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Latin-American Endoscopy. A Perspective The Latin American Digestive Endoscopy Forum FLAED

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Introduction

Late January 2009, a selected group of Expert Endoscopists from the Latin American area meet in Puerto Vallarta-México. They were coordinated by Dr. Guido Villa Gómez and with the expertise of 2 worlds well known specialists Drs. R. Hawes and R. Lambert.

The aim of the workshop was to discuss with an open mind, the regional characteristics of the Gastrointestinal Endoscopy Development, which necessary differs from more advanced areas such as Europe, North America or Asian countries.

To review the "state of the art", of diagnostic as well as therapeutic endoscopy and to visualize the development of our specialty in the years to come.

Method

Under the Umbrella of Olympus Latin America, a group of senior and junior endoscopists were selected according to their position as chairmen of important latin-american endoscopy units, university units or training centers. There was a consensus on the names of endoscopists, invited to be part of the workshop focusing in young experts, by a direct questionnaire to the elders. 6 sub-groups of interest were defined with an expert as coordinator. Endoscopic ultrasound (EUS), CPRE, colonoscopy, images in endoscopy, endoscopical submucosal Disection (ESO) and Enteroscopy Capsule.

After two days of discussion a position paper with the results of the analysis and recommendations could be stated. NOTES advances pros and cons were also discussed.

Results

There is an enormous inequity in the Latin-American area of equipment, training and expertise. Endoscopies are not equal. The Quality Control Should be always present in education, in the endoscopy performance, in the need of better equipment and finally on the reimbursement for the procedures. Those quality criteria (ASGE) should be known by the endoscopists as well as the patients, and searched for as a real instrument for continuous improvement. Colonoscopy is becoming the most frequent endoscopic procedure nowadays (> 50-70%) according to the different countries and colon cancer incidence, being polyps

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resection the most required therapeutic procedure. New technology, such as magnification, chromo endoscopy, electronic staining, video capsule, balloon enteroscopes, EUS, ESO, are available but they are probably part of the secondary arsenal in advanced centers. Progressively it should be adopted for most handicapped units. Better knowledge of the related pathology and the endoscopic semiology is desirable. Staining is of great help and its use should be encouraged. Continuous Medical Education is a must for recognized endoscopists who need to jump into a new technique or a new application.

The new colonic explorations such as CT colonography and Colon Capsules were critically evaluated, suggesting a complementary role for the regular diagnostic and therapeutic colonoscopy, established as the goal standard. Those new methods probably could give a higher compliance rate, but as a consequence more regular colonoscopies, most of them therapeutic. Colonoscopists should be alerted when a colon capsule or a CT are required.

Colography is scheduled in order to perform a regular colonoscopy and polipectomy if necessary.

Adenomas and flat right colonic lesions should be searched, as the best formula to prevent colorectal cancer (Searching cancer is old fashioned and too late). Daily endoscopic schedule should be designed properly according to the cases permitting to fulfill the QC-standards. Employers schedule pressing is unacceptable. Published results usually are the bests with the bests endoscopists and it is our goal. Left colonoscopy is not considered a screening procedure anymore.

There is significant concern about Phosphosoda use due to adverse effects. Tailored preparation is desirable. Usually procedures scheduled AM have better outcomes than those PM. Flexibility in the assigned procedures and timing permits better cost/effectiveness of the endoscopy units and shortening of the waiting lists.

Due to population aging patients are becoming at a higher risks, more cancer, more vascular diseases, more diverticular diseases, more co-morbidities and less insurance companies support.

Sedation and anesthesia is a real issue, with different scenarios. Anesthesiologist nurses are not available in Latin- America. Diprivan Propofol® has emerged as a safer and easier alternative.

Critical evaluation of the indications permits waiting list shortening. (Avoiding overcontrol of polypectomies and Inflammatory Bowel Disease).

Extra replacement equipment should be provided by the suppliers in order to continue with the daily necessary work.

Better relationship with referral doctors and pathologists is also desirable and should be encouraged.

Figura 1. Participantes Latin-American Endoscopy.