

Audit of “Repeat Endoscopy For Gastric Ulcers Within 12 Weeks” in CUH

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Introduction

A peptic ulcer is a defect in the gastric or duodenal mucosa that extends through the muscularis mucosa into the deeper layers of the wall, gastroscopy (OGD) being the most accurate diagnostic test.

All ulcers with malignant features (i.e. an ulcerated mass lesion, elevated irregular ulcer borders, or abnormal adjacent mucosal folds) should be biopsied. Additionally, in areas with high gastric cancer incidence, all gastric ulcers should be biopsied. If a specific aetiology is suspected biopsies of both the gastric ulcers and surrounding mucosa may be helpful to confirm this (i.e. sarcoidosis, Crohn disease, eosinophilic gastroenteritis).

JAG (Joint Advisory Group on GI Endoscopy) recommendations is to repeat OGD for all gastric ulcers within 12 weeks.

British Society of Gastroenterology recommends that gastric ulcers should be biopsied and re-evaluated after appropriate treatment (including *H. pylori* eradication where indicated), within 6–8 weeks, 90% of the time.

As per UpToDate, surveillance OGD (with repeat biopsies if ulcer still present) should be performed after 8 to 12 weeks in patients with gastric ulcers and any one of the following:

- persisting symptoms despite therapy;
- unclear aetiology;
- giant ulcer (>2 cm);
- biopsies not performed (or inadequate sampling) during index endoscopy;
- ulcers with malignant features;
- patients with bleeding ulcers at initial presentation who show signs of continued bleeding.
- presence of risks factors for gastric cancer (age >50 years, *Helicobacter pylori*, immigrants from a region with high prevalence of gastric cancer, family history of gastric cancer, presence of gastric atrophy, adenoma, dysplasia or intestinal metaplasia).

Aims/Background

The aim of this audit was to validate the level of compliance regarding current practice in Cork University Hospital against the JAG recommendations on repeat OGD for all gastric ulcers within 12 weeks.

References

1. <https://thejag.zendesk.com/hc/en-us/articles/360023288813-When-should-gastric-ulcers-be-rescoped->
2. <https://www.uptodate.com/ Gastric ulcer>
3. https://www.bsg.org.uk/wp-content/uploads/2019/12/Quality-standards-in-upper-gastrointestinal-endoscopy_-_position-statement-of-BSG-AUGIS.pdf

Method

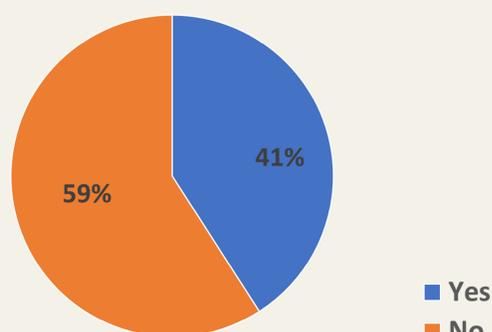
The audit was conducted in CUH. All patients with at least 1 ulcer found during gastroscopy between 1st of January 2020 and 21st of August 2020 were included in this audit. There were a total of 24 patients. Two patients were not included in data analysis (one patient RIP within one month following index endoscopy and the second had his index endoscopy 7 days prior to 21st of August).

Data was collected retrospectively through Unisoft and IPM system. Results were then compared with JAG recommendations.

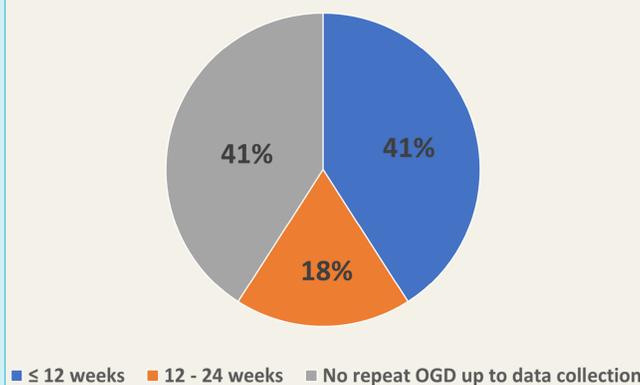
Results

41% of the patients with gastric ulcers had a repeat endoscopy within the 12-week timeframe. Additionally, 18% had a repeat OGD beyond 12 weeks.

Repeat OGD within 12 weeks



Repeat OGD



Presence of *H. pylori* was tested in most cases (20 out of 23), but only 50% of results were recorded.

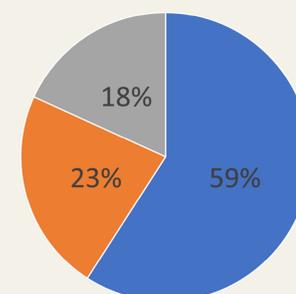
Hpylori at Index endoscopy (CLO test and/or Hpylori like organism on histology)



Results

Only 59% of patients had gastric ulcer biopsies taken at index endoscopy. 18% of cases had no biopsies taken during initial OGD and furthermore had no repeat OGD up to end of data collection.

Gastric ulcers biopsied at index endoscopy



- Yes
- No biopsy / repeat OGD
- No biopsy / no repeat OGD

50% of OGDs indication was haematemesis and/or melaena. 18% of OGDs no indication recorded.

11 out of 13 surveillance OGD performed showed healing/healed gastric ulcer.

Conclusions/Discussions

As the data collection/ audit was conducted in the first half of 2020 it is possible that the low level of compliance with the JAG recommendation could be explained in the context of the COVID-19 pandemic.

All patients with evidence of active infection for *H. pylori* should be offered treatment. In half of cases results of CLO test was not recorded. Additionally, there was no available data regarding choice of eradication therapy prescribed in the selected cases.

Maintaining accurate and informative data records is essential and efforts should be made to ensure continuous improvement.

Having pre-printed treatment regimens in endoscopy rooms that could be attached to endoscopy result and thus filed together could improve our data records and would ensure adherence in prescribing the appropriate eradication regimen.

In 9 cases there no biopsies taken at index endoscopy. 4 of these had a repeat OGD and ulcers have healed. Ideally, systems should be put in place that will allow tracking of gastric ulcers at index endoscopy and will generate a notification report at 12-week boundary if no follow up OGD has been performed up to that date.

Acknowledgements

We want to express our gratitude to Endoscopy staff nurses of CUH for their support and contribution in collecting the data for this analysis.