

Format for ANSWERING REVIEWERS



July 9, 2013

Dear Editor,

Please find enclosed the edited manuscript in Word format (file name: 2957-review.doc).

Title: "Title: How we can measure quality in colonoscopy?".

Author: Leonidas A. Bourikas, Zacharias P. Tsiamoulos, Adam Haycock, Siwan Thomas-Gibson

and Brian P. Saunders

Name of Journal: *World Journal of Gastroenterointestinal Endoscopy*

ESPS Manuscript NO: 2957

The manuscript has been improved according to the suggestions of reviewers:

1 Format has been updated

2 Revision has been made according to the suggestions of the reviewer

- (1) **“Colonoscopy is an important tool in CRC secondary prevention and all information is welcome. The review is similar to previously published articles but does not include references related to the levels of scientific evidence and recommendations for each outcome included in this study. Since endoscopy is considered, in part, operator dependent, some information on the endoscopist’s training and experience in the auditable assessment of colonoscopy quality is required. This aspect has not been included in the measurement of colonoscopy quality. Neither are technical aspects related to the scopes considered in the review. Some aspects such as sedo-analgesia / deep sedation, carbon oxide recommendations, and the percentage of polyps found remain under debate in current practice. Another subject that should be specified is the need for complete information on patient history and the need for active records of complications. The authors probably consider that these aspects are included in “indication appropriateness” and in the “complications rate”, but they are not the same concepts. The references should be improved.”**

a) We thank the reviewer for his helpful suggestions. ESGE’S guidelines and UK BCSP guidelines have been used for each quality metric included in the revised Table 1 and this is now mentioned in to the Table 1 legend.

b)As already clearly mentioned in the “introduction” and now into the revised abstract “ this paper does not aim to give technical details on how to perform colonoscopy but to summarize what to

measure and when, in accordance with the current identified quality indicators and standards for colonoscopy”. According to reviewer’s suggestion at the revised manuscript we made a basic comment on endoscopist’s technique clearly: “ Probably adequate withdraw technique and high technical endoscopist’s skills that exceeds the purposes of this paper.”-page 13.

c) Conscious sedation and CO2 insufflation have been incorporated at ESGEs consensus on quality assurance for colonoscopy and is our common practice at St Mark’s Hospital.

According to the published data of the BCSP in UK we included MAP or ADR+ as an additional metric and a relative comment has been included at the revised manuscript (page 15-16).

d) The need for a complete medical history prior to colonoscopy has now been clearly mentioned at the revised manuscript (page 4) and so has the need of active records of colonoscopy adverse events (page 16)

e) References have been updated.

- (2) **“Good paper. However, 1) There is no mention of cardiac comorbidities. The indications to decide between a CT colonography and a colonoscopy need to be mentioned. 2) Does the author really recommend nurse-led patient pre-assessment either in a dedicated clinic or by telephone consultation for every colonoscopy patient ?- this would not be an option in most hospitals. Vetting by a gastroenterologist is essential but bringing every patient to a pre-assessment seems a bit excessive. 2) No mention of any cardiac comorbidities (page 6). Increasing BMI is a problem world over. Any special precautions that would be put into place for the morbidly obese ? 3) Page 7- the actual procedure varies from hospital to hospital. Some institutions having the patient consented in clinic by the requesting consultant as well as giving the prescription for bowel preparation and patient leaflets and thus alleviating the need for postal issue for the same. This is beneficial in that this acts as an indirect vetting as well of high risk patients. This approach needs to have a mention in the paper. 4) Page 7- what is the standard bowel prep used in St Mark's ? Do the authors recommend bringing any high risk patients as an inpatient for bowel preparation and colonoscopy ? - if so- who ? 5) Page 8 - incomplete sentence -The use of CO2 capnography is recommended to identify hypoventilation and hypoxia if heavy sedation 35. 6) Page 11- no mention of any special precautions that would be used in high risk cardiac patients. 7) Minor corrections in the manuscript- page 10- adverse events (AE) has been put in twice. 8) 65 references for a paper which has briefly commented on quality of colonoscopy seems quite excessive. 9) Referencing needs to be updated for several references as for 21 / 22 / 42/43. 10) Figure 1- the figure shows that patient information leaflet is given when the patient comes in for the procedure. This is not the practice in St Marks. Please correct. 11) Figure 1- consent should not be ideally taken in the endoscopy room. (as is implied from your**

table). Some institutions consent the patients in clinic when requesting the colonoscopy.”

We thank the reviewer for thorough reading of our paper and his comments and suggestions which helped as to improve the quality of our work.

- a) A comment for patients with cardiac comorbidities and the utilisation of CT colonography has been imported into the revised manuscript (page 7 and 8-9)
- b) “We recommend nurse-led patient pre-assessment either in a dedicated clinic or by telephone consultation, especially when this has not been done by the vetting gastroenterologist.” This comment has been added in the revised manuscript (page 7)
- c) “Colonoscopy in obese patients may prove technically demanding in some cases however, in our practice and according to previous reports, routine colonoscopy is the screening test of choice and can be performed adequately in obese patients when optimal standards are fulfilled.” This comment with references related have been added into the revised manuscript (page 8).
- d) “Some institutions having the patient consented in clinic by the requesting consultant as well as giving the prescription for bowel preparation and patient leaflets and thus alleviating the need for postal issue for the same. This is beneficial in that this acts as an indirect vetting as well of high risk patients.” We agree with reviewer’s comment which has now been added into the revised manuscript (page 9).
- e) “In our institution we use a combination of 10 senna tablets and 2 doses of sodium picosulfate the day before colonoscopy for morning appointments, while the second dose of sodium picosulfate is taken in the morning of the same day for afternoon colonoscopies. Although hospitalisation has been related with poorer bowel cleansing and should be routinely avoided, hospital admission prior to colonoscopy may be required in some cases, especially for patients in whom reduced absorption of regular medications may prove problematic and may need intravenous administration. Fragile patients with multiple comorbidities which are at risk of cardiac or renal failure and should be monitored during bowel prep are often admitted to hospital prior to colonoscopy. Selection of these patients is a matter of careful clinical pre-assessment.”The above comments have been imported at the revised manuscript (page 9).
- f) Appropriate syntactic corrections were made and updated references have been added according to reviewer’s comments.
- g) Figure 1 has now been corrected.

Thank you again for publishing our manuscript in the *World Journal of Gastrointestinal Endoscopy*.

Sincerely yours,



Brian Saunders MBBS ,MD FRCP
Wolfson Unit for Endoscopy
St Mark’s Hospital and Academic Institute
London HA1 3UJ
United Kingdom
Office: +442082354227
Fax: +442084233588

E-mail: b.saunders@imperial.ac.uk