REDUCING THE IMPACT OF ENDOSCOPY STARTS TOMORROW

THE BEST ENDOSCOPY MIGHT BE THE ONE THAT IS NOT DONE!

The following information was devised by The Eco-Responsibility and Sustainability Development Committee from the French Society for Digestive Endoscopy (SFED). The European Society for Gastrointestinal Endoscopy (ESGE) are grateful for the opportunity to bring these important resources to a wider audience.

Endoscopy is an over-utilised but finite resource. The overall burden of care can be reduced by minimizing endoscopies performed inappropriately. It has been estimated that 1/3 of all endoscopies performed do not have a validated indication! [1,2]

The demand on endoscopy services is growing, without an increase in resources allocated. Let's avoid inappropriate endoscopies and target interventions to maximise the potential diagnostic and therapeutic benefits.

Surveillance procedures represent a significant burden for endoscopy units. Inappropriate surveillance adds to this burden, without any benefit to patient care. **Recommendations for when NOT to perform endoscopic surveillance: [3]**

Oesophagus	Cervical or Upper oesophageal gastric heterotopia (inlet patch)
	Grade A or B esophagitis
	Barrett's Oesophagus ≤ 1 cm without visible lesion
Stomach	Fundic gland polyps (except in polyposis)
	Focal Intestinal metaplasia (antrum) without risk factors (persistent Hp, history of gastric cancer)
	Ectopic pancreas and leiomyomas when confirmed or typical
	Lipomas
Duodenum	Duodenal ulcers except when symptoms persist
	Brunner's gland hyperplasia
Pancreas	Confirmed serous cystadenomas
	Cyst surveillance may be discontinued for patients with cysts<20mm showing no morphological changes and no worrisome features after 5-years of surveillance[4]
Colon	Hyperplastic polyps of the rectosigmoid
	Early follow up at 3 years
	1-4 adenomas < 10 mm with low-grade dysplasia[5] (5 years is enough)
	Serrated polyps < 10 mm without dysplasia (5 years is enough)
	In case on 5 years colonoscopy negative, patient can go back to screening
	Lesions without any features of deep invasion can be diagnosed endoscopically, EUS exploration is not recommended

References :

(1) The carbon cost of inappropriate endoscopy. Elli, Luca et al. Gastrointestinal Endoscopy, Volume 99, Issue 2, 137 - 145.e3.

(2) Rodríguez de Santiago E et al. Reducing the environmental footprint of gastrointestinal endoscopy: European Society of Gastrointestinal Endoscopy (ESGE) and European Society of Gastroenterology and Endoscopy Nurses and Associates (ESGENA) Position Statement. Endoscopy. 2022 Aug;54(8):797-826. doi: 10.1055/a-1859-3726.

(3) Rodríguez-de-Santiago E et al. Digestive findings that do not require endoscopic surveillance - Reducing the burden of care: European Society of Gastrointestinal Endoscopy (ESGE) Position Statement. Endoscopy 2020; 52: 491–497. doi:10.1055/a-1137-4721

(4) Ohtsuka et al. International evidence-based Kyoto guidelines for the management of intraductal papillary mucinous neoplasm of the pancreas. Pancreatology. Volume 24, Issue 2,. 2024. Pages 255-270

(5) Hassan C et al. Post-polypectomy colonoscopy surveillance: European Society of Gastrointestinal Endoscopy (ESGE) Guideline - Update 2020. Endoscopy. 2020 Aug;52(8):687-700. doi: 10.1055/a-1185-3109.