Complete Summary

GUIDELINE TITLE

Quality indicators for esophagogastroduodenoscopy.

BIBLIOGRAPHIC SOURCE(S)

Cohen J, Safdi MA, Deal SE, Baron TH, Chak A, Hoffman B, Jacobson BC, Mergener K, Petersen BT, Petrini JL, Rex DK, Faigel DO, Pike IM. Quality indicators for esophagogastroduodenoscopy. Gastrointest Endosc 2006 Apr;63(4 Suppl):S10-5. [30 references] PubMed

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

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SCOPE

DISEASE/CONDITION(S)

Upper gastrointestinal (GI) conditions, including upper GI bleeding and benign and malignant strictures

GUIDELINE CATEGORY

Diagnosis
Evaluation
Treatment

CLINICAL SPECIALTY

Gastroenterology

INTENDED USERS

Advanced Practice Nurses
Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

To identify a set of quality indicators that are particular to diagnostic esophagogastroduodenoscopy (EGD) and to therapeutic maneuvers that be carried out during the procedure

TARGET POPULATION

Patients undergoing esophagogastroduodenoscopy

INTERVENTIONS AND PRACTICES CONSIDERED

Esophagogastroduodenoscopy

MAJOR OUTCOMES CONSIDERED

Safety and efficacy of procedure

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Studies were identified through a computerized search of Medline followed by review of the bibliographies of relevant articles. When such data were absent, indicators were chosen by expert consensus.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus (Committee)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The American Society for Gastrointestinal Endoscopy (ASGE) and the American College of Gastroenterology (ACG), as leaders in promoting the highest quality patient care, formed a task force to identify end points that could be used to document high-quality endoscopic services. In most cases these end points will require validation before they can be generally adopted. The task force consisted of expert endoscopists selected by the board of directors of the ASGE and the ACG.

The task force developed quality indicators for the 4 major endoscopic procedures: colonoscopy, esophagogastroduodenoscopy (EGD), endoscopic retrograde cholangiopancreatography (ERCP), and endoscopic ultrasonography (EUS). Wherever possible, these indicators were chosen because there were published supporting data. These studies were identified through a computerized search of Medline followed by review of the bibliographies of relevant articles. When such data were absent, indicators were chosen by expert consensus. The goal was to create a comprehensive list of potential quality indicators, recognizing that only a small subset may ultimately be implemented. The resultant quality indicators were graded on the strength of the supporting evidence.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Grades of Recommendation

Grade of recommendation	Clarity of benefit	Methodologic strength/supporting evidence	Implications
1A	Clear	Randomized trials without important limitations	Strong recommendation; can be applied to most clinical settings
1B	Clear	Randomized trials with	Strong recommendation;

Grade of recommendation	Clarity of benefit	Methodologic strength/supporting evidence	Implications
		important limitations (inconsistent results, nonfatal methodologic flaws)	likely to apply to most practice settings
1C+	Clear	Overwhelming evidence from observational studies	Strong recommendation; can apply to most practice settings in most situations
1C	Clear	Observational studies	Intermediate-strength recommendation; may change when stronger evidence is available
2A	Unclear	Randomized trials without important limitations	Intermediate-strength recommendation; best action may differ depending on circumstances or patients' or societal values
2B	Unclear	Randomized trials with important limitations (inconsistent results, nonfatal methodologic flaws)	Weak recommendation; alternative approaches may be better under some circumstances
2C	Unclear	Observational studies	Very weak recommendation; alternative approaches likely to be better under some circumstances
3	Unclear	Expert opinion only	Weak recommendation; likely to change as data become available

*Adapted from Guyatt G, Sinclair J, Cook D, Jaeschke R, Schunemann H, Pauker S. Moving from evidence to action: grading recommendations—a qualitative approach. In: Guyatt G, Rennie D, eds. Users' guides to the medical literature. Chicago: AMA Press; 2002. p. 599-608.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The task force consisted of expert endoscopists selected by the board of directors of the American Society for Gastrointestinal Endoscopy (ASGE) and the American College of Gastroenterology (ACG). These documents were then reviewed and approved by the governing boards.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Recommendations were graded on the strength of the supporting evidence (Grades 1A-3). Definitions of the recommendation grades are presented at the end of the "Major Recommendations" field.

Preprocedure Quality Indicators

The preprocedure period includes all contacts between the endoscopist, the endoscopy nurse, and the unit staff with the patient before administration of sedation or insertion of the endoscope. Common issues for all endoscopic procedures during this period include proper indication, patient consent for the procedure, patient clinical status and risk assessment, steps to reduce risk such as through the use of prophylactic antibiotics, management of anticoagulants, and timeliness in the performance of the procedure.

Preprocedure indicators and discussion specific to the performance of esophagogastroduodenoscopy (EGD) include the following:

1. Accepted indication(s) are provided before performance of EGD. **(1C+)**

   Discussion. The indications for EGD are covered in detail in a separate publication (see Table below). It has been demonstrated that there is a statistically higher rate of significant pathologic findings when gastrointestinal (GI) endoscopy is performed for indications listed in the American Society for Gastrointestinal Endoscopy (ASGE) guidelines for GI endoscopy.

2. Informed consent is obtained, including specific discussions of risks associated with EGD. **(3)**

   Discussion. As with all other endoscopic procedures, consent must be obtained before the procedure from the patient or guardian on the same day (or as required by local law or per policy of the institution) as the procedure. Consent may be obtained in the procedure room. It must include a discussion of the risks, benefits, and alternatives to the procedure. The risks of endoscopy include bleeding, perforation, infection, sedation adverse events, missed diagnosis, missed lesions, and intravenous site complications. In upper endoscopy, specific risks include chest pains, sore throat, aspiration, and reaction to local anesthetic spray.

3. Prophylactic antibiotics are given to patients with cirrhosis with acute upper GI bleeding who undergo EGD. **(1A)**

   Discussion. Outcomes studies have shown both a decreased infection rate and a decreased mortality rate when prophylactic antibiotics are given to cirrhotic patients with GI bleeding.

4. Prophylactic antibiotics are given before placement of a percutaneous endoscopically placed gastrostomy (PEG). **(1A)**

Discussion. Several well-designed randomized controlled trials have demonstrated decreased local skin infections when appropriate prophylactic antibiotics are administered (e.g., first-generation cephalosporin). For this reason, antibiotics are recommended before percutaneous endoscopically placed gastrostomy placement.

Table: Indications and Contraindications for EGD

EGD is generally indicated for evaluating:

A. Upper abdominal symptoms that persist despite an appropriate trial of therapy
B. Upper abdominal symptoms associated with other symptoms or signs suggesting serious organic disease (e.g., anorexia and weight loss) or in patients >45 years old
C. Dysphagia or odynophagia
D. Esophageal reflux symptoms that are persistent or recurrent despite appropriate therapy
E. Persistent vomiting of unknown cause
F. Other diseases in which the presence of upper GI pathologic conditions might modify other planned management (examples include patients who have a history of ulcer or GI bleeding who are scheduled for organ transplantation, long-term anticoagulation, or long-term nonsteroidal anti-inflammatory drug therapy for arthritis, and those with cancer of the head and neck)
G. Familial adenomatous polyposis syndromes
H. For confirmation and specific histologic diagnosis of radiologically demonstrated lesions
    1. Suspected neoplastic lesion
    2. Gastric or esophageal ulcer
    3. Upper tract stricture or obstruction

I. GI bleeding
    1. In patients with active or recent bleeding
    2. For presumed chronic blood loss and for iron deficiency anemia when the clinical situation suggests an upper GI source or when colonoscopy results are negative

J. When sampling of tissue or fluid is indicated
K. In patients with suspected portal hypertension to document or treat esophageal varices
L. To assess acute injury after caustic ingestion
M. Treatment of bleeding lesions such as ulcers, tumors, vascular abnormalities (e.g., electrocoagulation, heater probe, laser photocoagulation, or injection therapy)
N. Banding or sclerotherapy of varices
O. Removal of foreign bodies
P. Removal of selected polypoid lesions
Q. Placement of feeding or drainage tubes (peroral, percutaneous endoscopic gastrostomy, percutaneous endoscopic jejunostomy)
R. Dilation of stenotic lesions (e.g., with transendoscopic balloon dilators or dilation systems using guidewires)
S. Management of achalasia (e.g., botulinum toxin, balloon dilation)

T. Palliative treatment of stenosing neoplasms (e.g., laser, multipolar electrocoagulation, stent placement)

EGD is generally not indicated for evaluating

A. Symptoms that are considered functional in origin (there are exceptions in which an endoscopic examination may be done once to rule out organic disease, especially if symptoms are unresponsive to therapy)
B. Metastatic adenocarcinoma of unknown primary site when the results will not alter management
C. Radiographic findings of
    1. Asymptomatic or uncomplicated sliding hiatal hernia
    2. Uncomplicated duodenal ulcer that has responded to therapy
    3. Deformed duodenal bulb when symptoms are absent or respond adequately to ulcer therapy

Sequential or periodic EGD may be indicated

A. Surveillance for malignancy in patients with premalignant conditions (i.e., Barrett's esophagus)

Sequential or periodic EGD is generally not indicated for

A. Surveillance for malignancy in patients with gastric atrophy, pernicious anemia, or prior gastric operations for benign disease
B. Surveillance of healed benign disease such as esophagitis or gastric or duodenal ulcer
C. Surveillance during repeated dilations of benign strictures unless there is a change in status

Intraprocedure Quality Indicators

The intraprocedure interval begins with the administration of sedation and ends with removal of the endoscope. This period includes all the technical aspects of the procedure, including completion of the examination and of any therapeutic maneuvers. Minimum performance elements that are generic to all GI procedures performed with the patient sedated include attention to patient monitoring, medication administration, reversal or resuscitative efforts, and photo documentation of pertinent landmarks or pathologic conditions. Both procedures and disease-specific quality indicators can be proposed for EGD practice, as follows:

5. Complete examination of the esophagus, stomach, and duodenum, including retroflexion in the stomach. **(2C)**

   Discussion. Except in cases of esophageal or gastric outlet obstruction, every EGD should include a complete visualization of all the organs of interest from the upper esophageal sphincter to the second portion of the duodenum. This may entail efforts to clear material from the fundus, as in assessment for the source of upper GI hemorrhage. Written documentation should confirm the

extent of the examination. If an abnormality is encountered, photo documentation is necessary. In studies of the learning curve of EGD, more than 90% of trainees successfully perform technically complete EGD after 100 cases. It is reasonable to expect that any practicing endoscopist be capable of visualizing the organs of interest with rare exception. This should include retroflexion in the stomach in all cases.

6. Biopsy specimens are taken of gastric ulcers. **(1C)**

   Discussion. Careful attention to the presence of mucosal abnormalities during EGD is crucial. Adequate and appropriate samples demonstrate an understanding of the importance of a complete and thorough examination. Biopsy specimens from gastric ulcers are required to assess for the possibility of malignancy. The optimal number and type (maximum capacity vs standard) has not been determined. In the setting of acute GI bleeding, it is acceptable not to perform biopsy of the ulcer provided that a subsequent repeat endoscopy is planned.

7. Barrett's esophagus is measured when present; with the location of the gastroesophageal junction and squamocolumnar junction in centimeters from the incisors being documented. **(3)**

   Discussion. Barrett's esophagus may be present in up to 5% of high-risk patients with gastroesophageal reflux disease (e.g., older white men) undergoing upper endoscopy. The risk of progression to dysplasia or cancer may be related to the length of Barrett's epithelium. Therefore, it is important to characterize and document the length and location of the salmon-colored mucosa during EGD. On the other hand, intestinal metaplasia of the Z line may occur in up to 18% of individuals without sufficient evidence that this significantly increases the risk of cancer to warrant surveillance programs when this is diagnosed. Accordingly, it is important that, when the presence of Barrett's tissue is suspected, these landmarks are clearly documented.

8. Biopsy specimens are obtained in all cases of suspected Barrett's esophagus. **(3)**

   Discussion. The diagnosis of Barrett's esophagus requires demonstration of specialized intestinal metaplasia (SIM) on a biopsy specimen. Only those with SIM are at increased risk for development of adenocarcinoma and are candidates for surveillance protocols. Although the endoscopic appearance may suggest Barrett's esophagus, a definitive diagnosis cannot be made without pathologic confirmation. For patients with known Barrett's esophagus undergoing EGD, an adequate number of biopsy specimens should be obtained to exclude dysplasia.

9. Type of upper GI bleeding lesion is described and location is documented. **(3)**

   Discussion. For peptic ulcers, at least one of the following stigmata is noted: active bleeding, nonbleeding visible vessels (pigmented protuberance), adherent clot, flat spot, clean based.

10. Unless contraindicated, endoscopic treatment is given to ulcers with active bleeding or with nonbleeding visible vessels. **(1A)**

    Discussion. A basic characteristic of a quality endoscopy is the completion of therapeutic procedures. It is impossible to define prospectively all potential therapeutic maneuvers in upper endoscopy for the purpose of quality monitoring. Nonetheless, given the clinical importance of the management of GI bleeding, monitoring these issues ought to be representative of the mastery of endoscopic therapy and overall clinical care. In general, practitioners performing EGD to diagnose the source of upper GI bleeding should be trained, equipped, and prepared to therapeutically manage the bleeding source when it is found.

    The first function of the therapeutic endoscopist is to find and define the location of the bleeding site. The site's description should be detailed enough to allow a subsequent endoscopist to find the site. A detailed description of the lesion is also necessary, including documentation of stigmata associated with different risks of rebleeding.

    This requires knowledge of not only the stigmata but also of their different rates of rebleeding in various clinical scenarios. The cause for failure to identify the bleeding site should be clearly stated, if this occurs.

11. In cases of attempted hemostasis of upper GI bleeding lesions, whether hemostasis has been achieved is clearly documented. **(3)**

    Discussion. In many prospective series evaluating various modalities for managing actively bleeding upper GI bleeding lesions, immediate hemostasis rates from 90% to 100% have been achieved. To gauge and track successful hemostasis, it will be necessary for endoscopists to clearly record whether their efforts to stop actively bleeding lesions are successful.

12. When epinephrine injection is used to treat nonvariceal upper GI bleeding or nonbleeding visible vessels, a second treatment modality is used (e.g., coagulation or clipping). **(1A)**

    Discussion. Multiple treatment modalities may be used in the treatment of nonvariceal GI bleeding. Current practices include the use of injection in conjunction with multipolar coagulation, heater probe thermal coagulation, endoscopic clipping, argon plasma coagulator, or various laser therapies in the exceptional case. The success or failure of such treatments should be photo documented when practical or clearly described. Epinephrine injection alone should not be considered adequate because studies have documented the superiority of combined modality therapy over epinephrine alone. In general, immediate hemostasis should be achieved in more than 90% of cases.

    Treating these lesions has been shown to significantly reduce rebleeding rates and should therefore be attempted in most instances. There are good supportive data for the endoscopic removal of adherent clots and subsequent treatment of underlying stigmata. However, because this is not yet standard

practice, it would be premature at this time to include attempts to remove and treat clots in this quality measure.

13. For the endoscopic treatment of esophageal varices, variceal ligation is used as the preferred modality in the majority of cases. **(1A)**

    Discussion. In bleeding from esophageal varices, banding is preferred over sclerotherapy for safety and efficacy. Medical treatment with octreotide or beta-blockers should be considered. After the initial treatment, follow-up plans should include a short interval, repeat endoscopy, and repeated treatment until varices are eradicated. Postprocedure plans should also include some recommendation concerning the use of beta-blockers for prevention of recurrent bleeding or a statement about why they are contraindicated.

Postprocedure Quality Indicators

Minimum postprocedure performance elements common to all procedures include completion of a procedure report, provision of patient instructions, plans for pathology follow-up, determination of patient satisfaction, and communication to other care providers. Postprocedure quality indicators specific to performance of EGD include the following:

14. Written instructions provided to the patient on discharge include particular signs and symptoms relevant to EGD. **(3)**

    Discussion. In upper endoscopy, patients should be informed to contact the physician if abdominal or chest pain, fever, chills, abdominal distention, or signs of gastrointestinal bleeding such as vomiting blood or passage of black, tarry, or bloody stools develops. Patients should also be notified about how they will be informed of any biopsy results.

15. In patients undergoing dilation for peptic esophageal strictures, proton pump inhibitor (PPI) therapy is recommended. **(1A)**
16. Patients diagnosed with gastric or duodenal ulcers are instructed to take PPI medication or an H_2 antagonist. **(1A)**

    Discussion. PPIs, when used in patients who have had peptic strictures, reduce the need for future dilations. Patients diagnosed with gastric or duodenal ulcers are instructed to take PPI medication or an H_2 antagonist.

17. Patients diagnosed with gastric or duodenal ulcers have documented plans to test for the presence of *Helicobacter pylori* infection. **(1A)**

    Discussion. *H pylori* is a common cause of gastric and duodenal ulcer disease. Successful eradication of this organism results in dramatically reduced rates of ulcer recurrence. Patients will only benefit from this therapy if a diagnosis of *H pylori* infection is made. Although nonsteroidal anti-inflammatory drugs (NSAIDs) may also cause ulcerations, it is not possible on the basis of clinical and endoscopic criteria alone to distinguish NSAID- from *H pylori*–caused ulcers. Therefore, all patients with gastric or duodenal ulcers should be

assessed for this infection. Testing may include gastric biopsy for rapid urease testing or histologic examination, culture, urea breath test, or stool testing.

18. Efforts to track rebleeding rates after hemostasis are included in endoscopy unit protocol for the reporting of adverse events. **(1C+)**

    Discussion. Beyond the usual tracking of postprocedure data recommended for all endoscopic procedures, it is particularly important to ascertain the rates of rebleeding when the quality of endoscopy performed to diagnose and treat upper GI hemorrhage is assessed.

Definitions:

Grades of Recommendation

Grade of recommendation	Clarity of benefit	Methodologic strength/supporting evidence	Implications
1A	Clear	Randomized trials without important limitations	Strong recommendation; can be applied to most clinical settings
1B	Clear	Randomized trials with important limitations (inconsistent results, nonfatal methodologic flaws)	Strong recommendation; likely to apply to most practice settings
1C+	Clear	Overwhelming evidence from observational studies	Strong recommendation; can apply to most practice settings in most situations
1C	Clear	Observational studies	Intermediate-strength recommendation; may change when stronger evidence is available
2A	Unclear	Randomized trials without important limitations	Intermediate-strength recommendation; best action may differ depending on circumstances or patients' or societal values
2B	Unclear	Randomized trials with important limitations (inconsistent results, nonfatal methodologic flaws)	Weak recommendation; alternative approaches may be better under some circumstances
2C	Unclear	Observational studies	Very weak recommendation; alternative approaches likely to be better under some circumstances
3	Unclear	Expert opinion only	Weak recommendation; likely to change as data become available

*Adapted from Guyatt G, Sinclair J, Cook D, Jaeschke R, Schunemann H, Pauker S. Moving from evidence to action: grading recommendationsda qualitative approach. In: Guyatt G, Rennie D, editors. Users' guides to the medical literature. Chicago: AMA Press; 2002. p. 599-608.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

A high quality endoscopy ensures that the patient receives an indicated procedure, that correct and clinically relevant diagnoses are made (or excluded), that therapy is properly performed, and that all these are accomplished with minimal risk.

POTENTIAL HARMS

The risks of endoscopy include bleeding, perforation, infection, sedation adverse events, missed diagnosis, missed lesions, and intravenous site complications. In upper endoscopy, specific risks include chest pains, sore throat, aspiration, and reaction to local anesthetic spray.

CONTRAINDICATIONS

CONTRAINDICATIONS

Contraindications to esophagogastroduodenoscopy can be found in the Table in the "Major Recommendations" field.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- Underlying this discussion of quality indicators is the assumption that adequate training and credentialing has taken place before a practitioner begins the practice of endoscopy. The American Society for Gastrointestinal Endoscopy (ASGE) has guidelines specifically addressing standards for training, assessing competence, and granting privileges to perform endoscopy. It is the task force's recommendation that these guidelines be adopted by facilities where endoscopic procedures are performed.

- The list of potential quality indicators was meant to be a comprehensive listing of measurable endpoints. It is not the intention of the task force that all end points be measured in every practice setting. In most cases, validation may be required before a given end point may be universally adopted.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better

IOM DOMAIN

Effectiveness
Patient-centeredness
Safety

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Cohen J, Safdi MA, Deal SE, Baron TH, Chak A, Hoffman B, Jacobson BC, Mergener K, Petersen BT, Petrini JL, Rex DK, Faigel DO, Pike IM. Quality indicators for esophagogastroduodenoscopy. Gastrointest Endosc 2006 Apr;63(4 Suppl):S10-5. [30 references] PubMed

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2006 Apr

GUIDELINE DEVELOPER(S)

American College of Gastroenterology - Medical Specialty Society
American Society for Gastrointestinal Endoscopy - Medical Specialty Society

SOURCE(S) OF FUNDING

American Society for Gastrointestinal Endoscopy

GUIDELINE COMMITTEE

American Society for Gastrointestinal Endoscopy/American College of Gastroenterology (ASGE/ACG) Taskforce on Quality in Endoscopy

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the American Society for Gastrointestinal Endoscopy Web site.

Print copies: Available from the American Society for Gastrointestinal Endoscopy, 1520 Kensington Road, Suite 202, Oak Brook, IL 60523

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Bjorkman, DJ, Popp, JW. Measuring the quality of endoscopy. Gastrointest Endosc 2006 Apr;63(4 Suppl):S1-2. Available in Portable Document Format (PDF) from the American Society for Gastrointestinal Endoscopy Web site.
- Faigel, DO, Pike, IM, Baron, TH, Chak, A, Cohen, J, Deal, SE, Hoffman, B, Jacobson, BC, Mergener, K, Petersen, BT, Petrini, JL, Rex, DK, Safdi, MA. Quality indicators for gastrointestinal endoscopic procedures: an introduction. Gastrointest Endosc 2006 Apr;63(4 Suppl):S3-9. Available from the American Society for Gastrointestinal Endoscopy Web site.

Print copies: Available from the American Society for Gastrointestinal Endoscopy, 1520 Kensington Road, Suite 202, Oak Brook, IL 60523

PATIENT RESOURCES

None available

NGC STATUS

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