Quality Assurance Guidelines for Colonoscopy in NHS Lothian

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**Approved by**

Lothian Colonoscopy Quality Group

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Background

Significant progress has been made in increasing the quality of colonoscopy in children and adults in NHS Lothian. To help improve standards these guidelines have been written to mandate elements of good clinical practice across the board. External providers who operate in NHS Lothian will also be required to adopt these standards.

Objectives

1) To define and mandate a set of quality standards in colonoscopy for NHS Lothian.
2) To advise and guide practice in specific cases and techniques.
3) To advise on teaching and refresher/update courses.

Mandated Quality Measures

Caecal intubation

Standard: Unadjusted caecal intubation rate of greater than 90%.
Aim: Unadjusted caecal intubation rate of greater than 95%.

Caecal intubation should be confirmed by a clear photo of the appendiceal orifice taken from a position proximal to the IC valve. A further photo should be taken of the IC valve. If the image capture device is not working this should be documented in the text of the report. Terminal ileal intubation is strongly recommended especially in the diagnosis and management of inflammatory bowel disease.

The decision to limit the procedure to a flexible sigmoidoscopy if the preparation has not worked well or colonoscopy is inappropriate lies with the endoscopist carrying out the procedure. A decision to undertake a flexible sigmoidoscopy should be made before commencing the procedure.

Retroflexion in the rectum

Standard: A photograph of the rectum in retroflexion should be taken unless contraindicated (active rectal inflammation or recent surgery). This is best achieved in the left lateral position. It can be taken during intubation or extubation.

Polyp detection and retrieval

Standard: 20% polyp detection rate. 90% Polyp retrieval rate.
Withdrawal time during negative colonoscopies

Standard: Documented inspection time of greater than 6 minutes in negative procedures. The time should be spread equally over each segment. The extubation time should be confirmed with the endoscopy nurse and will be documented when new reporting software is in place.

Sedation and Pain Scores

Standard: Sedation and pain scores should be monitored and discussed at annual appraisal.

Scope Guide

Standard: Use of the scope guide is mandatory for adult and paediatric patients unless contraindicated (pregnancy, implanted electronic device).

Recommended Techniques and Equipment to Increase Quality

Routine position change

Position change during extubation to maximise mucosal views is recommended with the transverse colon being imaged in the supine position in all patients. In high risk patients consideration should also be given to examining the caecum, ascending colon and hepatic flexure in the left lateral position, the splenic flexure, descending and sigmoid colon in the right lateral position and the rectum in the left lateral position.

CO₂ Insufflation

The use of CO₂ insufflation for colonoscopy is recommended for use in diagnostic colonoscopy and strongly recommended for use in therapeutic colonoscopy.

Entonox

Having entonox available to use on its own or as an adjunct to analgesia and/or sedation is strongly recommended.

Buscopan

Having buscopan available for use once the caecum has been intubated is recommended. This is especially helpful in chromoendoscopy. Glucagon can be used if buscopan is contra-indicated.
Polypectomy Quality

The guidelines on polypectomy are in line with the JAG DOPyS polypectomy assessment which can be accessed at:

http://www.thejag.org.uk/downloads%5CDOPyS%20Forms%20For%20International%20and%20reference%20use%20only%5CDOPyS%20v%2017.pdf

In summary careful examination of the polyp should be undertaken before removal assessing pit pattern with white light endoscopy and narrow band imaging or FICE if available. Pictures should be taken before and after removal of the polyp. If the image capture device is not working this should be documented in the text of the report.

Sessile Polyps

Sessile benign polyps less than 3mm should be removed by cold biopsy ensuring to take sufficient bites to complete removal before capturing an image.

Sessile polyps from around 3-7mm should be cold snared using the Exacto 9mm cold snare.

Sessile polyps larger than 8mm should be lifted with submucosal injection and then removed with a hot snare. Any residual polyp that can not be snared should be treated with Argon plasma coagulation.

An image of the polyp base is essential and one tattoo should then be placed 1-2cm distal to the lesion in polyps over 8mm. To do this 1-2ml of saline should be submucosally injected and then the SPOT can be injected into the bleb.

Difficult larger polyps fall into the following categories

a. Occupies more than 1/3 of the circumference of the colon.
b. Spans two adjacent haustral folds.
c. Is sessile and greater than 3cm in diameter.
d. Is pedunculated but has a thick stalk
e. Has a significant component on the oral side of the haustral fold requiring retroflection of the scope for adequate treatment.

Such polyps should be treated by an experienced endoscopist who is comfortable and proficient in the practice of endoscopic mucosal resection.
Pedunculated Polyps

Once good views have been obtained, the patient is in the optimal position and an image has been captured pedunculated polyps should be removed with an appropriately sized hot snare.

An image of the polyp stalk should be taken and tattoo placed as per instructions above.

Polyp Follow Up

All polyp follow up should be in line with the British Society of Gastroenterology 2010 guidelines:

(www.bsg.org.uk/images/stories/docs/clinical/guidelines/endoscopy/ccs_10.pdf)

In the following circumstances local advice applies:

Following surgery with curative intent for resection of colorectal cancer. In patients where the pre-operation colonoscopy was incomplete a colonoscopy should be arranged within the first year following surgery. In those who had a complete colonoscopy prior to surgery a follow up colonoscopy should be arranged 3 years following surgery. If these procedures are unremarkable then the patient should revert back to the BSG 2010 guidelines (five yearly surveillance).

Teaching/Refresher Courses

It is recommended that all colonoscopists attend a colonoscopy master class or a train the trainer course in colonoscopy every 5 years to keep up to date in this fast moving field.

Failure to meet agreed quality standards

The Lothian policy for supporting endoscopists who do not achieve national standards will be used to guide failure to meet these standards.