INADEQUACIES OF COLONOSCOPY PROCEDURE REPORTS IN A COLORECTAL CANCER SCREENING PROGRAM

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Aim

Colonoscopy is currently the most effective screening method for the detection and prevention of colorectal cancer (CRC). Guidelines by the ASGE and GRS (Global Rating Scale) quality initiative describe colonoscopy specific quality indicators. Of these, proper documentation in procedure reports is essential to measure the quality of colonoscopy. In Canada, a standardized reporting format currently does not exist. We aim to evaluate the quality of colonoscopy procedure reports in a formalized colorectal cancer screening program.

Method

The SCOPE Colorectal Cancer Screening Program is an initiative based in Edmonton supported by Alberta Health Services and the University of Alberta. Its goal was to increase awareness and operationalize a population based CRC screening program. Through SCOPE, a sample of colonoscopies performed from May-August 2008 and February-June 2009 by experienced gastroenterologists at regional hospitals was reviewed. Expert gastroenterologists were supplied with a standardized procedure template, but reporting method varied between dictation and an endoscopic software-based system. Procedure reports were reviewed to verify the documentation of key quality indicators.

Results

525 colonoscopy procedure reports were reviewed. The overall cecal intubation rate for screening was 98.3% (516/525). Overall, only 71.8% (377/525) of reports included documentation of bowel preparation quality or described the extent of procedure visibility. Documentation of cecal landmarks was absent from 8.5% (44/516) and use of photodocumentation to confirm cecal intubation was found in only 44.0% (227/516) of reports. When polyps were found, 25.9% (56/216) of reports did not indicate polyp size. As well, the method of polypectomy was not stated in 10.5% (22/209) of these cases. Documentation with endoscopy reporting software was used in 24.2% (127/525) of colonoscopies. In comparison with dictation based reporting, cases using a software-based system increased cecal landmarks documentation from 90.7% to 93.7% (119/127), bowel prep quality from 69.8% to 77.8% (99/127) and photodocumentation from 26.2% to 98.4% (125/127), respectively.

Conclusion

In a formalized, systematic CRC screening program, colonoscopy procedure reports were not reaching recommended guidelines for inclusion of quality indicators. Even with a standardized template, experienced gastroenterologists may still fail to include important quality indicators when dictating reports. The quality of reporting appeared to be higher for physicians utilizing dictation software. The application of software based or synoptic procedure reporting, with a standardized structure, may be the best method of optimizing colonoscopy documentation.