removal. It also does not measure one’s ability to detect and remove multiple adenomas in a single patient or one’s false-negative rate for cancer or advanced neoplasia, for example; these are probably more important to the hard outcomes and surveillance intervals than finding more patients with a single adenoma smaller than 5 mm (contributing to one’s high ADR). “Slowing down,” as emphasized in Dr. Vicari’s editorial, still appears important for these outcomes. If WT already predicts a few metrics, it likely also predicts others, some of which we may not be measuring or even be able to measure. It is acknowledged that one endoscopist’s “7 minutes” might not be as high in “quality” as another’s, so the actual threshold WT may be receiving too much emphasis. We do know from a few studies, including ours, that there is a “ceiling effect” to WT, above which ADR does not seem to improve, just as there is an ADR ceiling above which WT interventions are not helpful for further increasing the ADR. However, there is still unfortunately interendoscopist variability in several studies in multiple ADRs and cancer detection rates, even at respectable WTs and ADRs.

The issues are complex, but I agree that completion rates, adverse event rates, and neoplasia detection (and removal) rates (both ADRs and multiple ADRs and advanced neoplasia rates) are generally more important to monitor routinely than WT, as Dr. Yarze suggested. The ADR might not always tell you that your WT is too fast, however, and WT may be important for the things that you are not (yet) measuring, so my feeling is that it is still likely worthwhile to track.

Joseph Romagnuolo, MD, MSc, FRCPC, FASGE
Digestive Diseases Center
Department of Medicine
Medical University of South Carolina
Charleston, North Carolina, USA
doi:10.1016/j.gie.2010.05.003

To the Editor:

The report of a study of the Third Eye Retroscope (Advantis Medical Systems, Sunnyvale, Calif) by Waye et al,1 was accompanied by Dr. Barthel’s editorial2 that stated, “The any size adenoma per patient detection rate and the any size adenoma per mean withdrawal minute detection rate represent practical efficacy and efficiency standards for comparing the impact of different colonoscopy procedure modifications on adenoma detection, when applied across similar cohorts of colonoscopists and screened patients. These summary statistics are not easily confounded by the peculiarities of study design.”

However, the assumption that all studies have similar cohorts of colonoscopists and screened patients may not be well founded. As noted in the editorial, factors other than withdrawal time can affect endoscopists’ detection rates, whereas variations in patient demographics can influence adenoma prevalence. For example, cohorts with a higher proportion of older, male patients are likely to show a higher prevalence of adenomas compared with the general population. Such issues may account for the large disparity in mean adenoma per patient detection rates among studies and may limit the usefulness of that measure for comparisons.

There is now compelling evidence that a retrograde view assists the detection of lesions hidden behind folds, and there are currently two technologies that can provide such a retrograde view: CT colonography and the Third Eye Retroscope. Advantages of the latter include its ability to reveal small, medium, and large lesions and its effectiveness in screening and surveillance as well as in the evaluation of symptomatic patients. Further, the Third Eye Retroscope offers such a retrograde view during colonoscopy, the only technology that is capable of both detecting and removing colonic neoplasia in a single procedure.

The Third Eye Retroscope offers an opportunity for substantial improvement in our current standard of care. An increase in adenoma detection ultimately translates into colon cancer prevention and lives saved.

DISCLOSURE

The author disclosed the following financial relationship relevant to this publication: Dr. Triadafilopoulos serves on the Advisory Board and has an equity position with Avantis Medical Systems, Inc, the makers of the Third Eye Retroscope.

George Triadafilopoulos, MD
Division of Gastroenterology and Hepatology
Stanford University School of Medicine
Stanford, California, USA

REFERENCES

doi:10.1016/j.gie.2010.04.017

A retrograde view during colonoscopy assists detection of lesions hidden behind folds

To the Editor:

The report of a study of the Third Eye Retroscope (Advantis Medical Systems, Sunnyvale, Calif) by Waye et al,1 was accompanied by Dr. Barthel’s editorial2 that stated, “The any size adenoma per patient detection rate and the any size adenoma per mean withdrawal minute detection rate represent practical efficacy and efficiency standards for comparing the impact of different colonoscopy procedure modifications on adenoma detection, when applied across similar cohorts of colonoscopists and screened patients. These summary statistics are not easily confounded by the peculiarities of study design.”

However, the assumption that all studies have similar cohorts of colonoscopists and screened patients may not be well founded. As noted in the editorial, factors other than withdrawal time can affect endoscopists’ detection rates, whereas variations in patient demographics can influence adenoma prevalence. For example, cohorts with a higher proportion of older, male patients are likely to show a higher prevalence of adenomas compared with the general population. Such issues may account for the large disparity in mean adenoma per patient detection rates among studies and may limit the usefulness of that measure for comparisons.

There is now compelling evidence that a retrograde view assists the detection of lesions hidden behind folds, and there are currently two technologies that can provide such a retrograde view: CT colonography and the Third Eye Retroscope. Advantages of the latter include its ability to reveal small, medium, and large lesions and its effectiveness in screening and surveillance as well as in the evaluation of symptomatic patients. Further, the Third Eye Retroscope offers such a retrograde view during colonoscopy, the only technology that is capable of both detecting and removing colonic neoplasia in a single procedure.

The Third Eye Retroscope offers an opportunity for substantial improvement in our current standard of care. An increase in adenoma detection ultimately translates into colon cancer prevention and lives saved.

DISCLOSURE

The author disclosed the following financial relationship relevant to this publication: Dr. Triadafilopoulos serves on the Advisory Board and has an equity position with Avantis Medical Systems, Inc, the makers of the Third Eye Retroscope.

George Triadafilopoulos, MD
Division of Gastroenterology and Hepatology
Stanford University School of Medicine
Stanford, California, USA

REFERENCES

doi:10.1016/j.gie.2010.04.017