

## NAPS in 2016: why not everywhere?



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submitted 18.12.2016

accepted after revision 30.12.2016

### Bibliography

DOI <http://dx.doi.org/10.1055/s-0043-101689> |  
Endoscopy International Open 2017; 05: E222–E223  
© Georg Thieme Verlag KG Stuttgart · New York  
ISSN 2364-3722

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Many recently published data have shown that sedation with short-acting propofol seems to be the ideal drug for endoscopic procedures, whether for diagnostic [1–7] or therapeutic [3] purposes, even in elderly high-risk patients [8] or patients with liver cirrhosis [9]. Propofol is therefore recommended as the first choice over midazolam in currently published international guidelines [10–12]. Also many editorials for sedation in gastrointestinal endoscopy have been published over the last decade, showing that non-anesthesiologist propofol sedation (NAPS) and in particular nurse-administered propofol sedation (NAAP) is safe when performed by trained staff [13, 14] also when compared to anesthesiologist-administered sedation in a low-risk population [15, 16]. Results of the trial by Sathanantha et al. [17], published in the current issue of *Endoscopy International Open*, also confirm the safety of physician-directed nurse-administered propofol sedation (here combined with midazolam) in low-risk patients undergoing endoscopy and colonoscopy.

Although, performance of so-called NAPS or NAAP was already endorsed by different international societal guidelines including the 4 major American societies (American Gastroenterological Association, American College of Gastroenterology, American Society for Gastroenterological Endoscopy and American Association for the Study of Liver Diseases), the European Society of Gastrointestinal Endoscopy (ESGE) and however briefly, the European Society of Anaesthesiology (ESA) this topic is still a matter of debate [10, 11]. This committee had worked together in an attempt to improve the quality and safety of care for the patient undergoing gastrointestinal interventions. Despite the existing evidence and endorsement of different scientific societies, propofol is still underused in many countries [18] even given current evidence from several meta-analyses [19, 20] showing that NAPS is as safe as endoscopist-directed so-called “traditional” sedation. One reason might be the theoretical possibility of clinically significant side effects including respiratory and circulatory depression, which in fact occur at a very low rate [14]. Another reason is the position of

some anesthesiology societies mainly in countries where sedation by anesthesiologist is high-priced reimbursed. However, those arguments are almost entirely devoid of any evidence base but resulted in retraction by the ESA of the initially co-worked European sedation guideline [21]. However, since 2010 the guideline board of the ESA has still failed to underline their statement of guideline retraction, with evidence-based arguments as the authors of the letter to the editor did. The latest example of this comes from Portugal. After an article was published on use of propofol in colorectal cancer screening [22], anesthesiologists called on the Editorial Board to retract the text [23] without mentioning proper evidence for that action.

However, all currently available national and international guidelines, including the European guideline with anaesthesiologist in the committee, were focusing on patient safety as a precondition without any exception when sedation for gastrointestinal endoscopy is performed by non-anesthesiologists [10–12, 24, 25]. This underscores the total agreement between gastroenterologists and anesthesiologists focusing on patient safety as the main goal. The best example in this context is the German guideline [12], showing that cooperation instead of defense might be an ideal option regarding guideline development and coordinating nationwide training courses under well-defined conditions [26, 27]. One reason that this concept is successful might be the fact that in Germany there is no reimbursement when an anesthesiologist performs propofol sedation in the ambulatory or hospital setting, whereas in other countries, an attractive reimbursement is given. Up to now more than 8000 nurses have been trained in courses performed jointly with anesthesiologists and gastroenterologists as a prerequisite for recognition and certification of the course to maximize patients' safety as well as structural and personal preconditions [28]. Especially in the hospital setting, there are too few anesthesiologists to cover every patient undergoing gastrointestinal endoscopy with propofol as the evidence-based ideal drug in that setting. Therefore, alternative options (NAAP, NAPS) are increasingly recommended and performed in different

countries, as propofol shows more advantages than disadvantages, when the focus is strictly on evidence instead of politics.

Interdisciplinary cooperation according to the recommendations and contents of the European curriculum for sedation training in gastrointestinal endoscopy created by ESGE under anesthesiologist expertise and European Society of Gastroenterology and Endoscopy Nurses and Associates (ESGENA) might be the goal for further discussion. After all, it is time to prove that monetary aspects may not be influencing anesthesiology societies' avoidance of NAAP, as discussed in the article by Dumonceau JM: "NAAP: It's all about money" [29].

## Competing interests

None

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