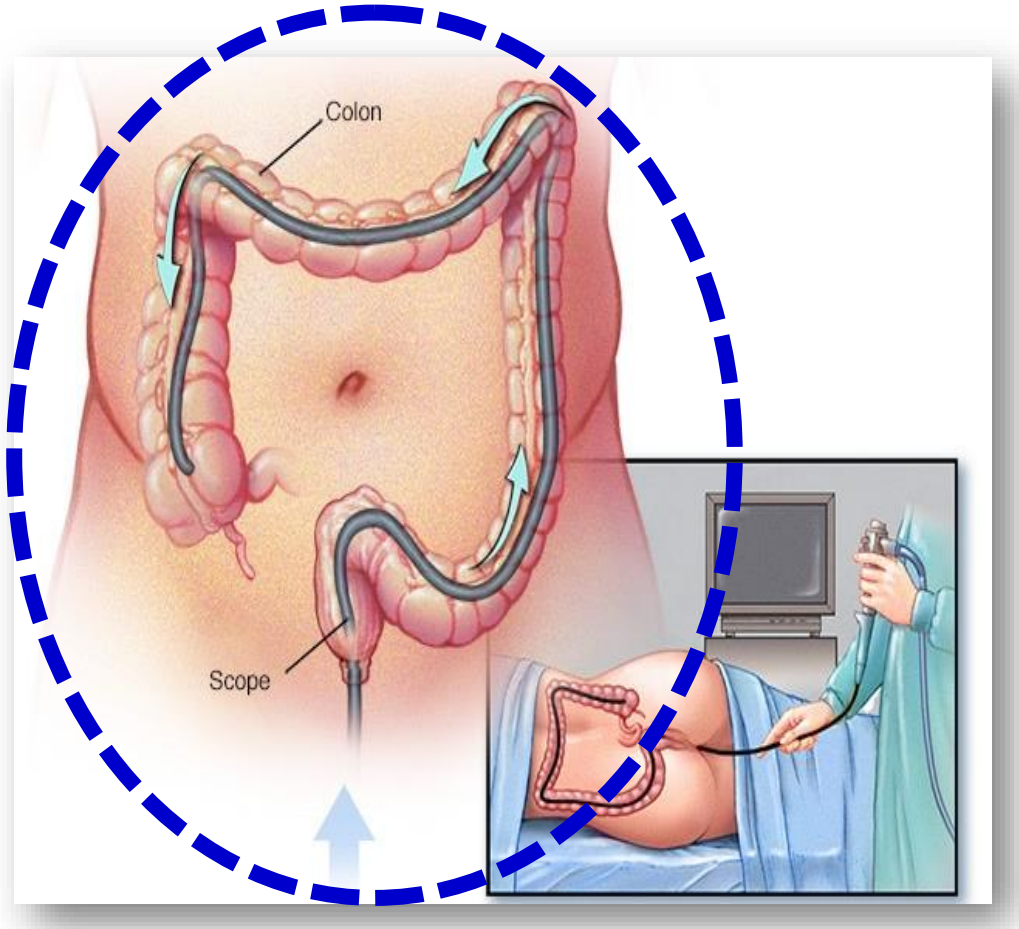
Queridos hermanos de Venezuela

A Colombia, este su otro país

Indiciadores de calidad en colonoscopia en 2023

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



El colonoscopio arma poderosa
Cuando es bien manejada

Càncer colorrectal

USA 2do càncer màs frecuente
3ª causa dse muerte por càncer
45 años tamizaciòn
Colonoscopia estàndar se oro
Detecta y previene CCR polipectomia

Siegel RL, CA Cancer J Clin 2022;72:7-33
Almario CV, Teccn Innov Gastrointest Endosc 2022;269-83

Càncer colorrectal

Beneficios de la colonoscopia
Incidencia 31-91%
Mortalidad 65-88%
Estudios analìticos

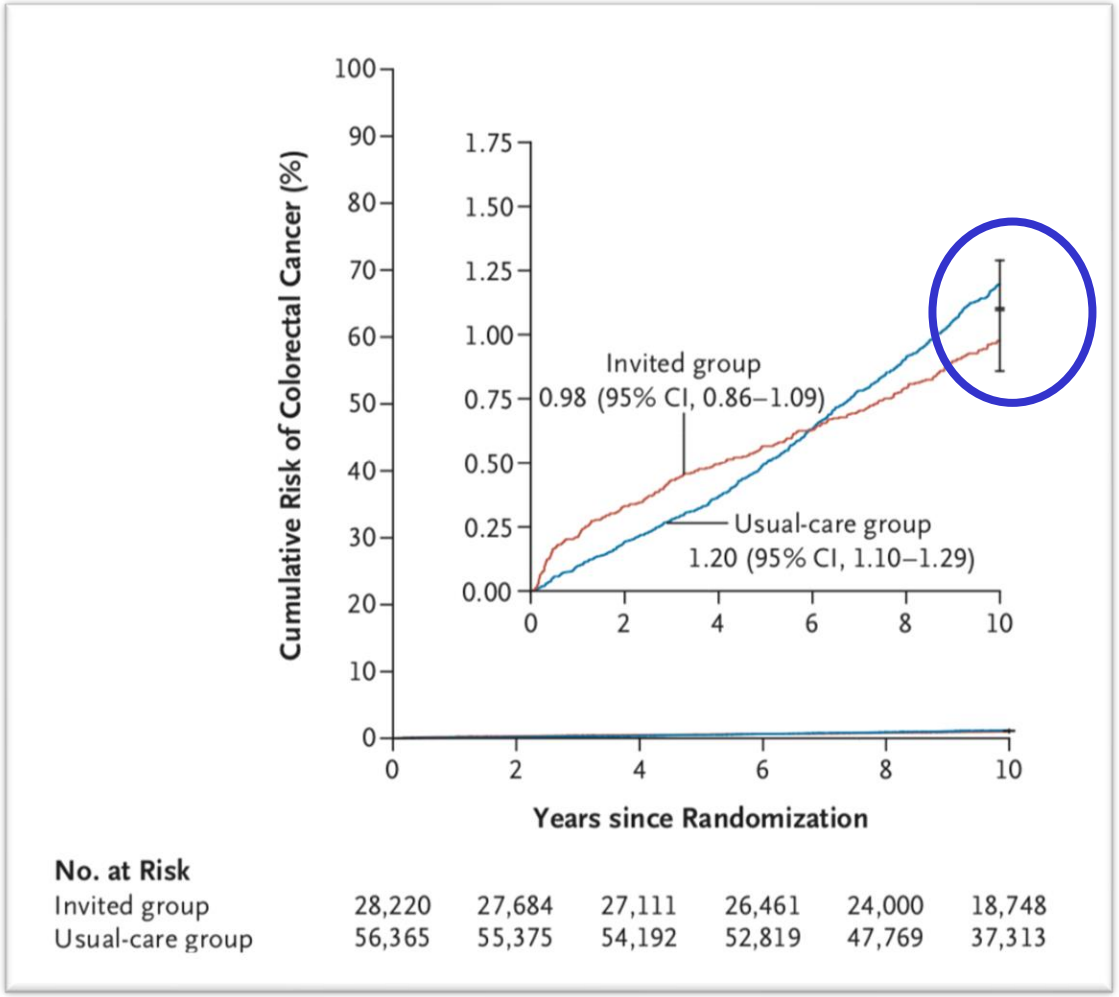
Shaukat A, Am J Gastroenterol 2021;116:458-79

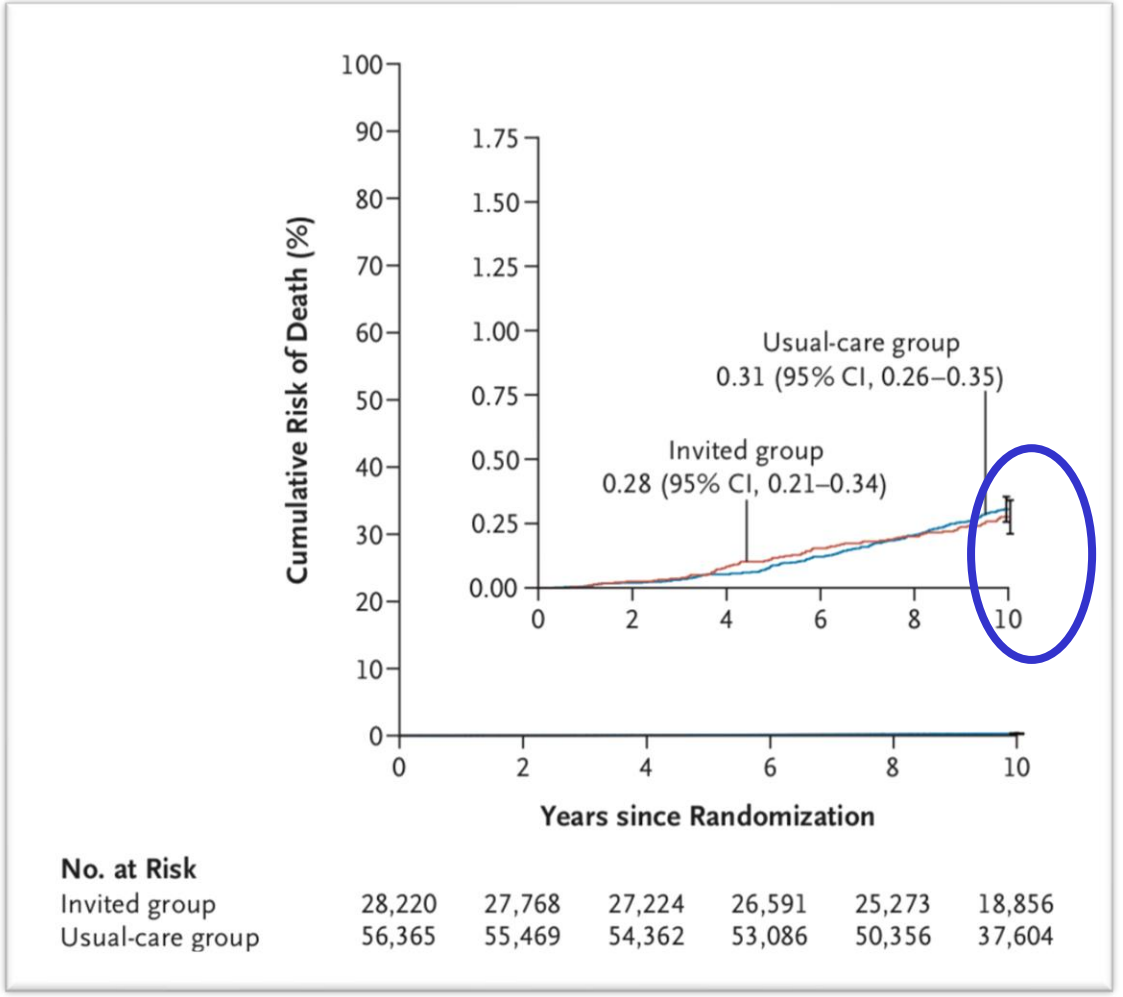
The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 OCTOBER 27, 2022 VOL. 387 NO. 17

Effect of Colonoscopy Screening on Risks of Colorectal Cancer and Related Death

M. Bretthauer, M. Løberg, P. Wieszczy, M. Kalager, L. Emilsson, K. Garborg, M. Rupinski, E. Dekker, M. Spaander, M. Bugajski, Ø. Holme, A.G. Zauber, N.D. Pilonis, A. Mroz, E.J. Kuipers, J. Shi, M.A. Hernán, H.-O. Adami, J. Regula, G. Hoff, and M.F. Kaminski, for the NordICC Study Group*





CANCER SCREENING

NEW STUDY QUESTIONS EFFECTIVENESS OF COLONOSCOPIES IN PREVENTING DEATH

8:14
58°

The NEW ENGLAND JOURNAL of MEDICINE

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Effect of Colonoscopy Screening on Risks of Colorectal Cancer and Related Death

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Tamizaciòn 42% invitados

29% Endoscopistas
ADR <25%

Tasa Intubaciòn del ciego
< Exigido

State of the Science on Quality Indicators for Colonoscopy and How to Achieve Them

Folasade P. May, MD, PhD[1,2] and Aasma Shaukat, MD, MPH[3,4]

Am J Gastroenterol 2020;115:1183–1190

REVIEW ARTICLE

Key quality indicators in colonoscopy

Douglas K. Rex*

Gastroenterol Rep 2023; 11: goad009

Gastroenterology 2021;161:701–711

CLINICAL PRACTICE UPDATE: EXPERT REVIEW

AGA Clinical Practice Update on Strategies to Improve Quality of Screening and Surveillance Colonoscopy: Expert Review

Rajesh N. Keswani,[1] Seth D. Crockett,[2] and Audrey H. Calderwood[3]

ESGE UNITED EUROPEAN GASTROENTEROLOGY ueg journal

Review Article

Performance measures for lower gastrointestinal endoscopy: a European Society of Gastrointestinal Endoscopy (ESGE) quality improvement initiative

Michal F Kaminski[1,2,3,4], Siwan Thomas-Gibson[5], Marek Bugajski[1,2], Michael Bretthauer[3,4], Colin J Rees[6], Evelien Dekker[7], Geir Hoff[3,8,9], Rodrigo Jover[10], Stepan Suchanek[11], Monika Ferlitsch[12], John Anderson[13], Thomas Roesch[14], Rolf Hultcranz[15], Istvan Racz[16], Ernst J Kuipers[17], Kjetil Garborg[3], James E East[18], Maciej Rupinski[1,2], Birgitte Seip[19], Cathy Bennett[20], Carlo Senore[21], Silvia Minozzi[21], Raf Bisschops[22], Dirk Domagk[23], Roland Valori[24], Cristiano Spada[25], Cesare Hassan[26], Mario Dinis-Ribeiro[27,28] and Matthew D Rutter[29,30]

United European Gastroenterology Journal 2017, Vol. 5(3) 309–334
This article is published simultaneously in the journals Endoscopy and the United European Gastroenterology Journal.

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DOI: 10.1177/2050640617700014
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SAGE

U Eur Gastroenterol J 2017;5:309-34

Standards of diagnostic colonoscopy for early-stage neoplasia: Recommendations by an Asian private group

Yasushi Sano,[1] Han-Mo Chiu,[9] Xiao-bo Li,[10] Supakij Khomvilai,[13] Pises Pisespongsa,[14] Jonard Tan Co,[15] Takuji Kawamura,[2] Nozomu Kobayashi,[4] Shinji Tanaka,[5] David G. Hewett,[16] Yoji Takeuchi,[6] Kenichiro Imai,[7] Takahiro Utsumi,[3] Akira Teramoto,[1] Daizen Hirata,[1] Mineo Iwatate,[1] Rajvinder Singh,[17] Siew C. Ng,[11] Shiaw-Hooi Ho,[18] Philip Chiu[12] and Hisao Tajiri[8]

Digestive Endoscopy 2019; 31: 227-44

Measuring and Improving Quality of Colonoscopy for Colorectal Cancer Screening

Christopher V. Almario,[1,2,3,4,5,6] Jaspreet Shergill,[1] and Janice Oh[1]

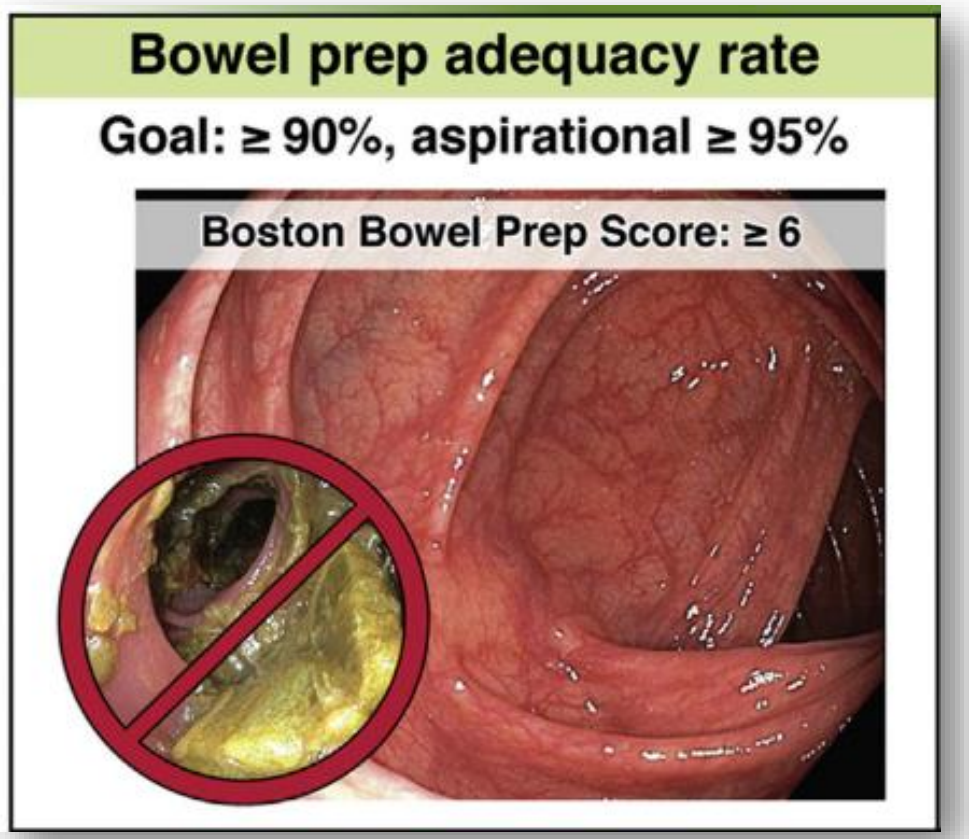
Tech Inn Gastrointest Endosc 2022; 269283

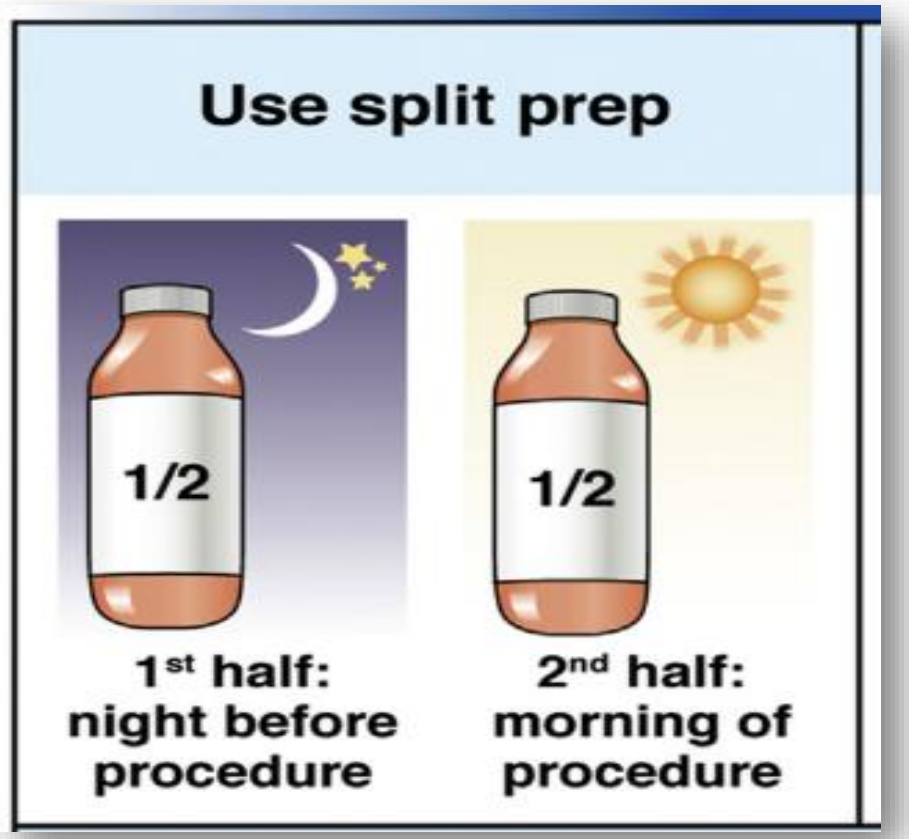
CLINICAL PRACTICE UPDATE: EXPERT REVIEW

AGA Clinical Practice Update on Strategies to Improve Quality of Screening and Surveillance Colonoscopy: Expert Review

Rajesh N. Keswani,[1] Seth D. Crockett,[2] and Audrey H. Calderwood[3]

Keswani RN, et al. Gastroenterology 2021;161:701–711





Keswani RN, et al. Gastroenterology 2021;161:701–711

Rees CJ, et al. Gut 2016;65:1923–1929
Kaminski MF, ueg Journal 2017;5:309-34
EDGE 2019

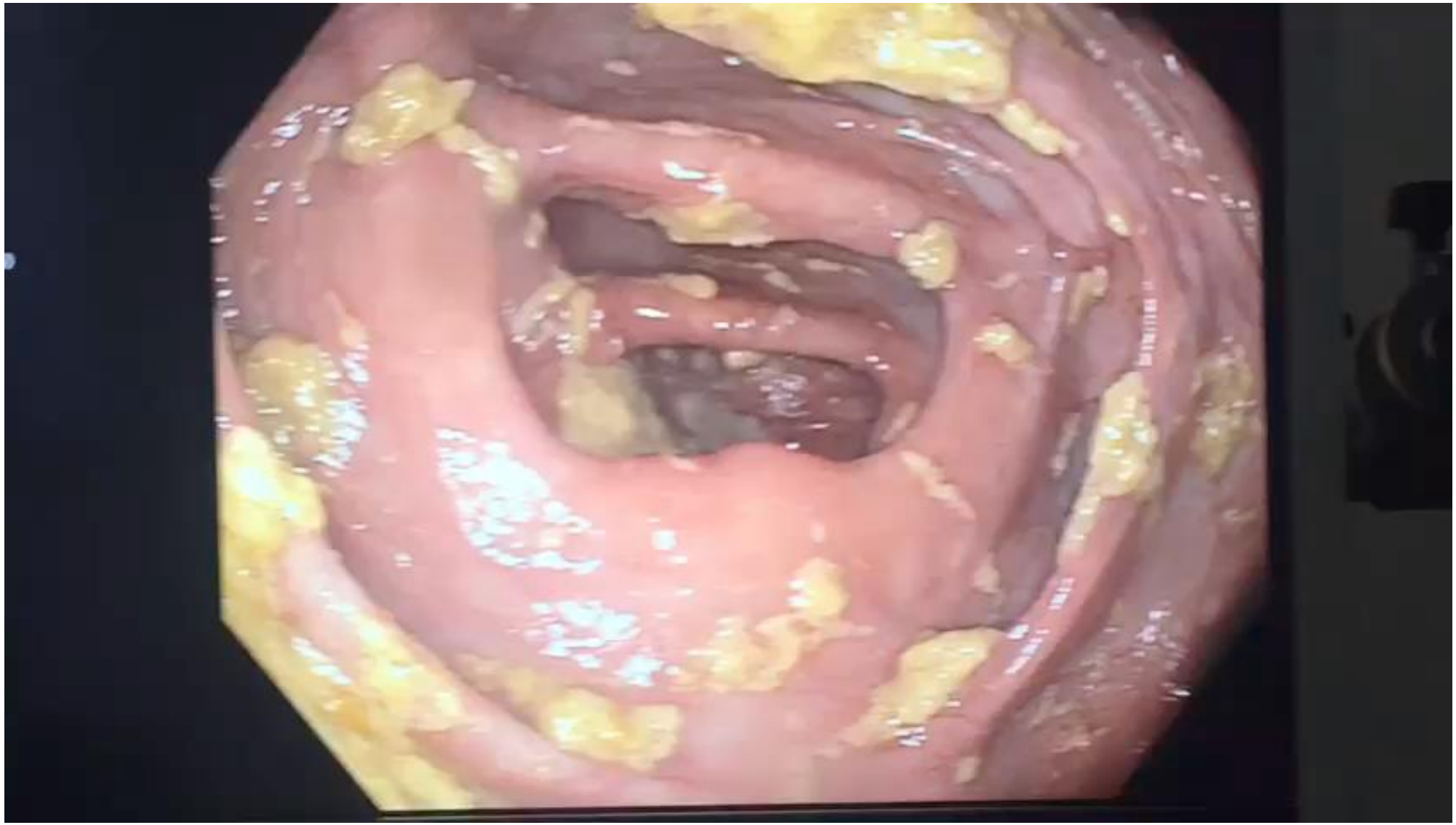
Colon mal Preparado

Impacta negativamente los principales Indicadores de calidad

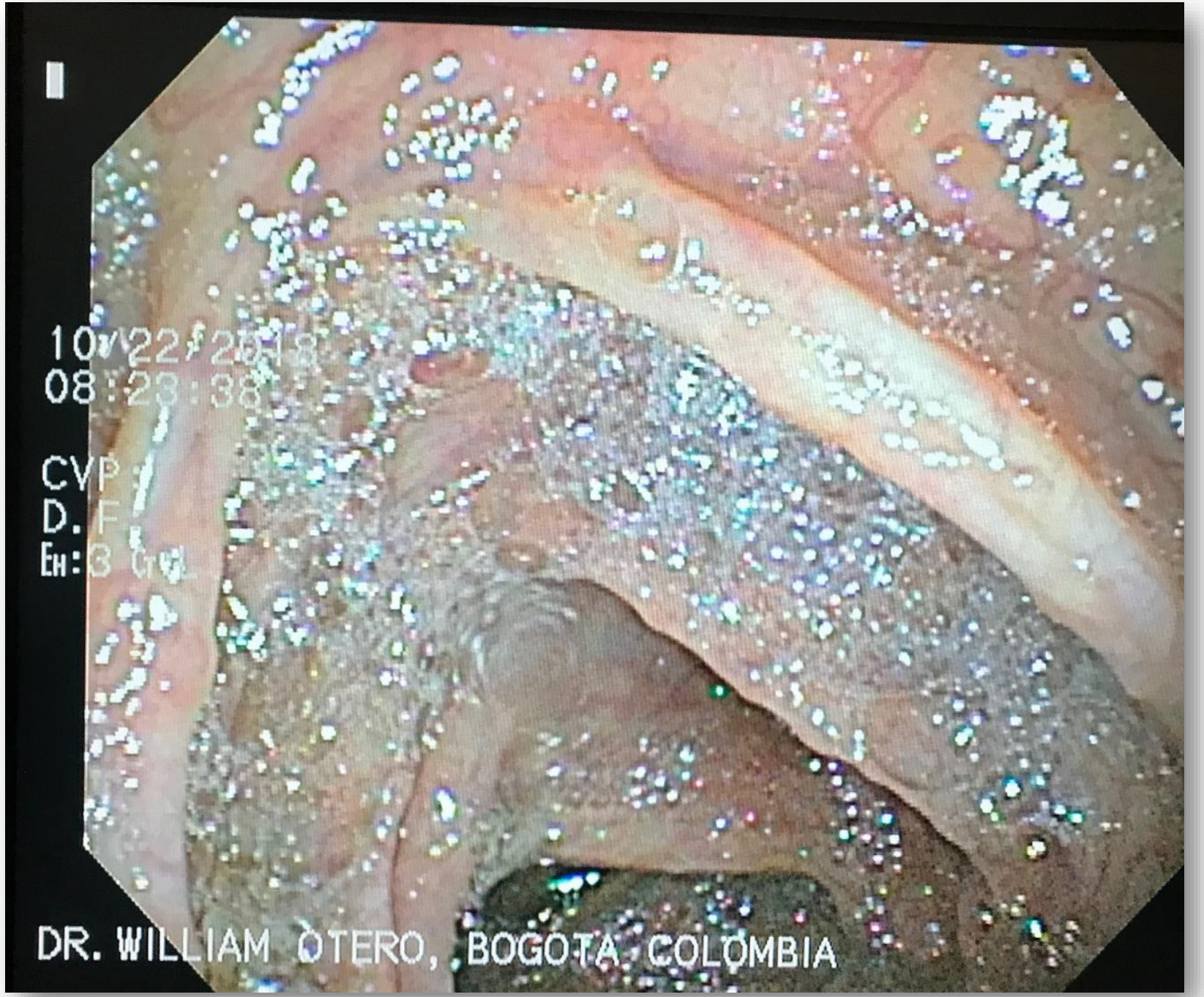
> Colonoscopias

Más costos

ASGE 2016, AGA 2021, ESGE 2019



Cortesía profesor Martín Gómez
Hospital Universitario Nacional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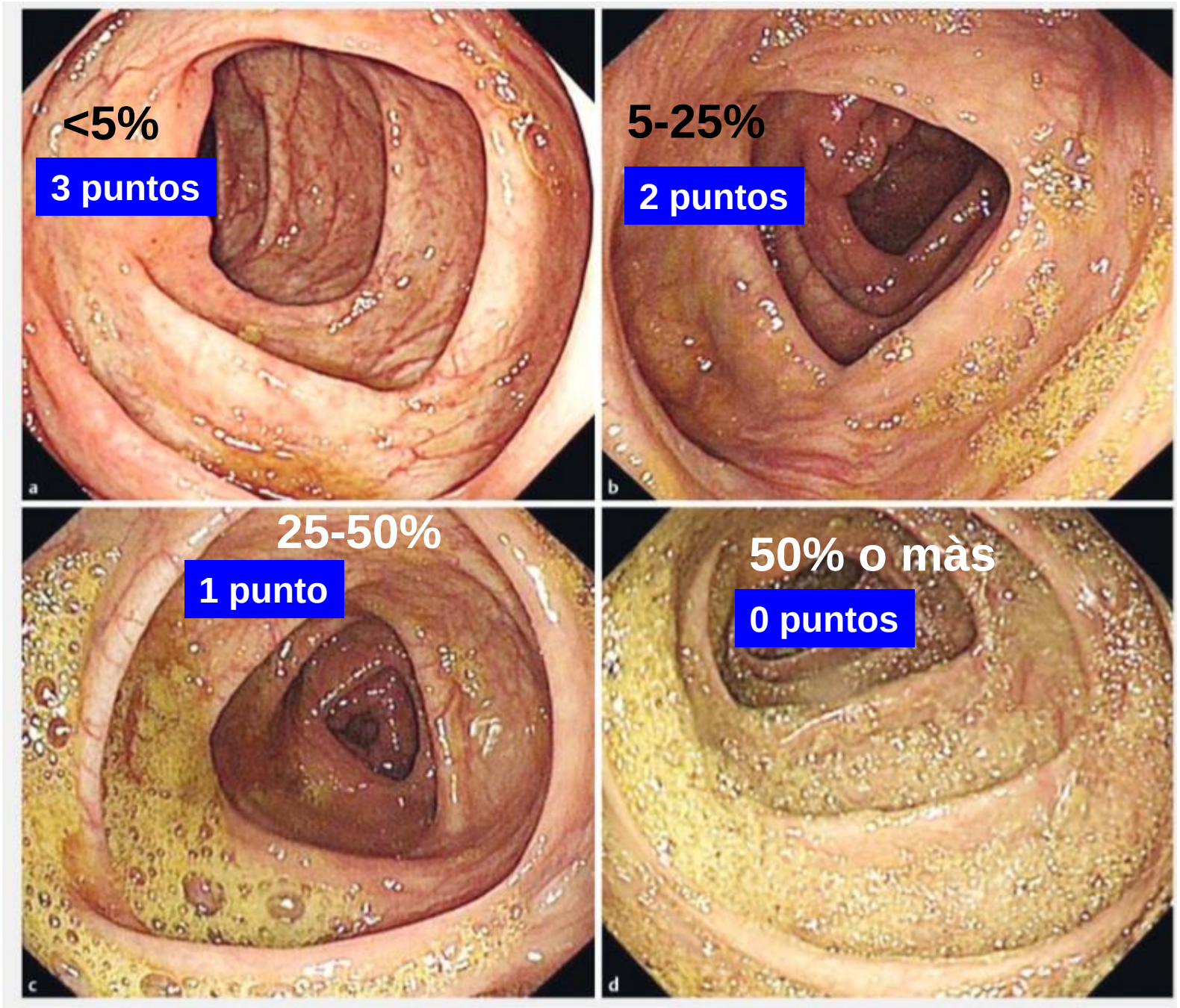
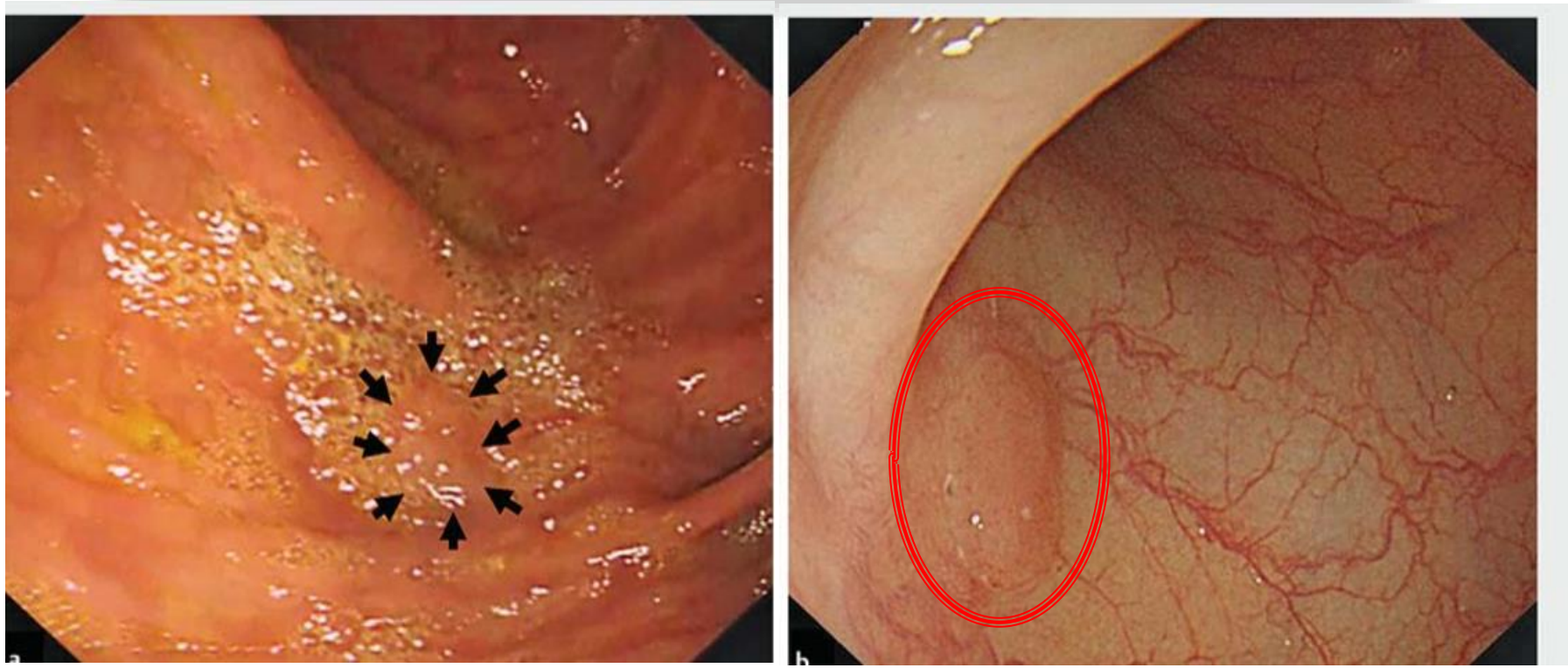
D. F
EH:3
DR. WILLIAM OTERO, BOGOTA, COLOMBIA



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

Impact of preprocedure simethicone on adenoma detection rate during colonoscopy: a multicenter, endoscopist-blinded randomized controlled trial

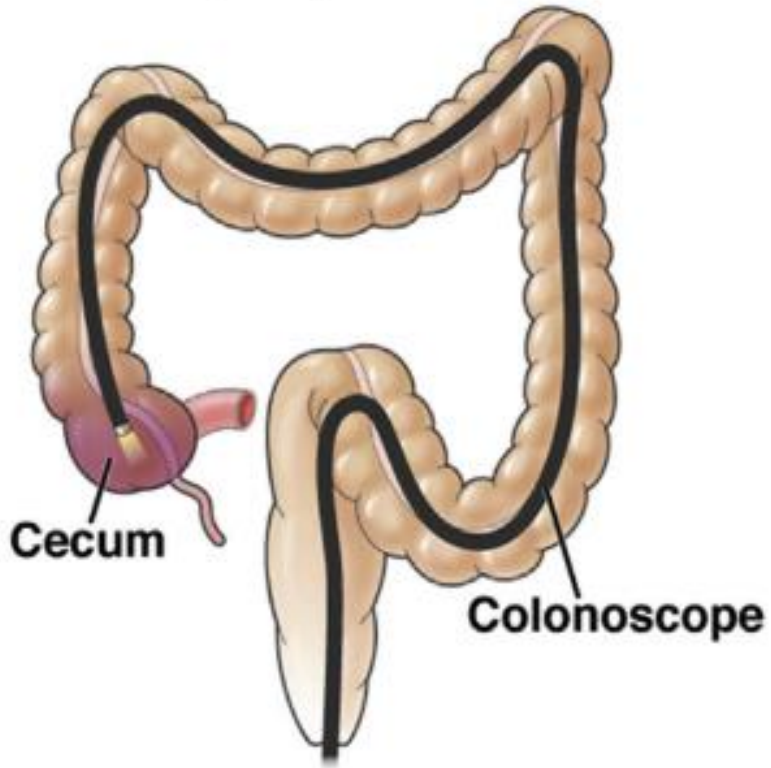
Authors
Yu Bai[1,*], Jun Fang[1,2,*], Sheng-Bing Zhao[1], Dong Wang[1], Yan-Qing Li[3], Rui-Hua Shi[4], Zi-Qin Sun[5], Ming-Jun Sun[6], Feng Ji[7], Jian-Min Si[8], Zhao-Shen Li[1]



Bai Y, Endoscopy 2018;50:128-136

Cecal intubation rate

Goal: ≥ 90%, aspirational ≥ 95%



Withdrawal time

Goal: ≥ 6 min, aspirational ≥ 9 min

Keswani RN, et al. Gastroenterology 2021;161:701–711

9-Minute Withdrawal Time Improves Adenoma Detection Rate Compared With 6-Minute Withdrawal Time During Colonoscopy

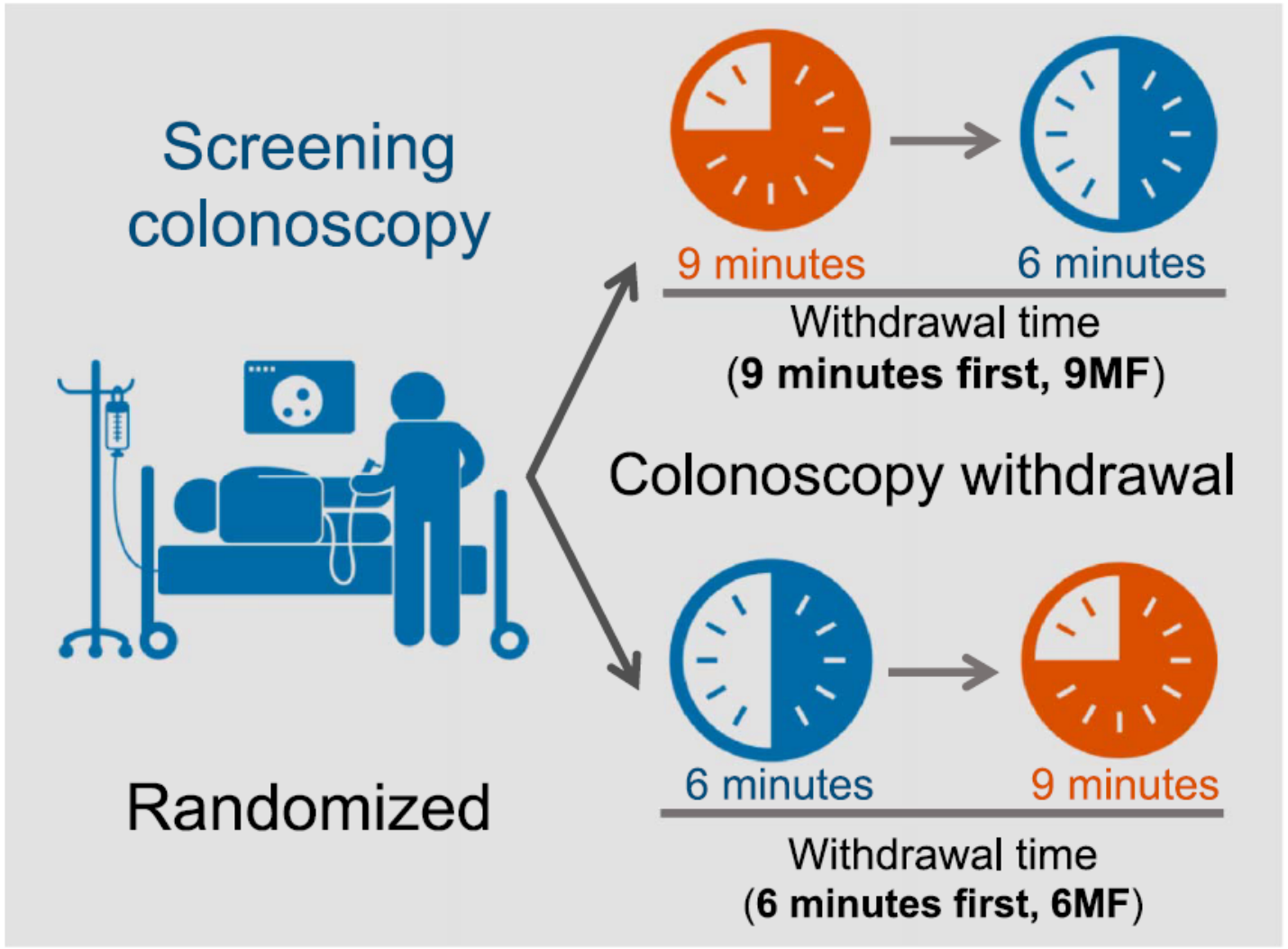
A Meta-analysis of Randomized Controlled Trials

Muhammad Aziz, MD, Hossein Haghbin, MD,† Manesh Kumar Gangwani, MD,‡ Mohamad Nawras, BSc,‡ Yusuf Nawras, BSc,‡ Dushyant Singh Dahiya, MD,§ Amir Humza Sohail, MD,‖ Wade Lee-Smith, MLS, BS,¶ Faisal Kamal, MD,# and Aasma Shaukat, MD, MPH***

Conclusion: The 9-minute withdrawal time improved ADR and APC compared with the 6-minute withdrawal. Given the high-quality evidence, we recommend that clinicians at least perform a 9-minute withdrawal to achieve higher quality metrics including ADR to reduce interval CRC.

J Clin Gastroenterol 2023;online mayo 30

9-minute withdrawal time reduces adenoma miss rate of screening colonoscopy



9 MF versus 6 MF

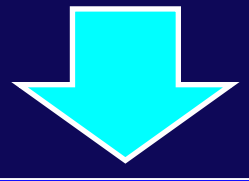
Reduced adenoma miss rate
14.5% vs. 36.6%, p<0.001

Reduced advanced adenoma miss rate
5.3% vs. 46.9%, p<0.001

Lower rate of shortening surveillance interval
7.7% vs. 16.1%, p<0.001

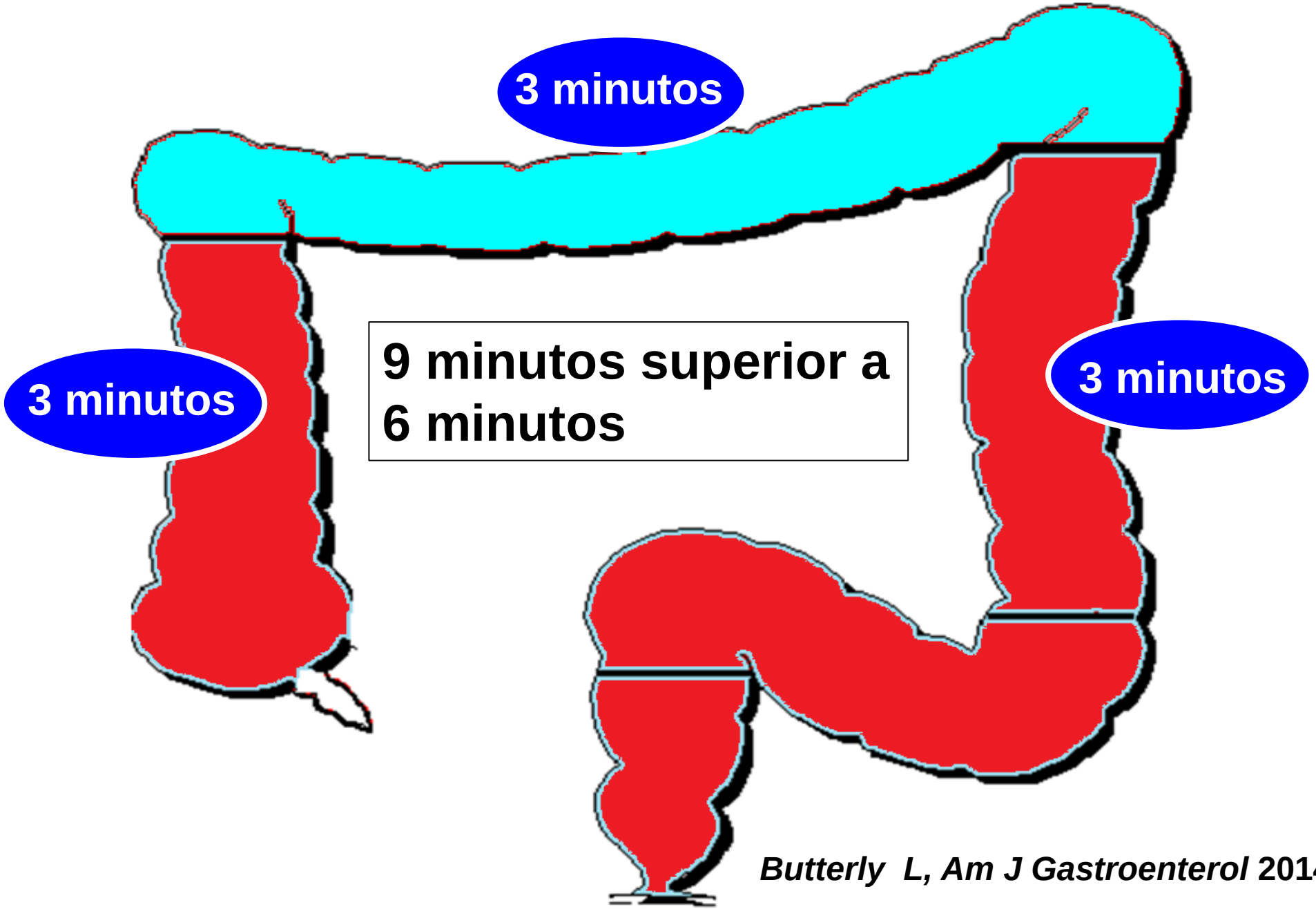
Zhao S, et al Am J Gastroenterol 2023;118:802–811

6 minutos



2023

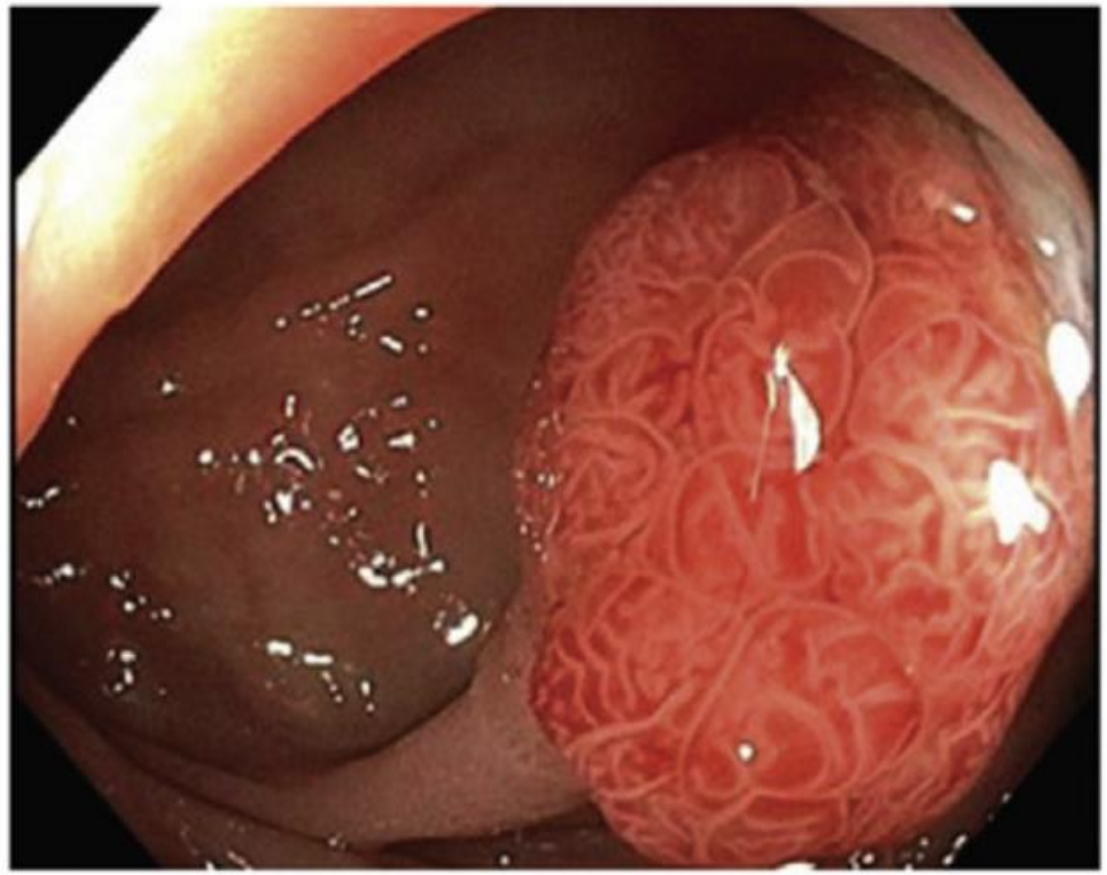
9 minutos



Butterly L, Am J Gastroenterol 2014; 109:417–24

Adenoma detection rate

Goal: ≥ 30%, aspirational ≥ 35%



Keswani RN, et al. Gastroenterology 2021;161:701–711

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**

Cada 1% ADR

< Mortalidad CCR 3%

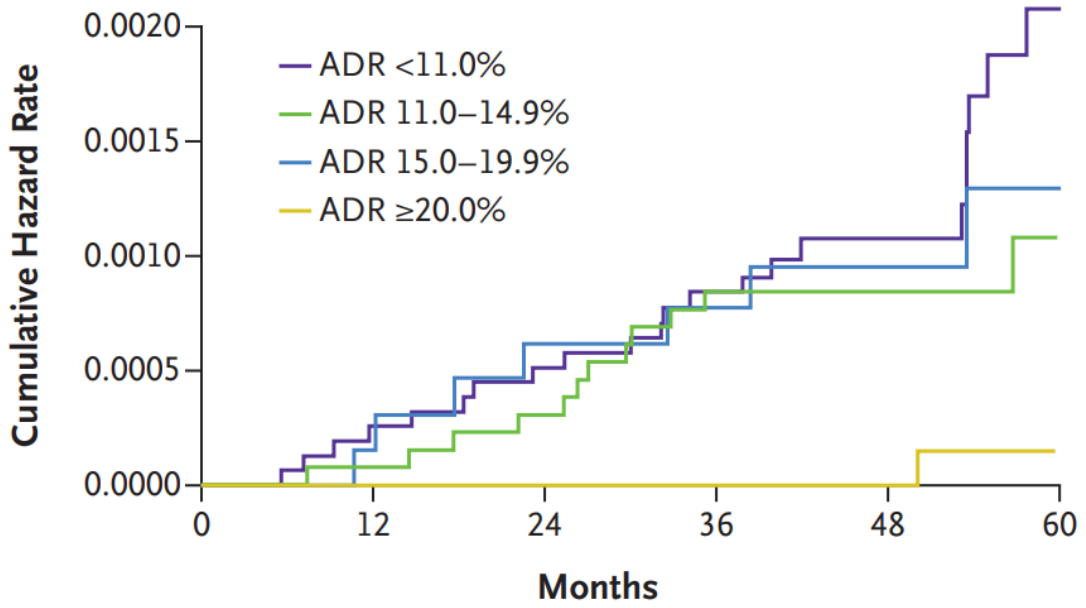
Corley DA, N Engl J Med 2014;370:1298-306

ORIGINAL ARTICLE

Quality Indicators for Colonoscopy and the Risk of Interval Cancer

Michal F. Kaminski, M.D., Jaroslaw Regula, M.D., Ewa Kraszewska, M.Sc., Marcin Polkowski, M.D., Urszula Wojciechowska, M.D., Joanna Didkowska, M.D., Maria Zwierko, M.D., Maciej Rupinski, M.D., Marek P. Nowacki, M.D., and Eugeniusz Butruk, M.D.

ADR >20% 0.011%
ADR < 20% 0.115%
10 veces !!



No. at Risk						
ADR <11.0%	15,883	15,805	15,744	15,669	9355	4717
ADR 11.0–14.9%	13,281	13,223	13,182	13,120	7571	4003
ADR 15.0–19.9%	6,607	6,582	6,562	6,539	4022	2529
ADR ≥20.0%	9,255	9,235	9,202	9,166	7155	5548

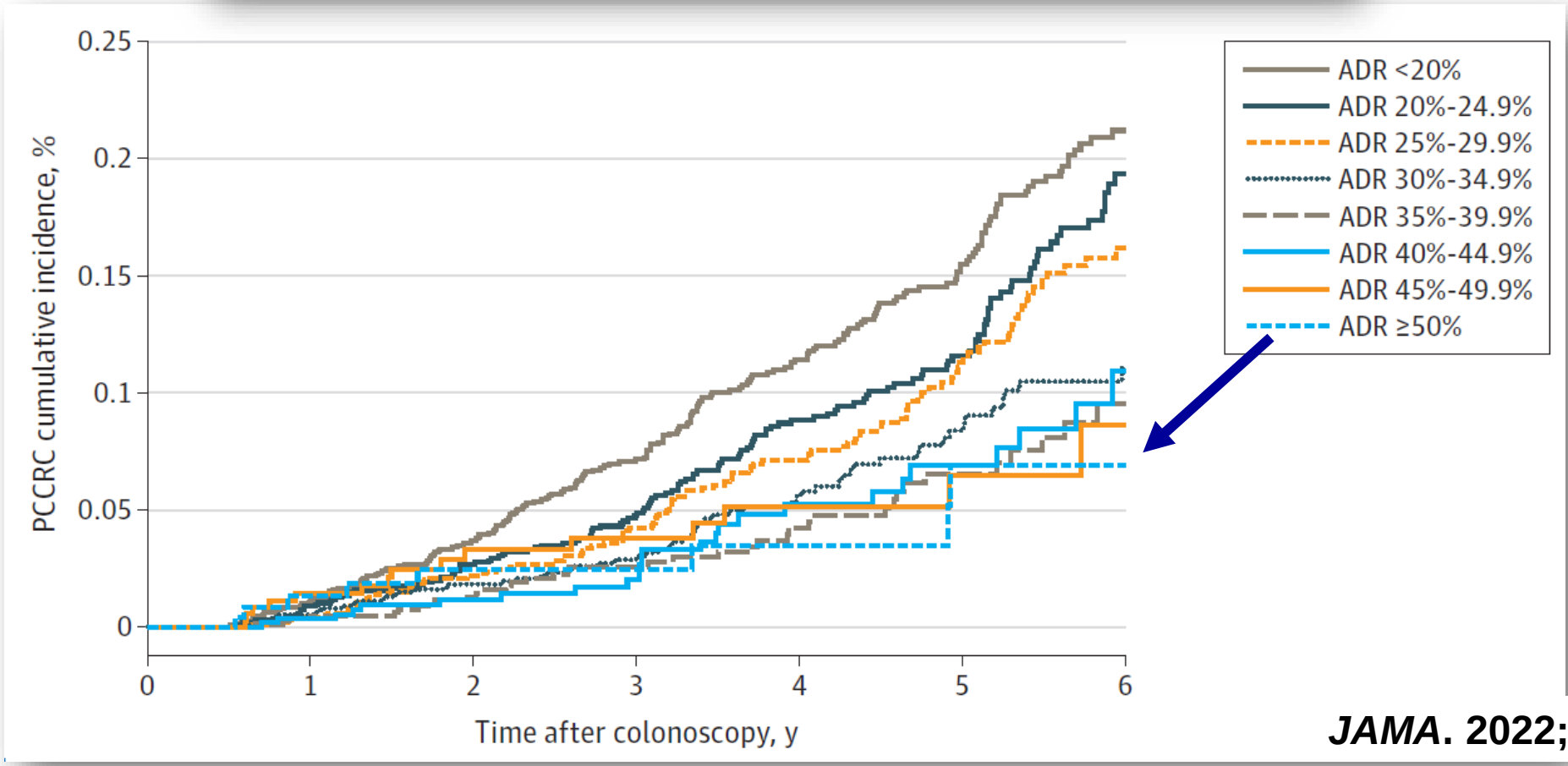
Kaminski MF, N Engl J Med 2010;362:1795-803

Càncer
Pos colonoscopia

JAMA | Original Investigation

Association of Physician Adenoma Detection Rates With Postcolonoscopy Colorectal Cancer

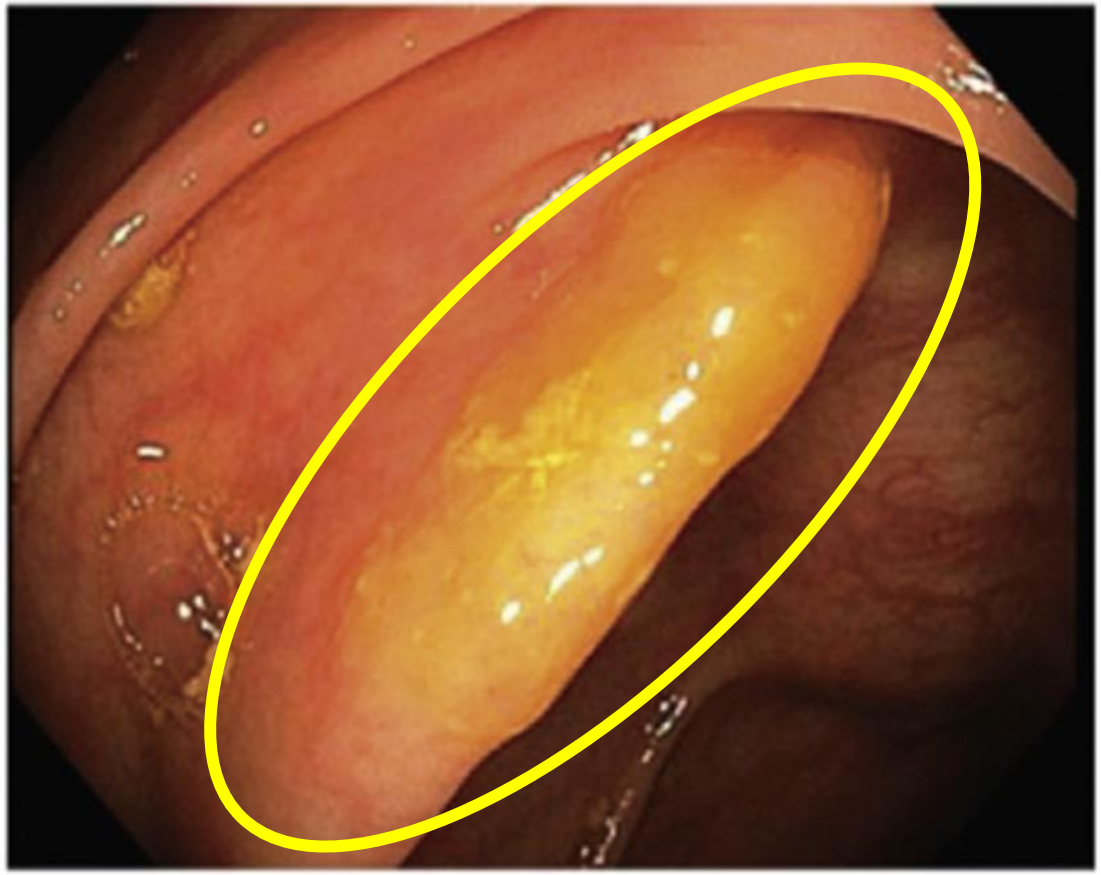
Joanne E. Schottinger, MD; Christopher D. Jensen, PhD; Nirupa R. Ghai, PhD; Jessica Chubak, PhD; Jeffrey K. Lee, MD; Aruna Kamineni, PhD; Ethan A. Halm, MD; Celette Sugg-Skinner, PhD; Natalia Udaltsova, PhD; Wei K. Zhao, MPH; Rebecca A. Ziebell, BS; Richard Contreras, MS; Eric J. Kim, MS; Bruce H. Fireman, MA; Charles P. Quesenberry, PhD; Douglas A. Corley, MD



JAMA. 2022;327:2114-2122

Serrated lesion detection rate

Goal: ≥ 7%, aspirational ≥ 10%



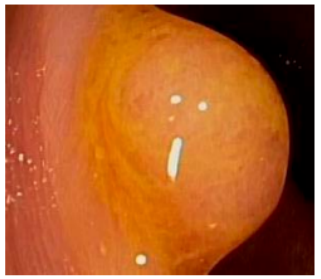
Keswani RN, et al. Gastroenterology 2021;161:701–711

Higher Serrated Polyp Detection Rates Are Associated With Lower Risk of Postcolonoscopy Colorectal Cancer: Data From the New Hampshire Colonoscopy Registry

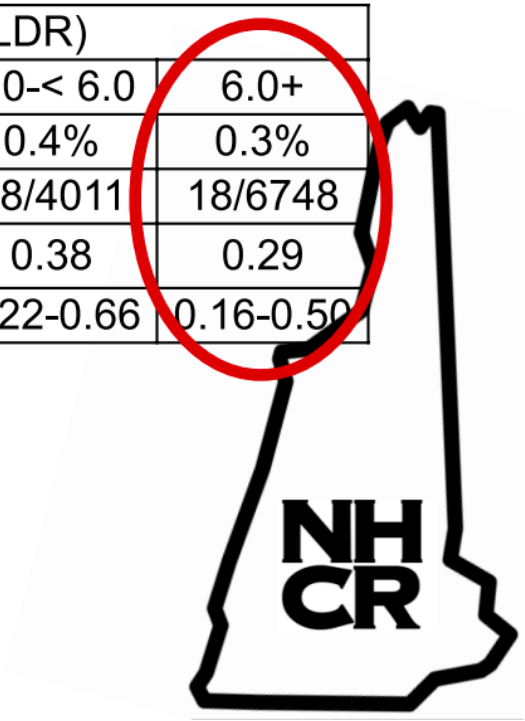
Joseph C. Anderson, MD[1,2,3,4], Douglas K. Rex, MD[5], Todd A. Mackenzie, PhD[1], William Hisey, MSc[3,6], Christina M. Robinson, MS[3,6] and Lynn F. Butterly, MD[1,3,6]

Endoscopist SSLDR and Post Colonoscopy CRC Risk

Sessile serrated lesion Detection Rate (SSLDR)						
		<1.0	1.0-<2.0	2.0-<4.0	4.0-< 6.0	6.0+
Unadjusted risk	%	1.4%	0.6%	0.6%	0.4%	0.3%
	N	58/4117	46/8075	22/3950	18/4011	18/6748
Adjusted Hazard	HR	1.0	0.41	0.45	0.38	0.29
	95% CI	Ref	0.28-0.61	0.27-0.75	0.22-0.66	0.16-0.50

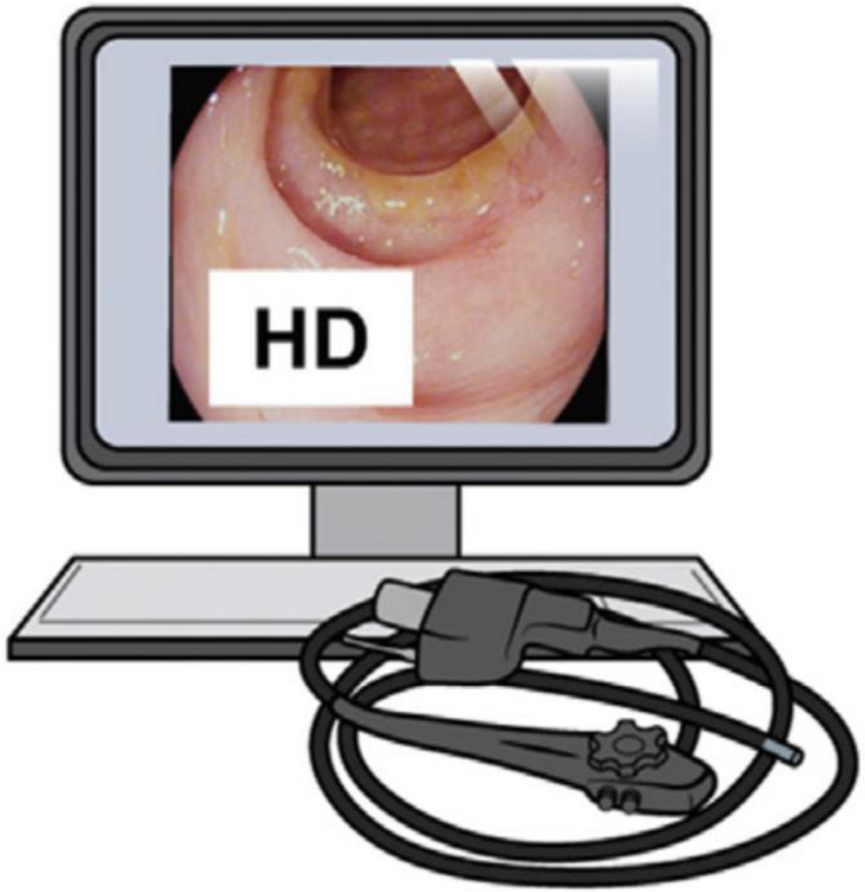


SSLDR of 6% or greater provided optimal protection from PCCRC



Am J Gastroenterol 2023, Online Agosto 10

Use high-definition colonoscopes



Keswani RN, et al. Gastroenterology 2021;161:701–711

Colonoscopia menos eficaz para prevenir CCR derecho

Pálidas, Planas, entre haustras

Colono360°, "Endocuff"

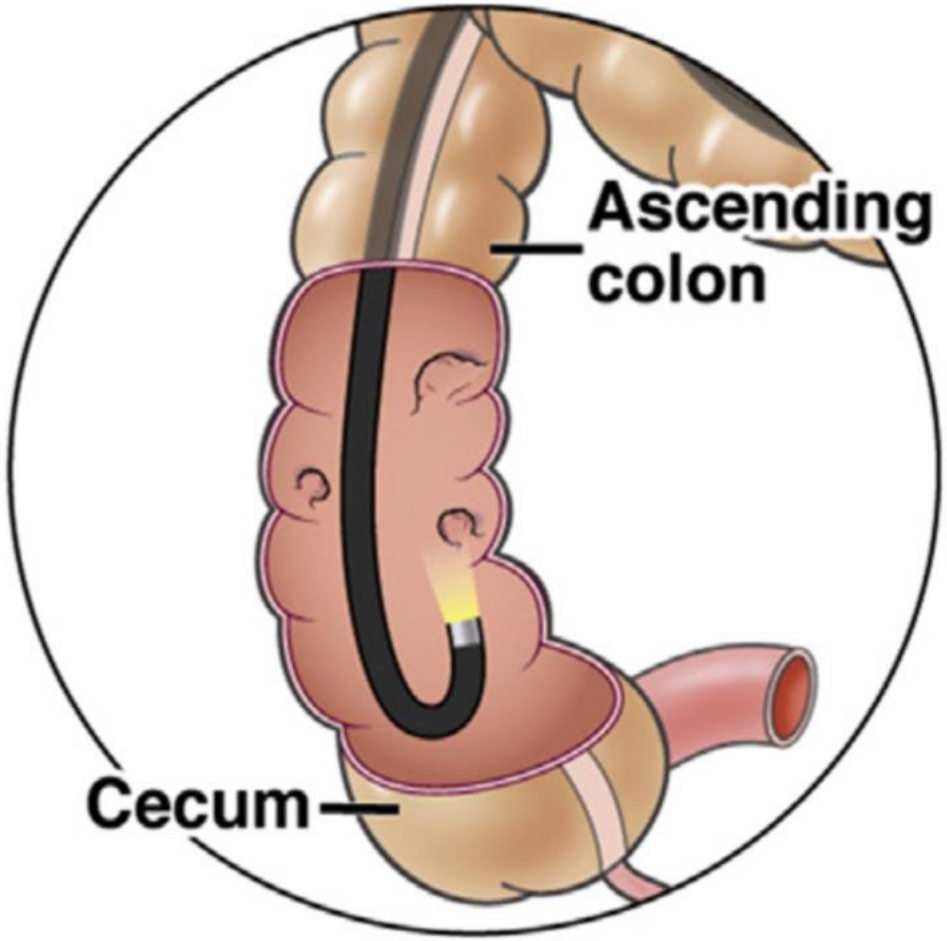
Cambios Posición

Segunda Mirada

Retroflexion Proximal

Baxter NN,. J Clin Oncol 2012; 30: 2664-9.
Brenner H, J Natl Cancer Inst 2010; 102: 89-95.
Rex DK. Endoscopy 2010; 42: 320–323.
Singh H, Gastroenterology 2010; 139: 1128-37.
Rex DK, Clin Gastroenterol Hepatol 2020;18:158-62

Perform 2nd look in right colon



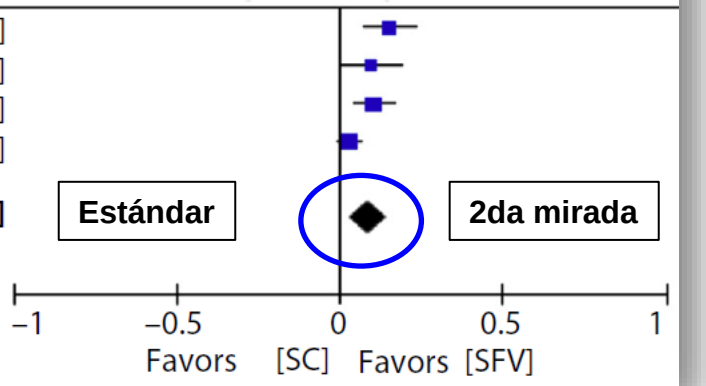
Keswani RN, et al. Gastroenterology 2021;161:701–711

Increasing adenoma detection rates in the right side of the colon comparing retroflexion with a second forward view: a systematic review

Madhav Desai, MD, MPH,[1] Mohammad Bilal, MD,[6] Nour Hamade, MD,[1] Venkata Subhash Gorrepati, MD,[5] Viveksandeep Thoguluva Chandrasekar, MD,[1] Ramprasad Jegadeesan, MD,[1] Neil Gupta, MD,[3] Pradeep Bhandari, MD,[2] Alessandro Repici, MD,[4] Cesare Hassan, MD,[4] Prateek Sharma, MD[1]

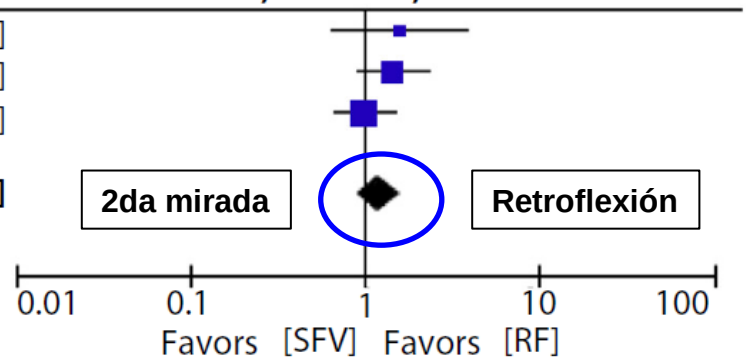
Study or Subgroup	SFV Events	SFV Total	SC Events	SC Total	Weight	Risk Difference M-H, Random, 95% CI
Clark 2016	177	280	134	280	21.9%	0.15 [0.07 - 0.23]
Guo 2017	59	178	43	182	19.6%	0.10 [0.00 - 0.19]
Kushnir 2015	136	400	94	400	26.3%	0.11 [0.04 - 0.17]
Lee 2017	260	1020	231	1020	32.2%	0.03 [–0.01- 0.07]
Total (95% CI)		**1878**		**1882**	**100.0%**	**0.09 [0.03 - 0.15]**
Total events	632		502			

Heterogeneity. $Tau^2 = 0.00$; $Chi^2 = 10.37$, df = 3 (P = .02); $I^2 = 71\%$
Test for overall effect: Z = 2.91 (P = .004)

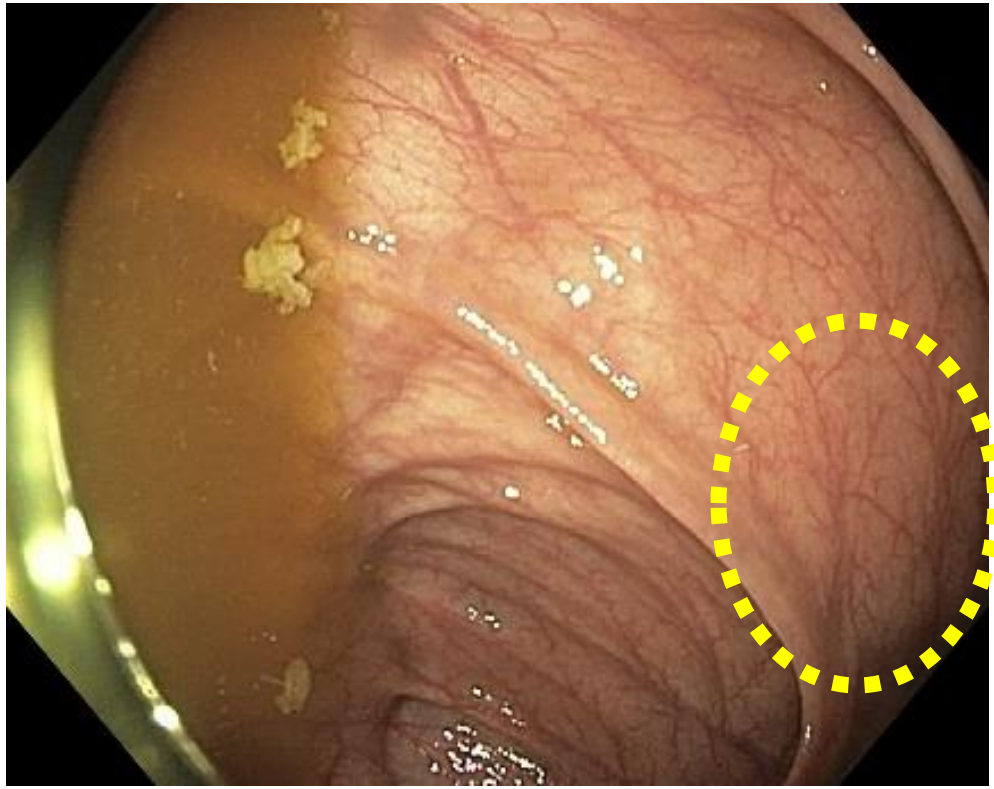


Study or Subgroup	SFV Events	SFV Total	RF Events	RF Total	Weight	Odds Ratio M-H, Random, 95% CI
Harrison 2004	16	48	12	50	10.7%	1.58 [0.65 - 3.83]
Kushnir 2015	42	400	34	450	37.4%	1.44 [0.89 - 2.31]
Lee 2017	50	1020	50	1020	51.9%	1.00 [0.67 - 1.49]
Total (95% CI)		**1468**		**1520**	**100.0%**	**1.20 [0.90 - 1.61]**
Total events	108		96			

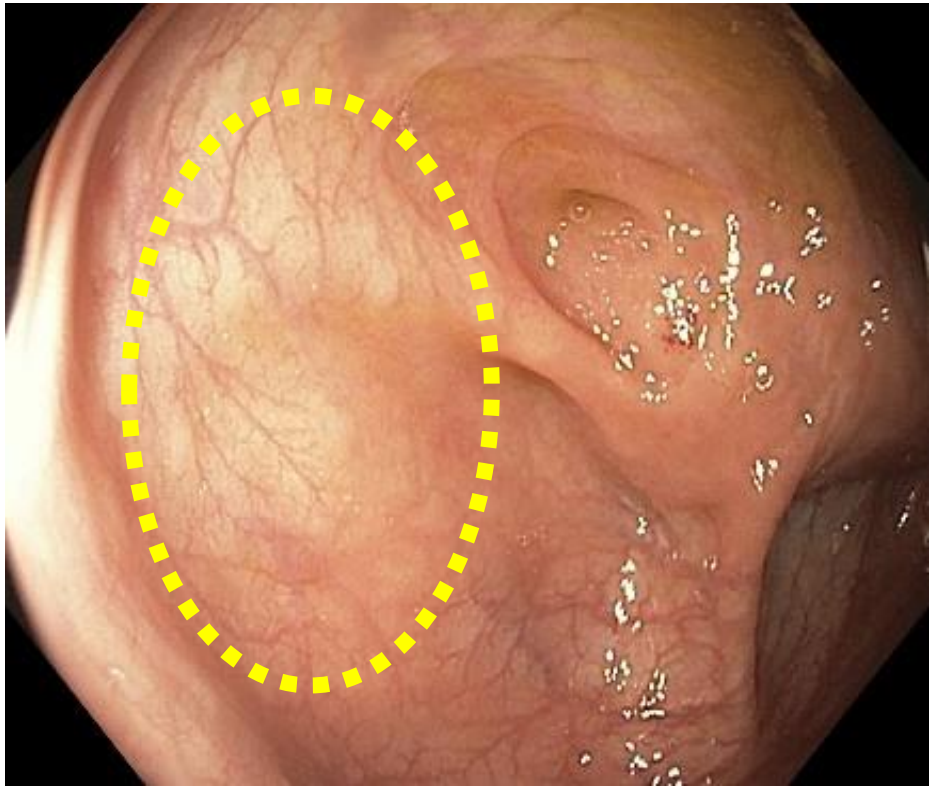
Heterogeneity. $Tau^2 = 0.00$; $Chi^2 = 1.72$, df = 2 (P = .42); $I^2 = 0\%$
Test for overall effect: Z = 1.25 (P = .21)



Ciego parcialmente visto

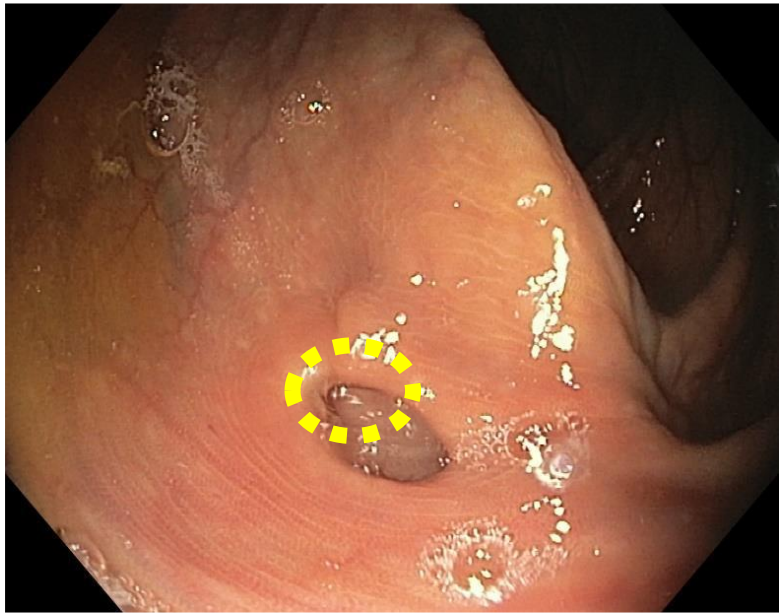


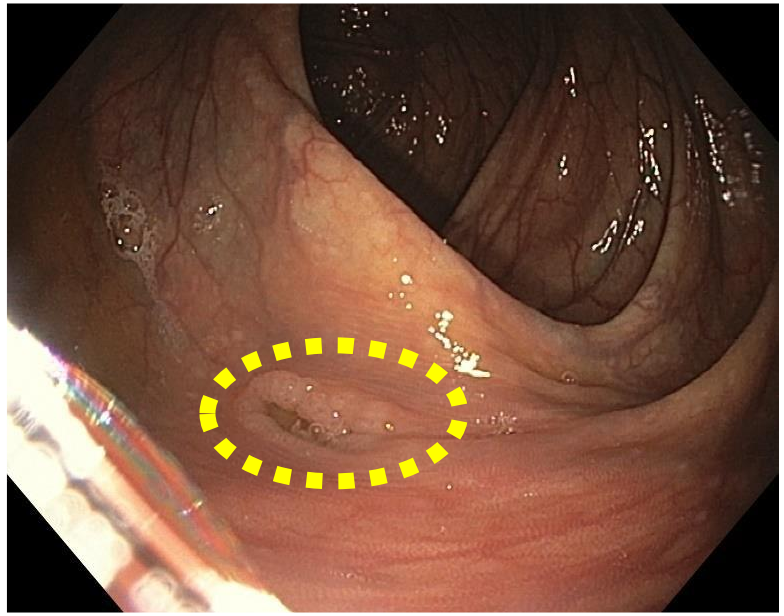
Ciego completamente visto

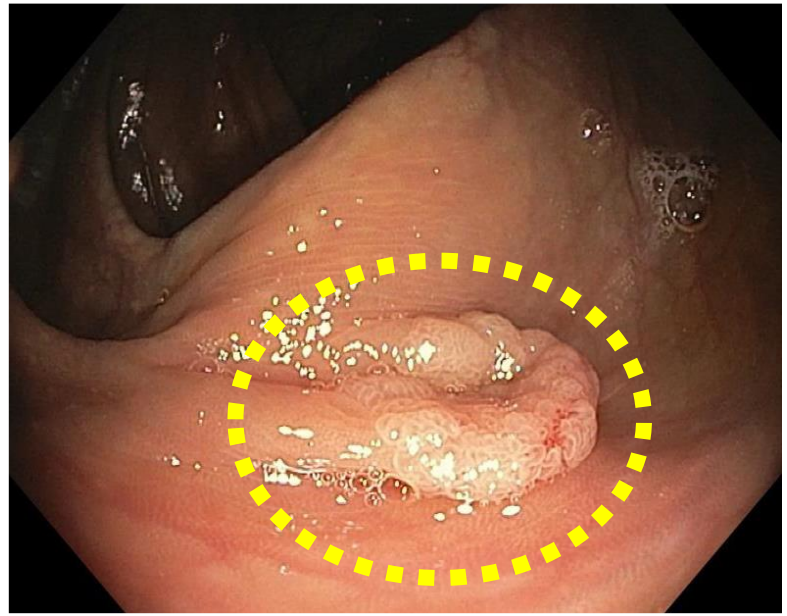


W.Otero 2023

Febrero 2022

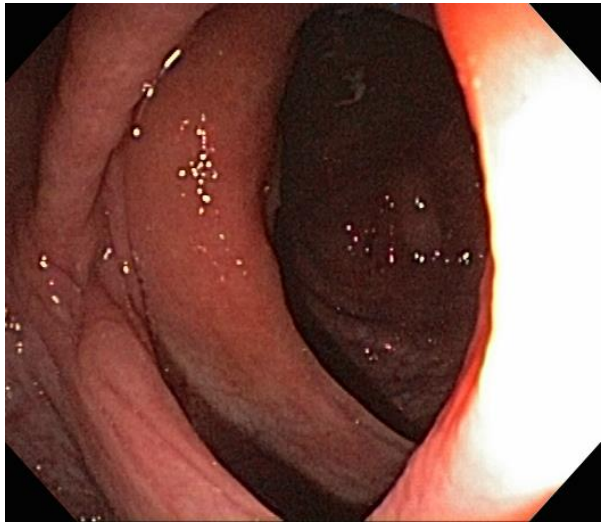


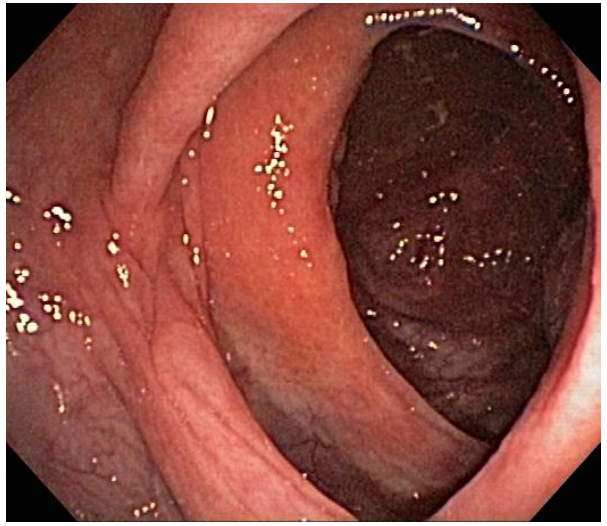




W. Otero 2022

Ciego parcialmente visto





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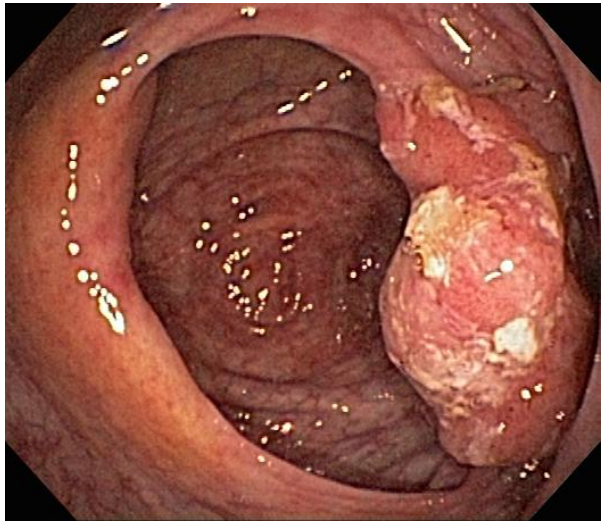
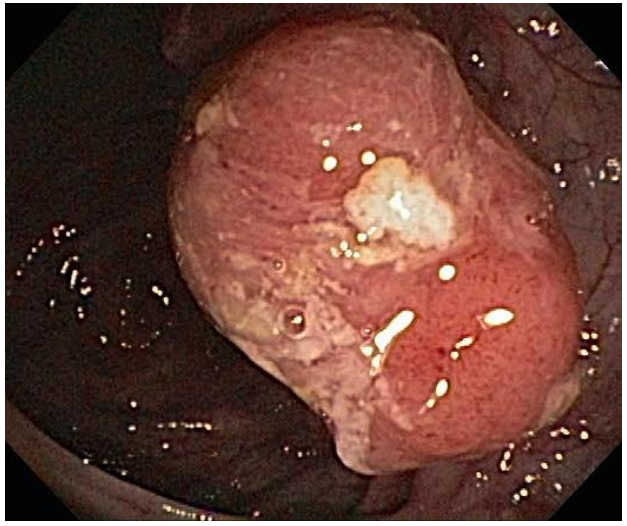
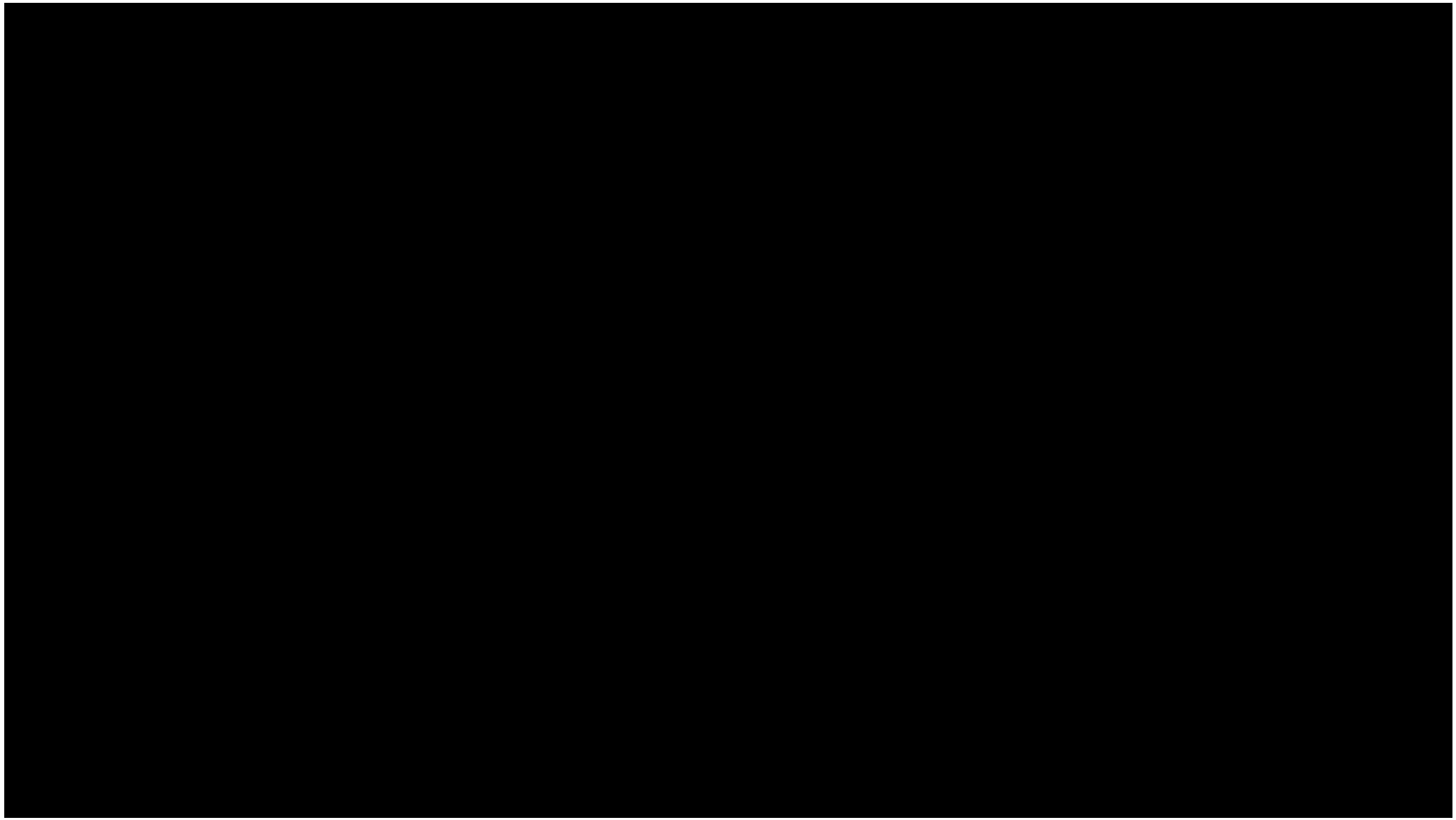




W.Otero 2023



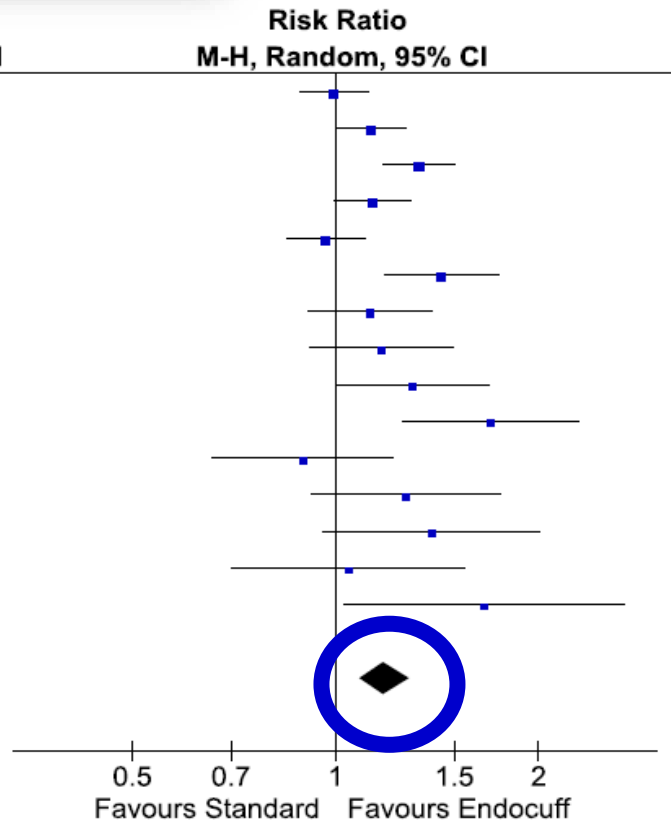
The effect of the endoscopic device Endocuff™/Endocuff vision™ on quality standards in colonoscopy: A systematic review and meta-analysis of randomized trials

Martin Walls[1,2] | Britt B. S. L. Houwen[3] | Stephen Rice[2] | Alexander Seager[1,2] | Evelien Dekker[3] | Linda Sharp[2] | Colin J. Rees[1,2]

Study or Subgroup	EAC Events	EAC Total	SC Events	SC Total	Weight	Risk Ratio M-H, Random, 95% CI
van Doorn 2017	275	530	278	533	10.2%	0.99 [0.89, 1.12]
Ngu 2017	363	888	320	884	10.1%	1.13 [1.00, 1.27]
Karsenti 2020	402	1026	304	1032	10.0%	1.33 [1.18, 1.50]
Rex 2018	191	299	166	295	9.6%	1.14 [0.99, 1.30]
Bhattacharyya 2017	162	266	167	265	9.6%	0.97 [0.85, 1.10]
Wada 2018	134	239	93	238	7.6%	1.43 [1.18, 1.74]
De Palma 2018	81	137	72	137	7.1%	1.13 [0.91, 1.39]
Rex 2020	62	101	52	99	6.2%	1.17 [0.92, 1.49]
Biecker 2015	87	245	69	253	5.7%	1.30 [1.00, 1.69]
Floer 2014	87	249	50	243	4.9%	1.70 [1.26, 2.29]
von Figura 2020	45	118	52	122	4.8%	0.89 [0.66, 1.22]
Jacob 2019	67	182	40	138	4.5%	1.27 [0.92, 1.75]
Triantafyllou 2017	43	100	31	100	3.8%	1.39 [0.96, 2.01]
Marsano 2019	23	42	22	42	3.4%	1.05 [0.70, 1.56]
González-Fernández 2017	39	174	22	163	2.6%	1.66 [1.03, 2.68]
Total (95% CI)		**4596**		**4544**	**100.0%**	**1.18 [1.09, 1.29]**
Total events	2061		1738			

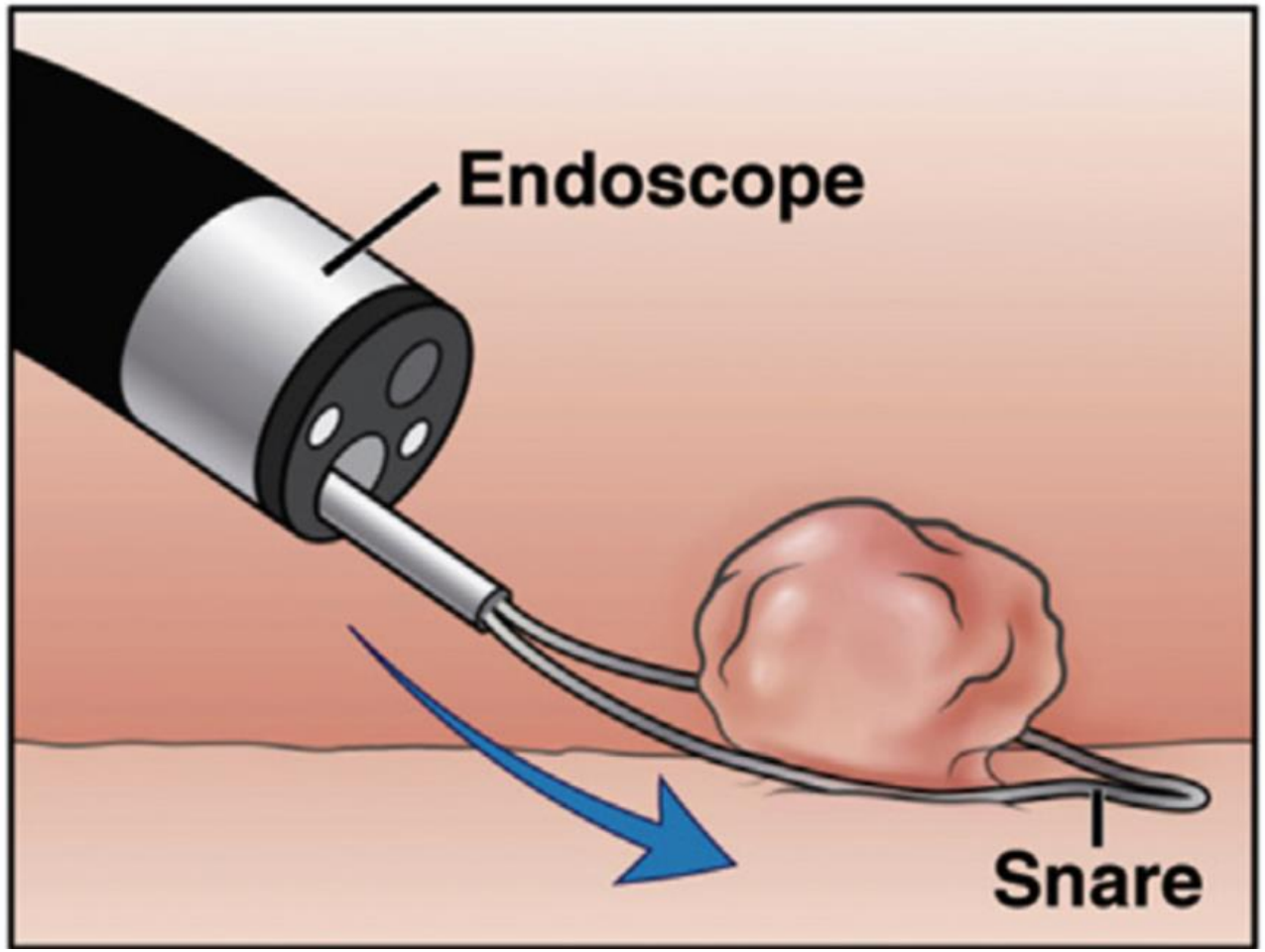
Heterogeneity: Tau² = 0.02; Chi² = 37.95, df = 14 (P = 0.0005); I² = 63%

Test for overall effect: Z = 3.84 (P = 0.0001)

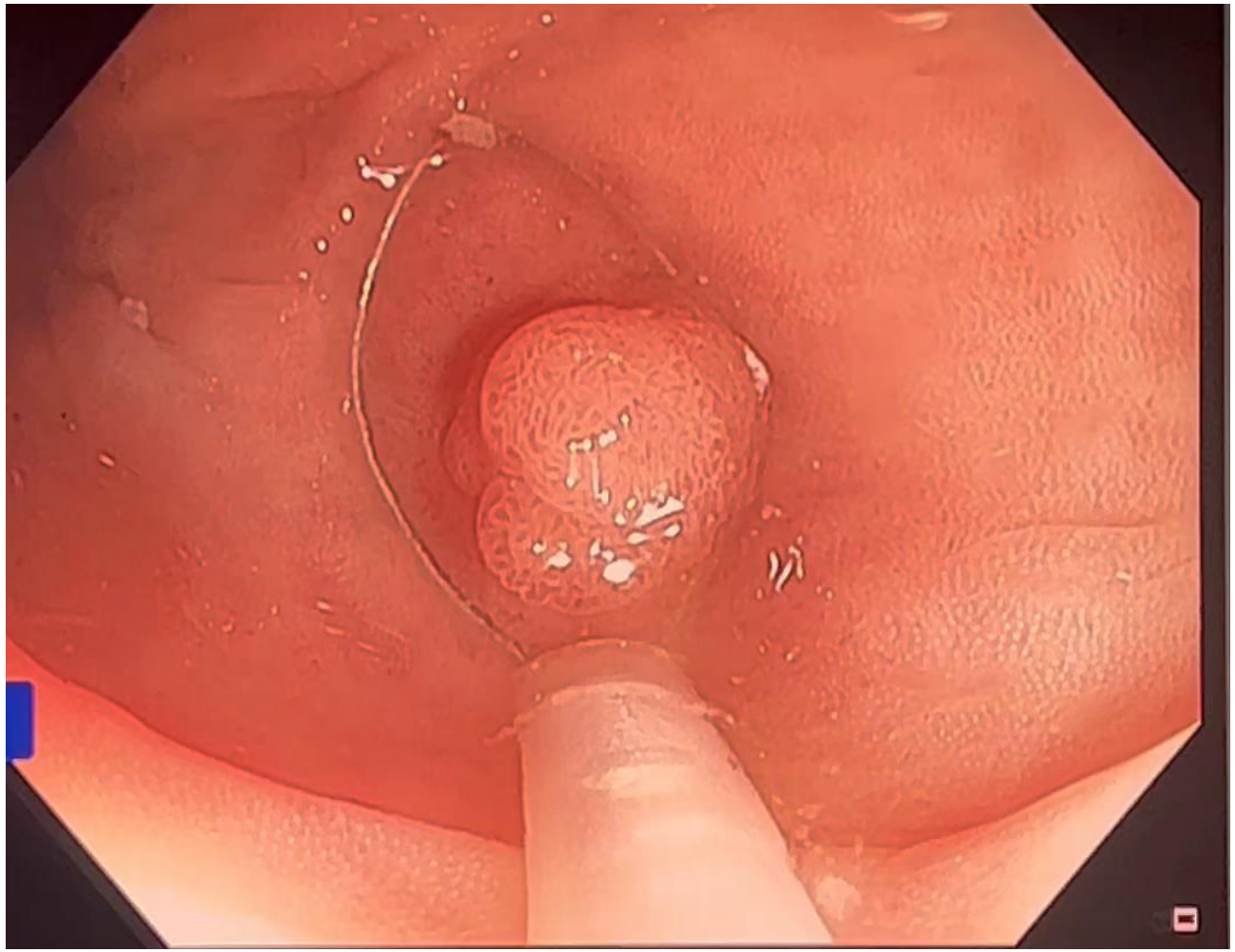


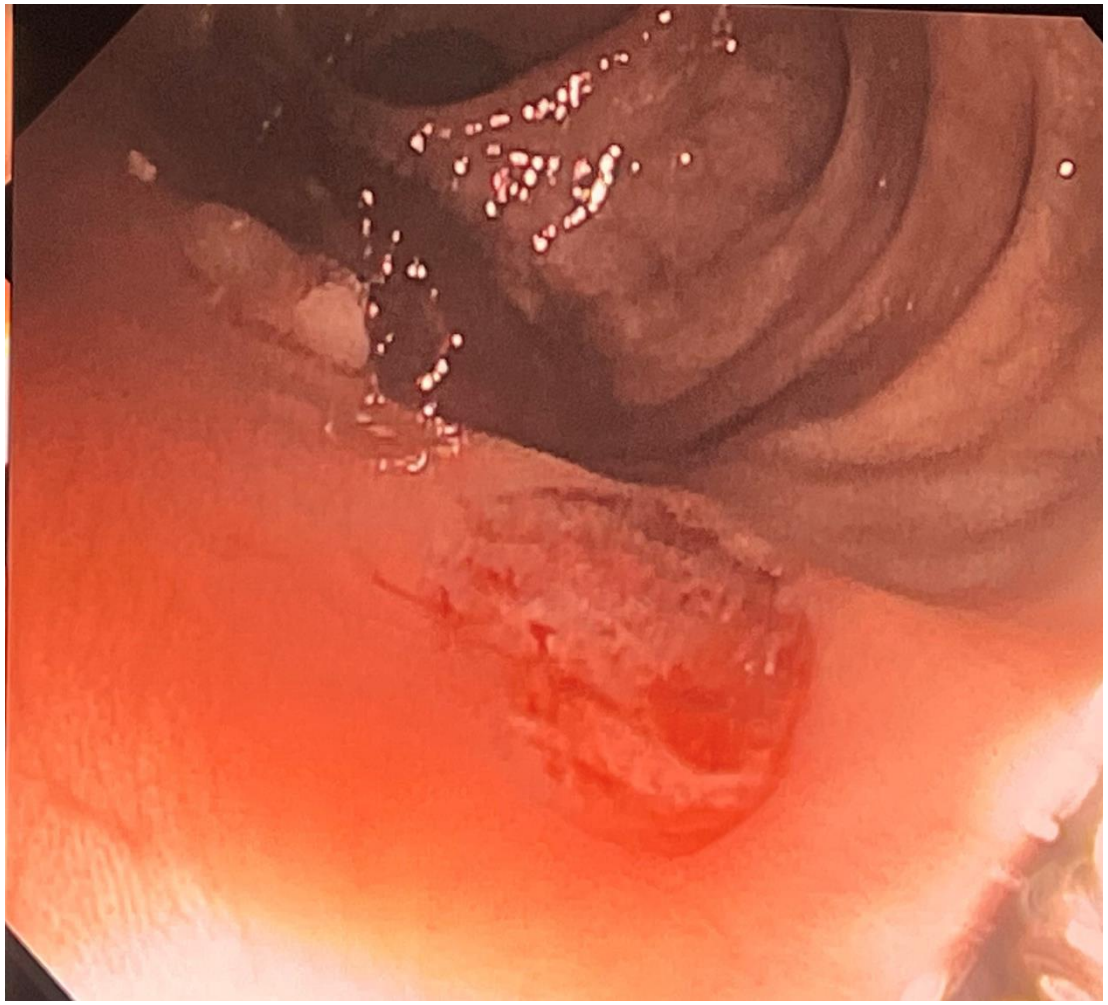
Walls M, Colorect Dis. 2023;25:573–585.

Use cold snares for all sessile polyps 3–9 mm



Keswani RN, et al. Gastroenterology 2021;161:701–711





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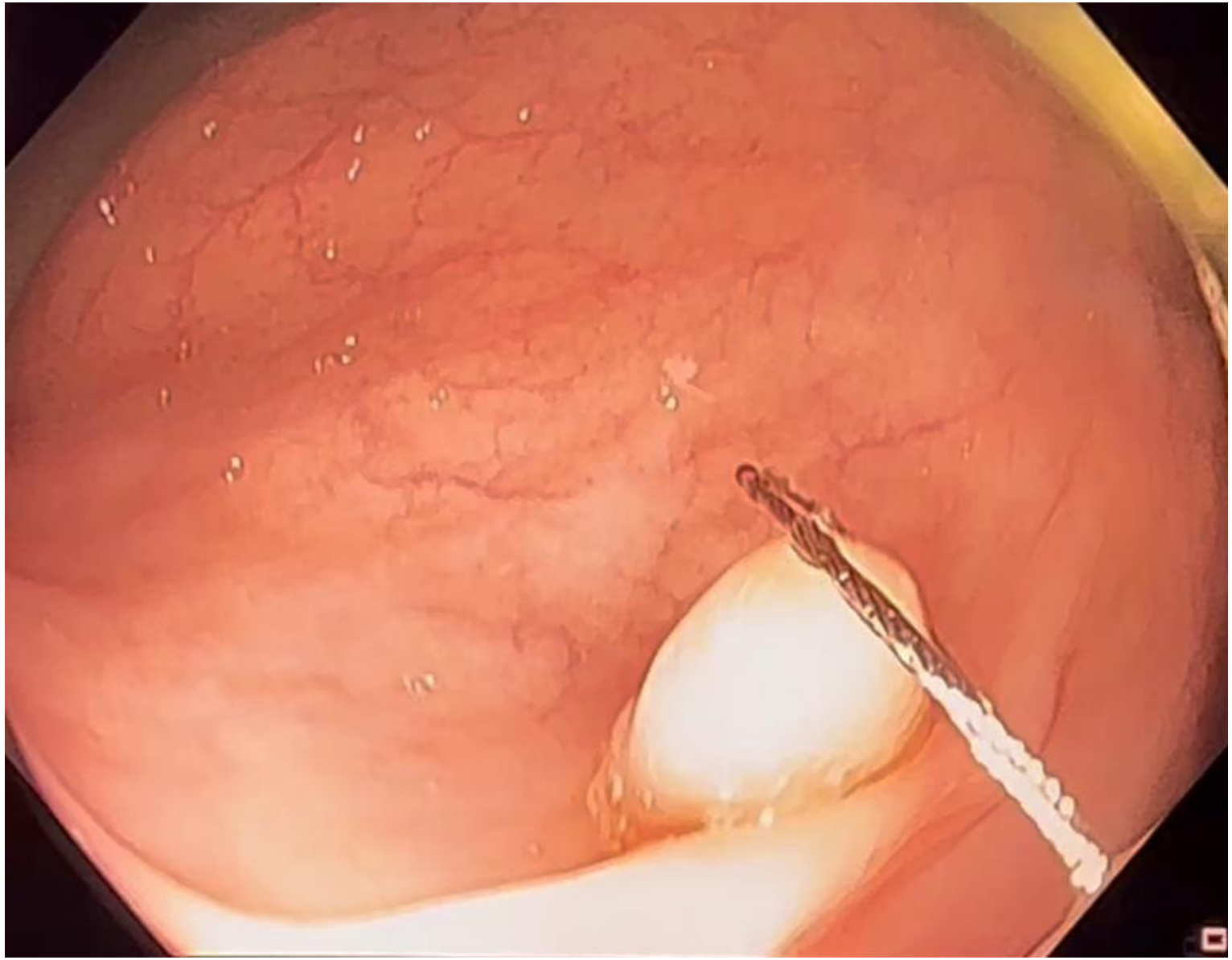

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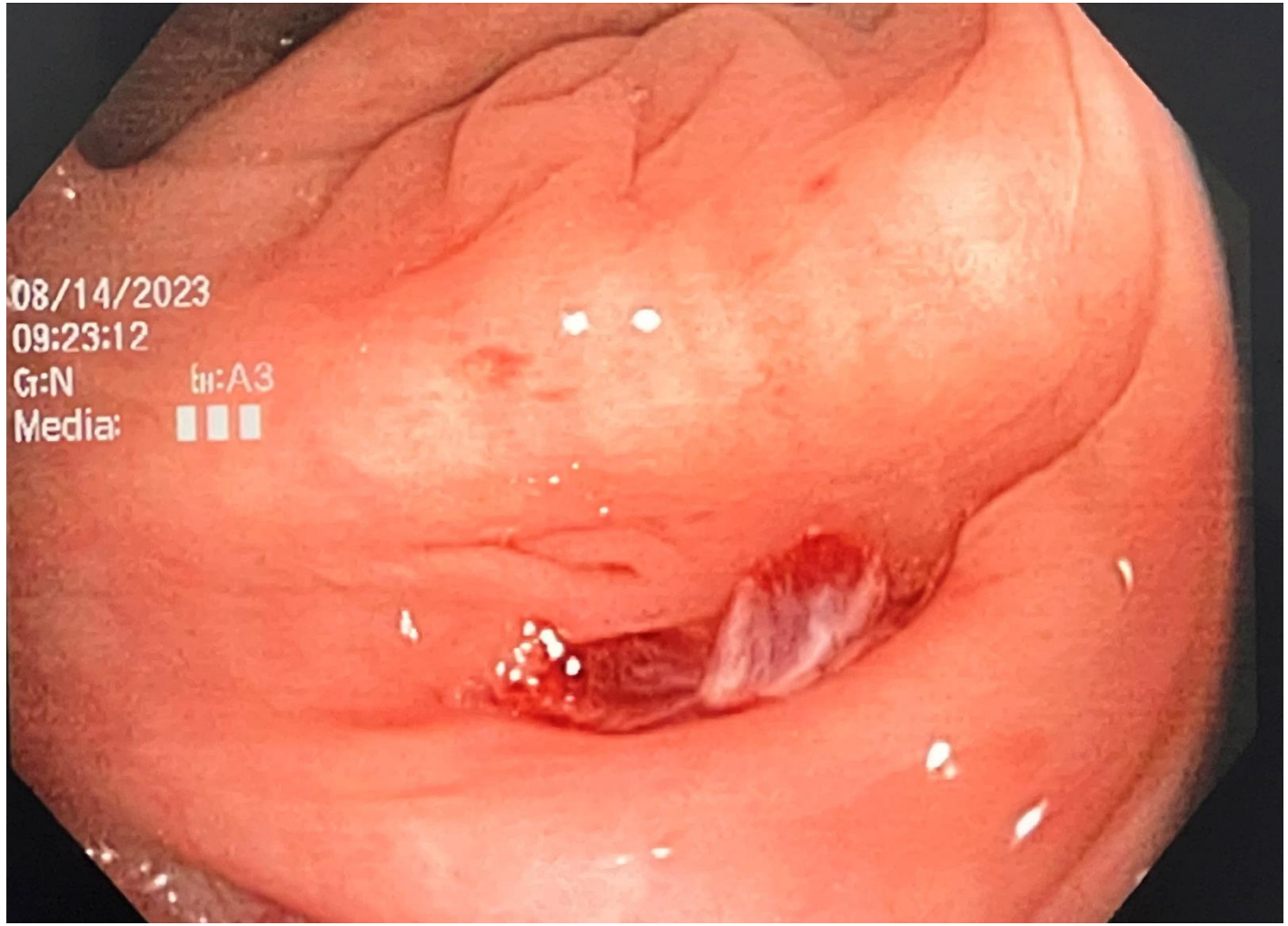
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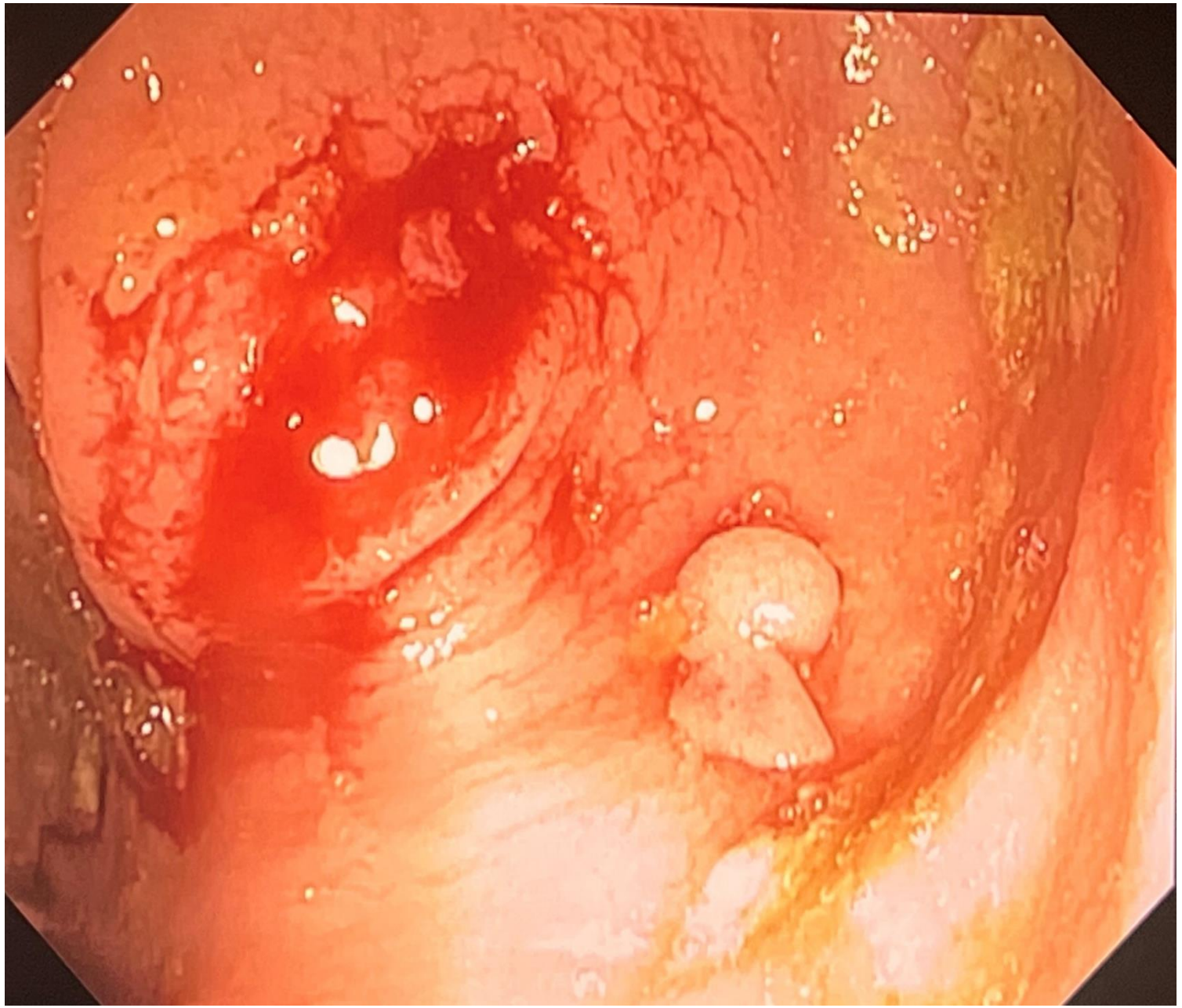
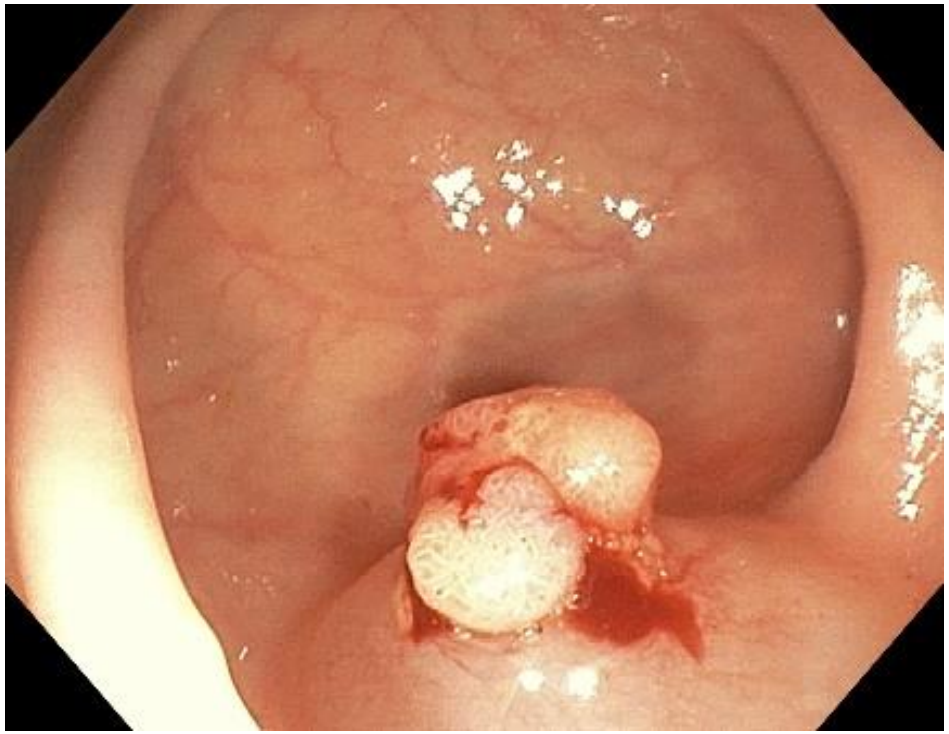
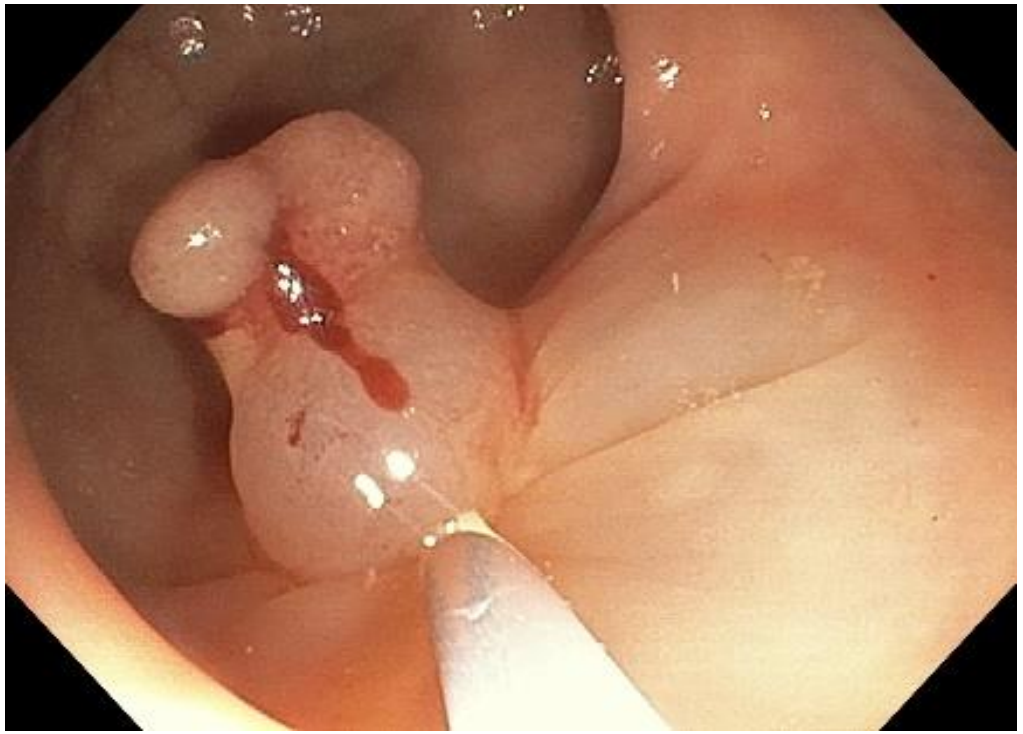


W Otero/23





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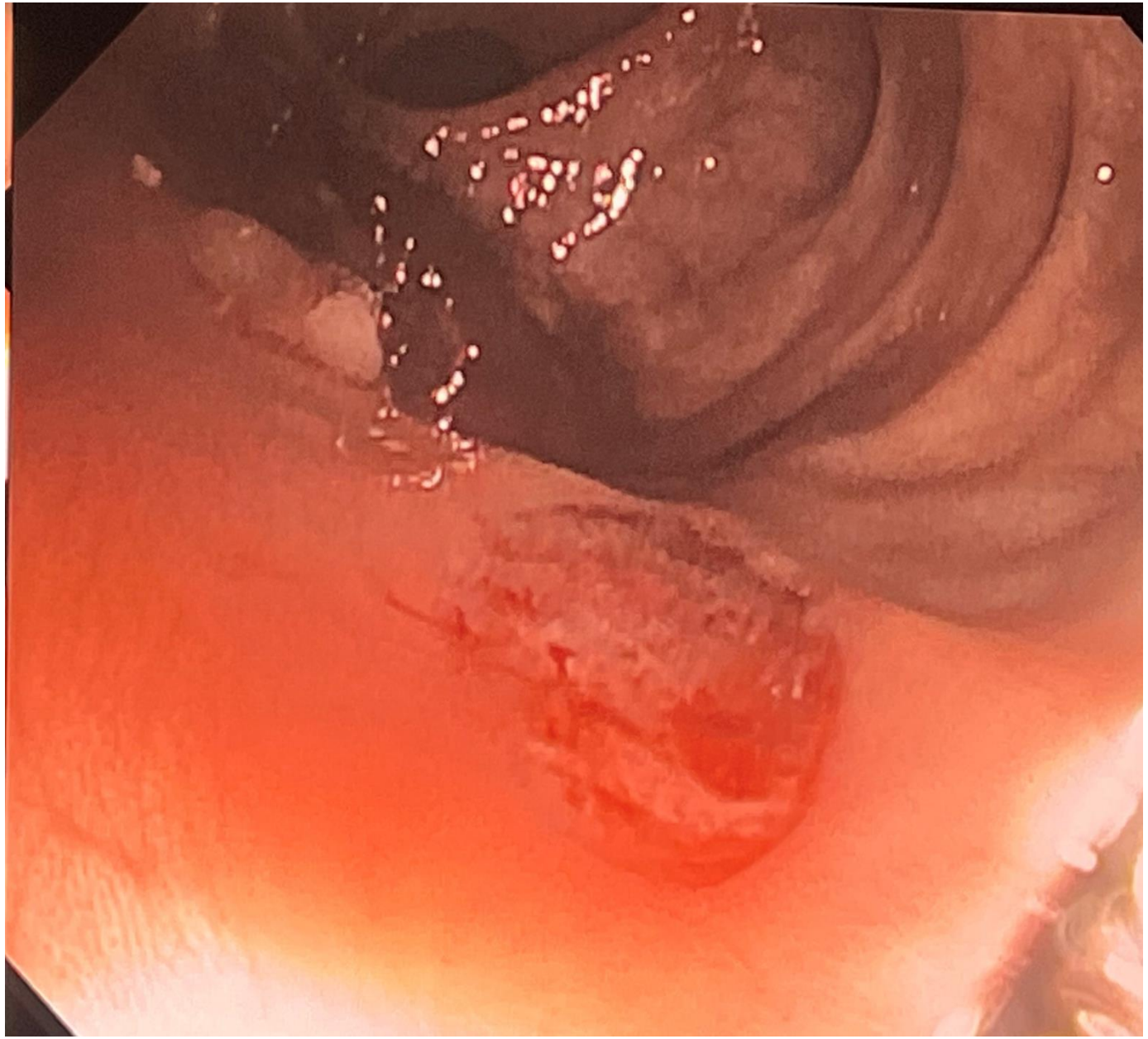

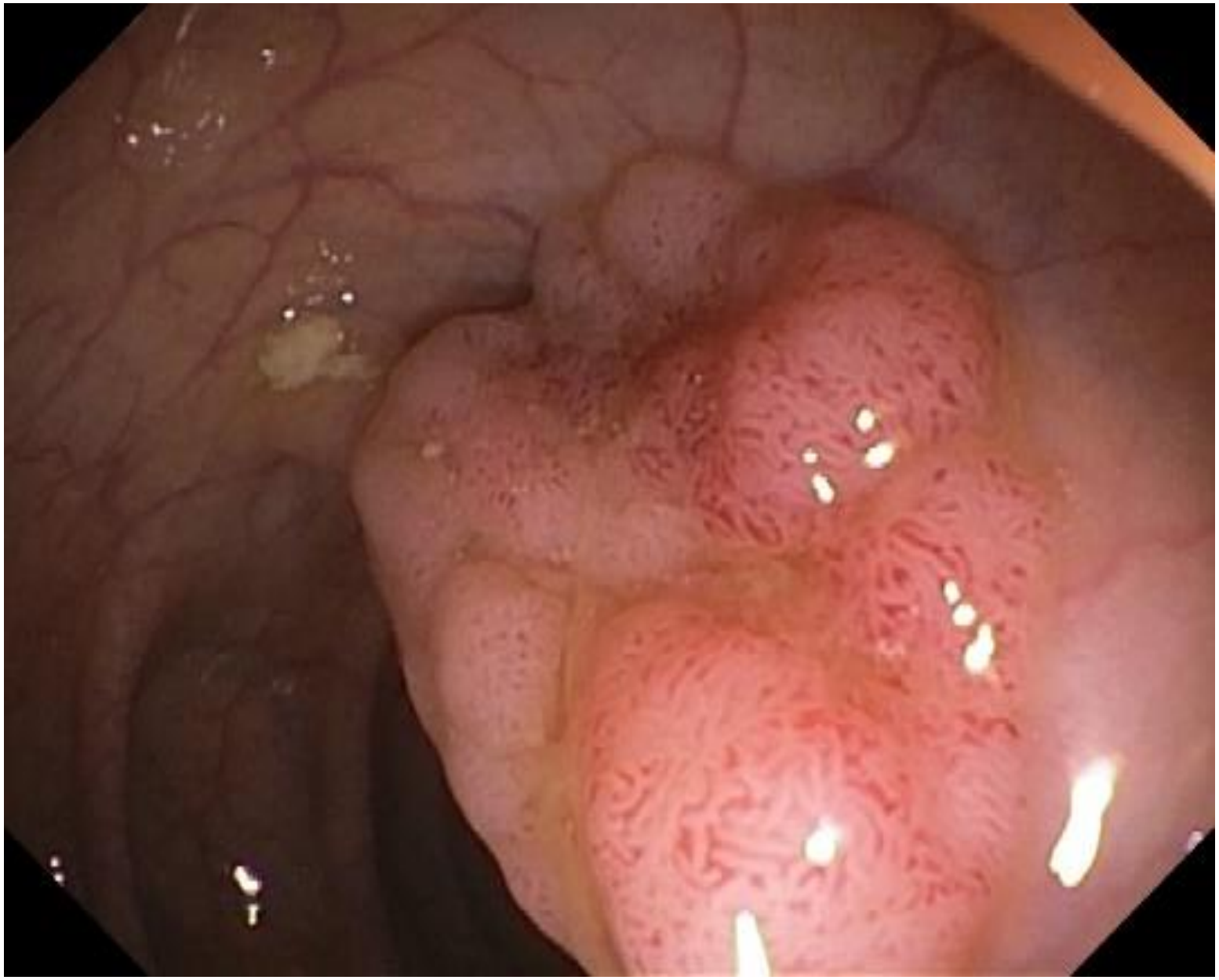

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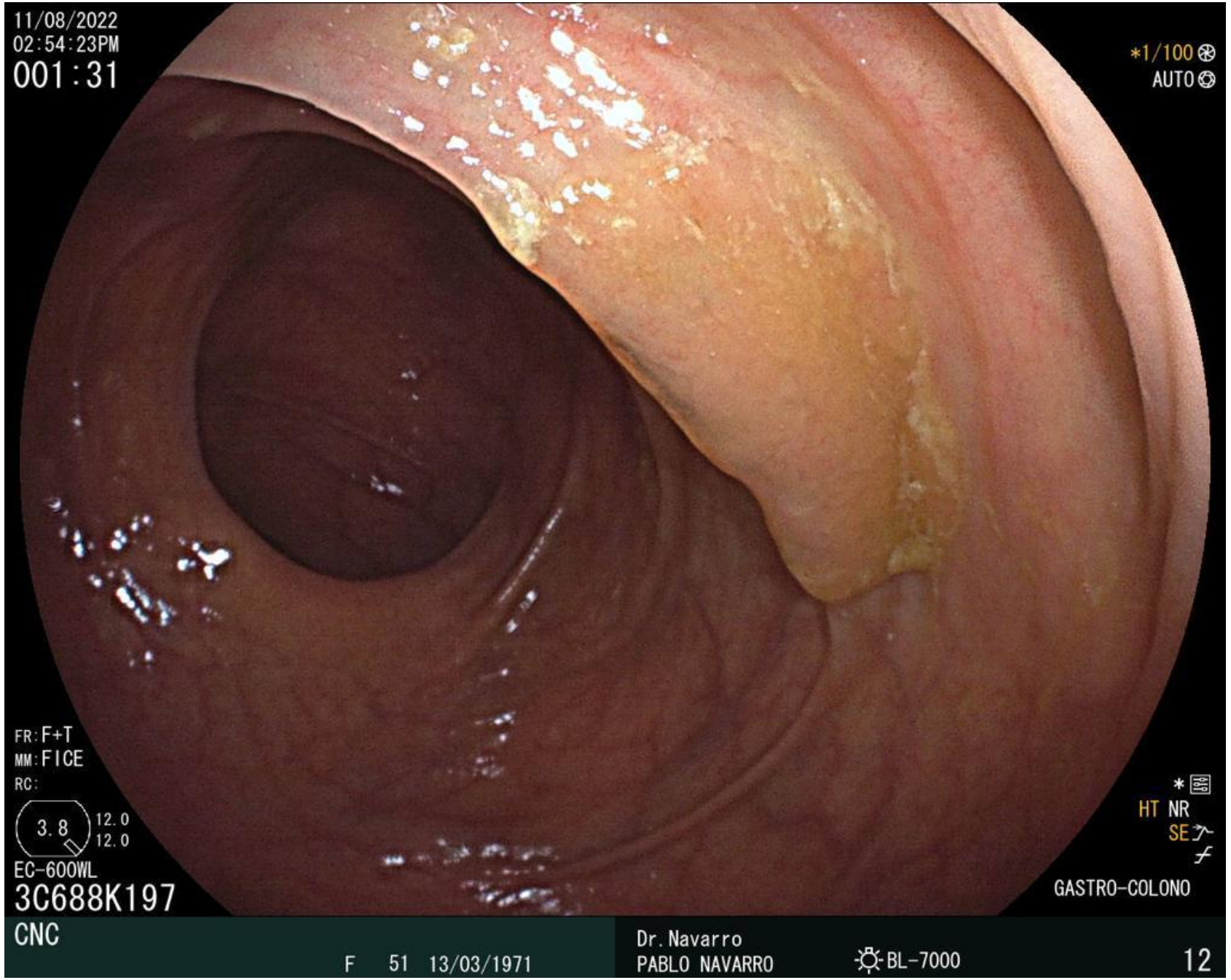
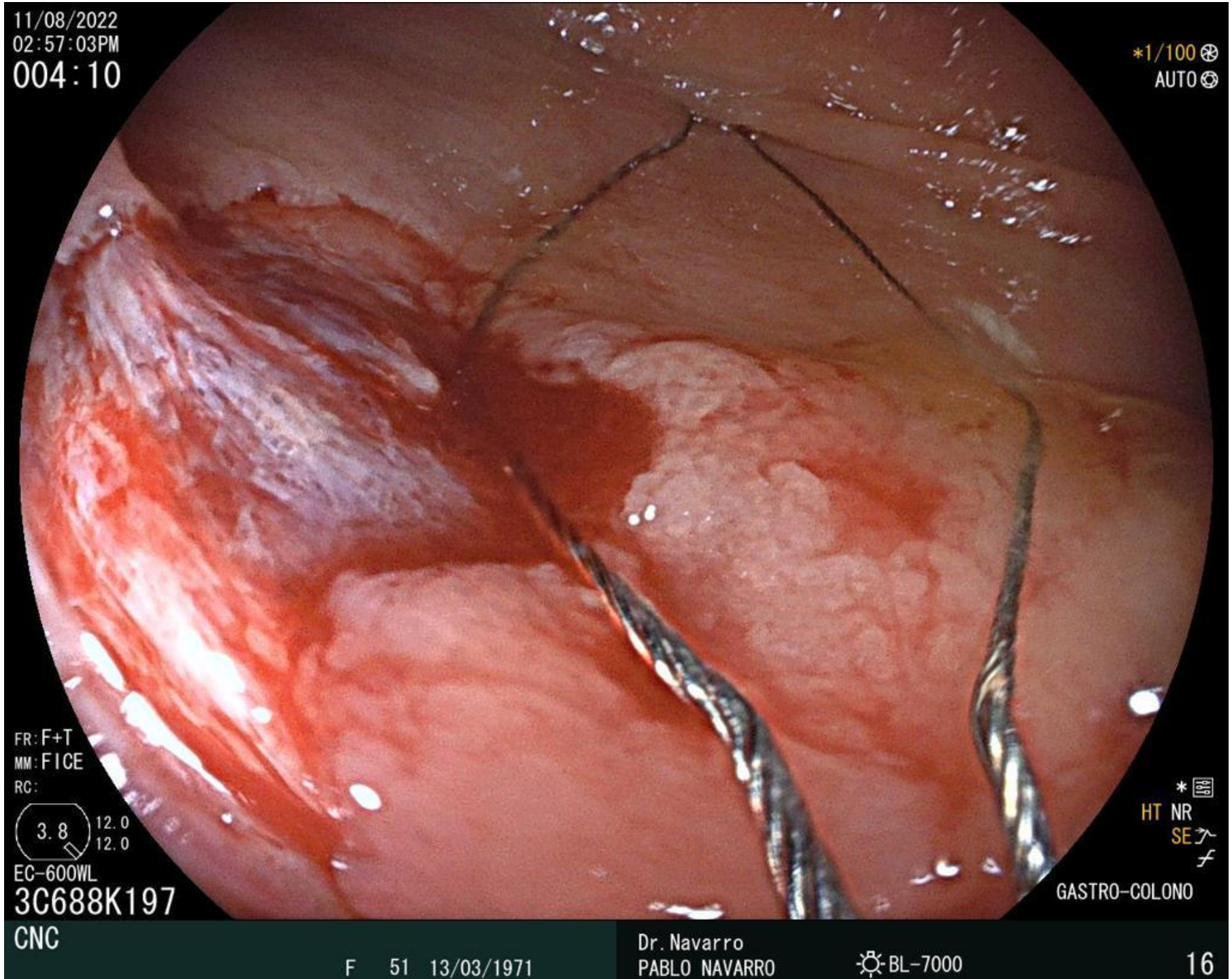


Dr Pablo Navarro
Costa Rica



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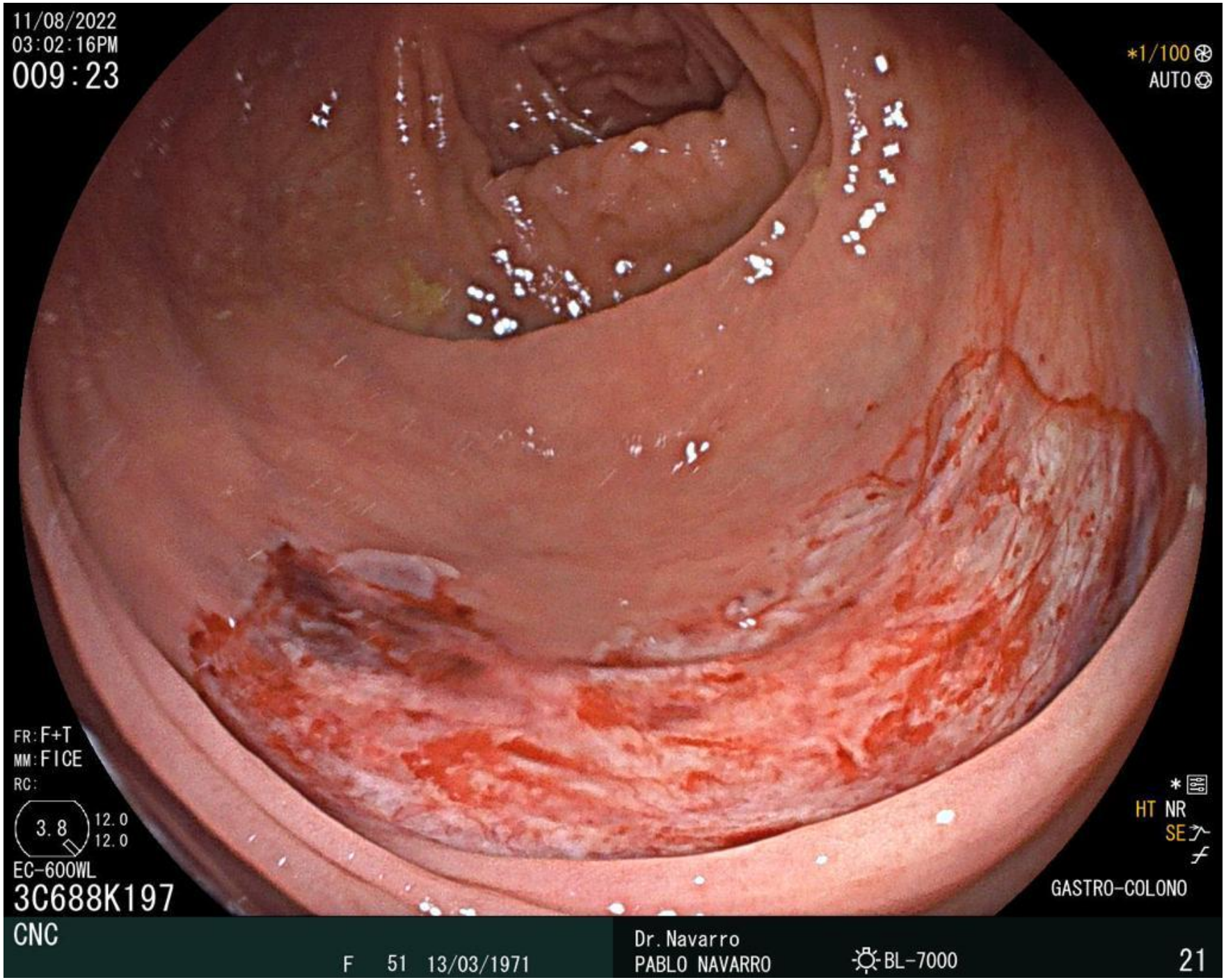
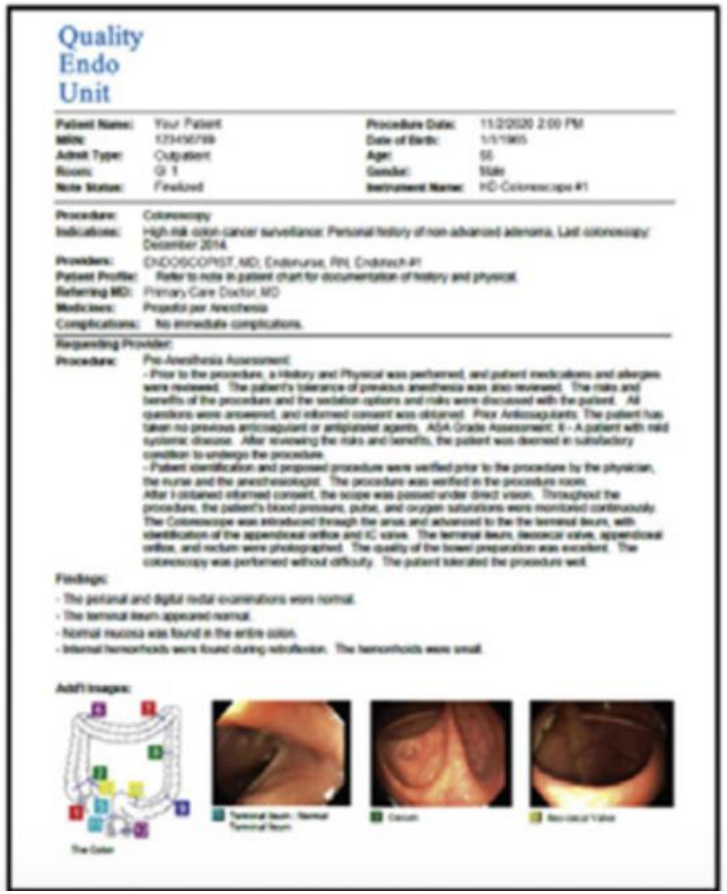


Dr Pablo Navarro
Costa Rica

Provide clear and detailed post-procedure documentation



Quality
Endo
Unit

Keswani RN, et al. Gastroenterology 2021;161:701–711

Centro de Gastroenterología Y Endoscopia.

CENTRO DE GASTROENTEROLOGIA Y ENDOSCOPIA LTDA
Unidad de Gastroenterología, Endoscopia Digestiva, Enfermedades del Hígado
CLL 117 #6A -60, Con 603A

NOMBRE:	OLGA LUCIA ARDILA OSPINA
EDAD:	49 AÑOS
IDENTIFICACIÓN:	52049147
TELEFONO:	3133025443
OCUPACIÓN	PSICOLOGA
EMPRESA:	SERVISALUD
REMISIÓN:	CONSULTA EXTERNA
FECHA:	2 febrero 2022
PROCEDIMIENTO:	POLIPECTOMÍA
INDICACIÓN	PÓLIPO DE COLON ASCENDENTE
ESPECIALIDAD	MD GASTROENTEROLOGO
LOCALIDAD	ENGATIVA
CORREO ELECTRONICO:	OLARDILAS@GMAIL.COM
CALIDAD DE LA PREPARACION:	BOSTON 3/9 (1-1-1)
PUNTAJE DE BURBUJAS:	1-1-1
TIEMPO DE LLEGADA AL CIEGO:	2 MINUTOS
TIEMPO DE RETIRADA	9 MINUTOS

Previo al examen se realizó encuesta epidemiológica y al ingreso del consultorio sobre síntomas de COVID-19. Se realiza lavado de manos según recomendaciones de la OMS, y se hace uso de los EPP).
Previo consentimiento informado con la respectiva información de cuestionario Covid-19 y siguiendo las recomendaciones de seguridad para mitigar el contagio de Covid 19, se realizó el examen bajo sedación administrada por la Dra. Maryori Herrera, anestesióloga

Hallazgos:
INSPECCIÓN: normal.
TACTO RECTAL: normal.
ANO RECTO: hemorroides internas grado I
SIGMOIDES: NORMAL
COLON DESCENDENTE: NORMAL
COLON TRANSVERSO: materia fecal, áreas examinadas normales
COLON ASCENDENTE: CINCO cm antes de la válvula ileocecal, del mismo lado de la misma, se encontró pólipo sésil de aproximadamente 20-25 mm, de apariencia vellosa. El pólipo está dentro de un divertículo. Por la complejidad de este pólipo, se decide remitirla a un hospital de tercer nivel para su resección. No se le tomaron biopsias para evitar que se llegara a producir fibrosis que impidiera su elevación al momento de mucosectomía. En la institución de tercer nivel se decidiría la forma de la resección (endoscópica o quirúrgica)..

DIAGNOSTICO.

1. HEMORROIDES INTERNAS GRADO I
2. POLIPO EN COLON ASCENDENTE EN ESTUDIO

SE REMITE A UN HOSPITAL DE TERCER NIVEL PARA LA MUCOSECTOMIA DEL PÓLIPO ENCONTRADO
Solicitar cita después de la resección

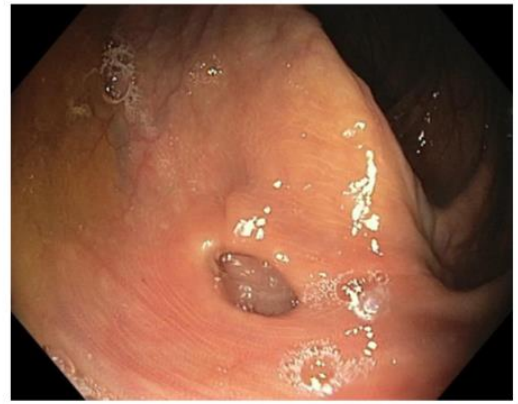
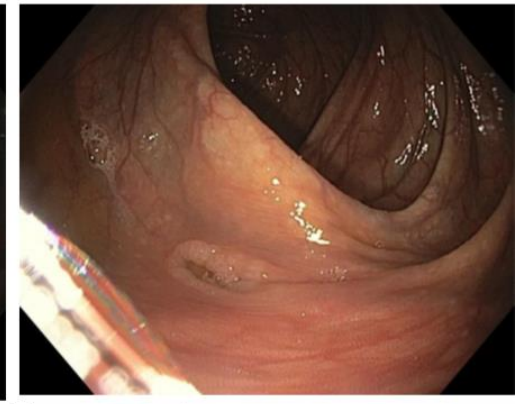
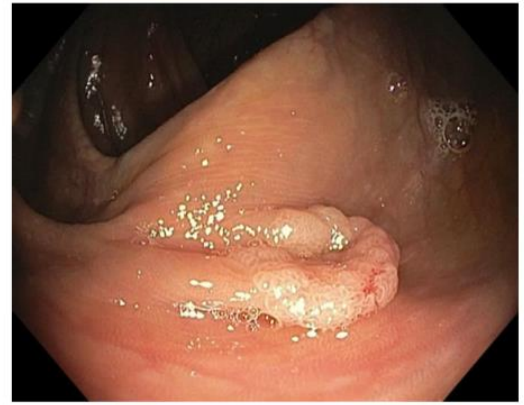
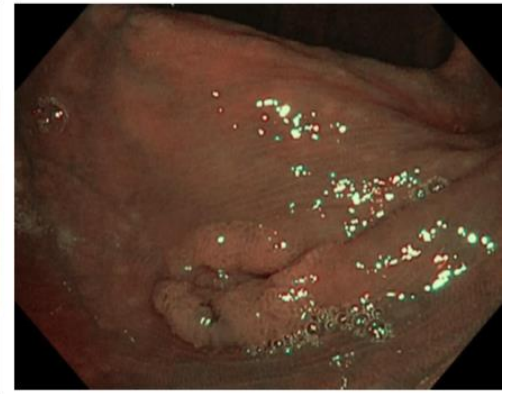
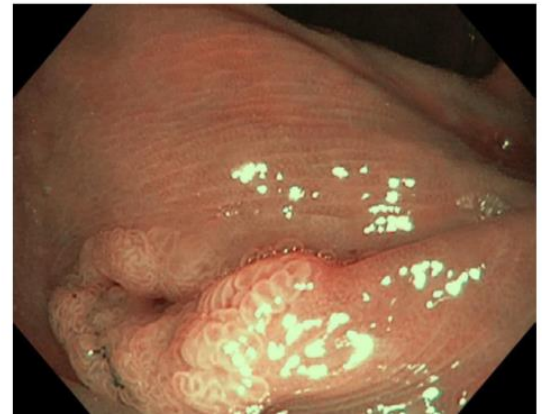
Recomendaciones:
Estas son las recomendaciones que usted debe tener en cuenta las próximas 24 horas después de haberse realizadas un examen de COLONOSCOPIA TOTAL.
• Después de 30 minutos del procedimiento debe iniciar dieta normal.
• Si presenta dolor abdominal intenso, vómito o deposiciones negras o sangrado rectal abundante, debe dirigirse al servicio de urgencias de su centro de salud más cercano y en lo posible llevar el resultado endoscópico. Además, Llamar al servicio de gastroenterología para informar teléfono: 3505210870.
Recomendación post venopunción:
— Inmediatamente después del retiro del catéter debe hacerse presión constante por 5 minutos.
— Si después de 5 minutos presenta sangrado en el sitio de la venopunción debe continuar con presión constante y elevar la extremidad (brazo).
— Si después de 5 horas presenta dolor, inflamación y enrojecimiento en el sitio de la venopunción, debe ponerse un paño limpio y humedecido en agua tibia, sobre la zona afectada.

Recomendación pos-sedación.
El día de hoy no puede conducir y no debe realizar trabajos que requieran concentración. No tomar licor. No consumir sedantes

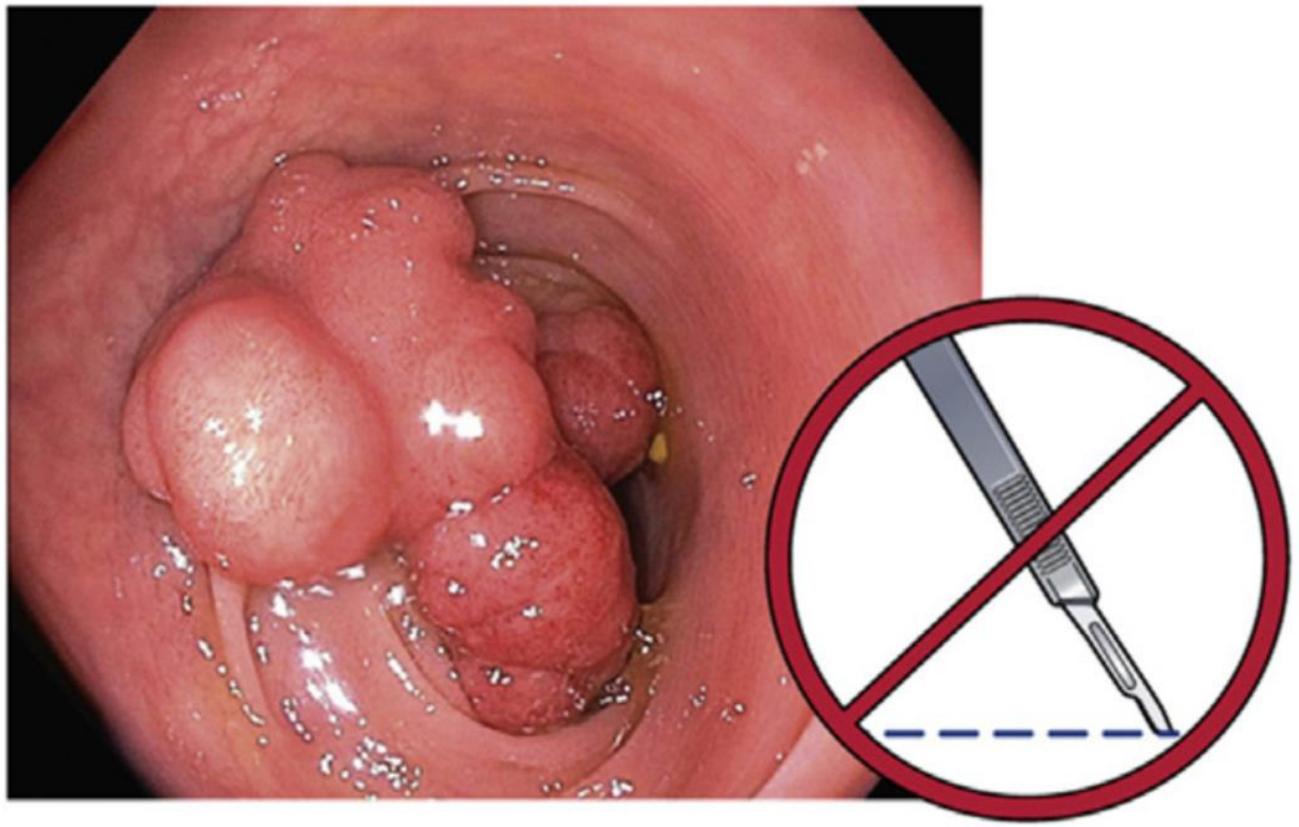
Control: llevar los resultados de su examen a su médico tratante.

Centro de Gastroenterologia Y Endoscopia.
RM 19375414
GASTROENTEROLOGO

CENTRO DE GASTROENTEROLOGIA Y ENDOSCOPIA LTDA
Unidad de Gastroenterología, Endoscopia Digestiva, Enfermedades del Hígado
CLL 117 #6A -60, Con 603A

Refer patients with benign complex polyps for endoscopic resection not surgery



Keswani RN, et al. Gastroenterology 2021;161:701–711

Follow guidelines when assigning screening or surveillance intervals

Normal colonoscopy	10 years
Small HP only	10 years
1–2 small adenomas	7–10 years
1–2 small SSLs	5–10 years
3–4 small adenomas/SSLs	3–5 years
5–10 small adenomas/SSLs	3 years
Advanced adenoma	3 years
Advanced SSL or TSA	3 years

Keswani RN, et al. Gastroenterology 2021;161:701–711

Otros indicadores de calidad

Tacto rectal: Siempre
Tatuaje: pòlipos >20 mm (No recto o ciego)
Diarrea crónica: Biopsias de mucosa normal (Colon, ileon)
Estudio histológico de pólipos: 90%
Vigilancia en EII
Perforación: 0.07%

Rees CJ, Gut 2016, Online Sept 29

Indicador de calidad

Retrovisión del recto ?

Ruiz-Rebollo ML, GIE 2015;82:421-2
Rex DK, GIE 2015;82:22-3

Online Submissions: wjg.wjgnet.com
wjg@wjgnet.com
doi:10.3748/wjg.14.6503

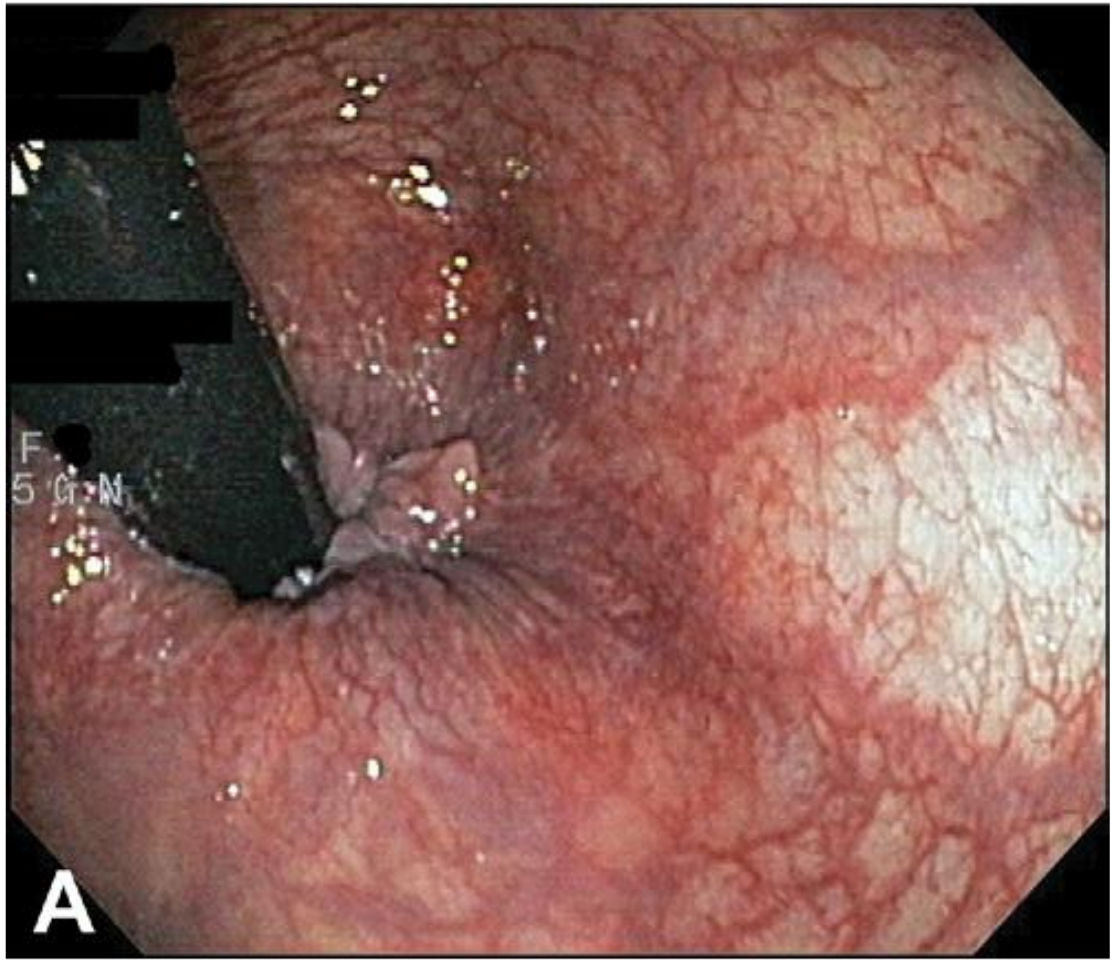
World J Gastroenterol 2008 November 14; 14(42): 6503-6505
World Journal of Gastroenterology ISSN 1007-9327

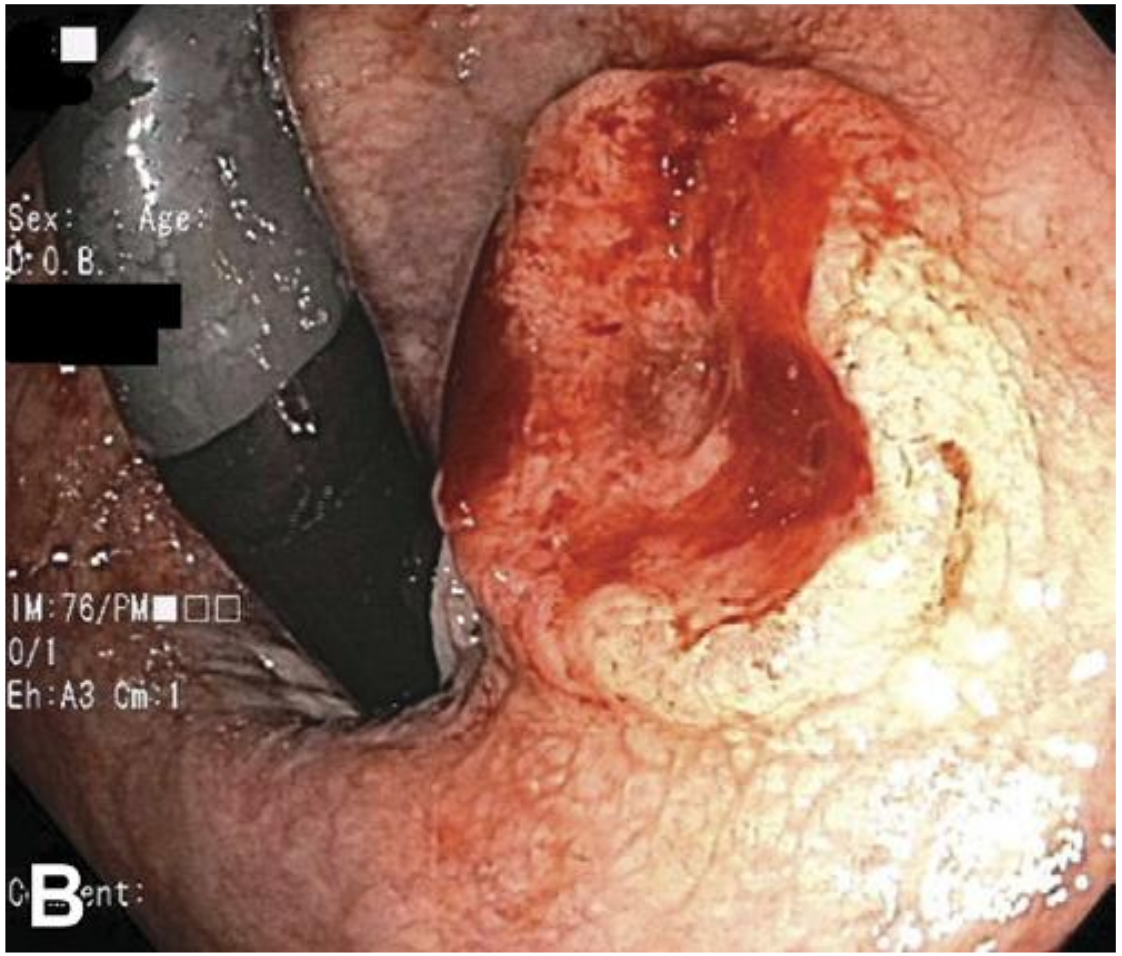
RAPID COMMUNICATION

Routine rectal retroflexion during colonoscopy has a low yield for neoplasia

1502 pacientes, Retrovisión exitosa 93.9% (1411)
43 pólipos en recto distal
33 Se vieron con la inserción y la retroflexión
7 solo con retroflexión
6 hiperplásicos sésiles, 1 adenomatoso 4 mm
Ángulo de visión de 140° y 170º similares

Abdo Saad A, Rex DK. World J Gastroenterol 2008; 14: 6503-05





Enero 2006

5 años después

Enero 2011

Rex DK, Gastrointest Endosc 2011;74:728-9

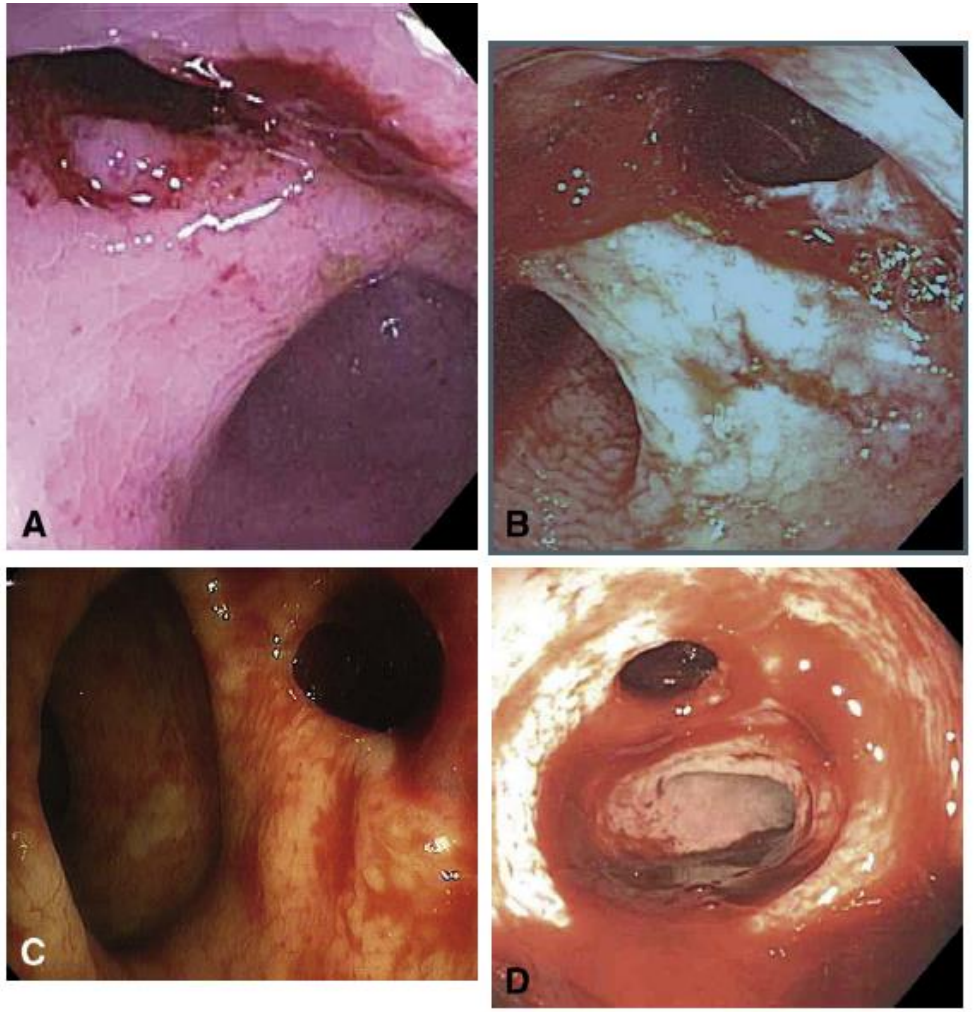
Rectal perforation during colonoscopic retroflexion: a large, prospective experience in an academic center

Matthew R. Quallick, MD, William R. Brown, MD

Denver, Colorado, USA

39.054 Colonoscopias

4 casos
0.10/1000



GIE 2009;69: 960-3

Otros indicadores

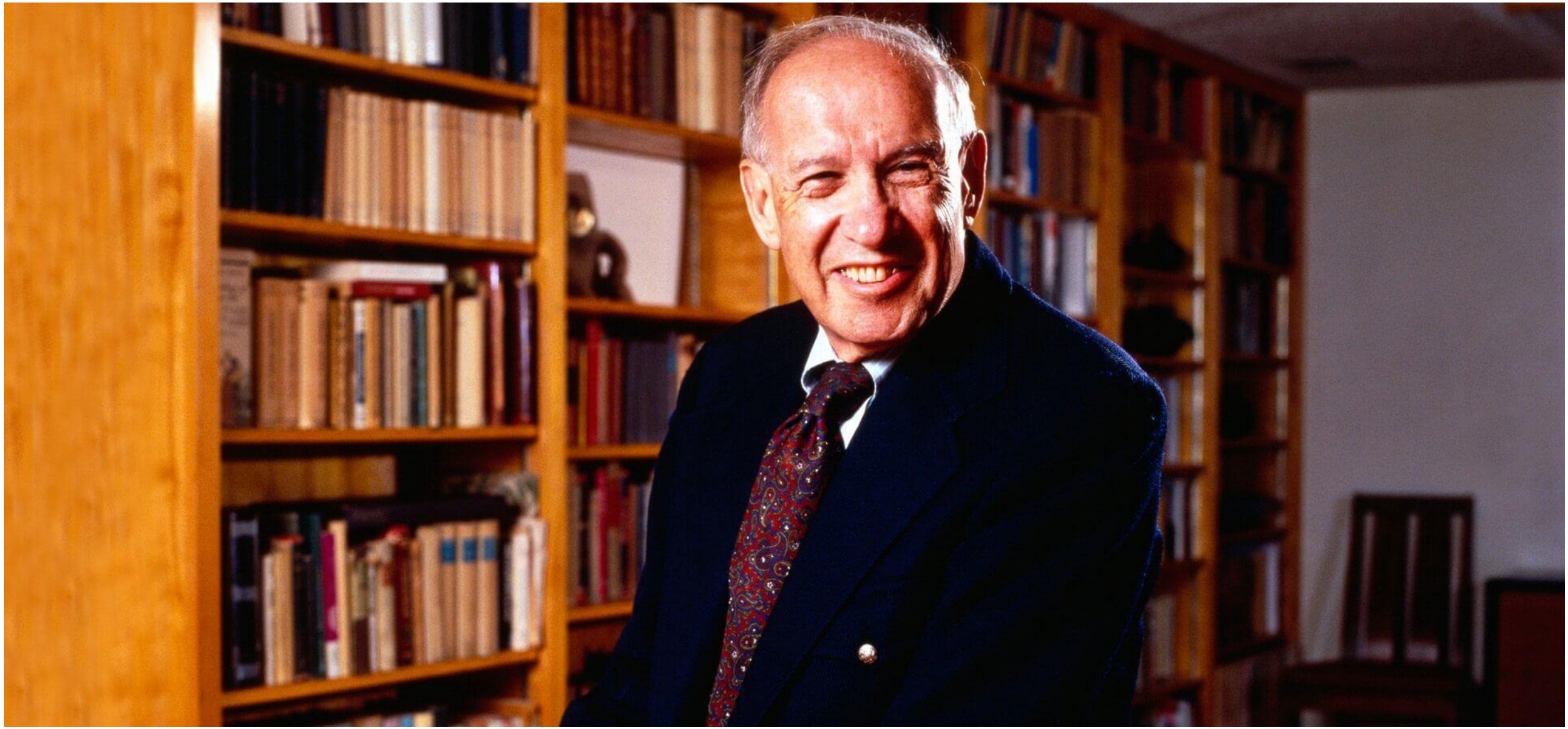
Tasa de cáncer colo-rectal pos colonoscopia (PCCRC)
Tasa de pérdida de adenomas (AMR)
Adenomas pos-colonoscopia
Tasa de detección de adenomas
Tasa de detección de pólipos (PDR)
Tasa de pérdida de adenomas avanzados (AAMR)
>10mm, displasia de alto grado y/o componente velloso

Rex DK. Gastronterol Rep 2023;11:goad009

Mensajes para la casa

La protecciòn contra CCR depende colonoscopistas.
Indicadores calidad impactan incidencia mortalidad CCR
Colonoscopistas deben cumplir con indicadores
Retroalimentaciòn y auditoria mejoran desempeño
Medir indicadores periódicamente (c/250 exàmenes)

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



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


Mercedes-Benz
SAFETY CAR
Allianz
AMG

Progreso permanente

No es un examen de rutina
No es un trabajo
Es una pasión!

Yo

Muchas gracias!