



Open access endoscopy

Guidelines for the practice of endoscopy are developed by the American Society for Gastrointestinal Endoscopy by using evidence-based methodologies. A literature search is performed to identify relevant studies on the topic. Each study is then reviewed for both methodology and results. Controlled clinical trials are emphasized, but information is also obtained from other study designs and clinical reports. In the absence of data, expert opinion is considered. When appropriate, the guidelines are submitted to other professional organizations for review and endorsement. As new information becomes available, revision of these guidelines may be necessary.

These guidelines are intended to apply equally to all who perform GI endoscopic procedures, regardless of specialty or location of service. Practice guidelines are meant to address general issues of endoscopic practice. By their nature, they cannot encompass all clinical situations. Clinical situations may justify a course of action at variance to these recommendations.

Open access endoscopy (OAE) is defined as the performance of endoscopic procedures requested by referring physicians without a prior clinic consultation. Traditionally, physicians have requested consultations for their patients by a GI endoscopist to determine whether endoscopic intervention was indicated.^{1,2} However, OAE has become increasingly used in both the United States and Europe. A recent ASGE survey estimated that 60% of respondents used some form of OAE, comprising over 25% of practice for some physicians.² OAE is most commonly offered for EGD, colonoscopy, and flexible sigmoidoscopy. The widespread use of OAE may reflect efforts to decrease costs related to endoscopy by eliminating potentially unnecessary office-based consultations. Moreover, increasing demand for endoscopic procedures (e.g., colorectal cancer screening) have impacted endoscopist workload. Therefore, the endoscopist's efficiency might be improved through utilization of OAE. However, OAE is not a substitute for consultation.

There are several pertinent issues that may arise in the use of OAE: (1) appropriateness of referral (indication/fit for procedure); (2) patient acceptance and preparedness for endoscopy; (3) informed consent; (4) yield of procedure; (5) assurance of appropriate follow-up.

APPROPRIATENESS OF REFERRAL

There are now several studies that have evaluated whether patients sent for endoscopy using an OAE system are appropriately referred. Most have used the ASGE appropriate indications for endoscopy guideline to determine appropriate referrals.³ The rate of procedures performed for "generally not indicated" or unlisted indications for EGD or colonoscopy ranged from 15% to 50%.⁴⁻⁷ Most studies have found a significantly higher rate of inappropriate referrals by non-gastroenterologists as compared with gastroenterologists.⁸ There are only a few reports from U.S. centers studying OAE. Mahajan et al.⁹ studied 310 patients undergoing EGD or colonoscopy and found compliance with the ASGE guidelines in 95% of EGD and 81% of colonoscopy referrals. Zuccaro and Provencher¹⁰ audited over 3100 endoscopy reports in an OAE system and found that non-gastroenterologists referred appropriately 81% of the time compared with 85% for gastroenterologists.¹⁰ It should be noted that the ASGE guidelines are not all-inclusive for endoscopy. Therefore, the endoscopies that did not meet criteria established by the guidelines may still have been appropriate.

YIELD OF PROCEDURES

There are limited data on the findings of endoscopic procedures in patients referred in an open-access endoscopy system. Charles et al.⁸ found pathologic findings in 37% of patients appropriately referred (based on ASGE guidelines) compared with 20% of patients with inappropriate referrals. However, there are numerous unresolved issues regarding the yield of endoscopy. These include acceptable rate of findings, determination of significant versus nonsignificant findings, impact of findings on subsequent patient management, and the value of a normal endoscopy. Determinations of appropriate indications for procedures are inextricably linked to yield.

PATIENT ACCEPTANCE AND PREPAREDNESS FOR ENDOSCOPY

Patient's referred for OAE need to receive adequate preprocedure education. It has been shown that this education impacts patient compliance with and tolerance of the procedure, as well as endoscopy success rates.^{11,12} In one English study of patient satisfaction, OAE was found to be acceptable to

patients.¹³ In another study, no differences in patient satisfaction were found between those patients referred for endoscopy from a gastroenterology clinic versus OAE.¹⁴

However, another British study found that the majority of patients preferred to be seen in a specialty clinic first, and that additional diagnoses that may have been missed through OAE were made during that clinic visit.¹⁵

INFORMED CONSENT

Although many endoscopists will provide preprocedure education and informed consent during an office visit before the endoscopy, OAE does not readily allow this process to occur. One study has shown that OAE patients have are less knowledgeable about the procedure than other patients.¹⁶ However, patient knowledge can be improved through the use of a mailed informed consent package.¹⁷ Alternatively, patients can be provided with appointments for preprocedural education administered by nursing staff or via videotape.^{18,19}

SUMMARY

OAE is commonly used. Although study results are mixed, several potential problems have been identified, including inappropriate referral and poorly informed, less satisfied patients. Endoscopic procedures performed without sedation, such as flexible sigmoidoscopy, may be more easily integrated into an OA program. The practice of OAE may be reasonable, but with several provisions.

- Detailed information for primary care providers regarding indications and contraindications to endoscopic procedures must be made available (including, but not limited to the ASGE "Appropriate use of gastrointestinal endoscopy" guideline).
- Opportunities for feedback to primary care providers regarding appropriate and inappropriate referrals.
- Detailed information for patients regarding the nature of endoscopic procedures.
- Detailed information for patients/referring providers on preparation issues before endoscopic procedures.
- Mechanisms for the endoscopist to receive preendoscopic information about the patient.
- Detailed mechanisms for reporting of results and establishing proper follow-up.

OAE can be safely used only if medical complexity, transfer of information, and patient safety and satisfaction are addressed in all cases. As OAE use continues, more data should be available to optimize its use.

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APPENDIX 1

INDICATIONS FOR OAE

Examples of acceptable indications for OAE (including, but not limited to):

- Dyspepsia that is poorly responsive to PPI trial
- Chronic GERD to rule out Barrett's esophagus
- History of colon adenomas
- Family history of colon cancer
- Guaiac positive stool
- CRC screening

APPENDIX 2

EXAMPLES OF INFORMATION TO BE MADE AVAILABLE TO PATIENTS/PHYSICIANS

Detailed information for patients regarding the nature of endoscopic procedures:

- ASGE handouts on EGD, colonoscopy and flexible sigmoidoscopy

Detailed information for patients/referring physicians on preparation issues before endoscopic procedures.

- ASGE information

Mechanisms for the endoscopist to receive pre-endoscopic information about the patient

- List of criteria such as demographic and insurance information, indication for the procedure, and pertinent information about the patient's health that may affect performance of the procedure (anticoagulation, heart murmur, serious heart, lung, or systemic disease).

Detailed mechanisms for reporting of results and establishing proper follow-up.