American College of Gastroenterology & American Society of Gastrointestinal Endoscopy Task Force on Quality Indicators for Colonoscopy – 2024 (By Smit Deliwala)

Priority Indicators – 1/3

2024 Priority Colonoscopy Quality Indicators

Prioritize high-priority indicator thresholds before progressing to other indicators

Adenoma detection rate (ADR) ≥ 35%

Patients ages ≥45 undergoing **index/subsequent screening, surveillance, or nonfecal diagnostic** colonoscopy with ≥1 adenoma **verified by pathology**

Men ≥ 40% Female ≥ 30%

Excludes positive noncolonoscopy screening tests (including CT colonography) and therapeutic procedures for resection of neoplasia, genetic syndromes, and IBD

ADR in **positive** fecal screening tests like FIT or multitargeted stool DNA - ≥ 50% (55% M | 45% W)

Rate of using appropriate screening and surveillance intervals ≥ 90%

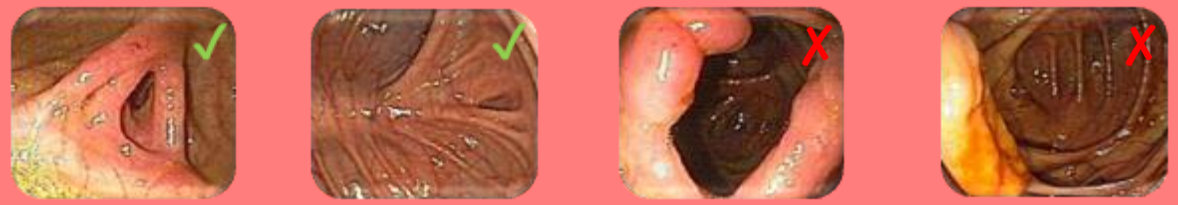
Frequency following recommended post-polypectomy and post-cancer resection surveillance intervals and 10-year intervals between screening colonoscopies in **average-risk patients with negative results and adequate bowel cleansing**

Cecal intubation rate ≥ 95%

Cecal intubation rate with photography (all examinations) ≥ 95%

Cases with intent to treat or aborted because of poor prep or severe colitis **are not counted**

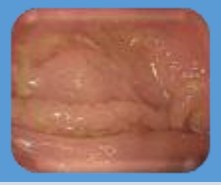
Cecal intubation - passage of colonoscope tip proximal to the ICV **and fully into the cecal caput** so that the appendiceal orifice can be identified and the medial wall of the cecum between the appendiceal orifice and ileocecal valve can be examined



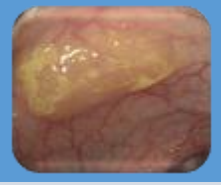
NEW Sessile serrated lesion detection rate (SSLDR) ≥ 6%

Patients ages ≥45 years undergoing **screening, surveillance, or diagnostic** colonoscopy with one or SSLs **verified by pathology**. SSLDR 6% with a similar target in FIT-**positive** patients

Excludes positive noncolonoscopy screening tests, genetic cancer syndromes, IBD, or neoplasm therapy



SSLs - At least two features to diagnose SSL:
1) Clouded surface,
2) Indistinctive borders,
3) Irregular shape, OR
4) Dark spots inside crypts



NEW Bowel preparation adequacy rate ≥ 90%

Patients with adequate bowel preparation = Boston Bowel Preparation Scale (BBPS) score ≥ 2 in **each of 3 colon segments** OR description of the preparation as **excellent, good, or adequate.**

Patients with **inadequate preparation** -> repeat colonoscopy within 1 year

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Procedure Indicators – 2/3

PRE-PROCEDURE

1. **Rate of bowel preparation adequacy** — **Performance Target ≥ 90%**
2. **Appropriate indications** — **PT ≥ 95%**

INTRA-PROCEDURE

3. **Cecal intubation rate (CIR)** — **PT ≥ 95%**

Detection Indicators

4. **Adenoma detection rate** — **PT ≥ 35%**
5. **ADR in positive fecal screening tests** — **PT ≥ 50%**
6. **SSL detection rate** — **PT ≥ 6%**
7. **Adenomas per colonoscopy** — **PT ≥ 0.6%**
8. **Withdrawal time (WT)** — **PT ≥ 8 min**
   - Time ≥ 8 min w/o bx or polypectomy
   - Excludes positive noncolonoscopy screening tests, genetic cancer syndromes, IBD, or neoplasm therapy
   - For endoscopists with low ADR/SSLDR and WT 8 min -> Evaluate technique and increase WT

Resection Indicators

9. **Documenting lesion features/resection** — **PT ≥ 98%**
10. **Cold snare for 4 to 9 mm lesions** — **PT ≥ 90%**

Resection reports = lesion shape, location, and resection method

- ✗ Terms like "small" and terminal digit rounding
- ✓ Photograph polyps ≥ 10 mm with an **open snare against it**
- ✓ Photograph small polyp same or **w/ sheath tip at polyp base**
- ✓ **Describe** lesions as pedunculated or nonpedunculated
- ✓ Use "sessile," "flat," and "pedunculated" or **Paris classification**
- ✓ Describe LST by **morphology**
- ✓ **Report** polyp location and resection method
- ✓ Cold forceps and snare are comparable for lesions ≤3 mm
- ✓ All therapeutic steps of lesion resection **should be described**

POST-PROCEDURE

11. **Track, document, and conduct QI review of adverse events** — **PT ≥ 95%**
    - RF for bleeding - size > 1 cm, high # of polyps, proximal colon, comorbidities, or antithrombotics.

12. **Use of appropriate screening and surveillance intervals** — **PT ≥ 90%**
    - Negative screening colonoscopy -> repeat examination in **10 years**
    - High-risk family history – multiple FDR with CRC or advanced lesions or FDR with CRC or advanced precancerous lesion at age < 60 years has a **5-year repeat examination**

Follow-up in average-risk adults

Baseline colonoscopy finding	Recommended interval for surveillance colonoscopy
Normal	10 years
1-2 tubular adenomas <10 mm	7-10 years
3-4 tubular adenomas <10 mm	3-5 years
5-10 tubular adenomas <10 mm	3 years
Adenoma ≥10 mm	3 years
Tubulovillous or villous adenoma	3 years
Adenoma with HGD	3 years
> 10 adenomas on single examination	1 year
Piecemeal resection of adenoma ≥ 20 mm	6 months

2nd surveillance stratified by adenoma findings at baseline and 1st surveillance

Baseline colonoscopy finding	Recommended interval for 1st surveillance	Finding at 1st surveillance	Recommended interval for next surveillance
1-2 tubular adenomas <10 mm	7-10 years	Normal	10 years
		1-2 tubular adenomas <10 mm	7-10 years
		3-4 tubular adenomas <10 mm	3-5 years
		Adenoma ≥10 mm; tubulovillous or villous adenoma; or adenoma with HGD; or 5-10 adenomas <10 mm	3 years
3-4 tubular adenomas <10 mm	3-5 years	Normal	10 years
		1-2 tubular adenomas <10 mm	7-10 years
		3-4 tubular adenomas <10 mm	3-5 years
		Adenoma ≥10 mm; tubulovillous or villous adenoma; or adenoma with HGD; or 5-10 adenomas <10 mm	3 years
Adenoma ≥10 mm; or tubulovillous or villous adenoma; or adenoma with HGD; or 5-10 adenomas <10 mm	3 years	Normal	5 years
		1-2 tubular adenomas <10 mm	5 years
		3-4 tubular adenomas <10 mm	3-5 years
		Adenoma ≥10 mm; tubulovillous or villous adenoma; or adenoma with HGD; or 5-10 adenomas <10 mm	3 years

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Quality Indicators for Colonoscopy in IBD – 3/3

Intraprocedure colonoscopy indicators

13. Ulcerative Colitis Disease Activity Scores **PT ≥ 90%**

- Document disease extent/activity for classification, prognosis, and risk stratification
  1) Mayo Endoscopic Score (MES)*
  2) Modified Mayo Endoscopic Score (MMES)
  3) Ulcerative Colitis Endoscopic Index of Severity (UCEIS)*
  4) Ulcerative Colitis Colonoscopic Index of Severity
- Endoscopic healing is an essential clinical target associated with long-term clinical remission, avoidance of colectomy, and corticosteroid-free clinical remission (MES of 0 and UCEIS ≤1)

14. Crohn's Disease Activity Score **PT ≥ 90%**

- Record both symptomatic and endoscopic assessments to quantify response
  1) Crohn's Disease Endoscopic Index of Severity (CDEIS)
  2) Simple Endoscopic Activity Score in Crohn's Disease (SES-CD)*
  3) Rutgeerts Score
- Endoscopic healing by an SES-CD <3 points or SES-CD ulceration subscore of 0
- Rutgeerts score grades early neo-terminal ileum (TI) lesions to predict postsurgical outcomes and for possible therapy escalation. Recurrence is a score of ≥i2

*Recommended in STRIDE II (RCT)

Postcolonoscopy indicators

15. Ulcerative Colitis Colonoscopy Surveillance **PT ≥ 90%**

- Appropriate recommendation for follow-up surveillance for UC and/or indeterminate colitis

Suggested scoring systems for inflammatory bowel disease (IBD) activity

Scoring scale	Disease	Scoring	Notes
Mayo Endoscopic Score (MES)	Ulcerative colitis	0: Normal or inactive colitis	
		1: Erythema, mild decrease in vascularity	
		2: Friability, marked erythema, vascular pattern absent, erosions seen	
		3: Ulcerations and spontaneous bleeding	
Simple Endoscopic Activity Score in Crohn's Disease (SES-CD)	Crohn's disease	0: None	A maximum score of 12 for each segment is documented from the ileum, right-sided colon, transverse, left-sided colon, and rectum – Max score 60
		1: Aphthous ulcers, <10% ulcerated surface, <50% affected surface, single narrowing passed	
		2: Larger ulcers, 10-30% ulcerative surface, 50-75% affected surfaced, multiple narrowing	
		3: Very large ulcers, >30% ulcerated surface, >75% affected surface, narrowing cannot be passed	
Rutgeerts score	Crohn's recurrence in the neo-TI	i0: No lesions, normal-appearing neo-TI	i0 or i1: remission i2-i4: recurrence is with i3 or i4: likely to relapse
		i1: ≤ 5 aphthous ulcers in the neo-TI	
		i2: >5 aphthous ulcers in the neo-TI with normal-intervening mucosa or skip areas of larger lesions or lesions in the ileocolonic anastomotic	
		i3: Diffuse aphthous ileitis with diffusely inflamed mucosa	
		i4: Diffuse inflammation with large ulcers, nodules, and/or narrowing	

Timing of surveillance in ulcerative/indeterminate colitis undergoing screening colonoscopy without dysplasia

1 year	2-3 years	3-5 years
PSC (including after liver transplant)	Prior resected visible dysplasia <5 years	Mucosal healing and ≥ 2 examinations without dysplasia
Family history of CRC in FDR <50 yo	Mild active inflammation	Overall disease affecting <1/3 of the colon
Prior invisible dysplasia <5 years ago	Pseudopolyps (but not dense)	
Active inflammation (more than mild)	Family history of CRC (but no FDR <50 yo)	
Dense pseudopolyps		
Colonic stricture		

References

1. Rex DK, Anderson JC, Butterly LF, Day LW, Dominitz JA, Kaltenbach T, Ladabaum U, Levin TR, Shaukat A, Achkar JP, Farraye FA, Kane SV, Shaheen NJ. Quality Indicators for Colonoscopy. Am J Gastroenterol. 2024 Aug 21. doi: 10.14309/ajg.0000000000002972.
2. Murra-Saca, Dr.J. (no date) El Atlas Gastrointestinal. Available at: http://www.gastrointestinalatlas.com/ (Accessed: 27 September 2024)
3. Lorenzo-Zúñiga V, Moreno-de-Vega V, Boix J. Rev. Esp Enferm Dig. 2012; 104: 426-431
4. Gupta S, Lieberman D, Anderson JC, Burke CA, Dominitz JA, Kaltenbach T, Robertson DJ, Shaukat A, Syngal S, Rex DK. Recommendations for Follow-Up After Colonoscopy and Polypectomy: A Consensus Update by the US Multi-Society Task Force on Colorectal Cancer. Gastroenterology. 2020 Mar;158(4):1131-1153.e5.
5. Kaltenbach T, Anderson JC, Burke CA, Dominitz JA, Gupta S, Lieberman D, Robertson DJ, Shaukat A, Syngal S, Rex DK. Endoscopic Removal of Colorectal Lesions-Recommendations by the US Multi-Society Task Force on Colorectal Cancer. Gastroenterology. 2020 Mar;158(4):1095-1129.
6. Jung P, Kim HW, Park SB, Kang DH, Choi CW, Kim SJ, Nam HS, Ryu DG, Shin DH, Na JY, Yun MS. Clinical and endoscopic characteristics of sessile serrated lesions with dysplasia/carcinoma. Korean J Intern Med. 2023 May;38(3):349-361. doi: 10.3904/kjim.2022.322. Epub 2023 Mar 27.