We believe that we need a collaborative effort to issue a revised, updated set of recommendations on the administration of sedation for the performance of endoscopic procedures that will replace the recommendations that the Tri-Societies (AGA, ASGE, ACG) issued in March 2004. In announcing the 2004 recommendations, the Tri-Societies noted that the recommendations may be modified as future developments occur.

We believe that modifications are long overdue and that all GI patients—regardless of the setting in which they receive their care—need a clear, consistent message from our societies that addresses confusion regarding billing issues and recent developments and trends in sedation practice, including the use of propofol. These were precisely the reasons the Tri-Societies convened their workgroup and issued the 2004 recommendations.

With more than a decade of additional learning with respect to the developments and trends in sedation practice, along with important guidance from regulatory agencies following the 2004 recommendations, it is time to revise the recommendations. Specifically, there are at least four statements that need to be revisited:

• “In general, diagnostics and uncomplicated therapeutic endoscopy and colonoscopy are successfully performed with moderate (conscious) sedation.”

• With respect to the use of propofol, “[c]linically important benefits over standard sedatives have not been consistently demonstrated in average-risk patients undergoing standard routine upper and lower endoscopy.”

• “[W]ith adequate training physician-supervised nurse administration of propofol can be done safely and effectively.”

• “The routine assistance of an anesthesiologist/anesthetist for average risk patients undergoing standard upper and lower endoscopic procedures is not warranted.”

These statements are at odds with current clinical practice, given that the use of propofol is now in many centers the standard-of-care for upper and lower endoscopic procedures. Even in 2004, the Tri-Societies acknowledged that propofol has numerous clinical advantages over other modes of sedation for endoscopy. And, since that time, more current guidelines have noted that “[d]ata . . . support that propofol administration is superior to other agents with regard to recovery time and physician satisfaction,” “at discharge, propofol-sedated patients have better scores on psychomotor testing, reflective of greater learning, memory, and mental speed,” and “propofol use provides similar or higher levels of patient satisfaction.” Nevertheless, physicians across the country are confronting restrictive payor policies that are founded on the outdated notion—reflected in the 2004 recommendations—that propofol is not medically necessary for an array of endoscopic procedures.

We also believe that our societies should revisit the 2004 recommendations regarding who may appropriately administer propofol in light of more recent regulatory guidance. As you
know, the U.S. Food and Drug Administration has taken a clear position that propofol should be administered “only by persons trained in the administration of general anesthesia and not involved in the conduct of the surgical/diagnostic procedure.” The FDA rejected an effort by the American College of Gastroenterology to remove this warning label in 2010, refusing to accept the ACG’s studies showing that individuals without specific anesthesia training could safely administer propofol. The practical effect of the FDA’s position is that gastroenterologists must work with anesthesiologists/anesthetists to provide propofol, because failure to do so would place physicians at unacceptable risk of liability. And, yet, the 2004 recommendations state that “with adequate training[,] physician-supervised nurse administration of propofol can be done safely and effectively.” The practical effect is that gastroenterologists across the country, along with our patients, are caught between inconsistent guidelines.

We recognize that the development of an updated set of recommendations on the administration of sedation for the performance of endoscopic procedures will require thoughtful deliberation, but this work must be done. Our physician colleagues, regulators and payors need current clinical guidance on the development of appropriate clinical pathways and, most importantly, our patients deserve better.

We hope that the Tri-Societies will respond in regards to completing this important work, acknowledging that the use of propofol sedation (monitored anesthesia care) has now become the standard of care for the majority of GI endoscopy. We ask that they team with one another to convene a Tri-society workgroup that will create a set of recommendations on the administration of sedation for the performance of endoscopic procedures to serve our patients in 2015 and beyond.