NYSGE 2018 Summer Course

“Introduction to Endoscopy”

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Intro to Endoscopy:

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- Endoscopy is easy to master

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- Endoscopy is a diagnostic procedure
- Endoscopy is a surgical procedure
- Endoscopy is easy to master
- Endoscopy is extremely difficult to master
- Endoscopy is safe

- Endoscopy is a diagnostic test
- Endoscopy is a surgical procedure
- Endoscopy is relatively easy to master
- Endoscopy is extremely difficult to master
- Endoscopy is safe
- Endoscopy is risky

Overview

- Evaluation of the patient for endoscopy
- Informed consent issues
- Medication/Medical issues
- Preparations for endoscopy
- Timing and Location issues

Evaluating a Potential Patient for Endoscopy

- Appropriateness of sedation, appropriateness of procedure
- Diagnostic exams AND therapeutic exams to be done for appropriate indications.
- Cardiac, respiratory clearance is not trivial, esp if meds need to be with-held.

- 62 yo asymptomatic patient with 1 adenoma resected the year before, no family history, requests repeat exam because his friend gets yearly colonoscopies and he wants to be sure - **colonoscopy appropriate?**

- 93 yo nursing home patient, recently declining mental status, cardiac stents on plavix, not eating, dwindling, normal lfts, cbd 13mm, gallstones in gallbladder – **EUS appropriate?**

Pre-Endoscopy History and Physical

- Need to Know: all med hx, all meds, allergies, cigs, etoh, drug history, Abd/chest/neck surg history, Fam GI and cancer history, recent ROS – chest cold, fever, etc. Need to listen to heart, lungs, examine abdomen, extremities, document global neuro status
- Bloods – not generally necessary unless pertaining to specific GI issue being evaluated
- EKG – Not required for non cardiac patients

- **“Open Access Endoscopy”** - walk in exams
- Common in many sites both academic and non academic settings
- Generally good outcomes regarding prep and endoscopy.
- No opportunity to “pre-evaluate” a complaint with a blood test or other diagnostic study
- No prior relationship may affect medical legal outcomes in the case of complications.

- **“Informed consent”** - The process of explaining the reasons, risks, benefits, limitations, and alternatives of the proposed procedure, answering questions, and obtaining permission to proceed.
- It is humane and ethically appropriate to propose and reasonable intervention to a patient, and proceed only if that patient, of sound mind, agrees.
- It is legally mandatory that this consent be obtained on official documents

Limitations and problems with the process:

- Patients have variable ability to assess the procedure – Doctors have limitless ability to discuss procedure.
- “TMI” - causes fear and can be counter-productive to the patient's care.
- Patients and family members may have differing interests in proceeding

Recommendations:

- 1) Do your best to tailor your informed consent to the patient in front of you.
- 2) Do follow the legal counsel of the hospital/Center in complex consent cases.
- 3) Be sure that the reason for the procedure is well documented in the medical record and that in complex cases, family/caretaker conversations are documented as well

Medical Issues and Medications

- 1) Cardiac Risk
- 2) Sleep apnea/Obesity
- 3) Pregnancy
- 4) anti-coagulants
- 5) Antibiotic prophylaxis.

Cardiac Patients:

- It is not clear exactly how safe or unsafe endoscopy is in a patient with a recent cardiac event.
- Increasingly, gastroenterologists are being asked to perform endoscopy for GI bleed risk assessment in patients prior to cardiac intervention
- Close co-management with a cardiologist is recommended.

Obesity/Sleep Apnea

- Sedation carries serious risks in the morbidly obese and sleep apnea patients.
- Expertise in airway management during the procedure is frequently needed.
- Outpatient (non hospital) settings are discouraged

Pregnancy

- Pregnant women are at risk for exacerbation of GI issues and the need for endoscopy is not rare.
- Safety concerns revolve around the risk of anesthetics to the development of the fetus, and the risk of early labor
- Endoscopy is safest in the 2nd Trimester, but can usually be safely accomplished at any stage
- Appropriate patient selection and the judicious co-management with fetal monitoring is advised

Anticoagulants

- Patients are risk stratified according to their cardiovascular issues, and procedures are stratified as to their invasiveness.
- Low risk procedures include EGD, EUS, and Colonoscopy, with or w/o forceps biopsy, ERCP and stent insertion/change w/o sphincterotomy
- High risk procedures are polypectomy, PEG, dilation, sphincterotomy, FNA, deep enteroscopy.
- Low risk procedures can be done without altering the anti-thrombotic therapy.

High Risk Patients:

- High Cha_2Ds_2Vasc score
- High risk lesions – afib, mech valve, recent stent, etc.
- Hold thienopyradine x 5-7 days, or warfarin/NOAC x 2-3 days before procedure when able
- Continue aspirin for all procedures
- Restart meds when confident no bleeding
- Consider heparin bridge in highest risk pts.
- ALWAYS consult with prescribing MD

Antibiotic Prophylaxis for Endoscopy

- Controversial question for orthopedists, internists, vascular surgeons, though indications have dwindled over time
- No cardiac factors invoke automatic atbx unless there is active infection like cholangitis (and then anti-enterococcal coverage is indicated)
- PEG, Variceal bleeding, colonoscopy in PD patient, fna of cystic lesion, ercp in poor drainage.

Preparation for Endoscopy

- Readiness for sedation/anesthesia

- No food for 8 hours

- No clear liquids for 2 hours

- No oral hypoglycemics

- half or 1/3 dose of insulin on day of procedure

- usual meds, esp. cardiac meds, with sip water in am

- Readiness for procedure – bowel prep, etc.

- Readiness for post-procedure – must have escort to go home.

Timing and Location – some parting thoughts

- Emergencies: difficult to know when best to intervene, but generally resuscitation more important than urgent intervention
- Medically “borderline” patients are best done in a hospital setting for everyone's protection
- Very ill patients, especially with possible airway issues (GI bleed, vomiting, food impaction) are best done with endotracheal intubation, though this inconveniences many and causes complaints

Time Out – Just another nuisance??

- Used to prevent errors in many disciplines – aerospace, industry, medicine
- Typically is used to confirm what is obvious and usually already known – name, operation, etc.
- However, can be quite valuable if used to maximum advantage

Good Luck!!!