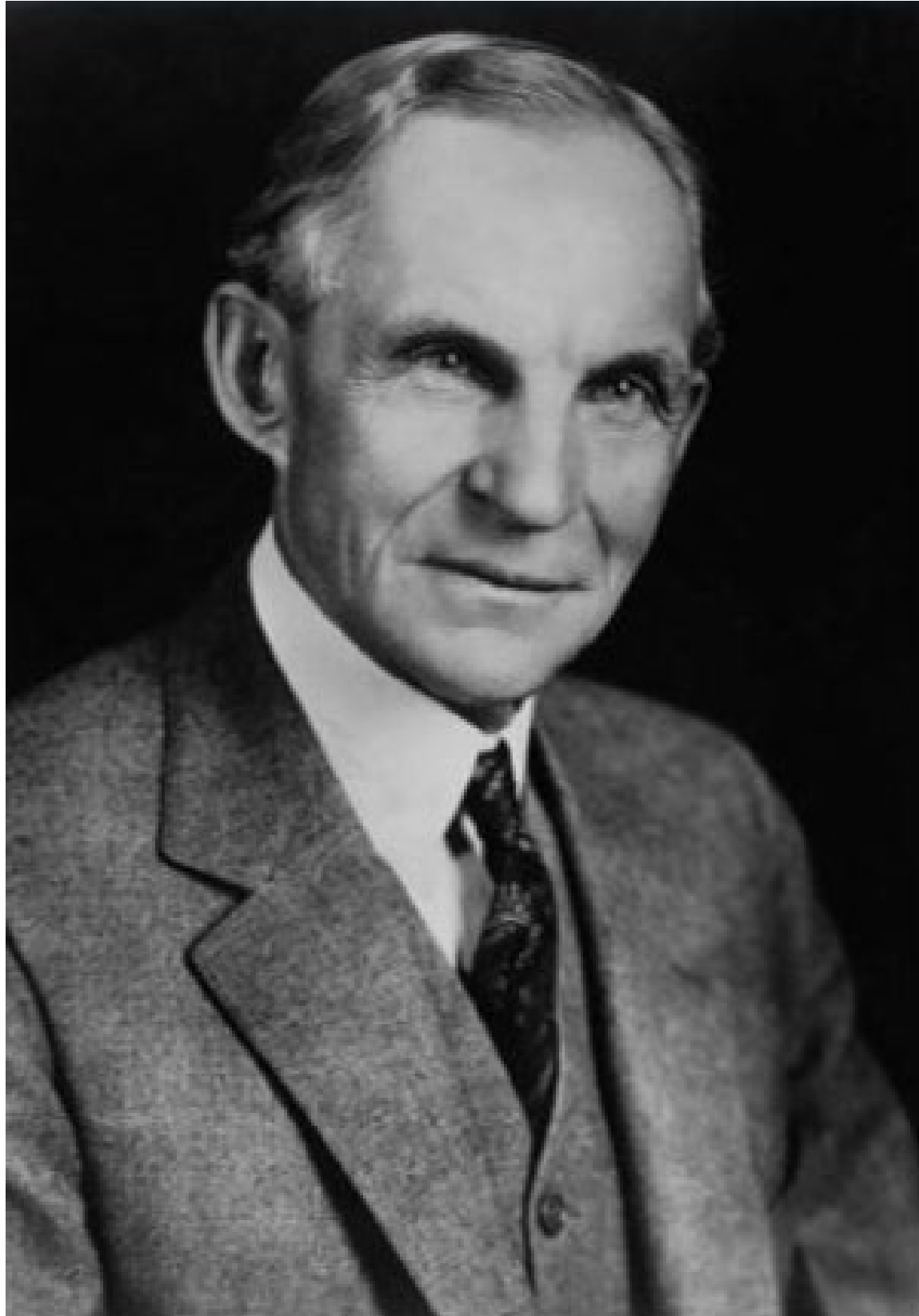


Revisión bibliográfica

Rosa M^a Sáiz Chumillas
Hospital General Almansa





“La calidad significa
hacerlo bien cuando
nadie está mirando”.



Hablaremos de Calidad en Gastroscoopia



Performance measures for upper gastrointestinal endoscopy: a European Society of Gastrointestinal Endoscopy (ESGE) Quality Improvement Initiative – Update 2025



QUALITY INDICATORS



Quality indicators for upper GI endoscopy





ESGE 2025

Consenso Delphi

Revisa guía 2016

PICO

11 indicadores principales y

4 secundarios

Mínimo $\geq 90\%$

Objetivo $\geq 95\%$



ASGE 2025

3ª actualización

2006, 2015

GRADE

29 indicadores

Indicadores de estructura,

proceso y resultado

Objetivos variables





Domain	Preprocedure	Completeness of procedure	Identification of pathology	Management of pathology	Complications	Patient experience	Post-procedure	
Key performance measure	NEW Appropriate indication (≥95 %)	NEW Visibility score recorded (≥95 %)	update Examination time ≥7 minutes (≥95 %)	Seattle protocol used for Barrett's esophagus (≥95 %)	Complications recorded after therapeutic procedures (≥95 %)		update Barrett's esophagus surveillance according to guidelines (≥95 %)	
	Fasting instructions received (≥95 %)	Accurate photo-documentation (≥95 %)	Standardized terminology used (≥95 %)	MAPS protocol used for gastric precancerous assessment (≥95 %)			NEW Gastric precancerous surveillance according to guidelines (≥95 %)	
Minor performance measure	NEW Time slot of ≥20 minutes allocated for upper gastrointestinal endoscopy (≥95 %)		update Observation time of ≥1 minute/cm and chromoendoscopy in Barrett's esophagus inspection (≥95 %)	update Chromoendoscopy in patients at risk for SCC (≥95 %)	NEW Patients' experiences measured (≥95 %)			



PRE-PROCEDIMIENTO



- Ayuno ≥ 2 horas líquidos / ≥ 6 horas sólidos.
- Tiempo mínimo 20 minutos EDA diagnóstica.



- Consentimiento informado. Antibióticos profilácticos si precisa.
- Plan de sedación y manejo de antitrombóticos.
- Realizar gastroscopia HDA en las primeras 24 horas.





Síntomas digestivos altos **refractarios** (ERGE, odinofagia, dispepsia > 6s)

Síntomas de **ALARMA** (Sd. Constitucional, disfagia y vómitos)

Hemorragia GI (exteriorización o anemia)

Diagnóstico (EEO, EB, úlceras, LPCG, E. celíaca, E. Crohn, enteropatías)

Hipertensión portal (varices, GHP)

Evaluación daño por **cáusticos** (agudo o crónico)

Evaluación previa cirugía **bariátrica**

Cribado y vigilancia lesiones precancerosas

Sospecha radiológica de patología y evaluación tras cirugía

Indicaciones terapéuticas (resección, coagulación, cuerpos extraños, sondas, dilatación, prótesis, tratamiento Zenker, Acalasia o gastroparesia, manejo complicaciones)





¡ATENCIÓN!





No suspender
Suspender
+Procinéticos

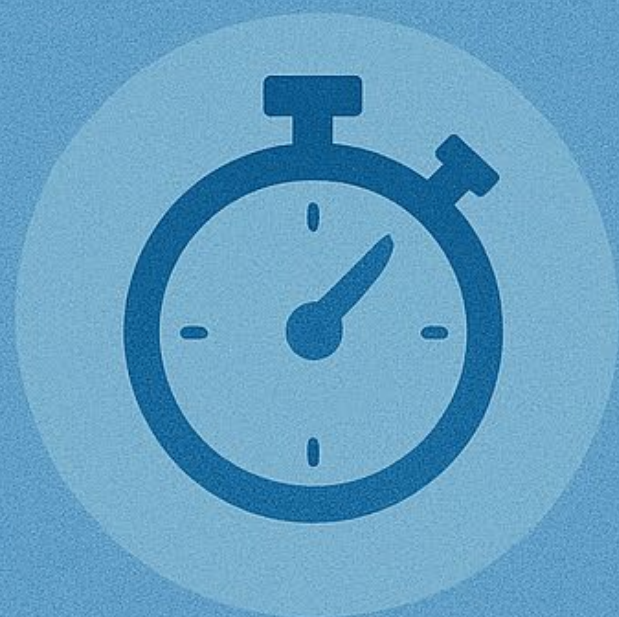
Dieta líquida 24
horas y ayunas 8
horas

Nombre comercial	Principio activo	Indicación principal	Vía de administración	Frecuencia
Ozempic®	Semaglutida	Diabetes tipo 2		1 vez /semana
Wegovy	Semaglutida	Obesidad / Sobrepeso		1 vez /semana
Mounjaro®	Tirzepatida	DM2 / Obesidad*		1 vez /semana
Rybelsus®	Semaglutida (oral)	Diabetes tipo 2		1 vez /día
Saxenda	Liraglutida	Obesidad		1 vez /día



Miguel A. et al. [Controversies on the effects of GLP-1 receptor agonist treatment on gastric emptying](#). Endocrinología, Diabetes y Nutrición, 2025





20 MINUTOS





Domain	Preprocedure	Completeness of procedure	Identification of pathology	Management of pathology	Complications	Patient experience	Post-procedure
Key performance measure	NEW Appropriate indication (≥95 %)	NEW Visibility score recorded (≥95 %)	update Examination time ≥7 minutes (≥95 %)	update Seattle protocol used for Barrett's esophagus (≥95 %)	Complications recorded after therapeutic procedures (≥95 %)		update Barrett's esophagus surveillance according to guidelines (≥95 %)
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Minor performance measure	NEW Time slot of ≥20 minutes allocated for upper gastrointestinal endoscopy (≥95 %)	update Observation time of ≥1 minute/cm and chromoendoscopy in Barrett's esophagus inspection (≥95 %) update Chromoendoscopy in patients at risk for SCC (≥95 %)			NEW Patients' experiences measured (≥95 %)		



INTRA-PROCEDIMIENTO



- Limpieza (escalas).
- Terminología estandarizada y clasificaciones.

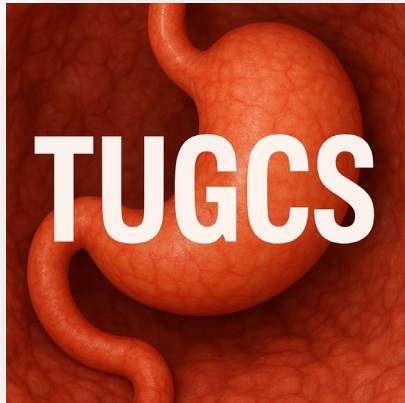


- Biopsias: **Disfagia → E eosinofílica (>6 x2); úlcera gástrica; Sospecha de E. celíaca.**
- Hemostasia en Hemorragia Digestiva Alta (HDA).
- Alta definición y cromoendoscopia virtual en Barrett y LPG.





Solo estómago



Solo Estómago y duodeno

Gastroscope RATE of Cleanliness Evaluation (GRACE) scale

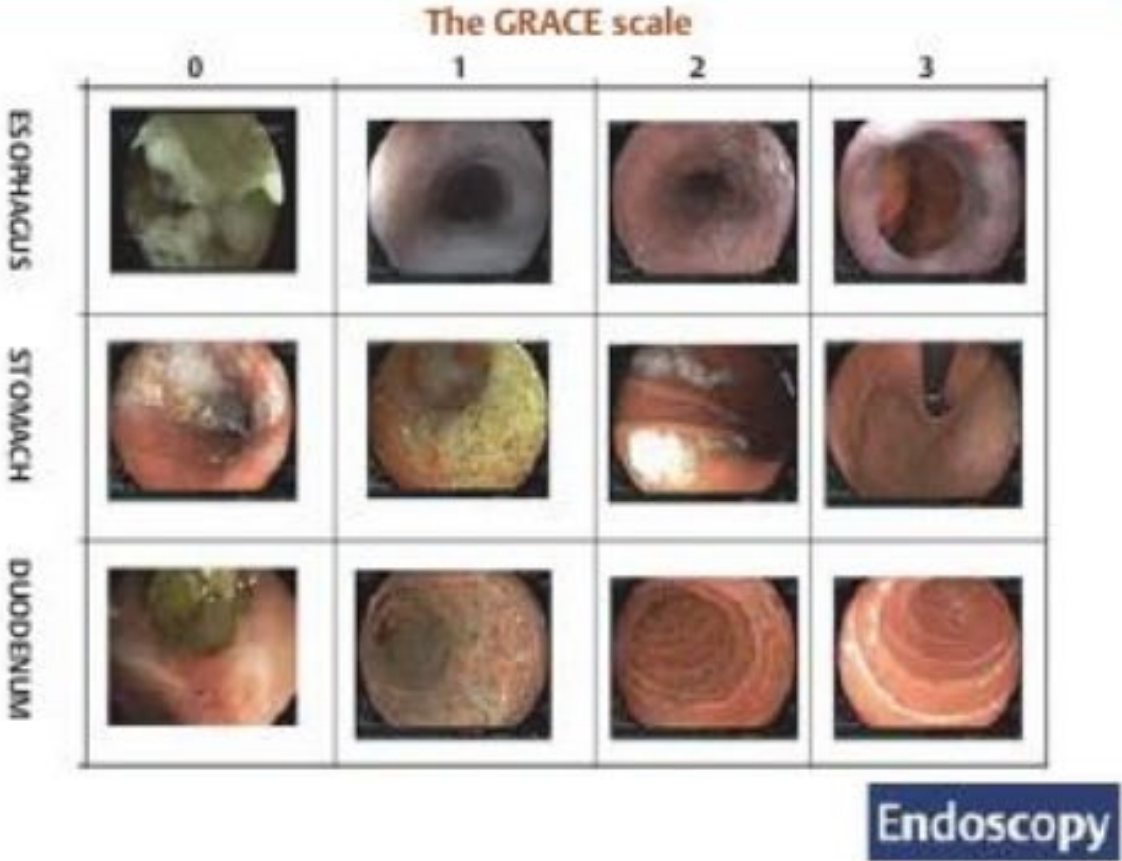
Impaired mucosal visualization can lead to a 10%–20% miss rate of gastric neoplasia

International multicenter study:

- 27 centers
- Internal, external, and real-time validation

	Validation		
	Internal	External	Real time
Endoscopists	4 experts	1 expert + 1 nonexpert per center	
Agreement	0.81	0.85	
Reliability	0.73	0.79	
Correct category			0.80

The GRACE scale had good interobserver agreement, reliability, and validity for assessment of mucosal visibility





	esophagus	stomach	duodenum
0 – substantial amount of fluid/foamy/content completely obscuring evaluation of the mucosa			
1 – substantial amount of opaque fluid/foamy/solid content that does not allow evaluation of some parts of the mucosa			
2 – small amount of hazy fluid/foamy/solid content enabling inspection of most of the mucosa			
3 – clean mucosa or minor amounts of transparent fluid not impeding mucosal inspection			





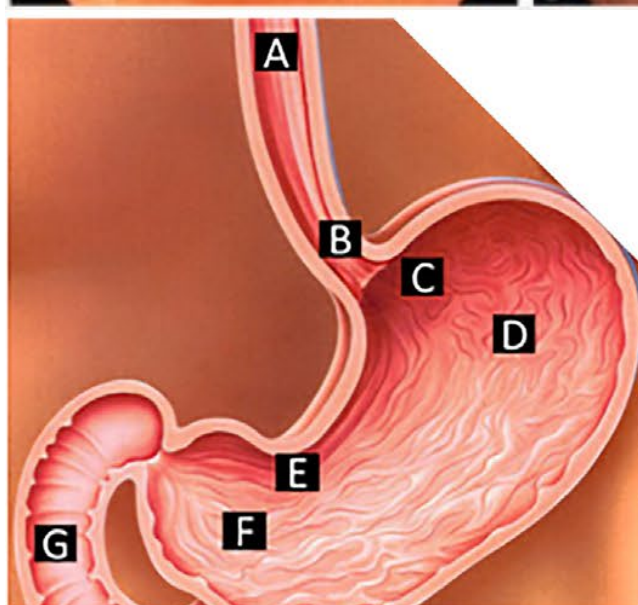
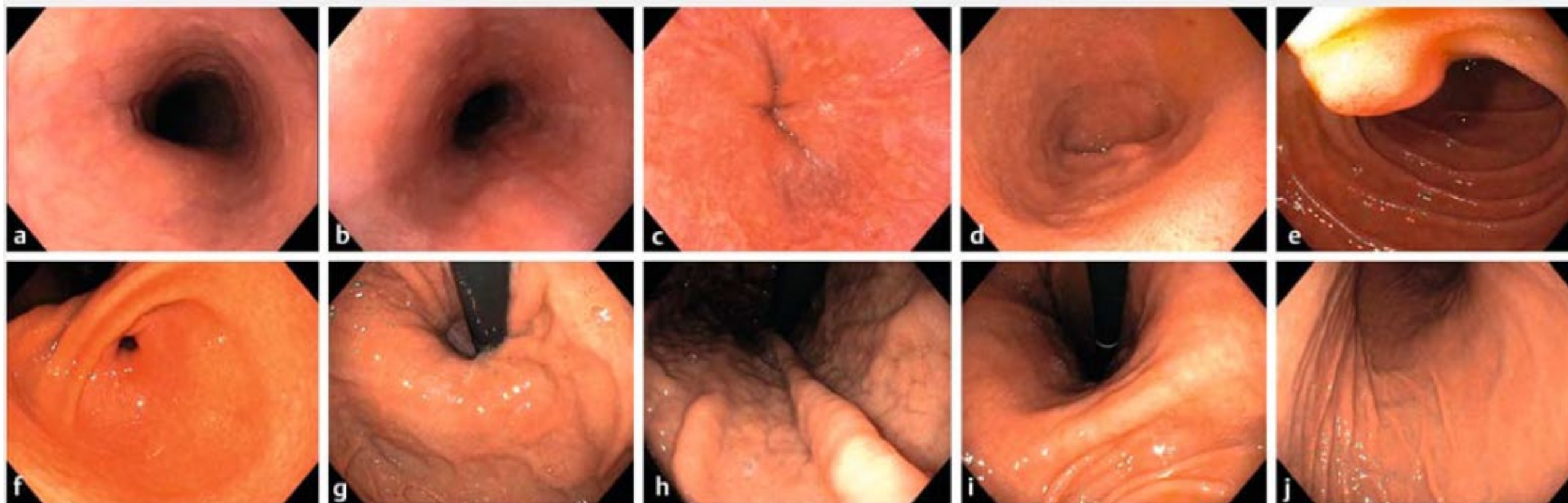
Barcelona scale

0: Non aspirable solid or semisolid, presence of bilis or foam which does not allow to visualize most part of the mucosa

1: Small part of the mucosa. small amount of semisolid, bilis or foam, which allow to visualize just a small part of the mucosa

2: Absence of any rests, so the visualization of the mucosa is near 100%

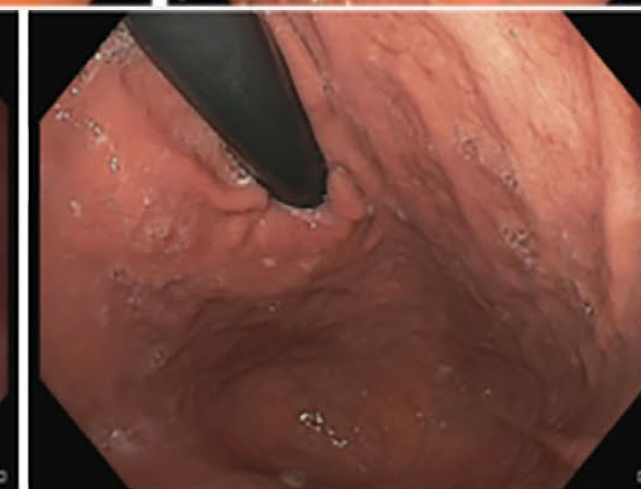




A Esophagus



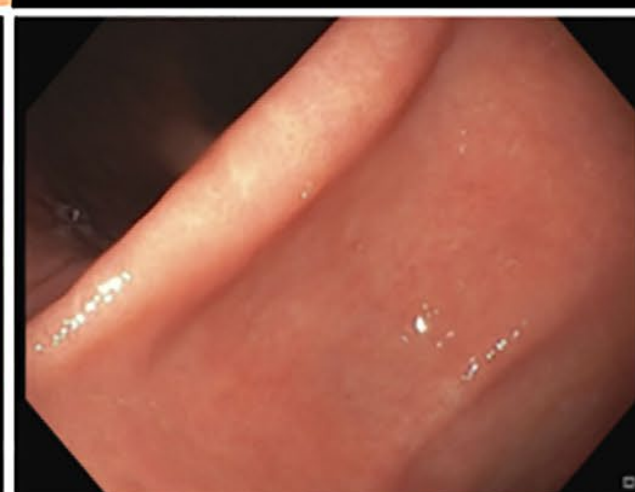
B Gastroesophageal junction



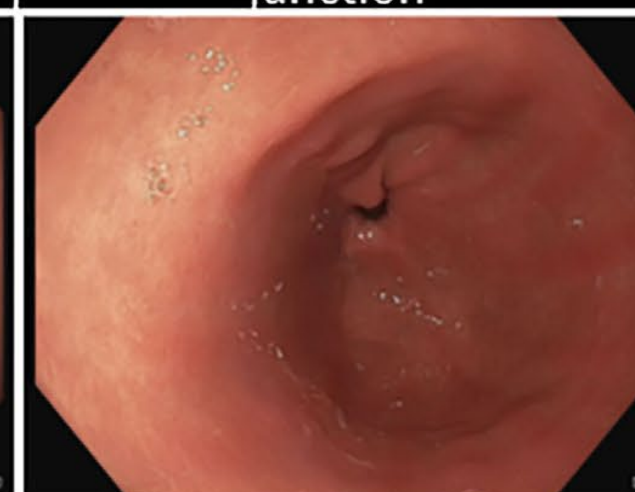
C Gastric cardia/fundus



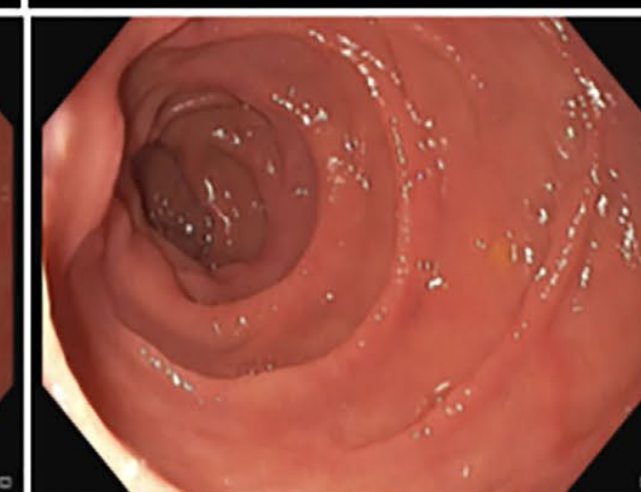
D Corpus



E Incisura



F Antrum/Pylorus



G 2nd portion of duodenum





	Identification of pathology	Management of pathology
	Examination time ≥ 7 minutes ($\geq 95\%$)	Seattle protocol used for Barrett's esophagus ($\geq 95\%$)
	Standardized terminology used ($\geq 95\%$)	MAPS protocol assessment ($\geq 95\%$)
	Observation time of ≥ 1 minute/cm and chromoendoscopy in Barrett's esophagus inspection ($\geq 95\%$)	
	Chromoendoscopy in patients at risk for SCC ($\geq 95\%$)	

1. Clasificación de Los Ángeles

2. Clasificación de Praga

3. Clasificación de Forrest

4. Clasificación de Paris

5. Clasificación de Baveno

6. Clasificación de Zargar

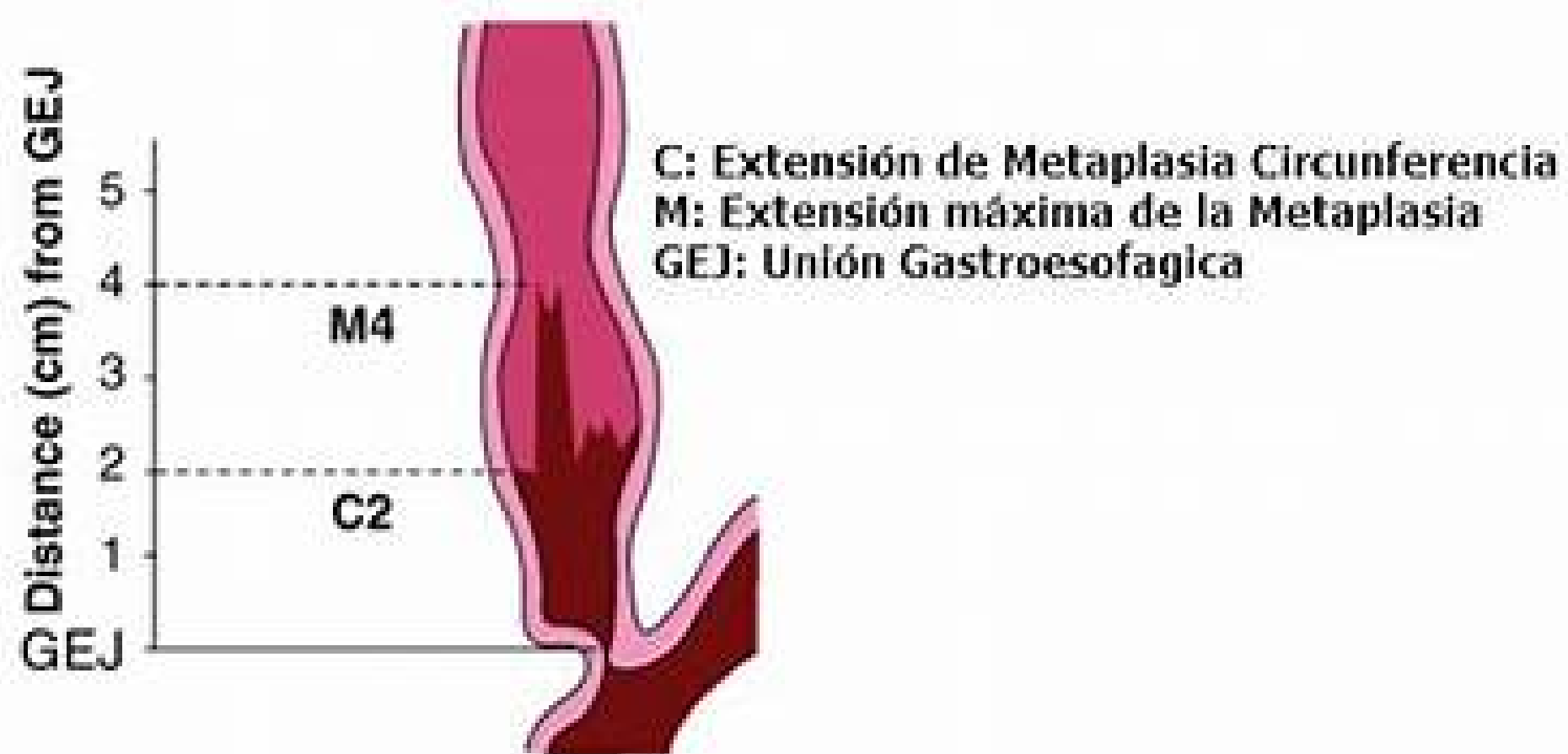
7. Clasificación de Spigelman

8. Otras: **EREFS**, Kodsi, Hill, Kimura-Takemoto, EGGIM

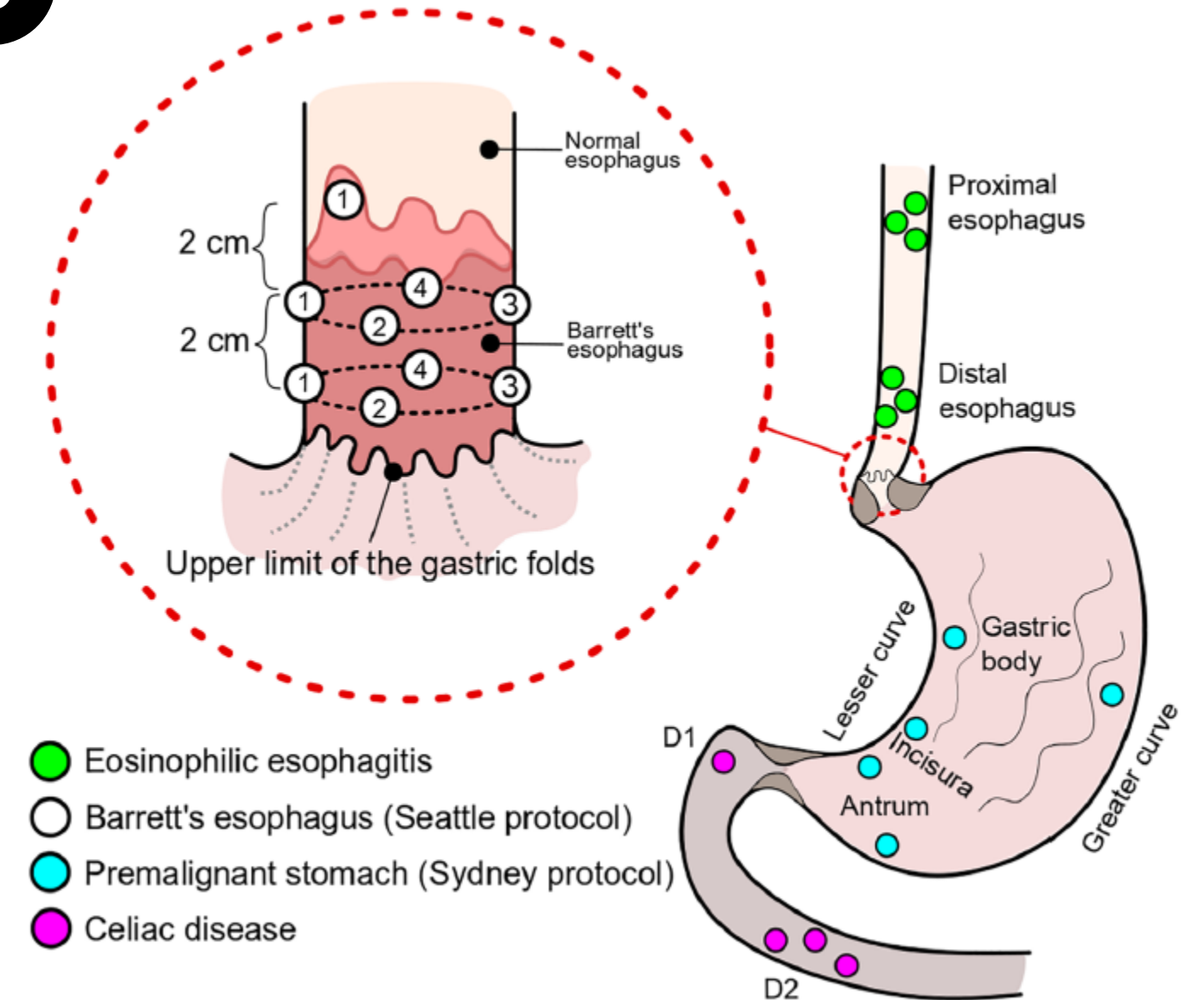


1

E. BARRETT



3



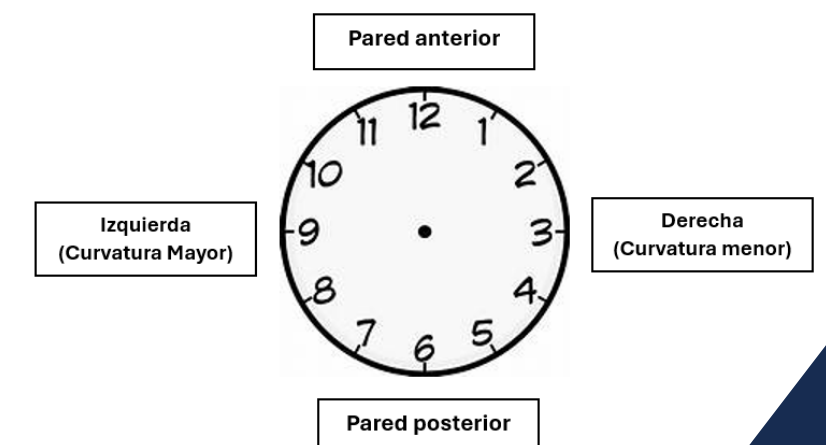
2

Cromoendoscopia virtual/ác. acético:

- ≥ 1 minuto/cm en E. Barrett.
- 30-40 minutos.

XXYY

Ej: 3803 → 38 cm
arcada dentaria y
3 horarias



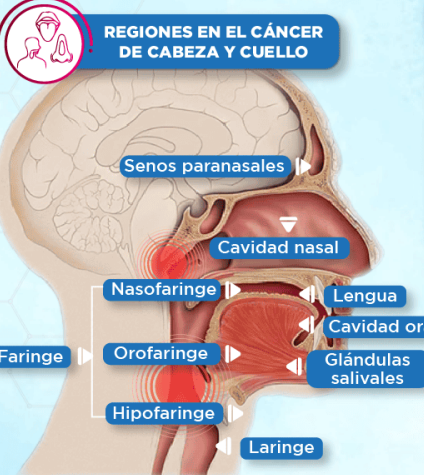
CÁNCER ESÓFAGO ESCAMOSO





DÍA MUNDIAL DEL CÁNCER DE CABEZA Y CUELLO

Suelen tener su origen en las células escamosas que recubren las superficies de la mucosa de la cabeza y el cuello.



REGIONES EN EL CÁNCER DE CABEZA Y CUELLO

Senos paranasales
Cavidad nasal
Nasofaringe
Lengua
Cavidad oral
Glándulas salivales
Faringe
Orofaringe
Hipofaringe
Laringe

SÍNTOMAS

Bulto en el cuello
Llagas en la boca o garganta que no sanan y duelen.
Dolor de garganta que no desaparece
Dificultad para tragar
Cambio o ronquera en la voz

FACTORES DE RIESGO

- Consumo de alcohol y tabaco
- La infección por tipos de virus del papiloma humano (VPH) que causan cáncer, sobre todo el VPH de tipo 16.
- Betel masticable (paan/buyo)
- Infección por el virus de Epstein-Barr
- Trastornos genéticos subyacentes (anemia de Fanconi).

¿CÓMO SE TRATAN LOS CÁNCERES DE CABEZA Y CUELLO?

El tratamiento del cáncer de cabeza y cuello puede incluir:

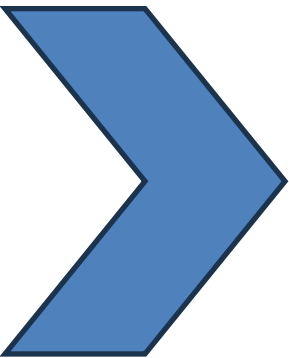
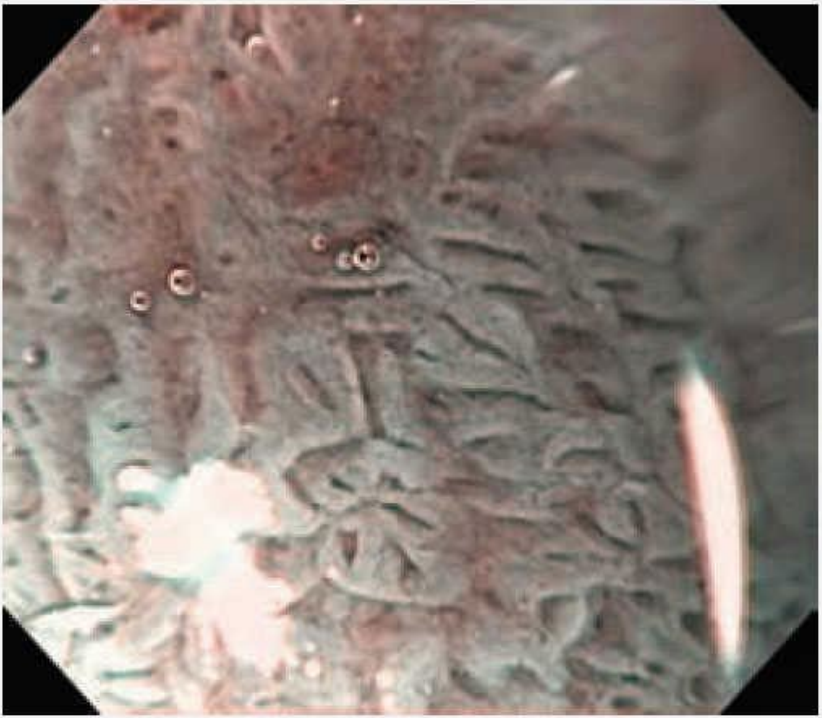
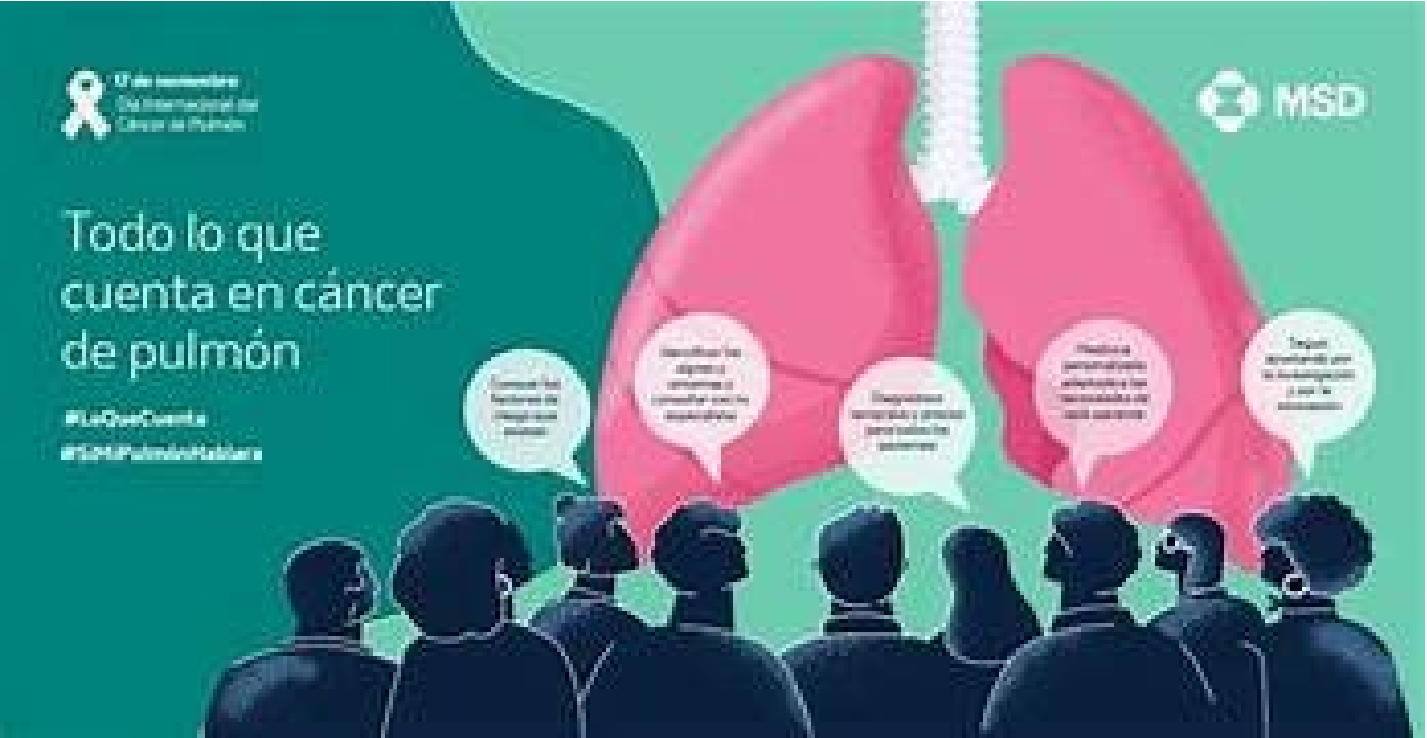
- Cirugía
- Radioterapia
- Quimioterapia
- Terapia dirigida
- Inmunoterapia
- Combinación de tratamientos.

El plan de tratamiento para cada paciente depende de varios factores, incluso la ubicación del tumor, el estadio del cáncer, y la edad y la salud general de la persona.

INCIDENCIA

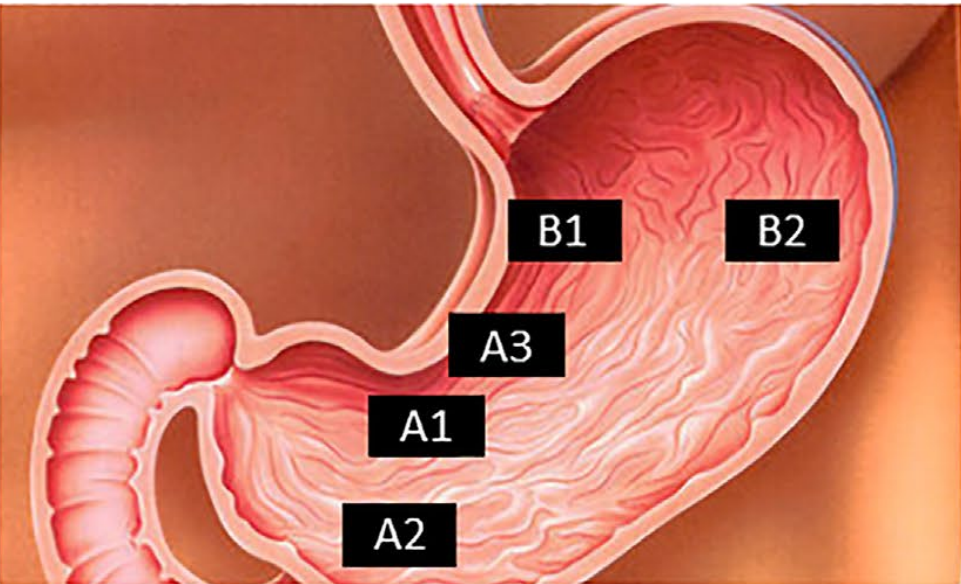
- Los cánceres de cabeza y cuello representan casi el 4 % de todos los cánceres en los Estados Unidos.
- El cáncer de cavidad oral y faringe fue el quinto más diagnosticado en hombres durante el 2012 - 2016 en Puerto Rico.

FUENTE: MSD | NIH

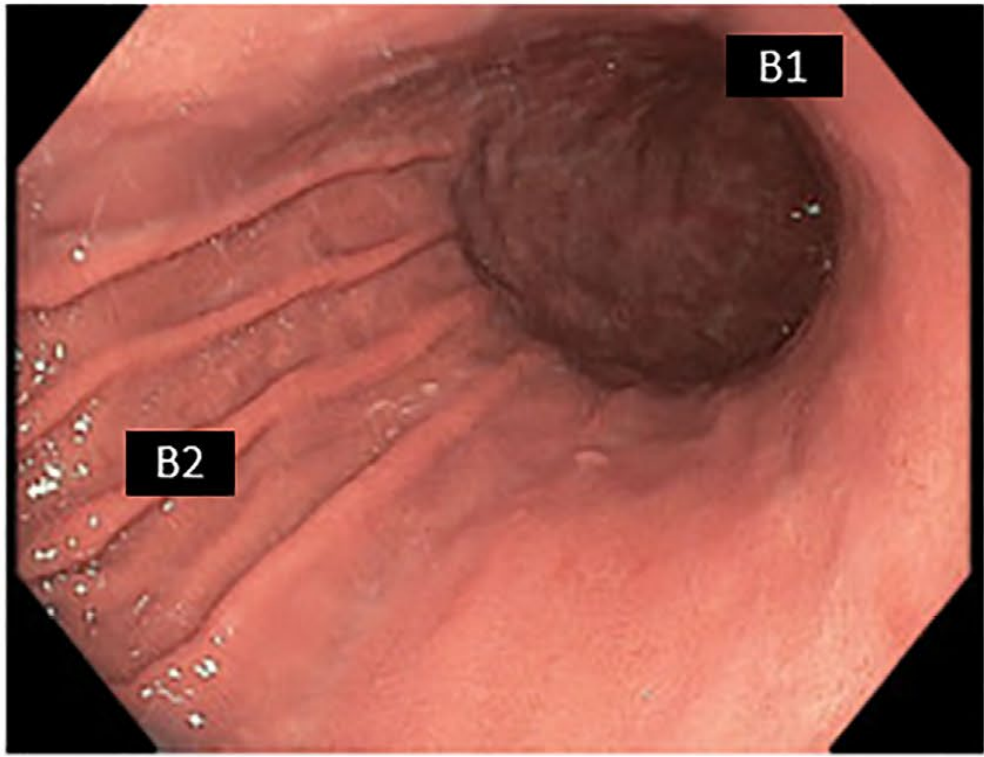
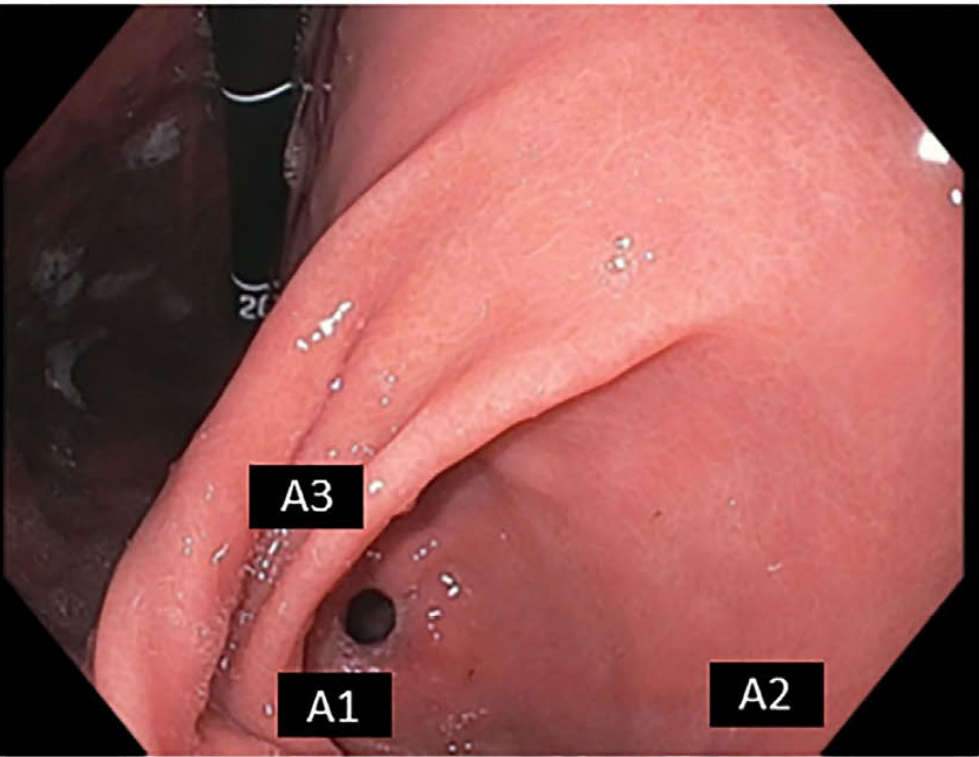




- Gastric sampling with systematic biopsy protocol indicated for patients with:
- 1) Known gastric pre-malignant condition (GPMC) or prior gastric cancer with indications for surveillance
 - 2) Increased risk for gastric cancer of GPMC (e.g., family history of gastric cancer (first degree relative), foreign-born immigrants from high incidence regions)
 - A** 3) Endoscopic appearance concerning for GPMC

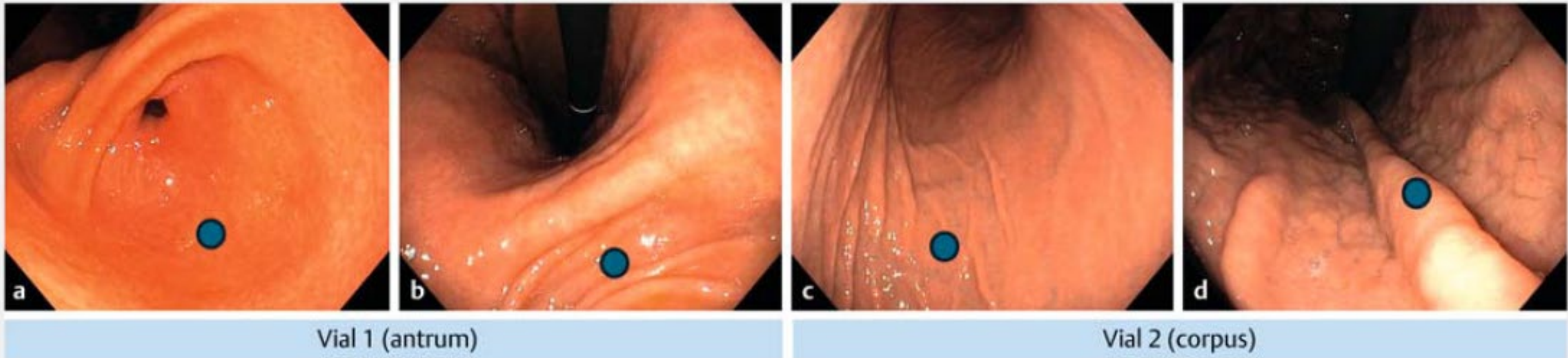


Sydney Protocol	
Antrum Biopsies (Jar A)	Corpus Biopsies (Jar B)
Antrum lesser curvature (A1)	Corpus lesser curvature (B1)
Antrum greater curvature (A2)	Corpus greater curvature (B2)
Incisura (A3)	



B





► **Fig.3** Example of the sites to perform the targeted or random biopsies in patients being evaluated for their risk of gastric cancer, with each single biopsy represented by a dot, according to the Management of precancerous conditions and lesions in the stomach (MAPS) protocol, using two separate vials: **a** greater curvature of antrum; **b** lesser curvature of antrum; **c** greater curvature of corpus; **d** lesser curvature of corpus.

► **Table 4** Risk stratification according to histological and endoscopic classifications and endoscopic surveillance interval recommendation for patients with gastric precancerous conditions.

Validated classification	Gastric cancer risk		
	No risk	Low risk	High risk
OLGA	Stage 0	Stage I–II	Stage III–IV
OLGIM	Stage 0	Stage I–II	Stage III–IV
Kimura–Takemoto	C0	C1 and C2	C3 to O3
EGGIM	0	1–4	5–10
Surveillance recommendation	Not recommended	Not recommended	Every 3 years

EGGIM, Endoscopic Grading for Gastric Intestinal Metaplasia; OLGA, Operative Link for Gastritis Assessment; OLGIM, Operative Link on Gastric Intestinal Metaplasia Assessment.

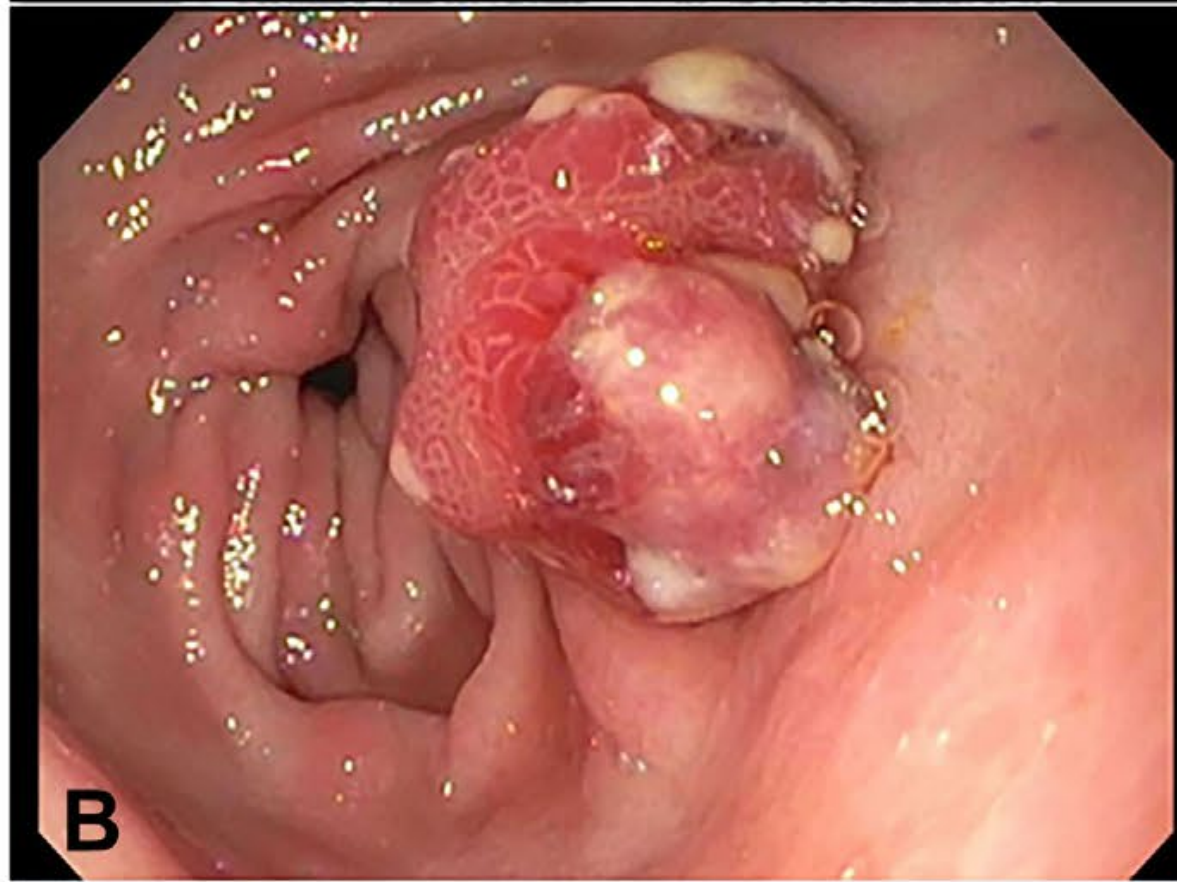




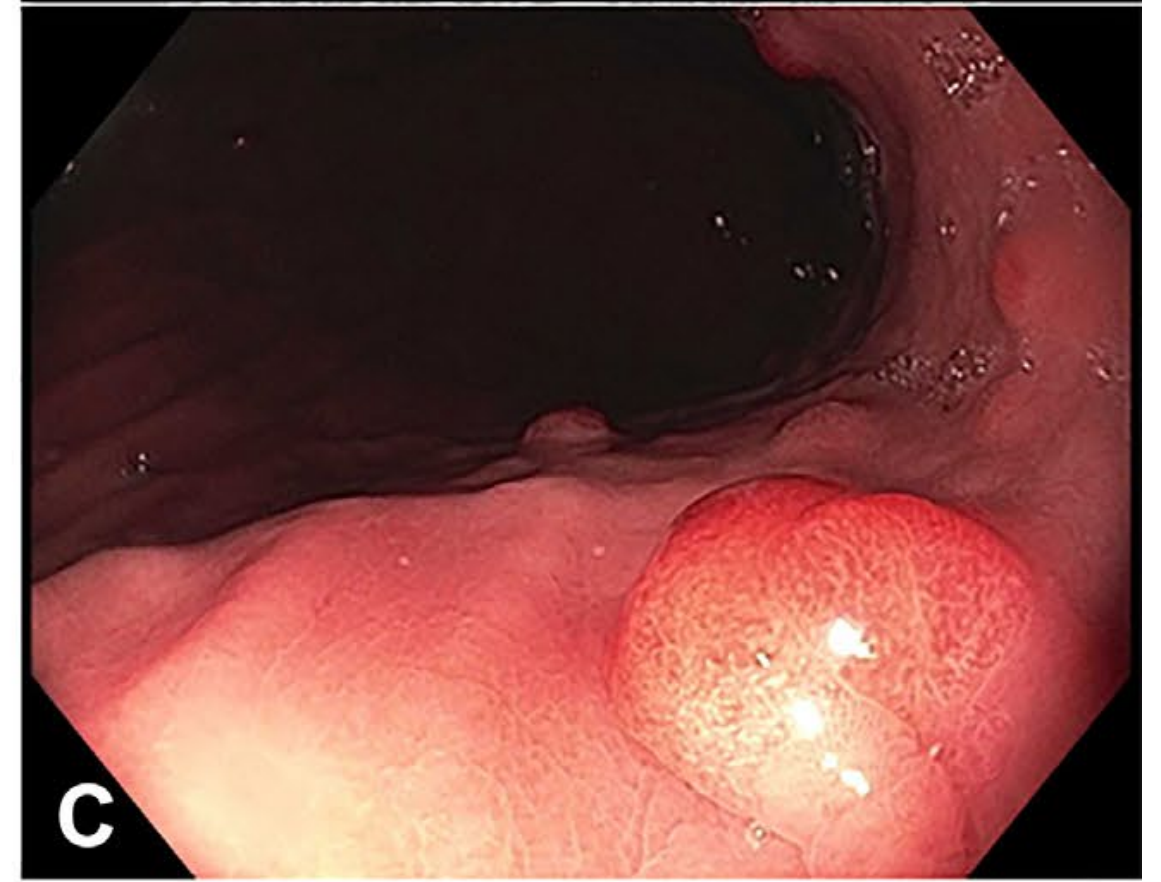
Fundic Gland Polyp



Gastric Hyperplastic Polyp



Gastric Adenomatous Polyp



RESECAR/BIOPSIAR LOS PÓLIPOS > 1 CM

Recomendación: 2C; Objetivo > 80%





Domain	Preprocedure	Completeness of procedure	Identification of pathology	Management of pathology	Complications	Patient experience	Post-procedure
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POST-PROCEDIMIENTO



- Registrar complicaciones.
- Experiencia del paciente en cuestionarios validados.



The Newcastle ENDOPREM™: a validated patient reported experience measure for gastrointestinal endoscopy

Laura J Neilson,^{1,2} Linda Sharp,^{2,3} Joanne M Patterson,⁴ Christian von Wagner,⁵ Paul Hewitson,⁶ Lesley M McGregor,⁷ Colin J Rees^{1,2,3}

Gastroenterology and Hepatology

Gastrointestinal Endoscopy
Satisfaction
Questionnaire
(GESQ)

Don't Search.. Discover!

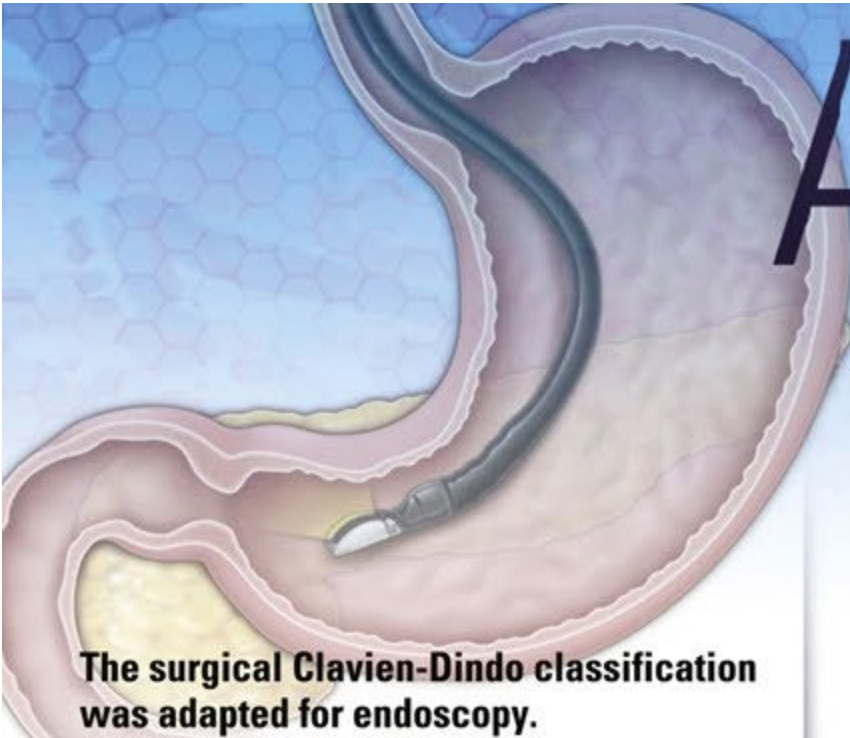


- Comunicación de hallazgos y recomendaciones.
- Seguimiento en Barrett no displásico.
- Erradicación de HP documentada.



Procedure	Organ	Complication	Rate, %
Polypectomy/endoscopic mucosal resection	Esophagus	Bleeding	3.1
		Perforation	0.4
		Stenosis	6.4
	Stomach	Bleeding	6.9
		Perforation	1.2
	Duodenum	Bleeding	6.7
		Perforation	0.9
Submucosal dissection	Esophagus	Bleeding	1.7–2.8
		Perforation	1.5
		Stenosis	6.3–11.6
	Stomach	Bleeding	7.2
		Perforation	2.6–3.2
	Duodenum	Bleeding	8.9
		Perforation	10.4
Dilation – pneumatic	Esophagus	Perforation	1–3
Dilation – Savary	Esophagus	Perforation	5
Dilation for achalasia	Esophagus	Perforation	5.3
Stenting for stenosis	Esophagus	Stent migration	11.4–16.3
		Bleeding	5.4–9.2
		Ingrowth/overgrowth	11.4–14.7
Stenting for leaks, fistulas, or perforations	Esophagus	Stent migration	16–24
		Bleeding	0.6–1.0
		Perforation	1–2
Percutaneous endoscopic gastrostomy	Stomach	Bleeding	0.3
		Perforation	0.5
		Peritonitis	0.5





The surgical Clavien-Dindo classification was adapted for endoscopy.

The AGREE classification was validated in 3 steps:

1. Perception of patients, nurses, and endoscopists corresponded with severity grading of the AGREE classification
2. The AGREE classification significantly correlated with ASGE classification
3. International validation by 57 expert endoscopists: Experts considered the AGREE classification as simple (86%), reproducible (98%), logical (98%) and useful (98%). 84% of the clinical cases were correctly graded by the experts according to the AGREE classification.

The AGREE classification provides a standardized and reproducible approach to the assessment of adverse in gastrointestinal endoscopy.

AGREE

Classification for **A**dverse events **G**astrointestinal **E**ndoscopy

Grading	Definition
No adverse event	▪ A telephone contact with the general practitioner, outpatient clinic, or endoscopy service without any intervention or ▪ Extended observation of the patient after the procedure, < 3 hours, without any intervention
Grade I	Adverse events with any deviation of the standard post-procedural course, without the need for pharmacologic treatment or endoscopic, radiologic, or surgical interventions. ▪ Presentation at the emergency ward, without any intervention or ▪ Hospital admission (< 24 hours), without any intervention or ▪ Allowed therapeutic regimens are drugs as antiemetics, antipyretics, analgesics, and electrolytes or ▪ Allowed diagnostic tests: radiology and laboratory tests
Grade II	▪ Adverse events requiring pharmacologic treatment with drugs other than those allowed for grade I adverse events (ie, antibiotics, antithrombotics, etc) or ▪ Blood or blood product transfusions or ▪ Hospital admission for more than 24 hours
Grade III	Adverse events requiring endoscopic, radiologic, or surgical intervention
Grade IIIa	Endoscopic or radiologic intervention
Grade IIIb	Surgical intervention
Grade IV	Adverse events requiring intensive care unit/critical care unit admission
Grade IVa	Single-organ dysfunction (including dialysis)
Grade IVb	Multiorgan dysfunction
Grade V	Death of the patient



UPPER GI ENDOSCOPY

Preprocedure information

Date of the exam:

Name:

Date of birth:

Indication:

Use of antithrombotic drugs:

☐ Yes ☐ No

Which drug(s):

☐ Active ☐ Interrupted, when?

Fasting for solids:

Fasting for liquids:

Premedication:

Periprocedure information

Drugs during endoscopy:

Type of endoscope (if no automated traceability):

Quality of cleanliness: scale name, score per segment, total score

Endoscopic findings

Esophagus

The esophageal mucosa appears normal. The esophagogastric and squamocolumnar junctions are located [X cm] from incisors, coincident with the hiatus.

Stomach

Cardia: the mucosa of the cardia appears normal.

Corpus/fundus: the mucosa of the corpus/fundus appears normal (biopsies).

Antrum (including incisura): the mucosa of the antrum appears normal (biopsies).

Duodenum

Bulb: the mucosa of the bulb appears normal. The villi appear normal.

Second portion: the mucosa of the second duodenal portion (descending part) appears normal. The villi appear normal. (If visible: The papilla appears normal).

Use of virtual chromoendoscopy:

Postprocedure information

Biopsies:

Number of vials:

Duration of the exam:

Names of all staff involved and roles:

STANDARDIZATION OF REPORTS (THE STAR PROJECT) UPPER GASTRO-INTESTINAL ENDOSCOPY: EUROPEAN SOCIETY OF GASTROINTESTINAL ENDOSCOPY (ESGE) QUALITY IMPROVEMENT INITIATIVE





Conclusiones

- La Calidad endoscópica **impacta** en los resultados clínicos, la detección precoz, la eficiencia, los costos y el medio ambiente.
- Ambas guías proponen la **auditoria anual de indicadores**, la participación de los endoscopistas en formación continua y compartir experiencias de implementación.
- **La experiencia** del paciente es relevante y se recomienda usar escalas para medirla de forma objetiva.





Gracias

Rosa M^a Sáiz Chumillas
rosasachu@gmail.com

