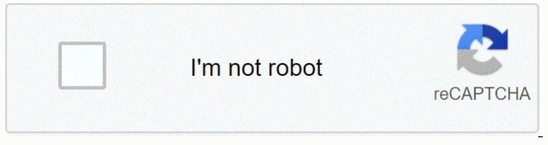

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Colonoscopy guidelines aafp

Colonoscopy is a necessary part of modern medical practice and one of the most commonly used invasive medical procedures. It is very important to diagnose various conditions, but it is most often used for the prevention and detection of colorectal cancer, the third most common cancer in men and women in the United States.1 Cancer affecting both men and women, colorectal cancer is the second leading cause of cancer mortality in the United States, causing approximately 50,000 deaths each year.2.3.4 Colonoscopy screening is associated with a reduced risk of colorectal cancer mortality.5 Gastrointestinal complaints are often reported to family doctors for the first time. Since family doctors are trained to diagnose, treat and, if necessary, properly target patients with gastrointestinal (GI) disorders, knowing when colonoscopy is required is one aspect of the role of a family physician. Like other endoscopic procedures, colonoscopy has become despecialized in recent years and is now performed by doctors in many specialties. Family doctors showed the ability to learn colonoscopy and safely and effectively perform the procedure. As family doctors practice in all areas, including rural and underserved areas, their ability to perform colonoscopy improves patients' access to care.6 These services are easily accessible and also help to reduce inconvenience to patients who might otherwise have to wait weeks or travel long distances to see a specialist in the procedure. Patients also benefit from faster diagnosis and treatment, as well as increased continuity of care. Section I - The scope of practice for family doctors colonoscopy can be a natural extension of the comprehensive care provided by the family doctor. According to the Census of members of the American Academy of Family Physicians (AAFP) (as of December 31, 2017), 2 percent of AAFP members perform colonoscopy in their practice.7 Family physicians choose the personal scope of the practice based on factors that include their teaching experience, the interests of their practices, and the needs of the patient population. Therefore, each family doctor must assess the proper practice of performing a colonoscopy. The doctor should consider his training and comfort level with the procedure, staff competence, office set-up, local standards of care, economic consequences and privileges requirements. Adenoma detection rate (ADR), defined as the detection rate of doctor's selection of colonoscopies detecting one or more adenoms, part of the Initial Quality Measure for Colonoscopy.8.9 The American Gastrointestinal Endoscopy Society (ASGE)/ACG Endoscopy Quality Task Force recommends a minimum ADR target of 25% or more in the population of men and women aged 50 and over undergoing screening for colonoscopy.8 The recommended AGS target is 30% or higher for screening. Men 50 years of age and older and 20% or more for coloroscopy screening in women 50 years of age and older.8 Studies have shown that that trained primary care physicians performing colonoscopy can achieve the quality objectives set and perform the procedure safely and effectively.10.11 For example, in a 2015 study of family doctors performing colonoscopy, ADR was 38.15% for men over 50 years of age and 25.96% for women over 50 years of age.12 In addition, studies have shown that that primary care physicians performing colonialcopy are positively compared with gastroenterologists and general surgeons when other observable factors, such as cecal intubation frequency, time required to complete the procedure and complications frequency used to determine technical competence.6,10- Both limited endoscopy capacity and insufficient number of doctors performing colonoscopy contribute to the suboptimal level of colorectal cancer screening. , in particular in underserved populations.12,18,19 Geographical proximity (time or physical distance from the healthcare provider) has also been identified as an obstacle to the screening of colorectal cancer and the cause of poorer outcomes for patients in rural areas.20 Quality, the safety and efficacy of colonoscopies performed by primary care physicians meets or exceed the criteria set by the ASGE/ACG Endoscopy Quality Working Group and are favourable for comparison with sub-specialists.11,12 Therefore, increasing the number of trained family doctors performing colonoscopy can improve colorectal cancer screening rates and access to healthcare, also reduce the number of cases of colorectal cancer and the diagnosis of later stages.12,18,19,21 The benefits for the patient to perform colonoscopy by his family doctor include less care fragmentation; increased comfort of the patient when the procedure is performed by a familiar, reliable doctor; reduced travel time; reduced costs for the patient; less laboratory tests; and high patient satisfaction.22 The provision of colonoscopy by family doctors also affects the community. Endoscopic procedures form a key part of clinical care in many hospitals and outpatient clinical cases. In order to continue this care, rural hospitals and the outpatient clinical environment need doctors who can perform colonoscopy. The presence of family doctors capable of providing modern endoscopic care can be one of the main clinical factors for the survival of small hospitals and outpatient clinical settings. Section II - Clinical indications Colonoscopy is the most commonly used colorectal cancer screening test in the United States.23 The U.S. Preventive Services Working Party (USPSTF) recommends screening adults for colorectal cancer from the age of 50 and continuing until the age of 75.4 This recommendation applies to persons who are present colorectal cancer and who do not have a family history known genetic disorder that may lead to high high risk of colorectal cancer (e.g. Lynch syndrome or familial adenomatous polyposium), personal history of inflammatory bowel disease, previous adenomatous polyp or previous colorectal cancer. 4 USPSTF does not recommend special screening methods, rather than providing information on various screening tests, including colonoscopy, effectiveness, strength, limitations and circumstances, so that doctors can make informed decisions with individual patients. AAFP Clinical Preventive Service Recommendation on Colorectal Cancer Screening in Adult States: AAFP recommends screening for colorectal cancer in feces immunochemical tests, flexible sigmoidoscopy or colonoscopy from the age of 50 and lasts until the age of 75. The risk, benefits and strength of supporting evidence differ from one selection method. 24 According to the Choice Wise campaign, national efforts to reduce waste in the health care system and avoid unnecessary or harmful tests and treatments, The American Gastroenterologists' Association (AGA) advises that individuals at an average risk of colorectal cancer who are undergoing selective colonoscopy should take an exam every 10 years, starting at 50 years and continuing to 75 years of age.25 Patients at higher risk may need more frequent screening. The list of indications for GI endoscopy of the American Gastrointestinal Endoscopy Society includes specific indications for colonoscopy (Table 1). Table 1: ASGE guidelines for GI endoscopy and colonoscopy GI endoscopy are usually indicated: If a change in management is likely based on endoscopy results. After an empirical study of suspected benign digestive disorder, the treatment was flawless. As an initial assessment method as an alternative to radiographic studies. When considering the primary therapeutic procedure. GI endoscopy is not usually specified: When the results will not contribute to the choice of management. Periodically monitor the cured benign disease, unless it is necessary to monitor the pre-stagnant condition. GI endoscopy is usually contraindicated: When the risk to the health or life of patients is assessed as higher than the most favorable benefits of the procedure. When it is not possible to obtain proper cooperation or consent of patients. When perforated whisky is known or suspected. Colonoscopy Colonoscopy is usually indicated in the following circumstances: assessment of the obsessive anomaly of barium or other imaging examination, which may be clinically significant, such as filling defect and rigour. Assessment of unexplained GI bleeding: Hematochezia. Melena after the upper SOURCE GI was removed. The presence of fecal occult blood. Unexplained iron deficiency anemia. Examination and care of colorectal neoplasia: screening of asymptomatic, moderate-risk patients for colonial neoplasia. A study to evaluate the complete colon of synchronous cancer or neoplastic polyps in a patient with or neoplastic polyp. Colonoscopy to eliminate simultaneous neoplastic lesions in or around the therapeutic cancer during eccleasic, followed by colonoscopy for 1 year and, if usual, then 3 years, and if normal, then 5 years after that for the detection of metacronic cancer. Monitoring of patients with neoplastic polyps. Monitoring of patients with significant history of colorectal neoplasia family. For dysplasia and cancer care in selected patients with long-term ulcerative or Crohn's colitis. For the assessment of patients with chronic inflammatory bowel disease in the colon, if a more accurate diagnosis or determination of the extent of disease activity will affect management. Clinically significant unexplained diarrhoea. Intraoperative detection of damage during surgery is not obvious (e.g. location of polypectomy, location of bleeding site). Treatment of bleeding from such lesions as vascular malformation, ulcers, neoplasia and the location of polypectomy. Intraoperative evaluation of anastomotic reconstructions characteristic of surgery for colon and rectal diseases (e.g. evaluation of anastomotic leakage and patting, bleeding, formation of sacs). As an addition to minimally invasive surgery to treat diseases of the colon and rectum. Management or evaluation of operational complications (e.g. dilation of anastomotic severity). Removal of a foreign body. Isolation or ablation of lesions. Decompression of acute megacolon or sigmoid volvulus. Dilation of the cylinder for stenotic lesions (e.g. anastomotic rigors). Palliative treatment of stent or bleeding tumours (e.g. laser, electrocoagulation, stenting). Marking of neoplasm for localization. Colonoscopy is usually not indicated in the following circumstances: chronic, stable, irritable bowel syndrome or chronic abdominal pain; there are unusual exceptions when colonoscopy can be performed once to rule out the disease, especially if the symptoms do not respond to treatment. Acute diarrhea. Metastatic adenocarcinoma of unknown primary site, in the absence of colonial signs or symptoms, when this does not affect management. Routine monitoring of inflammatory bowel disease (except for cancer care in the case of chronic ulcerative colitis and Crohn's colitis). GI bleeding or melena with a proven upper SOURCE of GI. Colonoscopy is usually contraindicated: Fulminant colitis. Documented acute diverticulitis. Reprint with permission early DS, Ben-Menachem T, Decker GA, et al; ASGE Standards Committee. Proper use of GI endoscopy. Gastrointest Endosc. 2012;75(6):1127-1131. Section III - Teaching methodology Family doctors usually acquire the skills to perform a colonoscopy during their family medical residency training. The Society of Family Medical Teachers (STFM) The Hospital Medical and Procedural Training Group adds a colonoscopy to its list of basic family medical procedures, which must be available to all residents and who must be able to be able to be carried out by self-completion.26 Working Group of members of the Academic Family Medicine Council (CAFM) and experienced faculty and program directors have issued a consensus statement on the procedural training of family medicine residency, which includes colonoscopy as one of the more complex or advanced procedures for which some family medical residences may be offered training to concerned residents.27 The AAFP considers that appropriate training can consist of documented education in the Residence Programme approved by the Accreditation Board for Graduate Medical Studies (ACGME) , which prepares residents to practice colonoscopy; continuing medical training (CME) courses with didactic and procedural training; and/or lessons learned focused on colonoscopy.28 Any method of training should develop both cognitive skills related to knowledge, when to perform a colonoscopy and how to properly interpret and manage the findings and technical skills related to the safe conduct of the procedure. Colonoscopy training should also decide how to recognize and immediately treat complications associated with the procedure (Table 2). Table 2: Possible complications of colonoscopy Bleeding Perforation Respiratory depression Bradycardia Hypothesaemia Hypotension Cardiac arrhythmias or ischemia Transient bactermia Postpolypectomy electrocoagulation syndrome Abdominal pain or discomfort Information from the STANDARDS OF THE ASGE Practice Committee, Fisher DA, Maple UN, etc. Colonoscopy complications. Gastrointest Endosc. 2011;74(4):745-752. Due to intravenous (IV) conscious sedation, advanced cardiac life support (ACLS) training and certification may be required in hospitals or outpatient clinical environments for colonoscopy privileging. Even if the certification of ACLS is not required, it is recommended that the doctor performing a colonoscopy be prepared for anesthetics or cardiopulmonary complications. Section IV – Testing, Proofing and documentation Although the number of procedures performed in training is sometimes recommended as a credential criterion, the figures alone do not prove the quality of the results. There is no scientific evidence to support the extent of colonoscopies performed with the acquisition of competence. It is clear that individual doctors have varying levels of hand dexterity and pre-existing experience with flexible sigmoidoscopy and acquire skills at different paces. On the basis of the review of the available evidence, the AAFP that the standard for determining the principal competence of a family physician in the field of colonoscopy should be 50 procedures performed as the primary operator.29-31 The American Primary Care Endoscopy Association (AAPCE) agrees, indicating that if a hospital or outpatient clinical environment decides to require a specific number of procedures during training, the requirement should not exceed 50 colonoscopies.32 The amount of continuous colonoscopy experience required to be maintained in order to maintain the requirement is to be exceeded. has not been fully investigated. The AAFP recommends that family doctors document all relevant procedural skills training and experience so that this information can be provided in an organized manner.33 This includes recording the application note for each patient (Table 3), a recording of colonoscopy experience and training (Table 4) and an assessment of the competence or recommendation of the residency programme or faculty instructor(s). Table 3: Suggested content of the procedure Please note the patient identification or code Of the procedure date Site of procedure (name of hospital or outpatient clinical situation) Patient age History of the patient's previous colonoscopy, including any problems with previous procedures Clinical colonoscopy indication Description procedure Description Complication table Table 4. Proposed documentation Colonoscopy Experience Procedures performed during training and practice Results data, including complication rate Letters of instructors, precepts and proctors documentation training, experience, demonstrate abilities and current expertise Hospital and outpatient clinical settings letters, document experience and results Section V – Credentials and privileges AAFP believes that any specialty hospital department should set up a family medical unit that would have the right to recommend privileges , which fall within the field of family medicine directly to the relevant committee.34 See The process of credentials and family medical privileges varies from organization to organization. The position of the AAFP is that clinical privileges should be based on the training and/or experience documented by an individual physician, proven abilities and current competence, and not on the specialisation of a doctor.35 AAFP has a policy specifically devoted to colonoscopy privileges. The AAFP's position is in line with the policies of other organisations influencing credentials and privileges: the American Medical Association (AMA)'s policy on patient protection and clinical privileges states in part: Staffing and clinical privileges in hospitals and other health facilities, the AMA believes: (1) the focus should be on the interests of patients; (2) The compliance and limits of privileges should be determined individually, taking into account the applicant's education, training, experience and proven current competence. In implementing these criteria, each measure should develop and apply reasonable, non-discriminatory standards for assessing the applicant's powers without anti-competitive intent or purpose. 36 The standards of the Joint Commission also require that the decision to grant or refuse to grant privileges and/or to renew existing privileges is an objective, evidence-based process there is no obstacle to granting privileges to certain activities for more than one clinical specialty. 2017 The Joint Commission's detailed accreditation and certification manual states: Issuing credentials includes the collection, verification and evaluation of information on three important parameters: current licensing; education and appropriate training; experience, the capacity and current competence to exercise the privilege sought [MS.06.01.03].37 All criteria relating to licensing, education, training and current competence should be consistently assessed for all professionals with this privilege [MS.06.01.05].37 The lack of community need may be cited as a reason to waive colonoscopy privileges from family doctors practicing in an environment shared with sub-specialists. However, this approach is not in line with the AAFP, AMA or The Joint Commission's privilege policy. Family doctors moving to a new practice site who plan to perform a colonoscopy would benefit from the policies and procedures of their chosen website regarding colonoscopy privileges and obtaining these privileges before actually moving to a new practice site, if possible. This approach is especially advisable if the family doctor is the first to ask for colonoscopy privileges in an environment where gastroenterologists only have such privileges. Table 5 lists recommended actions for family doctors who apply for GI endoscopy privileges. Privileges of invasive procedures are usually granted on a temporary basis with the requirement for a doctor to submit progress reports at specified intervals (e.g. three months, six months, one year). According to the specialty section section, the Department of Family Medicine should monitor these progress reports of the department's members and make recommendations for progress from temporary privileges to active privileges. In order to ensure continuous monitoring of quality, doctors may be required to submit an annual census of all invasive procedures listing any complications arising. Table 5: Apply for GI endoscopy privileges Get acquainted with the statutes and processes of the hospital or outpatient clinical environment related to credentials and privileges. Be cooperative still tenacious during the privileging process. View the priority resources that are available from the AAFP. Prepare a short CV describing education, including college, medical school, residency, board certification and certificate renewal. Lists of addictions in hospitals, outpatient clinical settings and public and/or national medical societies, including the duration of these links. All professional praise, elected office or duties of chairman of the committee shall be listed. Please indicate how many years in practice there are and describe the provision of high-quality care services in a number of complex The doctor may refer to the sample service record as evidence of professional excellence. Describe everything all CME courses on GI endoscopy and GI-related self-examination (e.g. atlases, articles). In addition, be able to demonstrate a continuing commitment to appropriate continuing medical education. Receive and include a summary of the place of residence or AAFP section stating that the rights requested fall within the field of family medicine specialty. Specify the number of rigid sigmoidoscopies performed, flexible sigmoidoscopies, colonoscopies and/or upper GI endoscopies. Include a journal listing the procedures by date, the patient's age and gender and the indication. Provide diagnostic data and clearly highlight the small number of complications. If necessary, describe any practical distribution experience(s) and/or identify the person who wants to be a proctor. Practical proctorship is not necessarily a prerequisite for doctors who have equivalent training and experience in GI endoscopy. Provide evidence of your ability to obtain unlawful insurance cover. Section VI - Various issues A. The current research agenda AAFP supports the need to carry out and publish studies on the operation of colonoscopy of family doctors. This study should focus on the following key areas: Quality assurance: Continuous case review programmes/studies should be launched to monitor the results of colonoscopies performed by family doctors, and these results should be compared with those of other specialties. Teaching methods, including cognitive and procedural aspects: issues related to the colonoscopy learning curve should be addressed. In order to further improve quality, research is needed to determine the ratio between the number of colonoscopies performed and the proven testing and retention of skills, if any. B. Relations with other organisations AAFP policy states: AAFP should seek to cooperate with other specialised societies, where appropriate, on procedural skills, including but not limited to: training, privilege and credentials and joint political action. 38 Unfortunately, in the past, some specialised societies were reluctant to cooperate with AAFP on endoscopy issues. In such situations, the AAFP had no choice but to develop its own education programmes. It would be ideal if AAFP and other specialised organisations could work together to improve patient care and spread information to train all doctors. The AAFP welcomes the possibility of cooperating with other groups that have members who perform colonoscopy. Colonoscopy.