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The Study Involved in the Role of Nurse to Treat Colorectal Cancer and Flexible Sigmoidoscopy

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Abstract

The impact of FS on CRC incidence and mortality during follow-up will be reported in the near future. The advantage of FS is that the bowel preparation required is less rigorous, and the procedure is easier and quicker to perform than a colonoscopy, with no sedation required.

Keywords: Flexible Sigmoidoscopy; Nurse; Colorectal cancer; Sigmoidoscopy; Disease

Introduction

Public awareness of the need for colorectal cancer (CRC) screening is growing thanks to media personalities such as other publicity drives. Many Canadian provinces have responded to this by developing CRC screening programs. The model most provinces have considered is the faecal occult blood test (FOBT), in line with recommendations by Health Canada. These initiatives are welcomed, although FOBTs only reduce CRC mortality by 15% to 25%, and screening programs that prevent CRC, as well as detect the disease early, may be of greater benefit. The current alter- native screening modalities are flexible sigmoidoscopy (FS) and colonoscopy. FS detects adenomatous polyps and malignancy up to the splenic flexure, where two-thirds of all CRCs are located. Therefore, the removal of adenomatous polyps should reduce the incidence of CRC. FS is currently being evaluated in three randomized controlled trials (RCTs) assessing almost 360,000 patients. The stage that CRC is detected is earlier than seen with symptomatic cancers. The impact of FS on CRC incidence and mortality during follow-up will be reported in the near future [1]. The advantage of FS is that the bowel preparation required is less rigorous, and the procedure is easier and quicker to perform than a colonoscopy, with no sedation required. On the other hand, FS will potentially miss right-sided lesions but colonoscopy views the whole colon; thus, colonoscopy is probably the most effective strategy.

However, the cost of offering colonoscopy as a screening program is prohibitive in the Canadian health care setting. FS would also be difficult to deliver in Canada because there are insufficient clinicians to provide the service and their time would be expensive. FS is relatively straightforward to perform, and if a less expensive section of the health care workforce could deliver this service then FS could be a viable screening option. The concept of training nurses to perform FS dates back over 30 years. Nurse endoscopy has subsequently been well described, particularly in centres in the United States (US) and the United Kingdom (UK). Studies have demonstrated that adequately trained nurses perform FS at least as competently as gastroenterologists. An RCT of 328 patients undergoing FS screening reported that the missed polyp rates determined by a repeat procedure were similar in both groups [2]. Data suggest that patient satisfaction is comparable among general surgeons, gastroenterologists and nurses performing screening FS.

Discomfort during the procedure is perceived by the patient to be similar between clinician and nurse FS. Serious adverse events are fortunately rare with FS and no study has reported any major complications, including one study series of 1000 patients referred to a nurse-led service. All evidence points to nurses performing FS screening just as well as clinicians. An MD degree does not confer any particular technical skill, and it seems reasonable that adequate training is a far more important indicator of the ability to perform FS [3]. Nurses are less expensive than doctors, and cost-containment is a major concern for the publicly funded Canadian health care system.

An important problem in developing nurse-led screening FS is providing adequate training. The FS program described in the study was adapted from UK and US experiences, with a theoretical component consisting of didactic teaching and a practical component consisting of 'hands-on' experience. The number of procedures a nurse needs to perform to become competent is uncertain. One study suggested the mean number of supervised FS needed to obtain competency was 20, with nurses and doctors learning at similar rates. A survey of American institutions found that the number of supervised procedures needed before a nurse was granted competency was set at a much more conservative level (range 50 to 300 procedures). In the UK, nurse endoscopy is particularly well developed and a survey of all hospitals in the UK revealed that almost 50% of responding hospitals employed a nurse endoscopist [4]. Training is also formalized, and largely occurs within a national framework in centres approved by The Joint Advisory Group on Gastrointestinal Endoscopy.

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