

Complications of Colonoscopy: A Study

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Perspective

Colonoscopy is a popular procedure used to diagnose and treat a wide range of illnesses and symptoms, as well as to test for and monitor colorectal neoplasia. Although up to 33% of individuals report at least one minor, temporary GI ailment following colonoscopy, severe problems are infrequent. The pooled overall serious adverse event rate in a 2008 systematic evaluation of 12 trials totalling 57,742 colonoscopies performed for average risk screening was 2.8 per 1000 procedures. If the colonoscopy is conducted for a reason other than screening, the risk of various problems may be increased. Patients undergoing colonoscopy with polypectomy account for more than 85 percent of major colonoscopy problems. A study of nearly 97,000 colonoscopies in Canada indicated that polypectomy was related with a 7-fold increase in the risk of bleeding or perforation. However, complication statistics are frequently not stratified by whether or not polypectomy was undertaken. As a result, the complications of polypectomy are mentioned alongside those of diagnostic colonoscopy. Although broad principles are addressed, a discussion of the diagnosis and management of all problems of colonoscopy is beyond the scope of this document. The 2008 American Society for Gastrointestinal Endoscopy Guideline for Sedation and Anesthesia in GI Endoscopy discusses in depth the cardiovascular and pulmonary risks associated with sedation.

Intraprocedural cardiopulmonary problems have been classified in various ways, ranging from modest variations in oxygen saturation or heart rate to major complications such as respiratory arrest, cardiac arrhythmias, myocardial infarction, and shock. In the 30-day post-procedure interval, colonoscopy is related with an increased incidence of cardiovascular events. According to a study of Medicare enrollees, the unadjusted rate of cardiovascular events requiring hospitalisation or emergency department visits was 1030 per 100,000 operations, which was substantially higher than the matched controls (885/100,000 procedures). The risk of cardiac events related with colonoscopy is known to rise with advanced age, higher American Society of Anesthesiologists Physical Status Classification System scores, and the presence of comorbidities. Colonic perforation during colonoscopy can occur as a result of mechanical stresses against the intestinal wall, barotrauma, or as a result of therapeutic operations. Persistent stomach pain and abdominal distention are early signs of perforation. Peritonitis may develop later in the course of the disease. Plain chest and belly radiographs may show free air, however CT scans have been demonstrated to be superior to upright chest films. As a result, for patients with an unrevealing plain film and

a strong suspicion of perforation, an abdominal CT scan should be explored. Hemorrhage is most commonly related with polypectomy; however it can occur during a diagnostic colonoscopy as well. Hemorrhage linked with polypectomy may develop immediately or may be delayed for several weeks following the treatment. Several big investigations have found bleeding in 1 to 6 out of every 1000 colonoscopies (0.1 percent -0.6 percent) [1-5].

A study that used Medicare data to analyse over 50,000 colonoscopies discovered that the rate of GI haemorrhage was significantly different with or without polypectomy. Several studies have found that polyp size is a risk factor for postpolypectomy bleeding. Additional risk factors may include the number of polyps removed, the duration of warfarin therapy, and the histology of the polyp. Comorbidities in patients, such as cardiovascular disease may increase the risk of bleeding but may also be indicators for anticoagulant usage. Multiple big studies found no link between aspirin use and postpolypectomy haemorrhage. Complications are unavoidable when doing a colonoscopy. As endoscopy takes on a larger therapeutic role in the treatment of GI problems, the risk of consequences is anticipated to rise. Understanding probable endoscopic complications, their projected frequency, and the risk variables associated with their occurrence may aid in reducing the incidence of difficulties. Endoscopists are expected to carefully choose patients for the proper intervention, be knowledgeable about the planned treatment and available equipment, and be prepared to manage any adverse events that may occur.

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