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GI learning, personalised

Summary

How to set up a safe, efficient and high-quality endoscopic service and achieve maximum endoscopy quality in emergency care?

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This educational presentation addresses how to structure endoscopy services and emergency GI bleeding management through systematic quality measurement, feedback, training, and adherence to evidence-based protocols.

KEY POINTS

- The speakers propose that value in endoscopy equals patient outcomes divided by resources expended, with training and high-quality procedures being the most cost-effective interventions.
- Core service requirements include named leadership with protected time, systematic capture and feedback of key performance indicators to individual endoscopists, and structured support for underperformers rather than punitive responses.
- For colonoscopy training, the speakers stated that competency typically requires about 233 procedures in UK data, with performance stabilizing around 350 to 400 procedures, and emphasized that nursing staff should be empowered to speak up about quality concerns.
- In emergency upper GI bleeding, the speakers recommend endoscopy within 24 hours for nonvariceal bleeding and within 12 hours for suspected varices, stating that urgent endoscopy does not reduce mortality compared to early endoscopy according to a New England Journal of Medicine study.
- The speakers advise using restrictive transfusion policy with hemoglobin threshold below 7, continuing low-dose aspirin, avoiding routine intubation, and using dual endoscopic therapy for ulcer bleeding, with the speaker noting that evidence for upfront IV PPI is weak.
- For lower GI bleeding, the speakers stated that meta-analysis shows urgent colonoscopy within 24 hours does not improve outcomes versus routine timing, recommending admission and scoping during hospitalization rather than emergent procedures.

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