Surveying and understanding colonoscopy technique

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Accepted 11 May 2012
Published Online First
21 July 2012

Bedford *et al*¹ report the results of their survey of hyoscine (Buscopan) use during colonoscopy and ask if the current British Society of Gastroenterology (BSG) guidelines in this area should be modified as a consequence. Current BSG guidance recommends ‘...Buscopan should therefore be used cautiously at the lowest possible dose or avoided in... patients with a history of closed angle glaucoma’. Despite the known limitations in interpretation of surveys and without dwelling on these, the authors do serendipitously raise the important question of colonoscopy quality and understanding of interventions used in practice to improve it. It is interesting that over the past decade the overwhelming focus on improvement in quality of colonoscopy has resulted in various surrogate measures such as caecal intubation rates, adenoma detection rates, withdrawal times, etc., with attempts at correlation of these with the more important but difficult to measure indicators such as interval cancers and rates of missed lesions.² Perhaps when we look at the literature on this subject, it is relevant to note that the most recently published placebo controlled randomised controlled trial looking at Buscopan use during colonoscopy reports a lack of any clear advantage, and also does not have glaucoma as an exclusion criterion among its participants.³ Bedford *et al*¹ suggest that an inappropriate withholding of Buscopan may result in potentially reducing the chance of a complete colonoscopy. However, other studies have not found any robust association between its use and an improvement in caecal intubation rates or completion rates.⁴ In recent years the focus has shifted to an effect on the improvement in adenoma detection rates, and once again there is conflicting evidence of any advantage with the use of antispasmodic agents.^{3–5} As with many other published interventions to improve adenoma detection rates, appropriately

designed studies that stratify for or achieve standardisation of training, experience, technique, equipment, setting (screening vs symptomatic patient population) and then randomly assign their subjects are relatively few, and therefore assigning a role for Buscopan as an independent measure to improve colonoscopy quality remains unproved at present. Other situations such as during therapeutic intervention (polypectomy or endoscopic mucosal resection) at colonoscopy, or as an adjunct along with other interventions such as dynamic position change may also be potentially appropriate for the use of Buscopan but remain difficult to analyse. Data from a different setting that may inform us in this situation may be from the frequent use of Buscopan during another procedure, namely endoscopic retrograde cholangiopancreatography, when again the most recent BSG survey⁶ did not report any ocular complications. Quantifying degrees of colonic spasm remains difficult and it would be reasonable on the basis of current data to suggest that enhanced inspection techniques such as using adequate insufflation, careful and if necessary repetitive examination of segments such as flexures, proximal aspects of folds and suctioning of liquid stool may all contribute to improved quality as measured by the above indicators.⁷ It would seem logical to suggest that the use of Buscopan may assist with enhanced inspection. However, as is evident with other data on technical advances such as narrow band imaging initially thought to improve adenoma detection rates, there seems to be a learning curve for improved detection that may be dependant on technique rather than technology or medication use.⁸ Individual colonoscopists may feel it is reasonable to use Buscopan in specific situations based on their experience, and this survey highlights that if they do use it, knowledge of its specific cautions and

contraindications may need to be precise and informed. From an organisational viewpoint, however, it would seem sensible to exercise caution in advocating the use of Buscopan as a marker of colonoscopy quality until better quality evidence is available. Meanwhile, there may well be a case for extending surrogate indicators of quality to include diagnostic accuracy and appropriate decision making.⁹

Provenance and peer review Not commissioned; internally peer reviewed.

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