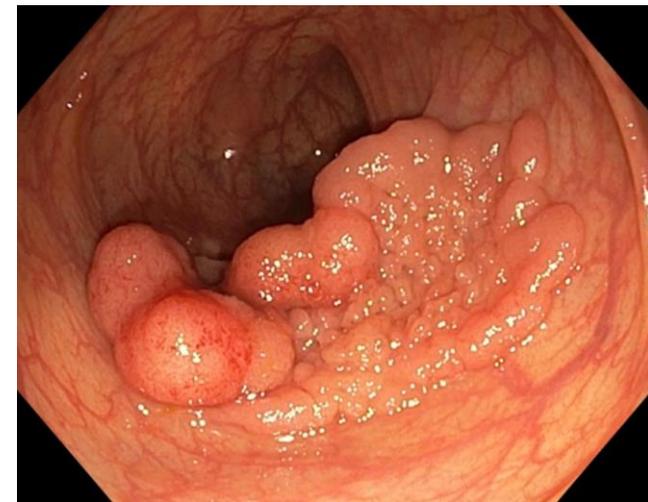
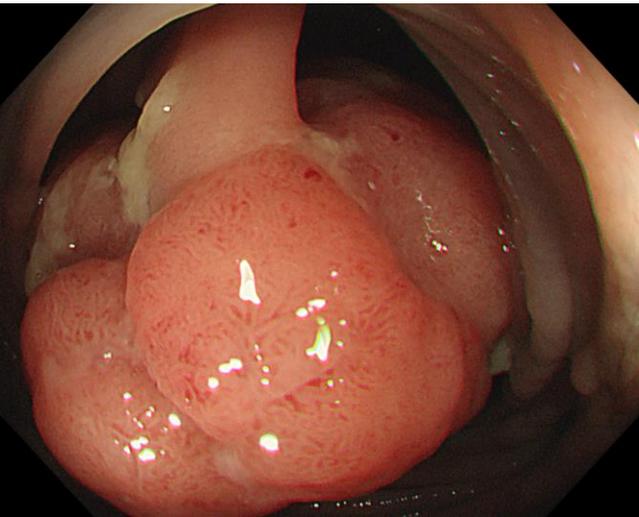


Is there justification for
levels of polyp
competency?

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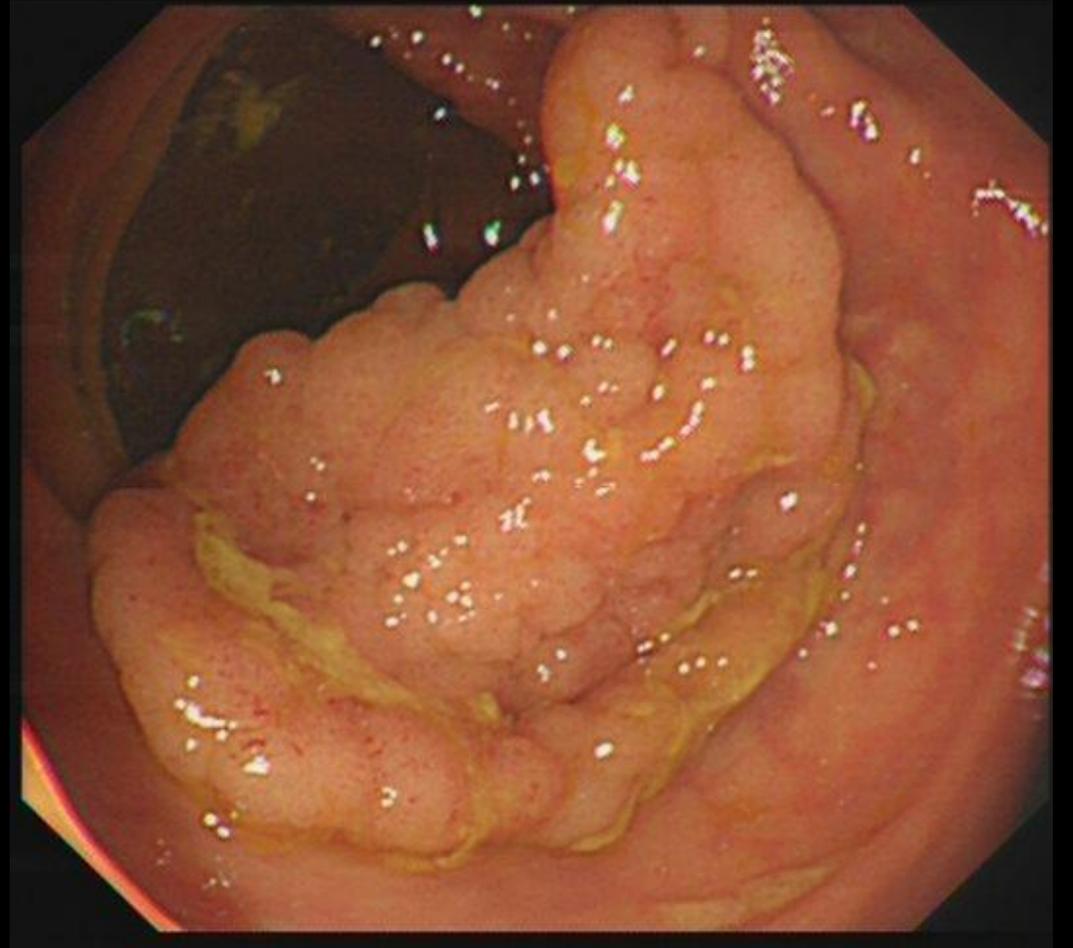
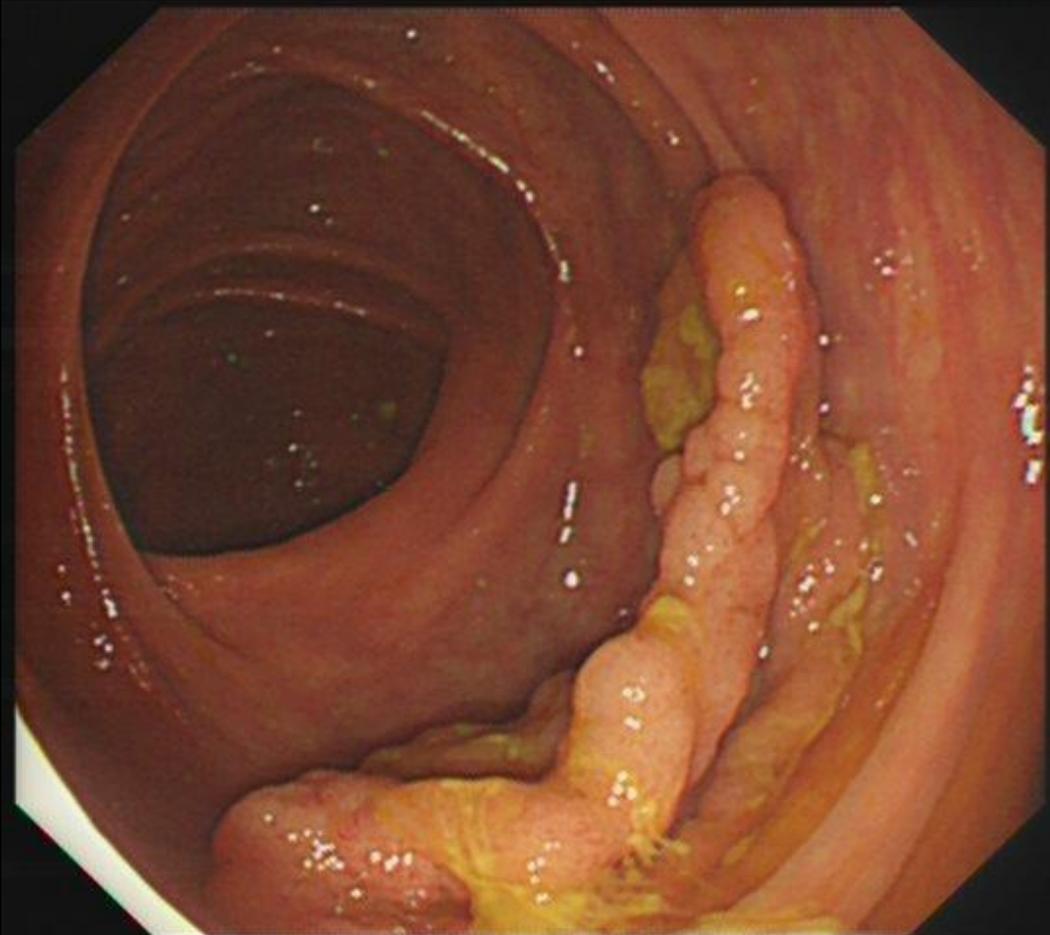


What exactly will be required?

- Defining levels of polypectomy competency in terms of complexity/time/risk
- Having training programmes with competency assessments at each level
- Being clear about who is allowed to do what – a badge or license for each level
- Clear pathways for patients with informed and shared decision making
- Evaluating these steps

Ultimately we want to achieve excellent
outcomes and ensure that
decisions are not constrained by what is on offer

Friday 14 September 2018 17:49



Unsedated 54 year old female with IBS
Would you remove this polyp now?
If not would you refer to a surgeon?

Operative data from US

- From 2000 through 2014, there were 1,230,458 surgeries for benign colorectal polyps and colorectal cancer in the United States. Among those surgeries, 25% were performed for benign colorectal polyps.

	Rates of surgery/100,000 population	
	2000	2014
Benign polyps	5.9	9.4
Colorectal cancer	31.5	24.7

Peery AF, et al. Increasing Rates of Surgery for Patients With Non malignant Colorectal Polyps in the United States. *Gastroenterology*. 2018 Apr;154(5):1352–3.)

Unwarranted variation in polypectomy

- Variation in practice

- Recognition
- Decision making
- Excision technique
- Tattooing
- Retrieval rates
- Surveillance decisions

- Unwarranted consequences

- Incomplete resection
- Post colonoscopy CRC
- Complications
- Unnecessary operations
- Waste resources
- Waste patient time
- Death

Approaches to improving quality

Define, measure and review metrics and deal with poor performance

OR

Put processes and structures in place before you start to have the best chance of getting it right first time

OR

BOTH

Polypectomy has been an afterthought

- We have
 - Metrics for safety and +/- for quality
 - A competency framework (DOPyS)
- BUT
 - Polypectomy training has lagged behind teaching intubation and detection skills

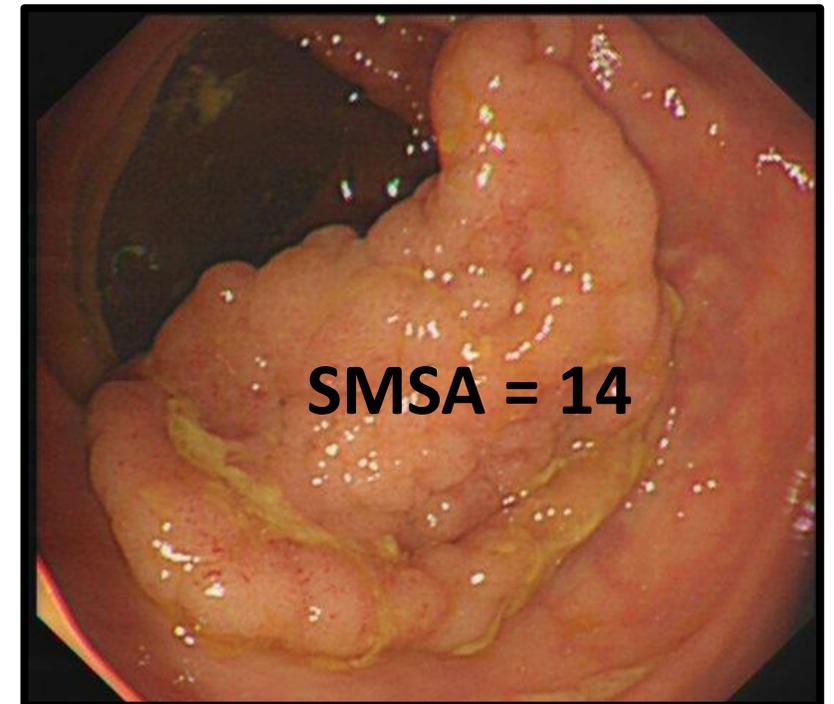
European Guideline (2010) for QA of CRC screening and diagnosis:
 “To help in the planning of location of endoscopic services for screening,
 the following four levels of competency are proposed”

Level	Type of polyp	Setting/endoscopist
1	Lesions <10mm in diameter	FS screening
2	Polypoid and sessile lesions <25mm providing there is good access.	All colonoscopists
3	Smaller flat lesions (<20mm) that are suitable for endoscopic therapy, larger sessile and polypoid lesions and smaller lesions with more difficult access	FIT screening positive colonoscopy
4	Large flat lesions or other challenging polypoid lesions that might also be treated with surgery	Regionally based colonoscopists

SMSA polypectomy scoring system

SMSA		Score
Size	<1cm	1
	1 - 1.9 cm	3
	2 - 2.9 cm	5
	3 - 3.9 cm	7
	>4cm	9
Morphology	Pedunculated	1
	Sessile	2
	Flat	3
Site	Left	1
	Right	2
Access	Easy	1
	Difficult	3

Level 1	4-5
Level 2	6-9
Level 3	10-12
Level 4	>12

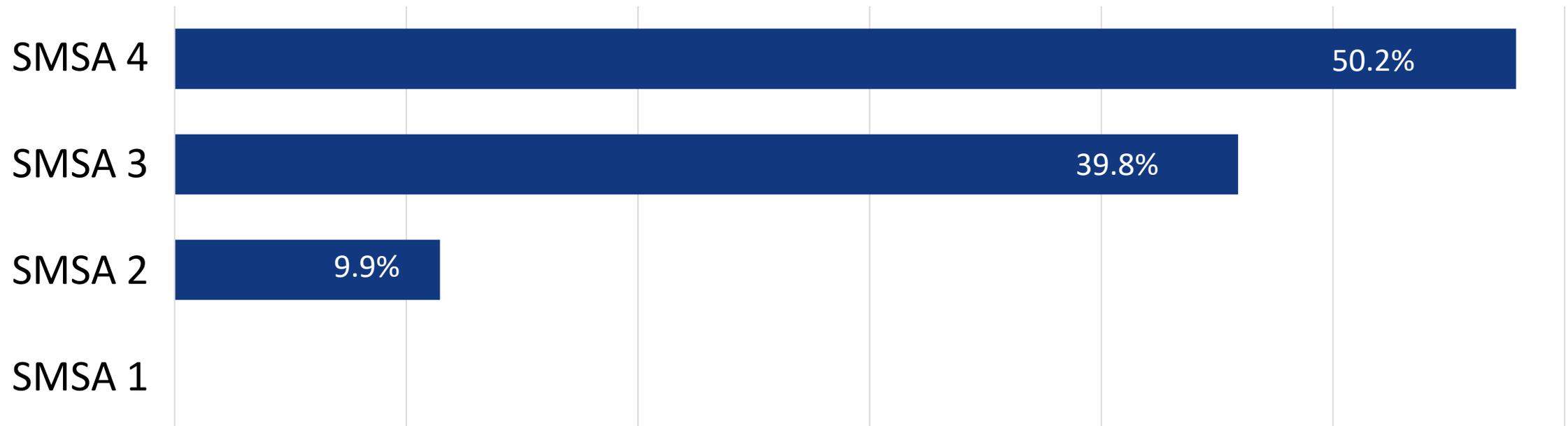


SMSA polypectomy scoring

- 220 polyps >2cm in 220 patients
- 37% level 2 and 3, 63% level 4
- SMSA related to complications and clearance but not cancer
- “The SMSA assessment tool enables lesions to be effectively stratified for prognostic information, training, level of expertise required, and reimbursement tariffs.”

Distribution of SMSA scores, n=2305

Sidhu M, et al. The size, morphology, site, and access score predicts critical outcomes of endoscopic mucosal resection in the colon. Endoscopy. 2018 Jan 25.



- SMSA 2
- Median procedure duration **10 min**
- Likelihood of
 - Success 98.7%
 - Delayed bleeding 1.7%
 - Recurrence 5.4%
 - Late recurrence

- SMSA 3
- Median procedure duration **15 min**
- Likelihood of
 - Success 97.4%
 - Delayed bleeding 5.0%
 - Recurrence 10.4%
 - Late recurrence

- SMSA 4
- Median procedure duration **30 min**
- Likelihood of
 - Success 94.0%
 - Delayed bleeding 7.8%
 - Recurrence 23.7%
 - Late recurrence

Sidhu M, et al. The size, morphology, site, and access score predicts critical outcomes of endoscopic mucosal resection in the colon. Endoscopy. 2018 Jan 25.

Conclusions

- In prospective data derived from over 2000 patients undergoing EMR for large LSL the SMSA polyp score reliably predicted
 - Success of EMR
 - Adverse events during and after EMR
 - Risk of recurrence after EMR
- The components of the SMSA polyp score can easily be obtained from an adequate referral letter/report

Sidhu M, et al. The size, morphology, site, and access score predicts critical outcomes of endoscopic mucosal resection in the colon. *Endoscopy*. 2018 Jan 25.

Implications of using SMSA

- List planning
 - Correct lesion for correct practitioner (avoid incomplete excision)
 - Accurate timing per lesion
- Predicting adverse events
 - Enhanced informed consent
 - Risk of complications can be prospectively discussed with patients and plans made
 - Post procedural care plans can reflect the risk of the procedure for example patients with a high risk of delayed bleeding
 - Modification of anticoagulation etc.
 - Risk of recurrence may dictate surveillance intervals
 - Allows prospective estimation of procedural costs
- Training
 - Right lesion allocated to correct stage of training

What is the justification? Hierarchy of issues

- What does the patient want?
 - Good experience, safe, high quality, informed choice
- Health system
 - Best possible outcome at low cost
- Endoscopist
 - Job satisfaction, payment, avoid complaints and litigation

What exactly will be required?

- Defining levels of polypectomy competency in terms of complexity/time/risk
- Having training programmes with competency assessments at each level
- Being clear about who is allowed to do what – a badge or license for each level
- Clear pathways for patients with unbiased and informed shared decision making
- Evaluating these steps
- Evaluate performance of polypectomy

Ultimately we want to achieve excellent outcomes and ensure that decisions are not constrained by what is on offer