

DISCLOSURE

All authors disclosed no financial relationships relevant to this publication.

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<http://dx.doi.org/10.1016/j.gie.2016.03.1490>

Competency in colonoscopy: Should we focus on the “how”?



To the Editor:

Sedlack et al¹ have highlighted the impact of a new competency assessment tool for colonoscopy. The validated measure encompasses motor and cognitive skills focused on aspects such as scope control, loop reduction, visualization, and pathology identification, to name but a few. They identified typical thresholds for minimal competency and the average number of procedures that will enable a practitioner to be deemed competent.

I fully agree with the use of such a tool. However, as yet, we have difficulty determining what factors are relevant in achieving competency. Areas of interest from an educational slant could include, for example, additional pedagogic measures including simulation use, hands-on workshops both locally and abroad, and the adoption of mastery learning styles. For example, in terms of pathology

identification, were additional teaching platforms such as videos or online resources used? Was recognition of learning theory adopted; for example, learner autonomy and a sense of relatedness, freedom for learners to explore their own ideas, safeguards to avoid too-rapid a move to gain competency beyond their reasonable limits at a particular time, reflection/feedback in a bidirectional nonjudgmental fashion, measures to deliver training in stages from low to high complexity, creation of a safe learning environment, external peer feedback, and self-directed learning?

Such aspects constitute various recognized learning theory domains, namely, self-determination, cognitive load, and situated cognition.² Other factors that could implicate competency achievement may include the type of endoscope used, with a focus on other modalities, eg, high-definition, magnification, or narrow-band imaging, and, of course, the use of expert centers, which typically house expert endoscopists.

I look forward to determining more the “how” as opposed to the “is.”

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The author disclosed no financial relationships relevant to this publication.

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ERCP-related retroperitoneum: Should postprocedure CT features alone guide the decision-making process?



To the Editor:

We read with keen interest the article by Kumbhari et al,¹ who reported on a substantive series of ERCP-related perforations and proposed a predetermined management algorithm based on the mechanism of injury. Nevertheless, several concerns arose, and we worry about the generalizability of their findings.

The authors state that only Stapfer I and II perforations were included in the analysis, claiming that types III and