2. Standardized Endoscopy **Reporting** Guidelines

Quality Management Partnership

INTENDED USE OF THIS RESOURCE

The endoscopist is responsible for reporting procedure details, key findings and the management plan to the physician who referred the patient for colonoscopy.

These guidelines outline the minimum requirements for standardized endoscopy reporting to the referring physician. Details regarding the clinical impression (Sections 5 and 6) and the management plan (Section 7) are of particular importance for the referring physician.

For a full list of evidence consulted in creating this resource, please see the accompanying document titled *Background and Resource Summary – The Early Quality Initiatives (EQIs) – Quality Improvement Resource Package for Endoscopy/ Colonoscopy.*

RATIONALE

The rationale of this document is to:

- Improve the continuum of care for patients
- Reduce the frequency of repeat examinations due to lack of information about the quality of examination, including bowel preparation quality and specific cecal landmarks
- Reduce inappropriate decisions for the timing of surveillance colonoscopy because the key polyp descriptors (size and/or morphology) were absent. This information may allow increased adherence to published guidelines for surveillance of polyps
- Reduce uncertainty about the follow-up arrangements and responsibility for follow-up
- Ensure that referring physicians receive consistent and predictable information about the procedure findings, management plan, and follow-up

Ontario Cancer Care Ontario

The College of Physicians and Surgeons of Ontario

GUIDELINES

The key elements outlined in Sections 1 through 7 must be reported to the referring physician. These elements may be reported separately as information becomes available. For example:

- Section 1 (Administrative information) should be reported across all reports
- Section 2 (Patient information) may be included in a 'consult note'
- Sections 3, 4 and 5 may be included in an 'intra-procedural report'
- Section 6 is only applicable if tissue was resected and may accompany Section 7
- Section 7 may accompany the 'intra-procedural report' if the colonoscopy was normal

1.0 Administrative information

- Patient identifiers (e.g., name, age, DOB, sex, etc.)
- Name of endoscopy facility and type of facility
- Time and date of procedure
- Name(s) of endoscopist and/or assistants, including names of trainees and/or fellows
- Name of referring doctor

2.0 Patient information

- Patient identifiers (e.g., name, age, DOB, sex, etc.)
- Indication for procedure
- Indicate whether the procedure is elective or emergent
- Patient history (e.g., relevant symptoms, family history, medications, etc.)
- Risk assessment (e.g., description of comorbidities, anticoagulation, infection risk, defibrillator status, etc.)
    - o Risk must be assessed using the ASA physical status classification . Other clinically relevant risk scores may also be used to assess the patient
- Bowel preparation details including type and dose as well as documentation of the bowel preparation quality
    - o Quality of preparation should be assessed with the aid of a three point scale
- Summary of the information that was provided to the patient and/or a summary of the informed consent discussion

3.0 Sedation and analgesia details

- Type and dosage of anaesthetic administered
- Level of sedation (i.e., conscious, deep, or general anesthesia)
    - o If conscious sedation is used, include the medication(s) given (with dosage(s)) as well as other agents if used (e.g., reversal agents)
- Type of provider responsible for administration of sedation (e.g., endoscopist, anesthesiologist, non-physician, etc.)
- Patient comfort

4.0 Procedure details & information regarding adverse events

- Endoscopic procedure that was performed
- Interventions that were performed (e.g., biopsy, polypectomy). Include excision/resection details:
  - o Number and location of biopsies and/or polyps
  - o Excision/resection methods (e.g., snare ± cautery, hot biopsy, piecemeal versus en bloc resection, etc.)
- Specific technical maneuvers (e.g., cecal retroflexion, rectal retroflexion, abdominal pressure, etc.) and patient positioning maneuvers that were used.
- Special considerations, if relevant (e.g., difficulty of procedure, reason(s) for difficult procedure, instrument changes, etc.)
- Extent of examination (e.g., state landmark names, integrating landmark images into the report is ideal)
  - o If the procedure was incomplete, provide the reason (e.g., looping, inadequate bowel preparation)
- Use of tattooing (if applicable)
- Use of surgical clips, bridging therapy, and/or cauterization and reason for their use (if applicable)
- Adverse events (intra- and/or post-procedural), including documentation of interventions and outcomes (if applicable)

5.0 Description of key findings

- Description of all positive findings (using standard terminology and descriptors, e.g. Paris classification), including details regarding anatomic location, length/size (dimensions in mm or cm), morphology, and mucosal elevation
- Description of pertinent negative findings, if relevant (e.g., no signs of recent bleeding, etc.)
- Overall impression, using standard terminology and descriptors

6.0 Histopathology results of resected tissue

- It is the responsibility of the endoscopist to:
  - o Ensure that the final histopathology report is provided to the referring physician once it is available (if relevant)
  - o Determine a management plan based on the results described in the final histopathology report and communicate this plan to the referring physician (if relevant)

7.0 Description of management plan

- Description of the discharge plan and immediate follow-up plan, including details regarding additional tests and/or referrals that are indicated as well as any medication changes (if relevant; e.g., restarting anti-coagulation therapy)
  - o It is the responsibility of the endoscopist to ensure that additional tests and/or referrals related to the procedure are ordered
- Description of the intermediate and long-term follow-up plans, including intervals for follow-up colonoscopy and/or FOBT
  - o If the follow-up plan will be determined after the final histopathology report is available, state that this is the case
  - o If the follow-up plan differs from standard practice, state the reason(s) for the discrepancy
- Documentation of communication directly to the patient/substitute decision-maker/legal guardian and the referring physician

APPENDIX

APPENDIX 1 ASA Physical Status Classification System	
Purpose	To assess the fitness of patient before selecting the anesthetic or prior to performing surgery
ASA Physical Status 1	A normal healthy patient
ASA Physical Status 2	A patient with mild systemic disease
ASA Physical Status 3	A patient with severe systemic disease
ASA Physical Status 4	A patient with severe systemic disease that is a constant threat to life
ASA Physical Status 5	A moribund patient who is not expected to survive without the operation
ASA Physical Status 6	A declared brain dead patient whose organs are being removed for donor purposes

Source: American Society of Anesthesiologists. Available online: https://www.asahq.org/resources/clinical-information/asa-physical-status-classification-system.

APPENDIX 2 Modified Mallampati Score	
Purpose	To assess ease of tracheal intubation
Patient Positioning	• Sitting upright with the head in a neutral position • Mouth opened as widely as possible • Tongue protruded maximally
Interpretation	Concealment of the soft palate by the base of the tongue (score of 3 or 4) is associated with more difficult intubation
Class I	Soft palate, uvula, fauces, pillars visible
Class II	Soft palate, uvula, fauces visible
Class III	Soft palate, base of uvula visible
Class IV	Only hard palate visible

Source: Samsoon, GL; Young, JR (1987). Difficult tracheal intubation: a retrospective study. Anaesthesia 42 (5): 487–90. doi:10.1111/j.1365-2044.1987.tb04039.x.

APPENDIX 3 $CHADS_2$ Score

Purpose	To assess risk of stroke in patients with non-rheumatic atrial fibrillation
Calculation	1. Assign 1 point for each of the following conditions: recent congestive heart failure, hypertension, age at least 75 years, or diabetes mellitus. 2. Assign 2 points for having history of stroke or transient ischemic attack (TIA). 3. Sum the points to calculate the total CHADS2 score. Higher scores are associated with higher stroke risk.

SCORING SYSTEM		
	Condition	**Points**
C	Congestive Heart Failure	1
H	Hypertension	1
A	Age ≥75 years	1
D	Diabetes mellitus	1
S_2	Prior stroke or TIA	2

INTERPRETATION		
$CHADS_2$ Score	**Stroke Risk (%)**	**95% CI**
0	1.9	1.2-3.0
1	2.8	2.0-3.8
2	4.0	3.1-5.1
3	5.9	4.6-7.3
4	8.5	6.3-11.1
5	12.5	8.2-17.5
6	18.2	10.5-27.4

Source: Gage B, Waterman A, Shannon W, Boechler M, Rich M, Radford M. Validation of Clinical Classification Schemes for Predicting Stroke: Results From the National Registry of Atrial Fibrillation. JAMA. 2001;285(22):2864-2870. doi:10.1001/jama.285.22.2864.

APPENDIX 4 Quality of Bowel Cleansing Assessment Scale

Very good to excellent preparation
Adequate preparation with colonic irrigation
Inadequate preparation

Source: Quality Management Partnership. (2015, March). Provincial Quality Management Programs for Colonoscopy, Mammography and Pathology in Ontario. Toronto: Cancer Care Ontario and the College of Physicians and Surgeons of Ontario.