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One for All, All for One

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See the article "Quality Metrics and Indicators in Colonoscopy".

Dear Editor,

I read Bou Daher and Sharara's manuscript with great interest (1). There are two specific points on which I would like an opinion from the authors. First of all, I would like to stress that the adenoma detection rate (ADR), as correctly described in the paper, has some limitations and one of most important ones is that this parameter is validated, but referable only to the operator quality rather than the quality of that specific examination. The authors suggested overcoming this obstacle using adenoma per colonoscopy (APC) rate or other ADR variants. However, all variants derived from ADR require an evaluation for a high number of examinations and a histological diagnosis. Moreover, the one-and-done phenomenon is rightly mentioned, a phenomenon that can influence the endoscopist's attention level precisely in the specific colonoscopy.

In the study (2), authors have tried to give ADR even more effectively. Above all they have re-evaluated the polyp detection rate (PDR). This was possible using segmentation of the parameter and the evaluation of the examinations with multiple diagnosed lesions. In fact, it is not clear why, when there is the possibility to classify intestinal cleansing using scales that evaluate the different colonic segments (3), the ADR should remain an overall parameter.

Furthermore, it should be specified that the ADR has a marked value considering its importance in the screening of colorectal carcinoma. However, even the visualization of minute lesions of other origin (lipomas, vascular lesions, etc.) could represent a valid method to define the degree of quality. To reinforce this concept, it is possible to have a correct visualization of the colon during colonoscopy and diagnose some minute vascular lesions of the proximal colon (< 5 mm) and this examination would, however, not be considered in the ADR count.

Another aspect explored by the study of Bou Daher and Sharara (1) is related to the timing of intestinal preparation. The studies analyzed by the review show how a split-dose regimen is better tolerated, more effective, and results in increased ADR. However, it is even truer that the time between the end of intestinal drug intake and the start of colonoscopy is an even weightier parameter in affecting the quality of the bowel preparation. This is even more important in patients at high risk of inadequate bowel preparation as the authors argued in the study of hospitalized patients (4).

I certainly agree with the conclusions of the review and believe that the study emphasizes the need for an objective and validated parameter per colonoscopy that contains all the other parameters used up to now.

Footnotes

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