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Remarkable Point Of View of Muslim Patients on Sexual Orientation Inclination for GI Endoscopists: A Multicenter Study

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Introduction

In this performance of two sub studies, the prevalence and outcomes of LNPCP polypectomy within the BCSP were analyzed. An LNPCP prevalence of 8% was observed. Technical and clinical success rates for endoscopic resection were 87% (95% CI, 82-91) and 87% (95% CI, 80-92), respectively. Cumulative recurrence rates after 12 months were 22% (95% CI, 15-32) after piecemeal resection and 8% (95% CI, 2-22) after en-bloc resection, and adverse events occurred in 5% of cases (95% CI, 3-9). The primary surgery referral rate for noninvasive LNPCPs was 7% (95% CI, 5-10). The prevalence of LNPCPs of 8% found in our study is in line with other large cohorts but is higher compared with an English BCSP cohort. It should be taken into account that in the English BCSP cohort, pre-selection occurred.

Although quality indicators for colonoscopy are widely implemented, increasing awareness has highlighted the need for quality indicators for polypectomy to further optimize screening programs. The measured quality outcomes for (large) polypectomy in this study were technical success, recurrence rate, and clinical success and showed room for improvement. The technical success rate in our regional cohort (87%) is lower than reported in expert centers (95%). To increase exposure, centralization within or between centers should therefore be considered, and additional training should be implemented in clinical practice. Furthermore, implementation of quality monitoring on endoscopic resection could improve the outcomes on quality parameters and reduce practice variation. The lower clinical success rate in our study can partially be explained by noncompliance with surveillance guidelines. Not performing surveillance after 6 months influences the clinical success rate because of lack of opportunity to treat possible recurrences early. This stresses the importance of compliance with surveillance guidelines, of which we, in line with current evidence,7 have shown that there is still substantial noncompliance of additional training, consultation with dedicated experts, and centralization of care for large colorectal polyps. Several limitations of our study should be acknowledged. First, we assumed the regional cohort to be a representative sample of the national cohort. Given the limited data from the national cohort, this assumption and extrapolation of results should be made with caution. However, we have shown that the 2 cohorts match on important parameters in this study. Second, recurrence rates may have been underestimated because of the limited compliance with surveillance guidelines. Follow-up colonoscopy was performed in only 67% of cases, of which most were performed within 12 months.

In addition, the lesions without follow-up mainly consisted of en-bloc resected 20mm-29mm lesions, influencing the recurrence rate only minimally. Furthermore, determining recurrence rates at 12 months for en-bloc resection may also have led to an under or overestimation, because not all patients within this group underwent a surveillance colonoscopy within 12 months because the surveillance guidelines advise follow-up after 3 years for these resections. Variance in surveillance intervals may also have caused bias in clinical success analysis at 12 months. Third, the accessibility portion of the SMSA score was not described in our cohort. Therefore, SMSA score was calculated with both easy and difficult accessibility.

Although we did not find any associations between SMSA score and recurrence rate or surgery referral rate, it should be noted that we could not draw any conclusions regarding the value of the SMSA score based on this cohort because exact accessibility per lesion was unknown. Fourth, the level of training of endoscopists participating in our study is not measured systematically, quality of resection is not retrievable, and it is unknown whether recent insights have already been implemented in clinical practice. However, all endoscopists have followed the national bowel cancer screening training program and have been certified for screening colonoscopies. Finally, our study showed variation between centers that unfortunately could not be further investigated at the national level. To gain more insight in the quality of polypectomy and variation between centers at the national level, the national Screen IT registry should be optimized for evaluation purposes and quality indicators for polypectomy should be included.

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