Die neuesten ESGE Guidelines zum Thema Live Demonstrationen

Position Statement

Thieme

Live endoscopy events (LEEs): European Society of Gastrointestinal Endoscopy Position Statement – Update 2021

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Bibliography
Endoscopy 2021; 53: 842–849
DOI 10.1055/a-1511-1657

ABSTRACT

The European Society of Gastrointestinal Endoscopy (ESGE) is dedicated to improving the quality of gastrointestinal endoscopy, including through educational activities such as live endoscopy events (LEEs). The primary goal of LEEs should be to facilitate the improvement of endoscopic patient care through the acquisition of best endoscopic practice. Patients should not expect additional benefit from being treated during a LEE compared to a routine setting. There is limited available evidence on LEE safety but to date there is no indication that patients are at increased risk from participation. Pre-recorded cases with live facilitation can also be used to fulfill learning outcomes. Establishing an endoscopic curriculum with clear learning outcomes is important to structure attendees' learning, assess course outcomes, and allow appropriate targeting of courses to learner experience. Increasingly, LEEs are streamed online and therefore the necessary measures should be taken to ensure that patients have given appropriate consent and that their anonymity has been safeguarded. ESGE recommends that an endoscopist who is not participating in the live demonstrations is named as patient advocate, and that patient safety should must be prioritized throughout. In all ESGE-organized LEEs the intended learning outcomes, procedural indications and descriptions, attendee feedback, and adverse events should be recorded and submitted in a post-event report to ESGE.

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▶ **Table 1** Live endoscopy events (LEEs): summary of European Society of Gastrointestinal Endoscopy (ESGE) recommendations.

The Patient	*Informed consent*. An additional separate written informed consent must be signed for LEE participation. Patients must be informed that they may at any point refuse or withdraw their consent. Patients must not suffer any disadvantage for refusing or withdrawing their permission, and their endoscopic procedures must be performed outside the LEE without significant delay. Patients must be informed as to whether the case is intended to be shown locally or broadcast online.
Patient advocate	*Patient care, dignity, and anonymity*. As an independent advocate for the patient, he/she must intervene and liaise with the director of the local organizing committee (LOC) if, at any time, any of those patient interests are put at risk by lack of adherence to the ESGE recommendations for LEEs.
	Post-LEE feedback. The patient advocate must give general feedback to the director of the LOC in a standard written report. This must include all potential or actual breaches of the ESGE recommendations, or any other action related to the LEE that may have exposed patients to an increased risk.
Curriculum	The main indication for LEEs is to demonstrate excellent endoscopic care delivered safely. Each LEE should therefore publish an "endoscopic curriculum" with learning objectives explicitly stated at the outset. The learning objectives should be specific and describe competencies that the attendee should be able to demonstrate by the conclusion of the LEE (see **Appendix 1 s**, available online-only, in Supplementary material).
	Learning objectives should be stated in the LEE advertising material to ensure attendees are aware of what to expect prior to registering for the course. Relevant learning objectives should be referenced prior to each case, and a summary at the end of each case or session is a vital component of each LEE. LOCs should aim to provide supplementary course material, e. g. in the form of videos or a literature library, to augment the learning objectives.
	The LOC is responsible for collecting feedback with regard to attendee experience of the course. This should address whether attendees felt learning objectives were met by the course (see **Appendix 2 s**) and provide a mechanism by which LOCs can improve the educational output of future courses.

Table 1 (2)

Course format	LEEs should aspire to provide an option for online streamed content if practicable and appropriate. LOCs must provide appropriate safeguards to ensure that online attendees are healthcare professionals or industry representatives.
Operator	*Patient care*. The operator is the only person responsible for the endoscopic outcome of the procedure. If the indication is deemed to be inappropriate, the LOC director should be immediately informed and the case cancelled. Even within the stated educational objectives of the LEE, the operator's primary focus must be optimal patient care.
	LEE procedure. LEE operators are expected to carry out only procedures in which they have extensive experience. New techniques, adding a potential clinical benefit for the patient, may be included at an LEE only if the LOC staff has already been trained in them.
	Post-procedure management. Although the LOC director is responsible for the clinical management of the patient, the visiting operator should liaise with the LOC director as needed. The visiting operator must be contacted with regard to any adverse patient outcome.
Moderator	*Patient care*. Excessive prolongation of the procedure because of extended discussions must be avoided. Moderator(s) or the audience may favor endoscopic approaches that are different from that of the LEE operator. In the setting of a clear difference of opinion on optimal patient care then management should be agreed between the operator, the LOC, and the patient advocate, with the central focus being patient safety.
	Educational benefit. Moderators must reinforce the educational message of LEE events. They should ensure that demonstration and discussion during live cases have a particular focus on the stated learning objectives. The moderators are also expected to interact with faculty and the audience to provide further perspectives and clarification. Moderators should direct learners towards the relevant literature to encourage evidence-based decision making.

Table 1 (3)

LOC director	*Patient selection and care*. High quality, safe procedures are a central expectation with regard to LEEs. Nevertheless, LEE procedures may be associated with more prolonged sedation/anesthesia, and the operator will be required to address educational aspects of the LEE, as well as the procedure itself. As a result an LEE may not represent the most suitable setting for patients with significant co-morbidities. The clinical management of the patient is the responsibility of the LOC director, the operator, and endoscopy team directly involved in each case. The LOC director will be responsible for intervening if concern is raised (including by the patient advocate) about patient safety during an LEE, and for the appropriate management of adverse events.
	Selection of faculty members. Only experts with adequate skills and experience in endoscopic training should be included (see above). The LOC director should specifically strive to invite faculty from diverse backgrounds to reflect the ESGE's aim to improve diversity and equity within endoscopy.
	Local staff support. The LOC must recognize that visiting operators may be unfamiliar with planned cases and the endoscopic setting. Local staff must present visiting faculty with relevant support and patient documentation and this must be done well ahead of the scheduled procedure.
	Availability of staff. The local director needs to involve invited faculty according to their experience and skills, and that of the host team. Only in exceptional circumstances should procedures be performed with which the host unit do not have experience.
	Disclosure of conflict of interest. The LOC director must ensure that faculty members disclose all their personal and financial conflicts of interests before the LEE. If any of these conflicts jeopardizes patient safety, the involved parties must be excluded from the LEE.

Die erwähnte Studie aus Augsburg

Original article

Thieme

Outcomes of endoscopic submucosal dissection (ESD) during live endoscopy events (LEE) – a 13-year follow-up

OPEN ACCESS

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submitted 24.4.2019
accepted after revision 30.9.2019

Bibliography

DOI https://doi.org/10.1055/a-1035-9240 |
Endoscopy International Open 2019; 07: E1723–E1728

eISSN 2196-9736

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ABSTRACT

Background and study aims There are no data showing the outcome of ESD during live endoscopy events (LEE). ESD performed during the Augsburg Endo-Update LEE were compared with matched routine procedures with the aim of demonstrating non-inferiority of LEE ESD.

Patients and methods ESD performed during the Endo-Update between 2006 and 2018 were reviewed. The controls were routine procedures matched according to age, location and lesion size. Resection, recurrence, survival and complication rates, procedure time and propofol sedation were assessed. Clinically relevant margins were assumed for resection and complication rates, procedure time and propofol sedation quantity.

Results Thirty-eight ESD were performed in the given time period, and were compared with 38 matched routine ESD. En bloc and curative resection rates in the LEE group and in the control group were 100 % and 87 % as well as 84 % and 71 % respectively, while procedure times were 135 and 125 minutes, respectively. Non-inferiority was demonstrated for resection rates and procedure time. The complication rate was lower in the LEE group as compared with the control group (5 % vs 13 %) while propofol sedation was similar in both groups (863 mg vs 872 mg). Recurrence and 5-year survival rates for both groups were 4 % vs 0 % and 70 % vs 65 % respectively.

Conclusions The resection rate and procedure time of ESD during LEE was non-inferior to those of routine ESD procedures. Comparison of the complication rates, however, was inconclusive owing to the low patient number and complication risk in both groups.

Weitere Studien zum Thema

Outcome of endoscopic retrograde cholangiopancreatography during live endoscopy demonstrations

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Received: 29 September 2011 / Accepted: 8 December 2011 / Published online: 21 February 2012

Abstract

Background A number of factors may result in lower than expected success rates for endoscopic retrograde cholangiopancreatography (ERCP) performed by overseas experts during live demonstrations (LDs). Stratifying the degree of ERCP difficulty may help in the assessment of procedure outcomes, but no prior reports have done so. This study aimed to compare the success rate and complications of ERCP between procedures performed in live demonstrations and for matched control subjects.

Methods From 2004 to 2011, a total of 82 patients who underwent ERCP during live demonstrations at the Endoscopy Unit of King Chulalongkorn Memorial Hospital were reviewed. The control for each patient was a patient admitted to the same ERCP unit with matched indications at the time closest to the demonstration course who had matching gender and techniques in therapeutic interventions during ERCP. The success rates and complications between the two groups were compared based on the grading scale for the degree of difficulty according to Cotton and colleagues.

Results For standard ERCP cases (levels 1–2), the success rate, complication rate, and duration of the procedure (DOP) did not differ significantly. In contrast, the success rate for complex ERCPs (levels 3–4) performed during LD was significantly lower (73% vs. 90%; $P = 0.006$). The complication rates and DOP were not significantly different ($P = 0.31$ and 0.23, respectively). The overall success rate was significantly lower for LD procedures than for control procedures (81% vs. 91%; $P = 0.02$).

Conclusions In this series, the standard ERCP performed during LD was associated with success and complication rates similar to those for the control subjects. Complex ERCP cases were, however, associated with lower success rates than those for the control subjects. A high proportion of complex ERCP cases during live demonstration can influence the overall success rate of ERCPs performed by overseas experts.

Surg Endosc (2012) 26:1931–1938
DOI 10.1007/s00464-011-2130-2

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Complications of Endoscopic Retrograde Cholangiopancreatography during Live Endoscopy Workshop Demonstrations

Background and Study Aims: Endoscopy workshops are thought to be associated with larger numbers of complications than routine clinical treatment. In this study, patients who underwent endoscopic retrograde cholangiopancreatography (ERCP) during live demonstrations were compared with matched patients treated in an ERCP unit.

Patients and Methods: Patients who underwent ERCP during workshops over a 12-year period were reviewed. The control for each patient was the next patient admitted to the same ERCP unit with similar indications. Possible delays before treatment, ERCP indications, the use of general anesthesia, standard endoscopic and special treatments, success and complication rates for ERCP, prolonged hospitalization periods, and financial benefits for patients were assessed.

Results: A total of 168 workshop patients and 168 control patients were compared. ERCP was delayed in 18 patients to allow treatment during the workshops. General anesthesia was used in 87.5% of the workshop patients, in comparison with 44% of the control patients ($P < 0.001$). The duration of the endoscopies and radiation exposure did not differ, and the endoscopic treatments carried out also did not differ significantly, with the exception of cholangiopancreatoscopy (7% in the workshop group versus 0%; $P < 0.01$). The success and complication rates were similar in the workshop and control patients, as was the duration of hospitalization. Among the patients treated during workshops, 45% benefited financially, as they were not charged for stents or other devices.

Conclusions: These results suggest that, in this setting, ERCP performed during live demonstrations is safe and raises no major ethical problems.

Endoscopy 2005; 37 (8): 695–699