Me, the intruder: revisited and rethought

Key words: ERCP. Sedation. Propofol.

Dear Editor,

I have read Dr. Luzón’s article (1) and have shared his opinions for a long time. As I indicated in my letter 13 years ago (2), all of our patients need to receive adequate sedation in endoscopic explorations, including endoscopic retrograde cholangiopancreatography (ERCP). It is also our obligation, as the person responsible for the procedure, to ensure that this is so. At present, and without renouncing any of my beliefs, I think it is necessary to ask ourselves several questions.

The most frequently administered drug for sedation in endoscopy is propofol (3). However, there are some doubts with regard to its use in ERCP, especially in the elderly and when administered by non-anesthesiologists, even in moderate sedation (4). In a recent editorial, García Cano et al. (5) highlighted the fact that more than a third of ERCPs transform into a complex procedure which requires advanced techniques from the very beginning such as cannulation. According to Luzón et al., 30% of the patients are ASA III-IV. I believe that attending to two complex procedures simultaneously is a potential source of error. Would you allow yourself to be involved in a surgical procedure by a surgeon who also controls the anesthesia?

ERCP is a procedure with a large number of legal claims and the first question that a judge always asks is: who participated in the procedure? In that moment, you will be completely alone again.

Currently, the trends of medicine and endoscopy tend towards sub-specialization and multi-disciplinarily teams. Does the exclusion of anesthesiologists from endoscopy go directly against both trends?

We need to reflect on the reason why endoscopists have been impelled to assume the responsibility of sedation: the lack of collaboration of the anesthesia services. This has multiple factors, but it is ethically unacceptable. Are all of those implications that have an economic justification acceptable from some point of view?

All doctors have the same purpose (anesthesiologists included): to create the optimal conditions of quality and safety in the care of patients. It is necessary to favor optimal work conditions for all those involved in a procedure as complex as ERCP: in the penumbra, in the semi-prone position, with the airway occupied and in the case of ASA IV and hemodynamically compromised patients. Does anyone still doubt what the best alternative in this situation is?

Finally, are we interested in taking responsibility for aspects that are not part of our specialty for reasons that are ethically unacceptable?

The answer is again what I proposed in an old editorial in this journal (6): biliary endoscopist has a part of the solution, not in his hands but in his head: just learn to say “NO”.

In a rebellious way like the intruder I still am: NO to all questions. We must demand the presence of an anesthesiologist in every complex ERCP.

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