2018 BSGIE ERCP survey

Dr X. De Koninck

Dr Ch Snauwaert

For the BSGIE

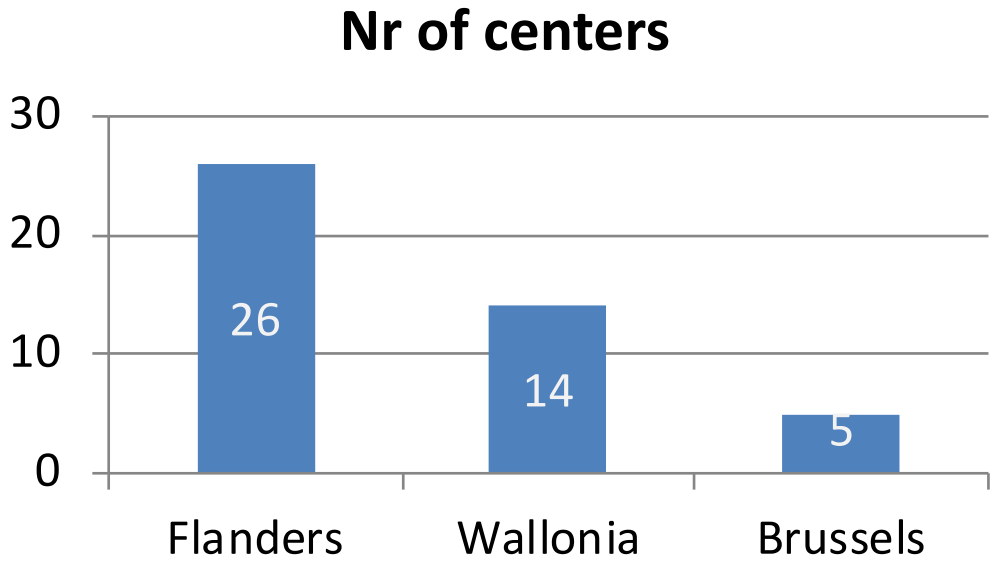
Introduction

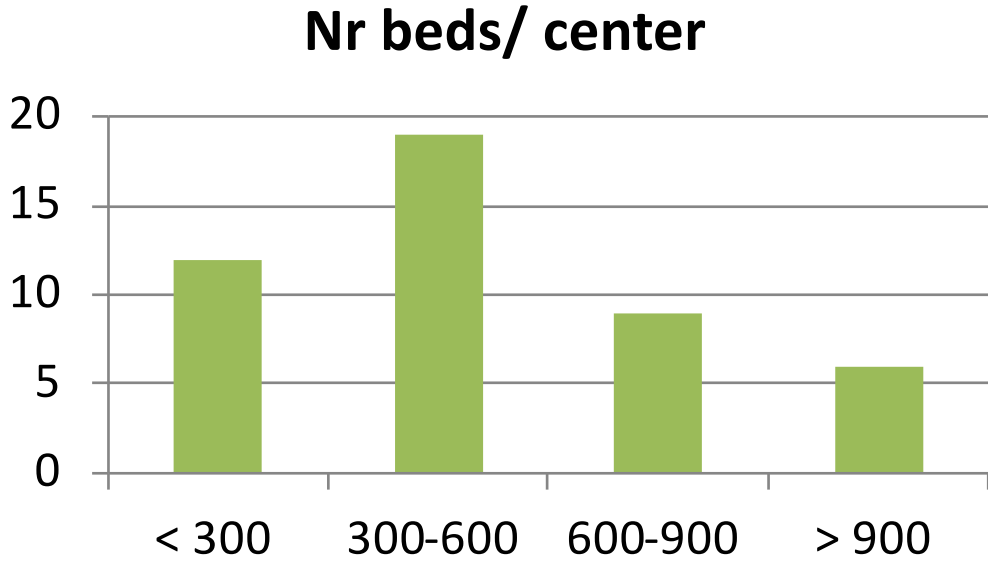
Material and Methods

- Online questionnaire
- One response requested per hospital site
- 32 questions reviewed by the BSGIE board
  - Case volume (2017)
  - Profile of endoscopists
  - Practice environment of ERCP (room, anesthesiology)
  - Availability for emergencies
  - Prophylaxis of ERCP complications
  - Indications of transfer of patient
  - Quality : disinfection protocol, informed consent, monitoring of performance
- Call for participation in june 2018, 3 recalls
- Dead line : augustus 31
- Anonymous.

Results

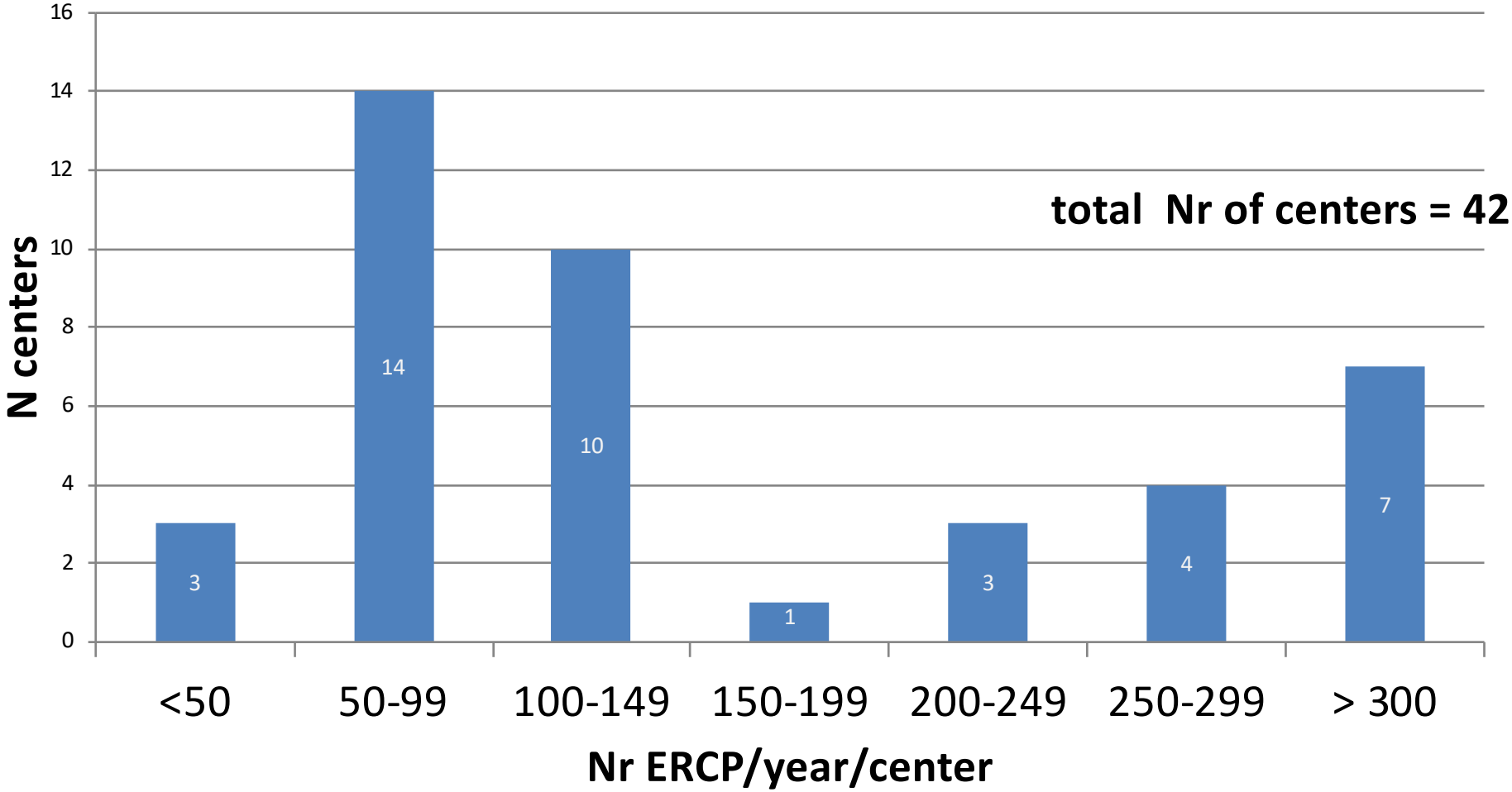
- 45 questionnaires complete or near complete





5 academic centers

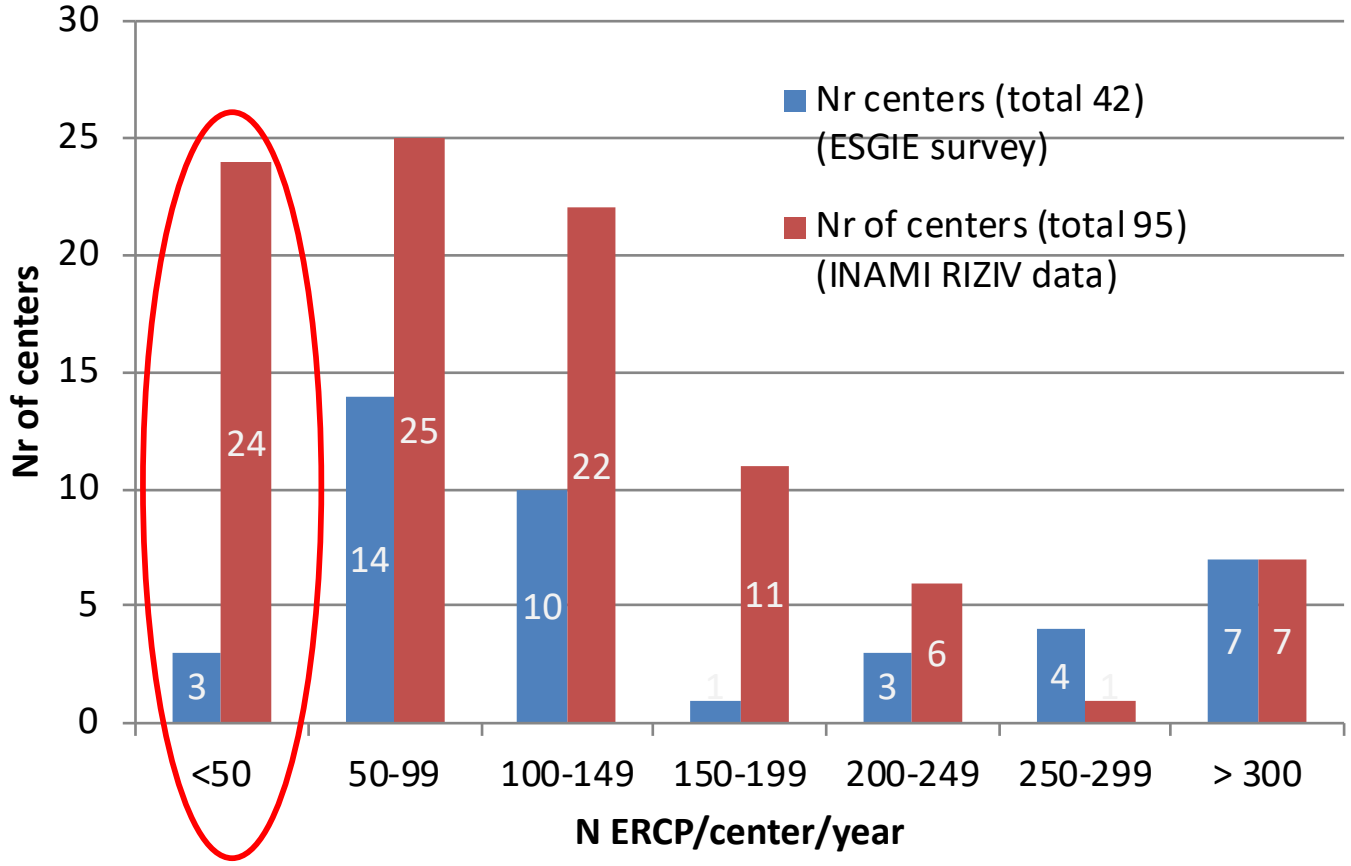
ERCP case volume



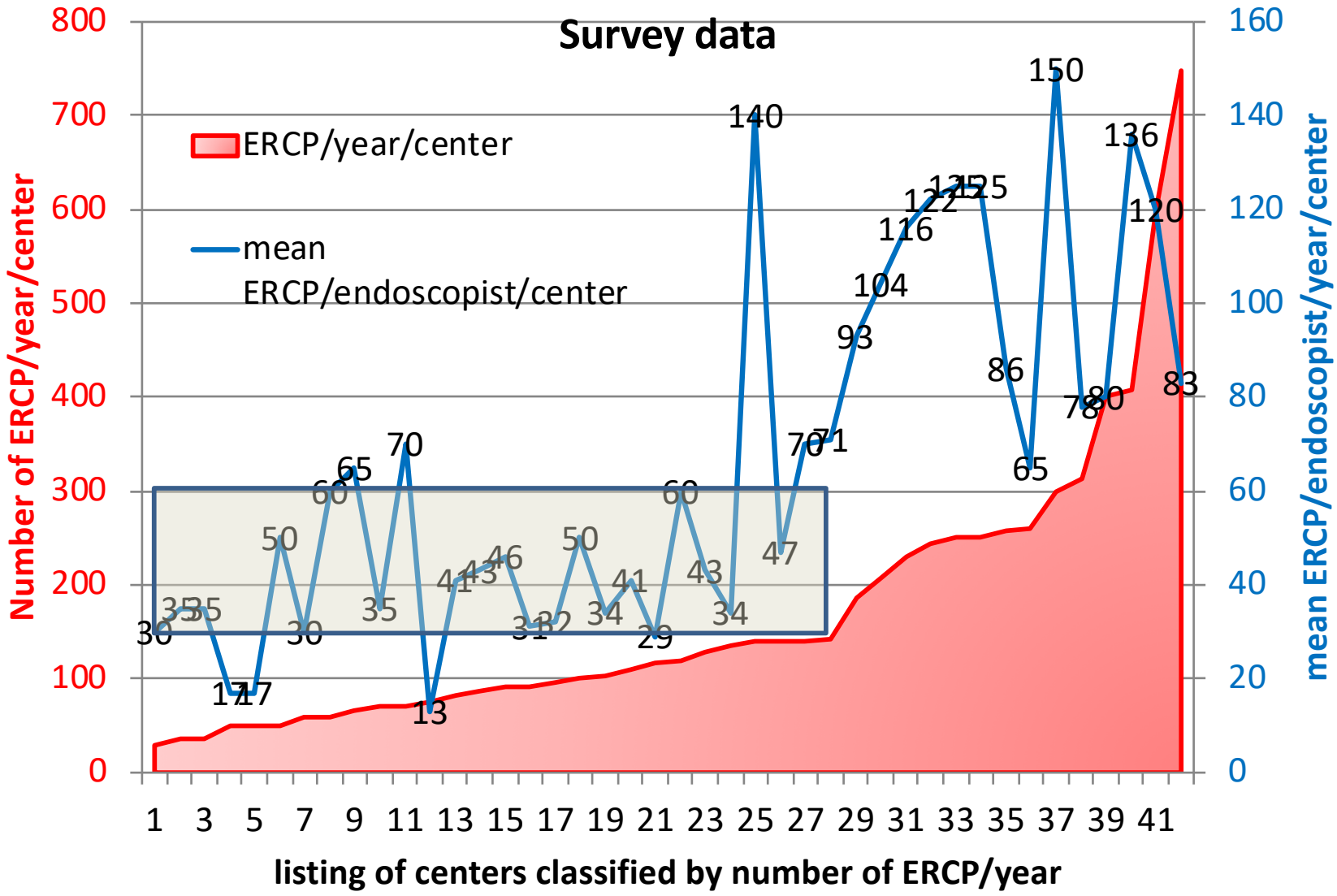
- 46 % centers = between 50 and 150 ERCP/year
- 40 % centers : < 100 ERCP / year
- 7 % centers < 50 ERCP/ year
- Performed by 113 endoscopists
- Among them 51 also perform EUS

Representativeness of the survey ?

- 8192 ERCP in the survey <> 12411 ERCP according to INAMI-RIZIV
- Low case volume centers under represented in the survey
- 51 % of centers : < 100 ERCP/year (INAMI-RIZIV data)

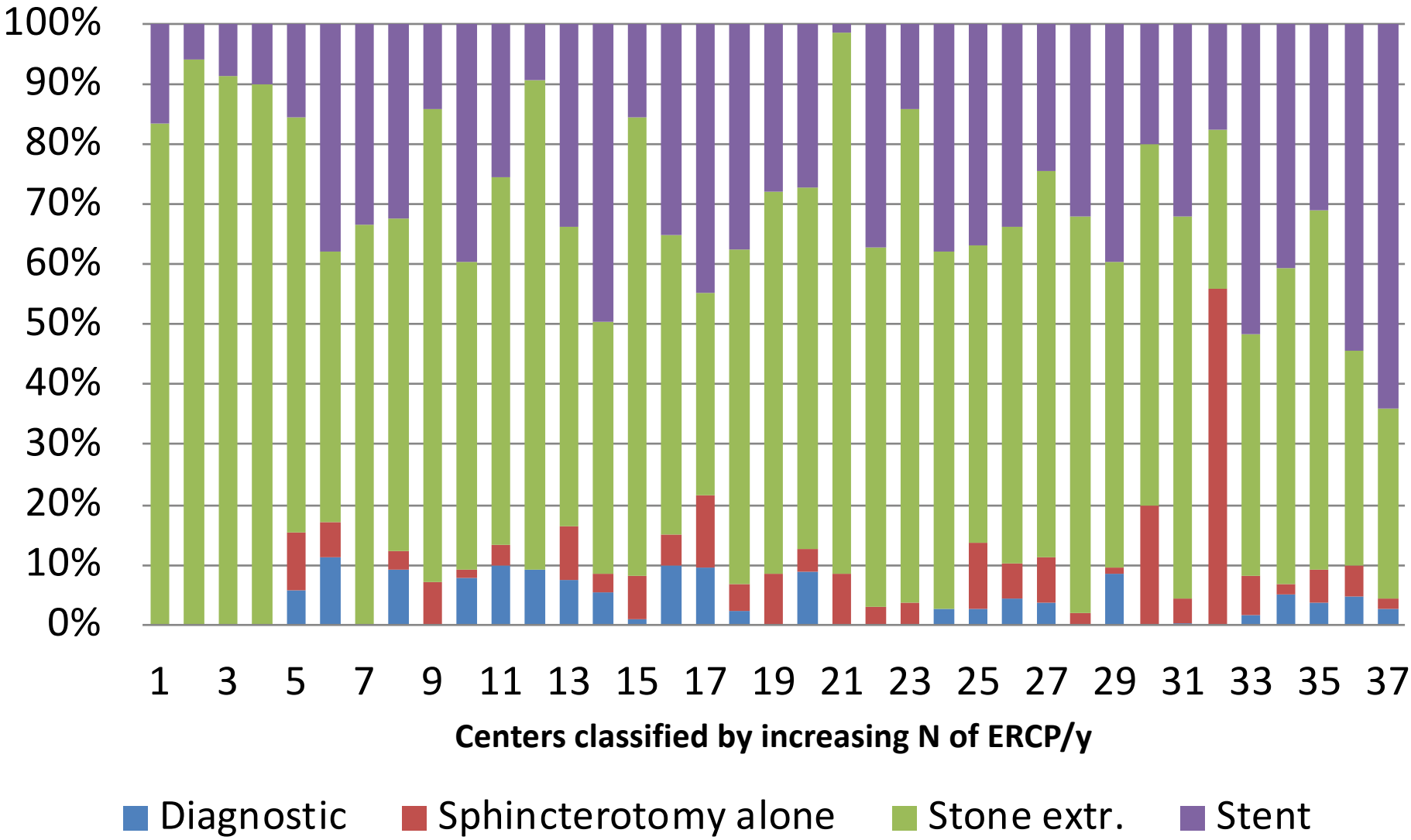


Mean ERCP/endoscopist/year

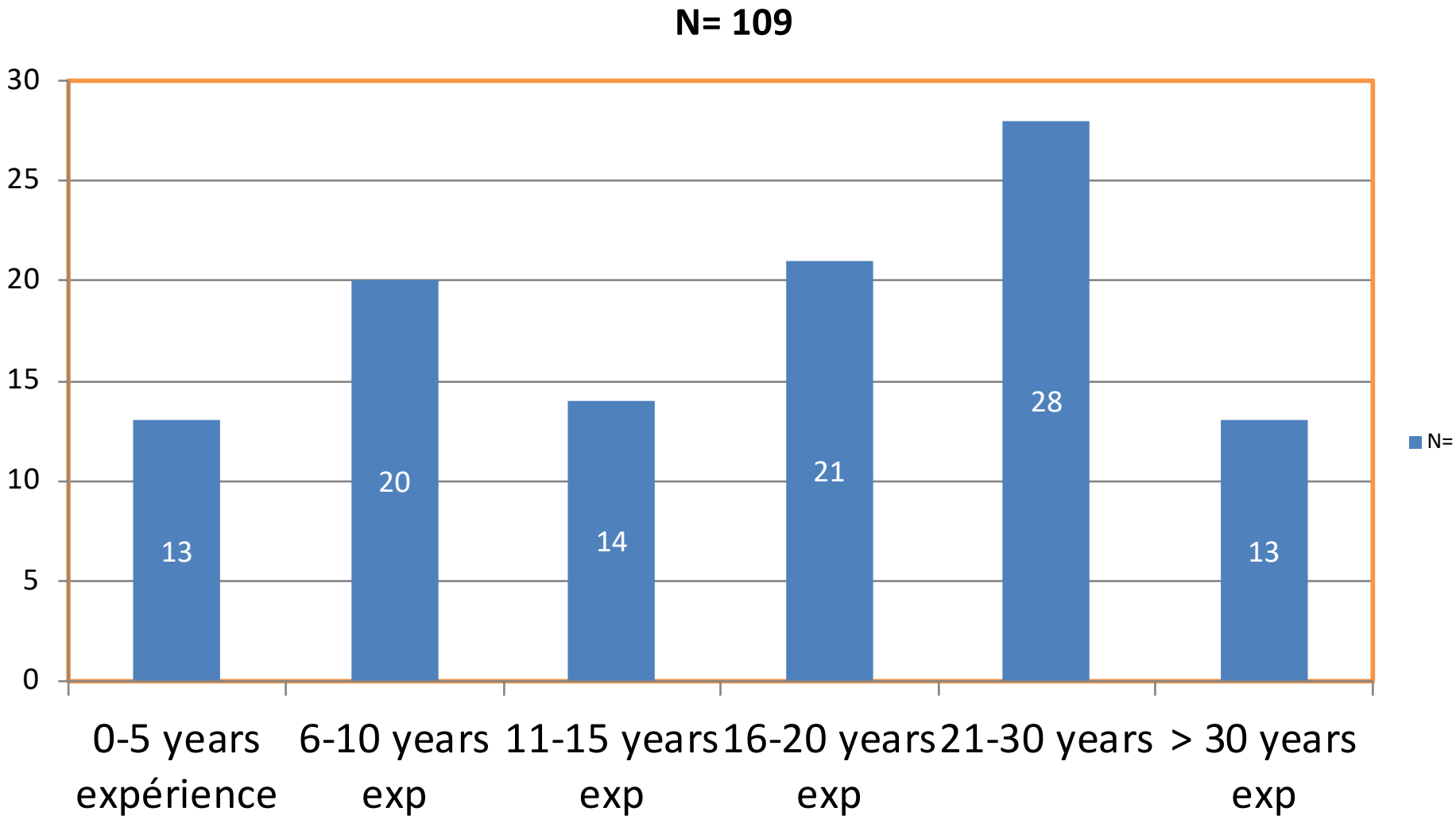


NB : biggest hospital in Fl. excluded

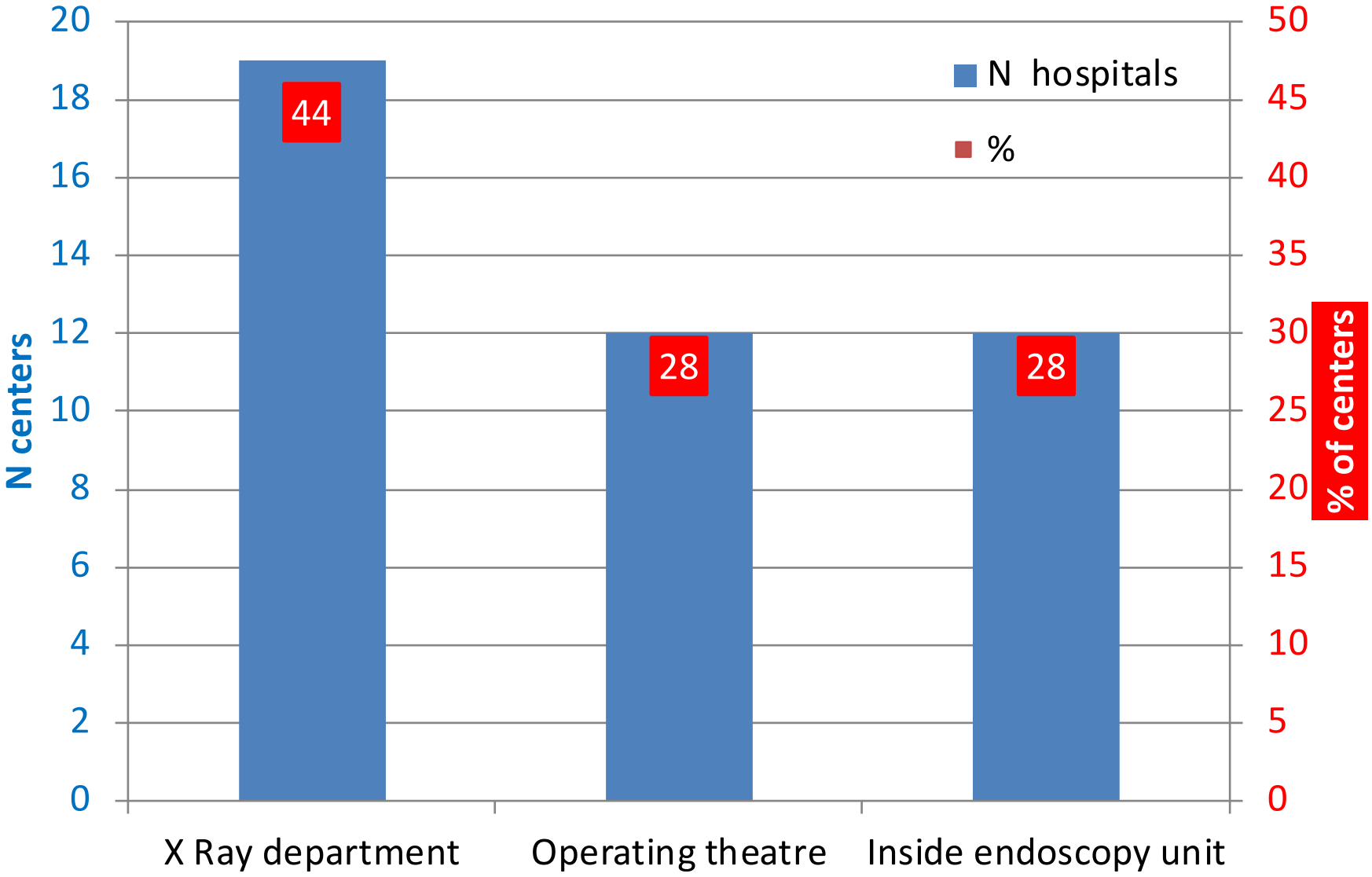
% ERCP by INAMI-RIZIV codes



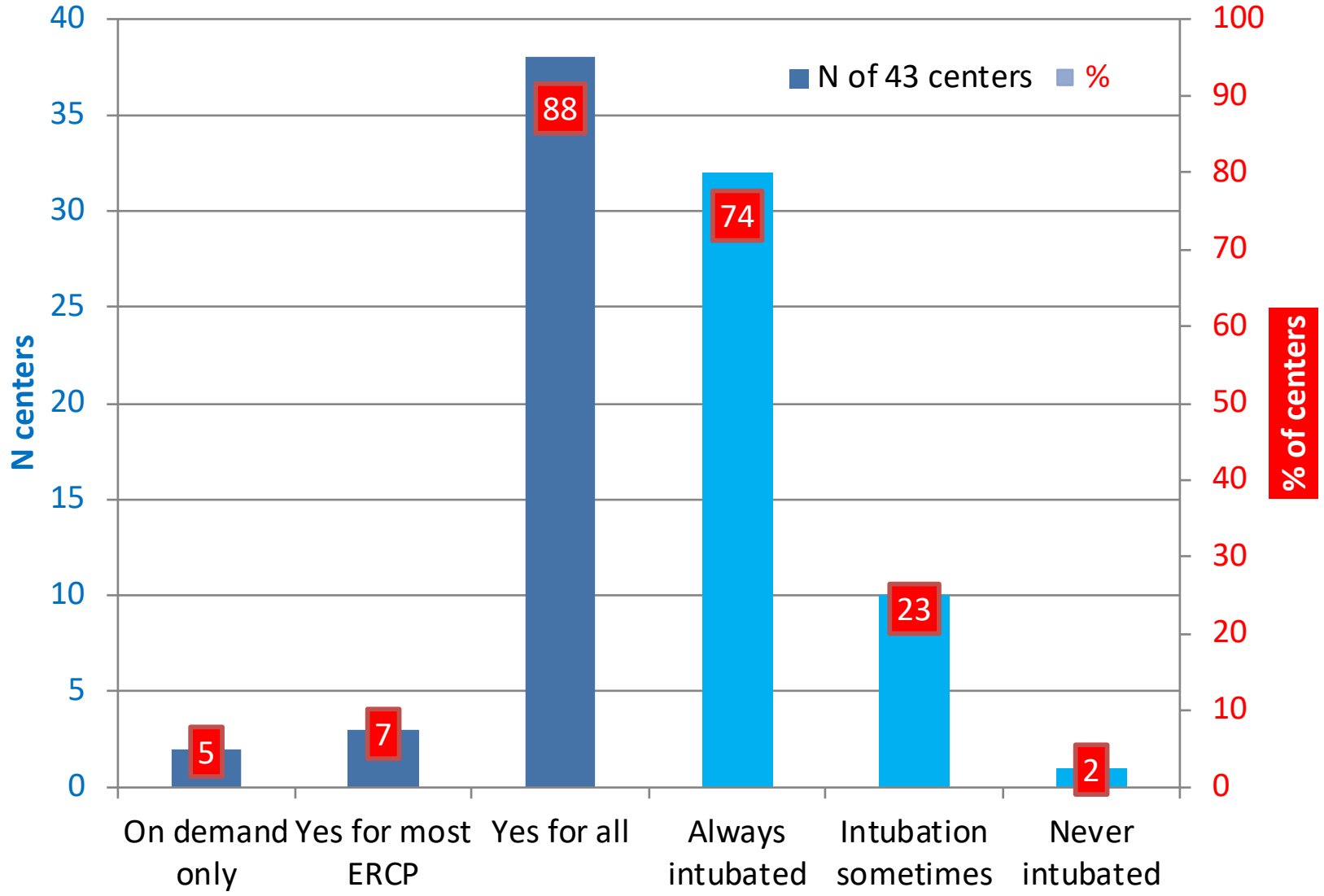
Years of experience in ERCP



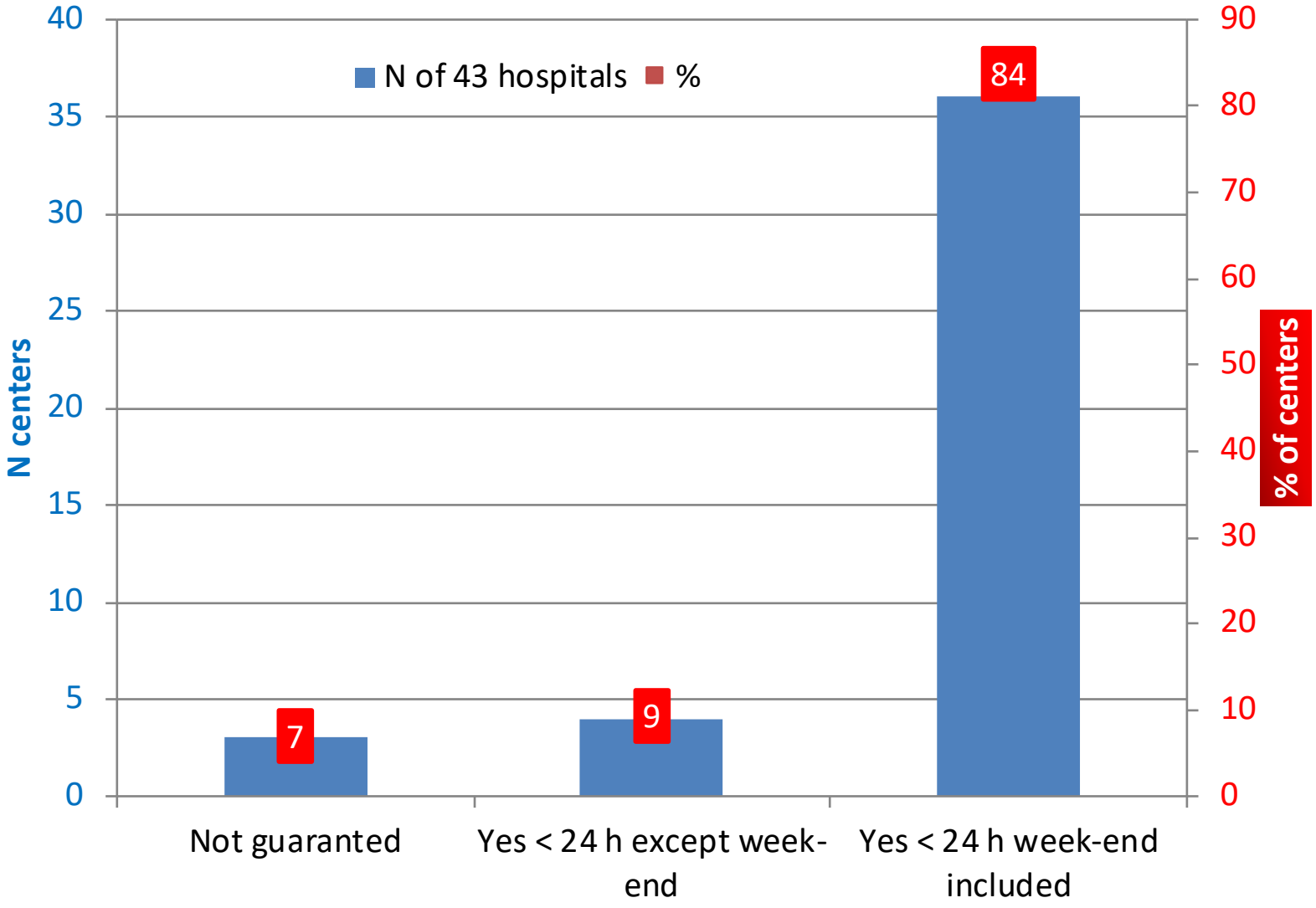
Where are ERCP performed ?



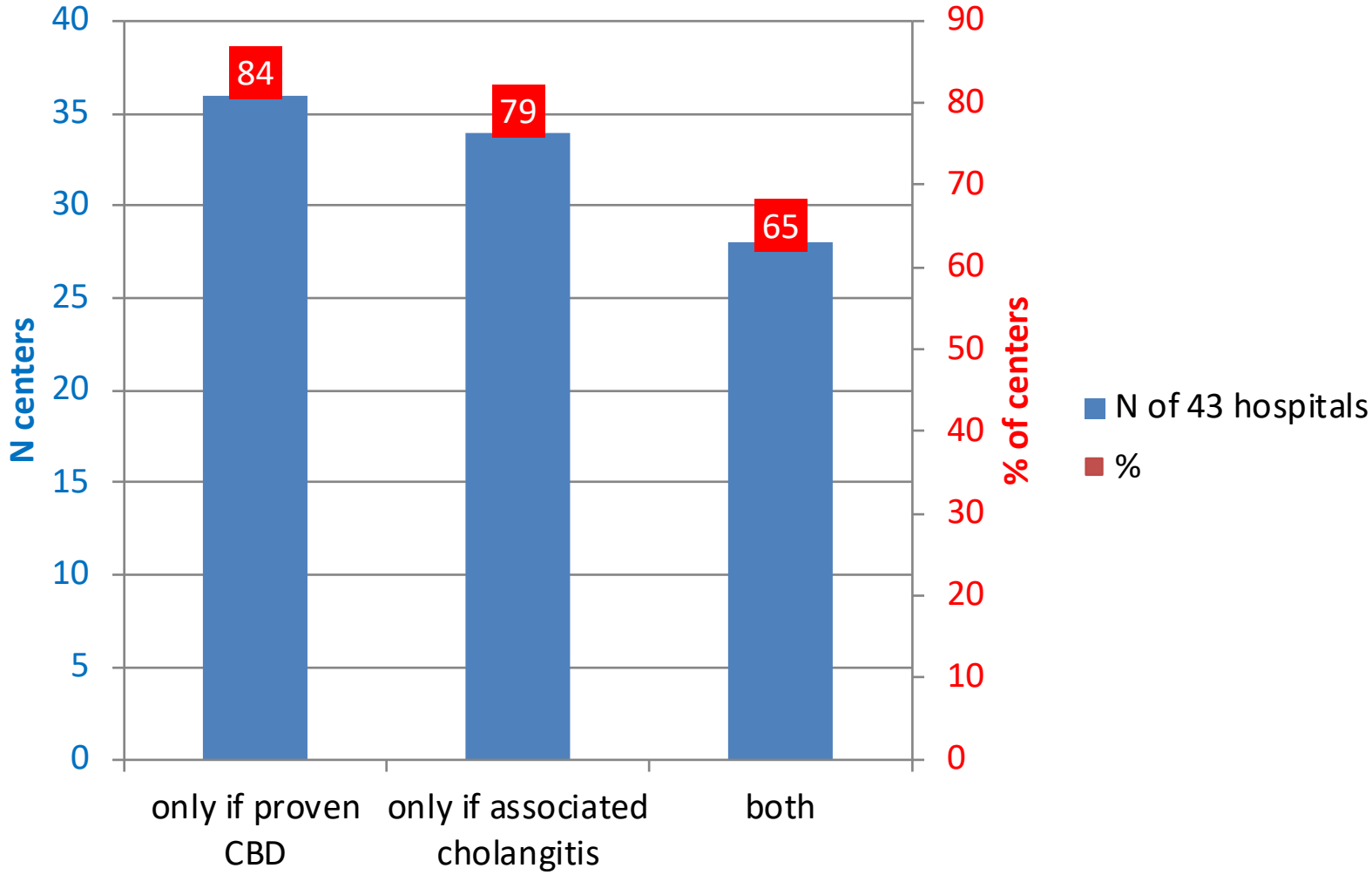
Anesthesiologist availability for ERCP and tracheal intubation habit



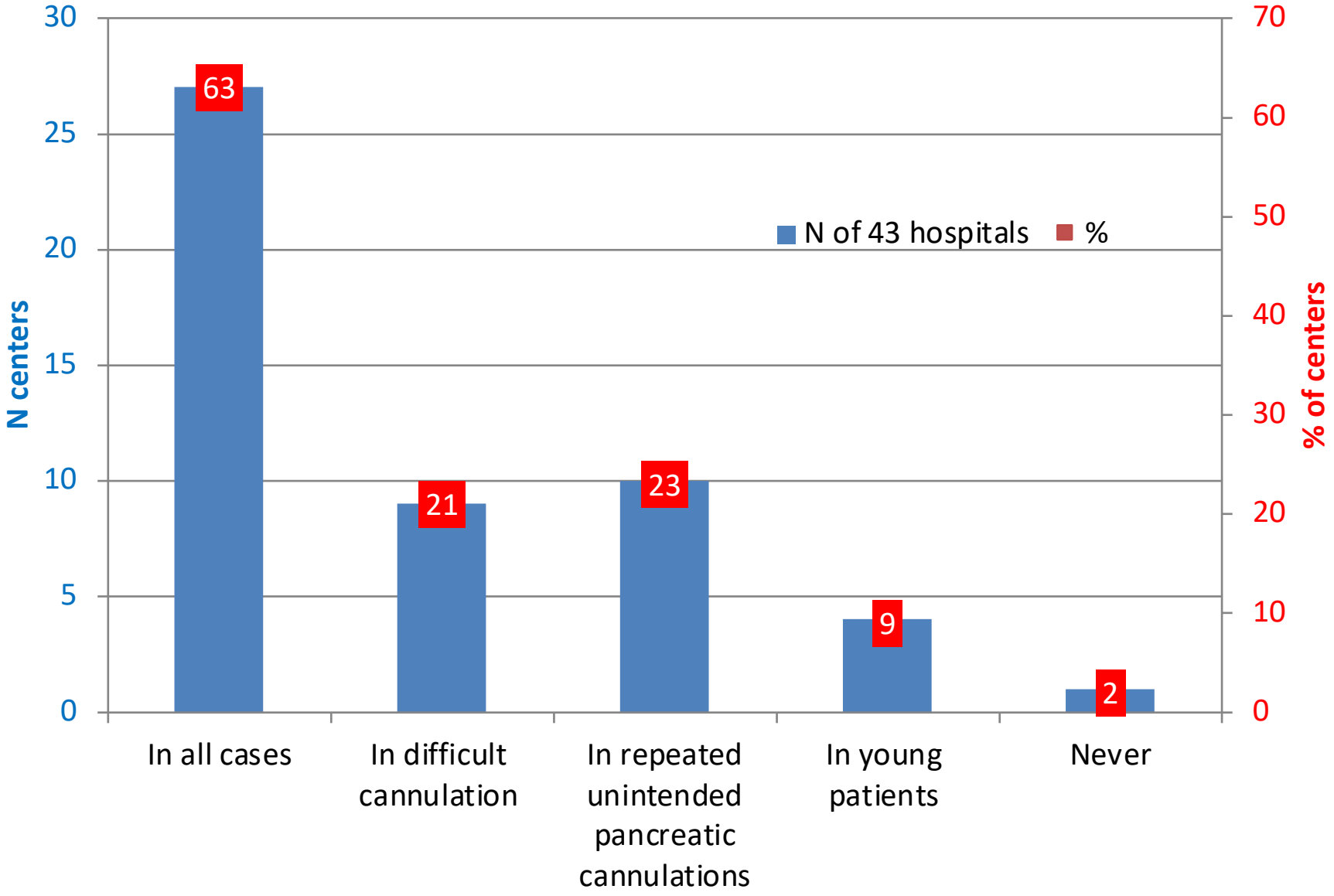
In your hospital practice, are you able to perform urgent ERCP for cholangitis?



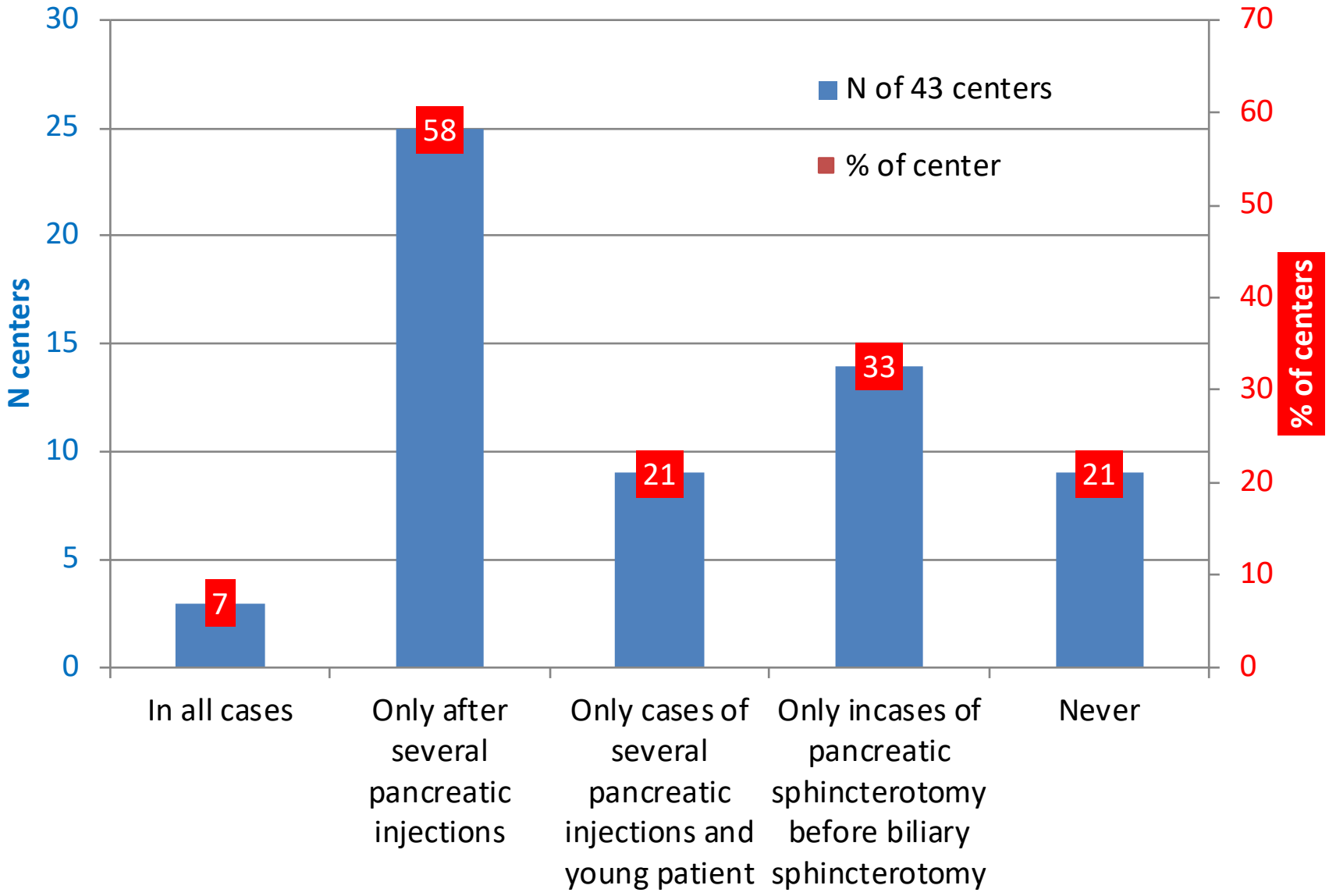
In case of suspected biliary pancreatitis, do you perform biliary sphincterotomy?



When do you administer a prophylactic NSAID ?



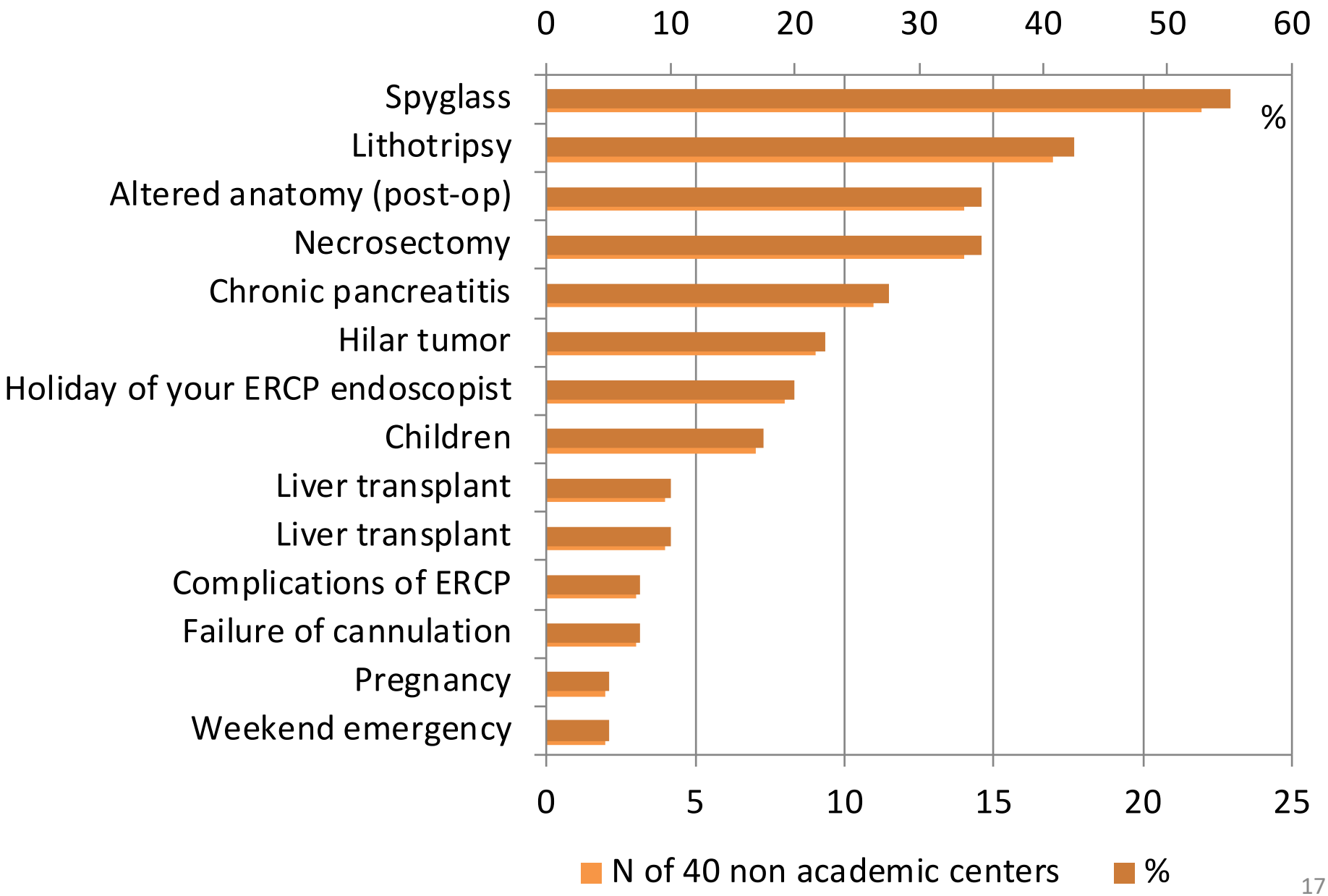
Do you place a prophylactic pancreatic stent in case of unintended pancreatic cannulation ?



Do you refer ERCP cases to other centers ?

- 33/40 (82 %) of non academic hospital refer at least 1 patient /year
- 91 % to academic center, 9 % in the same network
- < 5 patients/y in the majority

Indications of transfer



Scope disinfection- bacteriological surveillance

	Yes	Yes in %
Do you have a written protocol for duodenoscope disinfection ?	36	84
Do you have a protocol of microbiological surveillance of your duodenoscope ?	27 (from once a year to weekly)	63
Are you aware of a case of multi-drug resistant contamination of your duodenoscopes in your hospital	4 (VRE, 2 BLSE, Klebs)	9
Do you store your duodenoscope in a drying cabinet ?	27	66
If not, do you reprocess your scope before every new use (after > 24 h store) ?	19 (9 both cabinet and reprocessing)	76

Performance monitoring- informed consent

		N Yes	Yes in %
Do you monitor the ERCP performance in your hospital ?			
	cannulation success rate	13	30
	post ERCP pancreatitis	13	30
	other complications	12	28
Do your patients need to give informed consent prior to the ERCP? (indications, alternative, risks and complications)		31	76
If yes, how do you give information about the procedure?		31	76
	Orally	8	26
	Written (leaflet)	7	23
	Both	16	52
If yes, who gives the information in daily practice ?			
	By the practioner (whatever his-her specialty) in charge of the patient	14	45
	By one of the endoscopists of the unit	11	35
	By the nurse	6	19

		Yes : N=	% of Yes
Do you think the case volume of ERCP in your hospital is sufficient to maintain quality and performance?		41	95
Do you think some of the endoscopists of your unit should stop performing ERCP ?		2	5

Conclusions

- This survey gives us a good picture of the ERCP landscape in Belgium (2/3 of ERCP)
- The low case volume centers (< 50 /y) are however underrepresented in this survey.
- The ERCP case volume per hospital but also per endoscopist can rise questions in some centers.
- The need for urgent ERCP for cholangitis is overall well covered.
- The application of prophylactic measures recommended by the guidelines to prevent post ERCP pancreatitis is not uniformly widespread and remains operator dependent.
- Quality practices of patient informed consent, scopes bacteriological surveillance and monitoring of performance could be improved.

acknowledgment

Participating centers

Epicura site de Ath
AZ Alma
az glorieux ronse
Az groeninge kortrijk
AZ KLINA
AZ OUDENAARDE
AZ Sint-Jan Brugge
AZ Sint-Lucas Brugge
AZ St Dimpna Geel
Az vesalius
AZdamiaan
AZLokeren
Centre Hospitalier de Mouscron
CHA libramont
CHC Liege
CHIREC - Site de Braine l' Alleud
Chr citadelle liege
CHR HAUTE SENNE SOIGNIES
Chu Ambroise Pare
CHU Charleroi
Chu Liège
CHU Saint Pierre
CHU UCL NAMUR, site Godinne
CHU Tivoli
Cliniques universitaires Saint-Luc
Digestief Centrum
Erasme, ULB, Brussels
GZA ziekenhuizen
H.-Hartziekenhuis Lier
Heilig Hart Leuven
Heilige Familie Reet
Hopitaux Iris Sud
IFAC Marche-en-Famenne
Jessa
Malle
Monica Hospital Deurne
Onze-Lieve-Vrouw ziekenhuis - Aalst
RZ Tienen
Saint Pierre Ottignies
Sint andriesziekenhuis tielt
Sint Vincentiusziekenhuis Deinze
Sint-Jozef Kliniek Bornem
University Hospital of Ghent
UZL

Special

- Dr Ch. Snauwaert and Lode Moutton for IT design and data collection

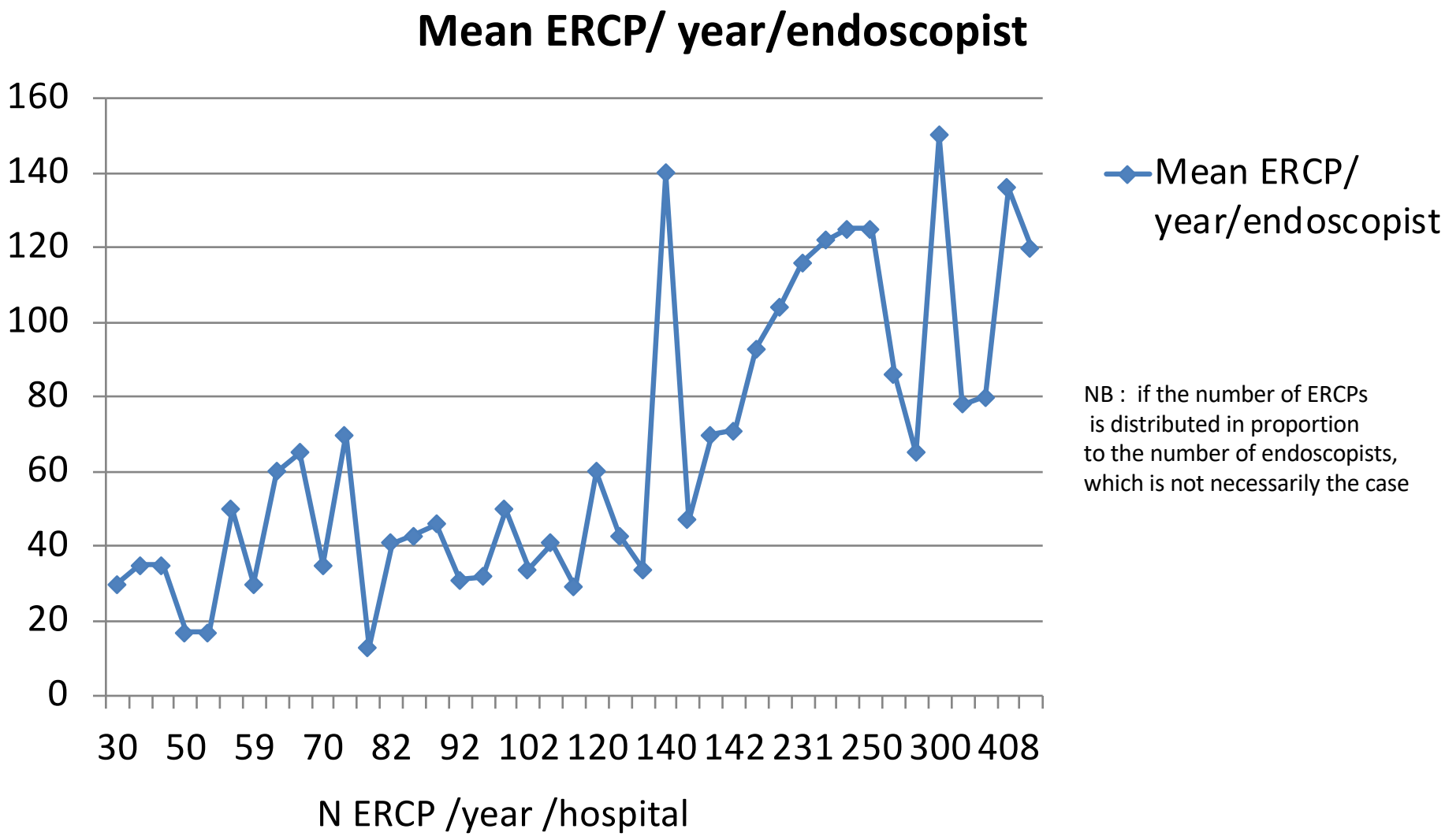
- BSGIE board and Anne Sophie Wirtz

2014 ESGE recommendations

ESGE recommends routine rectal administration of 100mg of diclofenac or indomethacin immediately before or after ERCP in all patients without contraindication.

In addition to this, in the case of high risk for post-ERCP pancreatitis(PEP), the placement of a 5-Fr prophylactic pancreatic stent should be strongly considered

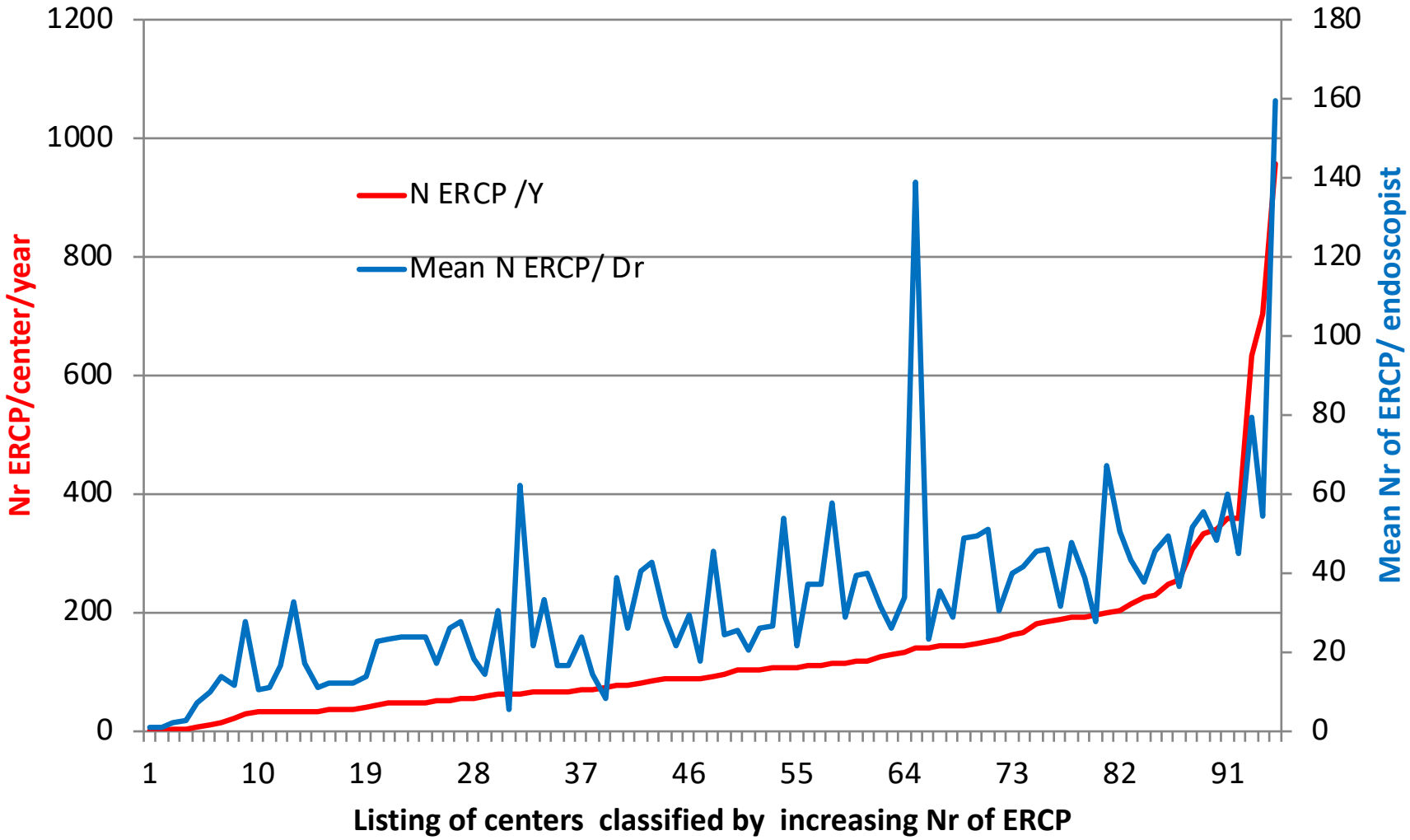
Survey data



NB : if the number of ERCPs is distributed in proportion to the number of endoscopists, which is not necessarily the case

NB : largest hospital in Fl. excluded

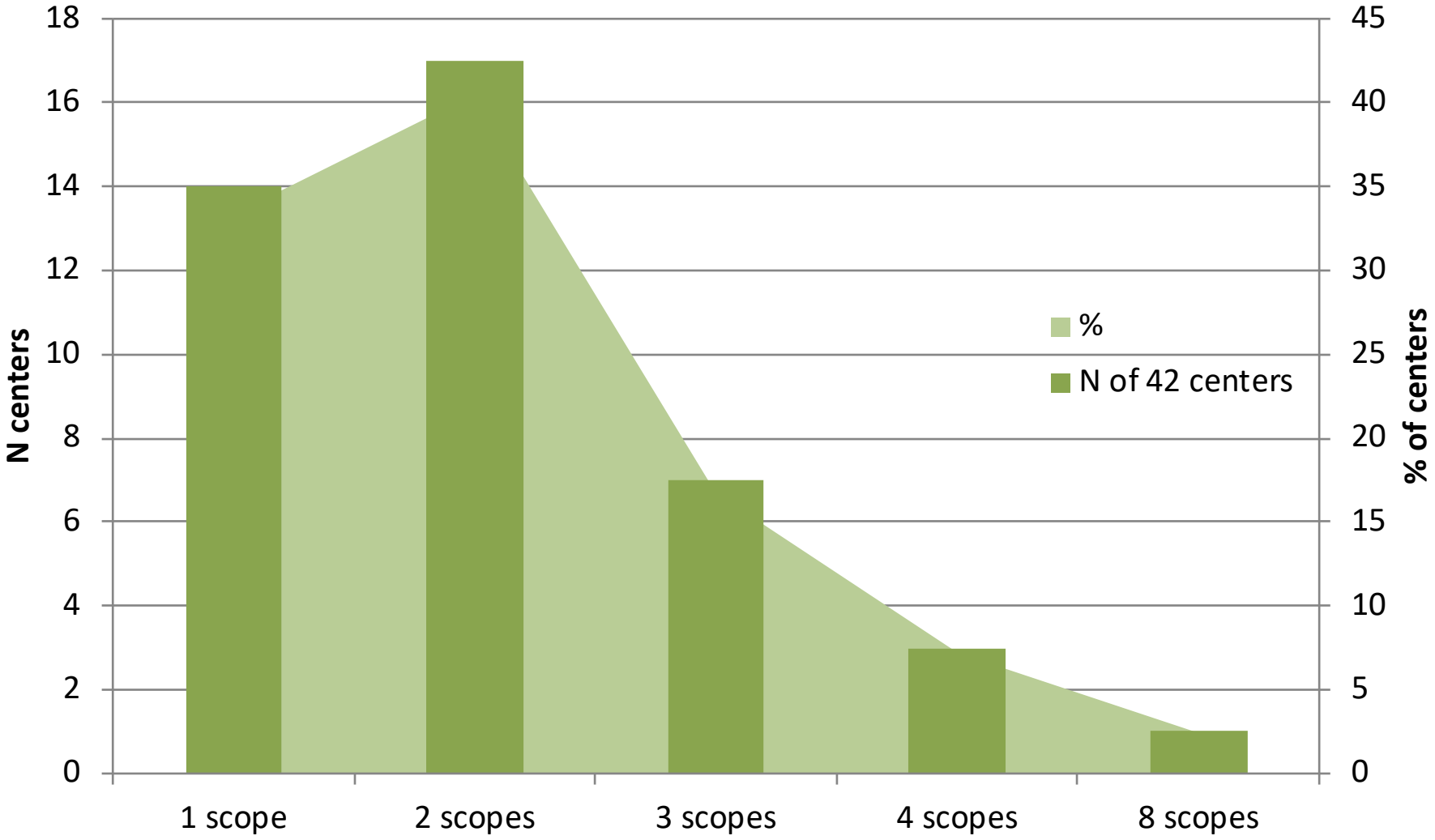
INAMI-RIZIV data



Availability of < 24 h ERCP in case of cholangitis

	N Hospitals = 43	%
No	3	7
Yes except Week-end	4	9
Yes WE included	36	84

How many duodenoscopes /center ?



Years of ERCP experience of endoscopists