Virtual colonoscopy's time has come

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Virtual colonoscopy (VC) has been getting a bad rap for quite some time. The gastroenterologists (gastros) have considered VC a threat. After all, why should a gastro give up $2,500 per procedure to allow radiology to gain $500 per procedure? Of course, when the gastro can't get to the cecum, she can always reach out to her friends in radiology for help.

Radiologists, and in some cases emergency room doctors and other physicians, are often not keen on doing VCs. Some consider it boring; they can easily become fatigued, especially considering that it takes about 30 minutes to complete a study. The threat of a "flat lesion" is ever present, twice as likely to be cancerous, and very likely to evade detection. This challenge often requires extra time to fully satisfy oneself that all is clear.

Running a profitable operation at 30 minutes per VC study, moreover, is very difficult. Losing money, with no apparent way to turn the situation around, is no fun at all. The dicey financial picture is compounded by the fact that reimbursement (at the Medicare level) has been elusive. Fortunately, 22 states are now providing reimbursement for the procedure.

So what are radiologists to do? They can get hold of a stereo display, a tracking system and a robust computer, and create an Interactive Virtual Reality (IVR) system. The time might be right to begin adopting this technology. Let's consider how the VC/colonoscopy situation is evolving and see how radiologists might benefit.

When I heard a gastro recently claim to be sending patients for a VC, due to having an overload of patients, I thought I was living in another world. But in high-population centers this is increasingly becoming the case—and with the Affordable Care Act impacting the landscape and baby boomers daily becoming ripe for colon screening, VCs may in fact become more prevalent.

The worst-case scenario for a busy gastro is to have patients who don't have any polyps. It would be wonderful for radiology to send those patients without polyps directly home and refer the multi-polyp patients back to the gastros; hence, VCs can play an invaluable role in a busy GI practice.

Bridging the radiology-surgery gap is just what the doctor ordered. The financial picture, using the scenario provided above, is interesting. Virtual colonoscopy, for $500 per case, can remove patients with zero polyps and send the tough cases back to the gastro for conventional colonoscopy at $2,500. This makes good financial sense, as only 1 of every 10 patients undergoing VC will have polyps. The situation is similar to mammography, where 12% of screening mammo patients are called back for further evaluation.Based on early studies with IVR, radiology can consistently complete a typical VC study in 8 to 10 minutes. Now we are talking about profitability on the radiology side of the equation.

The bottom line is that if radiologists can make money with each study, and build bridges to their colleagues in gastroenterology, things could be looking up for VC and radiology. Perhaps screening and diagnostic colonography could ultimately become the new standard approach to colon cancer surveillance. The radiologist could become the surgical planner, providing the surgeon with a virtual reality scene that replaces the old-fashioned paper report.

Of course, the remaining step is to secure complete reimbursement for VC. But I would argue that the time has come. Let's gather the data needed to prove the case for VC, and start putting us all in a better place.

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