CME

Continuing Medical Education Questions: December 2015

Steven L. Carpenter, MD

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Article Title: Interval Colorectal Cancer After Colonoscopy: Exploring Explanations & Solutions

QUESTIONS:

1. A 66-year-old female presents for her first screening colonoscopy. She has a history of chronic constipation, current tobacco use, diabetes mellitus type II, and medically complicated obesity (BMI 35.4 kg/m^2). Her pre-procedure vital signs were stable, and propofol sedation was used. During the procedure, cecal intubation was documented by photographs of the appendiceal orifice, terminal ileum, and ileocecal valve. Bowel preparation was fair. During the withdrawal phase of the exam, she develops a loud sonorous breathing pattern and her O_2 saturation drops below 90%, possibly due to sleep apnea. One 6-mm sessile suspected adenoma is resected quickly by cold snare in the descending colon. Upon completion of her colonoscopy, her O_2 saturation is greater than 92%. Your withdrawal time for the procedure was 4 minutes and 15 seconds.

   Which one of the following factors is the strongest contributor to her risk of developing an interval colorectal cancer?

   A. Obesity
   B. Tobacco abuse
   C. Low colonoscopic withdrawal time
   D. Incomplete resection of the descending colon polyp

2. A 74-year-old female with depression schedules a surveillance colonoscopy. Her last colonoscopy was performed 3.5 years ago, during which a 18-mm tubular adenoma was resected from her ascending colon in a piecemeal fashion. Full dose PEG was utilized to prepare for this procedure, and the bowel preparation was fair. Today, her vital signs are stable and her physical examination is unremarkable. Due to consistently poor colon preparation for prior procedures, her endoscopist now routinely utilizes split-dose PEG for all colonoscopies.

   Which one of the following potential measures would most likely increase the likelihood of identifying adenomas during this procedure?

   A. Documenting cecal intubation by ICV photographs
   B. Increasing colonoscopic withdrawal time
   C. Provision of high quality educational materials geared to improve colon preparation
   D. Utilization of narrow band imaging

3. An ambulatory endoscopy center has developed a quality improvement task force to improve patient safety and quality of colonoscopy performed in their unit. Adenoma detection rates, cecal intubation rates, and overall colonoscopic preparation quality are measured and reported for each endoscopist privileged to perform colonoscopy in the unit. The task force decides to update the informed consent form with emerging data regarding patient risk for the development of colorectal cancer between a normal screening colonoscopy and a follow-up examination. Noting that multiple studies vary significantly, they decide to reference the Nurses' Health Study and the Health Professional's Follow-Up Study.

   Based on this study, what data should they use to describe approximate interval colorectal cancer development risk after a negative screening colonoscopy?

   A. 20 cases of colorectal cancer per 1,000 colonoscopies
   B. 0.7 cases of colorectal cancer per 1,000 colonoscopies
   C. 1 case of colorectal cancer per 100 colonoscopies
   D. 5 cases of colorectal cancer per 1,000 colonoscopies