The tyranny of the scope

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When I was trained in internal medicine, so long ago, it was drummed into my head by some excellent teachers at the Winnipeg General Hospital, now called the Health Sciences Centre, that the main weapons we had in coming to a rational diagnosis was a careful medical history and physical examination. This has now changed. We, the gastroenterological community, have become mere technicians. Fully 40% of my consultations are for screening colonoscopy – in patients who are asymptomatic. Screening has become the watchword of the age. Of course, the yield is very small. In over 500 patients whom I have acquiesced to perform this invasive procedure, I have found one cancer – in a man who, in retrospect, had symptoms that he, for his own reasons, neglected to tell his doctors about. Yes, I have found a few polyps, which of course obligates me to repeat the procedure in one, three or five years, depending on the current mood of the enthusiasts. Therefore, my waiting list expands exponentially – to the detriment of patients who are really in need of the services of a subspecialist. We have created a society of anxious people who demand screening for just about everything – breast cancer, colon cancer and coronary artery disease – ad infinitum. In short, we have become mere technicians – we are no longer internists who happen to have the ability to push scopes virtually anywhere – and damned be the indication. This is reflected in the type of consultation letters we now receive – "patient has diarrhea – please scope". Scope what? "Patient has two grandparents who we think had colon cancer – please scope!" "Patient has epigastric pain – please scope – upper GI is negative, and by the way he/she is unresponsive to the latest acid destroyer!" No mention that he or she is unhappy with his or her job, spouse, life, or him or herself – please scope! Now we have the ultimate blow – endoscopy on demand. No longer necessary to discuss the problem – how much effective information will we gain by looking into another normal stomach and duodenum. How many variables are there anyway? How will we change management if we report to the demanders that the test is normal – well maybe a bit of gastritis, whatever that is. What concerns me about this wholesale epidemic of unnecessary endoscopic mayhem is the effect it has on the trainees. The following scenario is typical – it just happened (again) yesterday. A 21-year-old man presented to the emergency room with the following history. For the past month, he complained of bloody diarrhea, both day and night, plus a 9 kg weight loss, plus intermittent fever, plus night sweats, plus anorexia, plus aching in his knees. His family doctor referred him to three gastroenterologists – and his earliest appointment was in January 2003! (Likely due to the fact that those overworked doctors were full up with – you guessed it – screening colonoscopies or endoscopy on demand for nonulcer dyspepsia!) The teaching session went like this: "Well, doctor, what do you think, after your history and physical examination, is wrong with this young man?" "It sounds like inflammatory bowel disease or infectious colitis." "Correct. And what will you do to help this sick person?" "I think he needs a colonoscopy!" "Well, perhaps, but what do you think we should do now?" "Well, I would do a complete blood count and Lytes, and start an IV because he looks dehydrated." "OK, do that, but is there anything we should rule out first? In other words, what are some of the serious complications of ulcerative colitis that have not been clarified yet?" "Perforation? Toxic megacolon? Sepsis?" "Correct. And how do we rule those things out. And if you say colonoscopy I will throttle you!" "Should we do three views of the abdomen? That would

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rule out a perforation and toxic megacolon?" "Correct. To the top of the class." Later on, the abdominal films were reviewed and revealed classic signs of universal colitis. The patient was admitted, rehydrated and placed on steroids, and was much improved within 24 h. I met with the fellow and the clerk two days later. The clerk, who is very bright and enthusiastic, asked me when I would do the colonoscopy. I told him maybe in 10 years, provided that he did not come to surgery for his colitis, but I would do a quick sigmoidoscopy and get some biopsies to confirm the clinical diagnosis, which we did. To no one's surprise, the biopsies confirmed the clinical diagnosis. I told them that colonoscopy in this situation is contraindicated because it may precipitate a toxic megacolon or a perforation, and would not add to the management of the problem. I recall a conversation I had many years ago with Dr Fred Weinstein, who was the only other gastroenterologist in Alberta at the time. I would call him frequently when I, in my embryonic years in this profession, was stumped with a problem. He once said to me that it is much easier to pass a scope than to do a good history and physical examination. How perceptive he was! I also once had a long talk with Howard Spiro, one of our greats, who told me he gave up doing endoscopy in 1968 because he rarely found what was wrong with the patient by doing that procedure! He felt even at that time that he resented being a mere technician! Thanks for allowing me to vent my spleen in this forum. I guess the bottom line is that we, as gastroenterologists, should resist the siren song of technology and teach our trainees to do the same!