Correspondence

We try to publish authors' responses in the same edition with readers' comments. Time constraints might prevent this in some cases. The problem is compounded in a bimonthly journal where continuity of comment and redress are difficult to achieve. When the redress appears 2 months after the comment, 4 months will have passed since the article was published. Therefore, we would suggest to our readers that their correspondence about published papers be submitted as soon as possible after the article appears.

Technical Competency in Flexible Sigmoidoscopy.

To the Editor: Holman and colleagues[1] in their article have introduced objective recommendations for determining competency in flexible sigmoidoscopy. They suggest using the depth of insertion and procedure time as the reference standard. Added to evaluation of knowledge of colorectal cancer screening and attitudes through examination and direct observation, certainly depth of insertion and procedure time can be used to judge technical competency in residents. But the capacity to detect lesions is dependent both on the depth of insertion and the maximum reach, and routine insertion to below the splenic flexure would result in an unacceptable degree of missed lesions. In many instances, at 50 to 60 cm of insertion the looping of the instrument causes the scope to reach only the upper sigmoid or descending colon, which should be considered an incomplete examination. The routine use of maneuvers to shorten the colon during the examination will result in the examiner traversing a greater length of the bowel. Herein lies the importance of training in this screening procedure.

In his article on sensitive sigmoidoscopy,[2] Howard Long, a family physician, using a 65-cm video sigmoidoscope, reported traversing the transverse colon in more than 80% of patients without sedation, greatly increasing the reach and minimizing the risk of missed lesions, the bane of sigmoidoscopy. He did this by taking care to straighten the sigmoid and transverse colons over the scope by a combination of rotation, insertion-withdrawal, and abdominal pressure. He suggested spending 5 to 30 minutes in straightening the sigmoid colon, which might be the reason I do not see a similar study reported elsewhere and why this skill is not considered part of the determination of competency. Gastroenterologists routinely seem to reach the cecum at a 60- to 70-cm length during colonoscopy, and in their opinion, the flexible sigmoidoscope should easily traverse a greater degree of colon than the splenic flexure in most instances. I fear that the advent of the colonoscope has stunted the growth of the art of sigmoidoscopy. Family physicians are only too willing to refer their patients elsewhere for screening rather than spend the requisite time and effort to polish their skills.

Using the Gastro-Sim sigmoidoscopy simulator, Michael Tuggy[3] was able to improve the hand-eye skills of trainees and various performance parameters in live patients. The virtual reality training improved the directional movement of the sigmoidoscope and the percentage of colon viewed. Using this emerging technology (sigmoidoscopy and colonoscopy simulators) during residency training would facilitate a greater depth of insertion and the recognition of lesions, as achieved by Dr. Long almost 15 years ago.

The Holman et al study also showed decreased insertion depth in women who had a history of pelvic surgery. Previous studies[4,5] have shown that there is a correlation between suboptimal depth of insertion and female patients, previous abdominal surgery, and quality of preparation. Analysis of our own series of flexible sigmoidoscopies (unpublished data) shows that, in addition to the above reasons, incomplete examination is also correlated with the presence of sigmoid diverticula (which caused more patient discomfort and bowel spasm on attempted intubation) and patient symptoms of constipation and lower abdominal pain. In these subsets of patients, family physicians should consider performing or repeating the procedure under intravenous sedation or analgesia, which would greatly increase the effectiveness of sigmoidoscopy.

K. Ramakrishnan, MD
Department of Family and Preventive Medicine
University of Oklahoma Health Sciences Center
Oklahoma City

References

1. Holman JR, Marshall RC, Jordan B, Vogelman L. Technical competency in flexible sigmoidoscopy. J Am Board Fam Pract 2001;14:424–9.
2. Long HF. Sensitive sigmoidoscopy: a straight sigmoid technique. J. Am Board Fam Pract 1989;2:103–5.
3. Tuggy ML. Virtual reality flexible sigmoidoscopy simulator training: impact on resident performance. J Am Board Fam Pract 1998;11:426–33.
4. Brill JR, Baumgardner DJ. Establishing proficiency in flexible sigmoidoscopy in a family practice residency program. Fam Med 1997;29:580–3.
5. Stewart BT, Keck JO, Duncan AV, Santamaria NM, Allen P. Difficult or incomplete flexible sigmoidoscopy: implications for a screening program. Aust N Z J Surg 1999;69:19–21.