Post-colonoscopy colorectal cancer incidence

To the Editor: We note the publication of the post-colonoscopy colorectal cancer (PCCRC) article (Fourie *et al.*[1]). It denotes a baseline for South Africa (SA), and confirms that our PCCRC rates are globally on par.

We have several concerns we wish to note regarding inferred conclusions:

(*i*) The manner in which the PCCRC rate for medical gastroenterologists was established: It is seemingly unclear, but assumed, that the operator for the second diagnostic colonoscopy also performed the previous scope where the lesion was not diagnosed. This needs clarity and/or correction, as medical gastroenterologists, in the authors' conclusions, have a higher PCCRC rate. This seems methodologically unsound and casts unneeded aspersions.

(*ii*) The vast majority of the cohort (14 773) were excluded from analysis, and of these, most (40%) were on the basis of a background high risk of CRC (polyposis syndromes, hereditary non-polyposis CRC, previous CRC, previous adenomas and inflammatory bowel disease (IBD)). This cannot be accurately done on the basis of ICD-10 codes only, as per methodology, as many of the above do not have ICD-10 codes (e.g. serrated polyposis syndrome; no distinction made for adenomas – rather the use of a broad category of 'benign neoplasms'). It is anticipated that polyposis syndromes and IBD account for a minority of CRC cases, hence most were likely excluded given inadequate coding. The adenoma detection rate is a well-recognised and validated key performance indicator for colonoscopy quality, and not PCCRC. Adenoma detection rates are inversely correlated to PCCRC rates. This exclusionary approach potentially excludes scopes that detect adenomas, and by extension, lower rates of PCCRC. Not including these data in the analysis may inherently create significant bias. High-risk groups are of particular interest in our country, where we lack capacity to perform community-based screening, so that targeted screening is possibly a more feasible approach.

(*iii*) The indications for colonoscopy were not considered. It is expected that those performing endoscopy in patients with alarm symptoms will have higher rates of CRC and subsequently PCCRC identification. Conversely, performing colonoscopies for screening or low-yield indications could lead to lower rates of PCCRC. Without proper matching for indications, the PCCRC rates cannot be compared between groups. Similarly, the utility of endoscopy needs to be considered. Repeating annual colonoscopies in low-risk patients will lead to lower rates of PCCRC and increased cost. Other validated key performance indicators were not considered (bowel preparation, caecal intubation rates). These data are required to correctly interpret the quality of colonoscopies to match CRC rates.

(*iv*) The comparative groups were apportioned into surgeons, gastroenterologists and physicians/general practitioners. While it is acknowledged as a limitation, this leads to the data being uninterpretable. Most general specialist physicians do not receive training in endoscopy. It is unlikely that general physicians perform more colonoscopies than gastroenterologists.

(*v*) The Colleges of Medicine of SA require medical gastroenterology trainees to produce a logbook and meet a minimum number of colonoscopies. No such requirement exists for training in general surgery. We are of the view that the focus should be not on individual disciplines but on structured competency-based training to perform colonoscopy. This model is well engrained in countries such as the UK. Both trainer and trainees in the UK are expected to achieve competency through structured training, directly observed procedures and continuous evaluations. Furthermore, competency needs to be maintained, with key performance indices monitored.

We are of the considered view that key performance indices and quality data are needed in SA to improve outcomes and optimise utility of a limited resource. We are concerned with the conclusions made in the article, given the lack of clarifying data. Training, competence and continuous evaluation will strive to improve endoscopy quality.

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1. Fourie R, Bizos D, Kruger D. Post-colonoscopy colorectal cancers in privately insured patients in South Africa. S Afr Med J 2024;114(12):e1305. https://doi.org/10.7196/SAMJ.2024.v114i12.1305