LA NUOVA GASTROENTEROLOGIA
Corso Interregionale A.I.G.O.
Emilia-Romagna – Marche -Toscana
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LA PREPARAZIONE ALLA COLONSCOPIA SENZA FATICA

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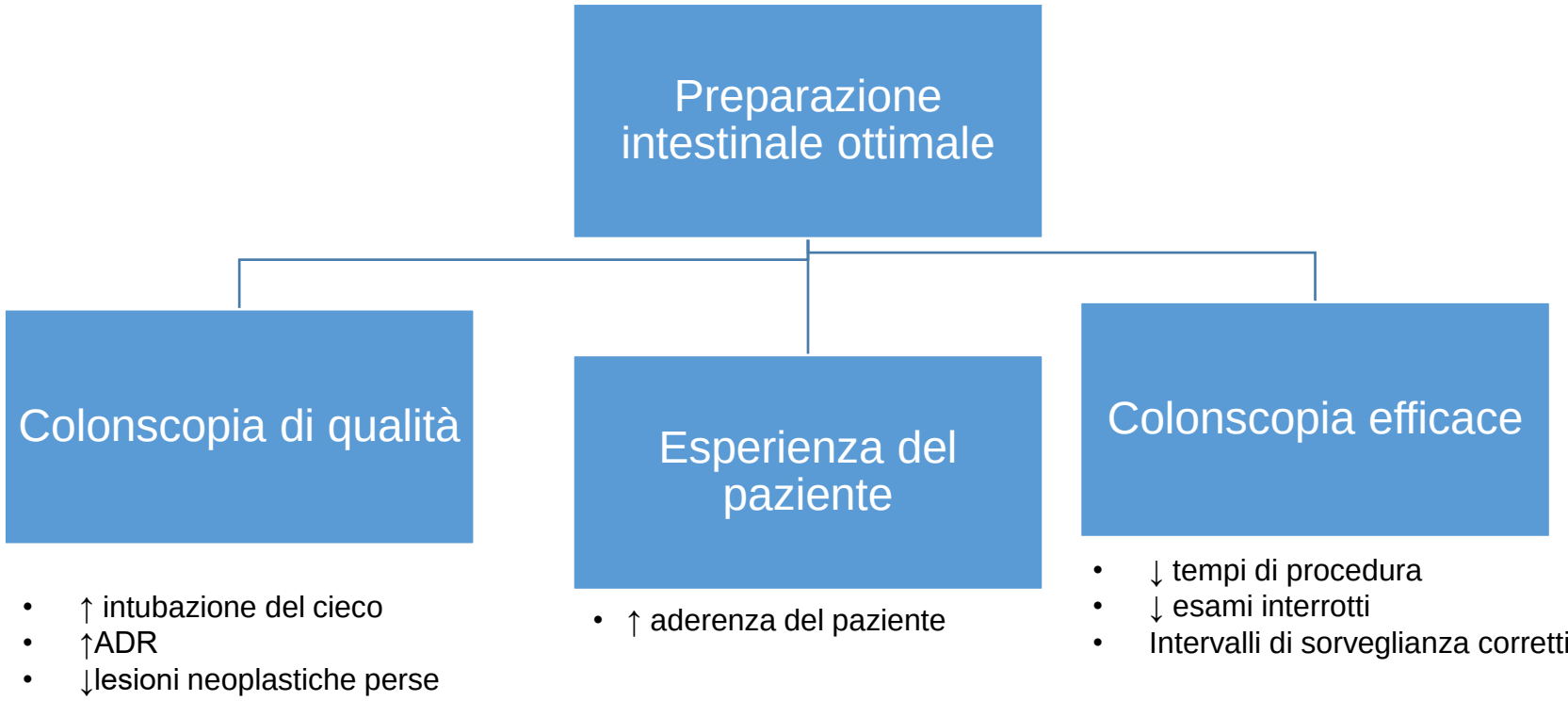

MIGLIOR RAPPORTO COSTO EFFICACIA DELLO SCREENING CARCINOMA DEL COLON-RETTO

Quality assurance item	Proposed standard
Consent and withdrawal of consent	Audit the number of patients who decline colonoscopy on the day of the procedure and the number of intraprocedural withdrawals of consent. Proposed standard: fewer than 5 % of cases to withdraw consent on the day of the procedure and fewer than 1 % during the procedure
Experience of the screening colonoscopist	We recommend that a minimum lifetime colonoscopy experience together with a minimum number of annual screening colonoscopies should be agreed. Proposed standard: to be agreed by screening boards
Bowel cleansing	The state of bowel cleansing should be audited. Proposed standard: at least 90 % of examinations should be rated as "adequate" bowel cleansing or better
Sedation, analgesia, and comfort	Audit of sedation practices, including average doses used of medication together with comfort scores. Proposed standard: no more than 1 % of patients should become hypoxic (saturation below 85 % for more than 30 seconds) or for other reasons require administration of a reversal agent
Unadjusted cecal intubation rate	Audit the completion rate for all colonoscopies. Proposed standard: *unadjusted* cecal intubation rate of at least 90 %
Adenoma and cancer detection rates	The number of detected adenomas and cancers should be audited. Proposed standard: to be agreed by screening boards
Colonoscope withdrawal time	Average withdrawal times should be audited. Proposed standard: a minimum of 6 minutes in at least 90 % of purely diagnostic examinations
Polyp retrieval rate	Screening programs anticipate that all resected polyps are retrieved for histological analysis. Proposed standard: ≥ 90 % of resected polyps should be retrieved for histological analysis
Significant interval lesions	We recommend that screening programs monitor size, appearance, location, and histology of all polyps larger than 1 cm and cancers found between screening examinations as well as after the patient has been discharged from a screening program. Proposed standard: to be agreed by screening boards
Specialist referral for removal of larger polyps	We anticipate that the removal of larger polyps will be deferred to a dedicated clinical session, perhaps at a separate tertiary referral centre. Screening programs should record how larger polyps detected at screening are managed, together with details of outcomes. Proposed standard: to be agreed by screening boards
Cleaning and disinfection	Adoption of manufacturers', national, and European standards for disinfection. Proposed standard: routine microbiological testing at intervals not exceeding 3 months
Tattooing sites of larger polyps and cancers	We recommend that screening programs set standards regarding which polyp sites should be tattooed. Proposed standard: the placement of tattoos following the removal of all polyps 2 cm or larger outside of fixed colonic landmarks such as the cecum and rectum
Unscheduled readmissions	We recommend that screening programs record details of all emergency admissions within 30 days of the screening colonoscopy. Proposed standard: to be agreed by screening boards
Perforation rate	We recommend that details should be recorded of all perforations complicating diagnostic and therapeutic procedures, that require surgical repair and that occur up to 2 weeks after endoscopy. Proposed standard: fewer than 1:1000 diagnostic or therapeutic examinations should result in a perforation requiring surgical repair
Bleeding rate	All cases of immediate and late bleeding following polypectomy should be recorded. Proposed standard: fewer than 1:20 cases of bleeding should ultimately require surgical intervention

«Quality in screening colonscopy: position statemente of the ESGE» (Endoscopy, 2012)

LA PREPARAZIONE ALLA COLONSCOPIA SENZA FATICA: COME?

1. ***Regime di preparazione?***
2. ***Lassativi: alto o basso volume?***
3. ***Simeticone***
4. ***Dieta: quale e per quanto tempo?***
5. ***Educare/Informare***

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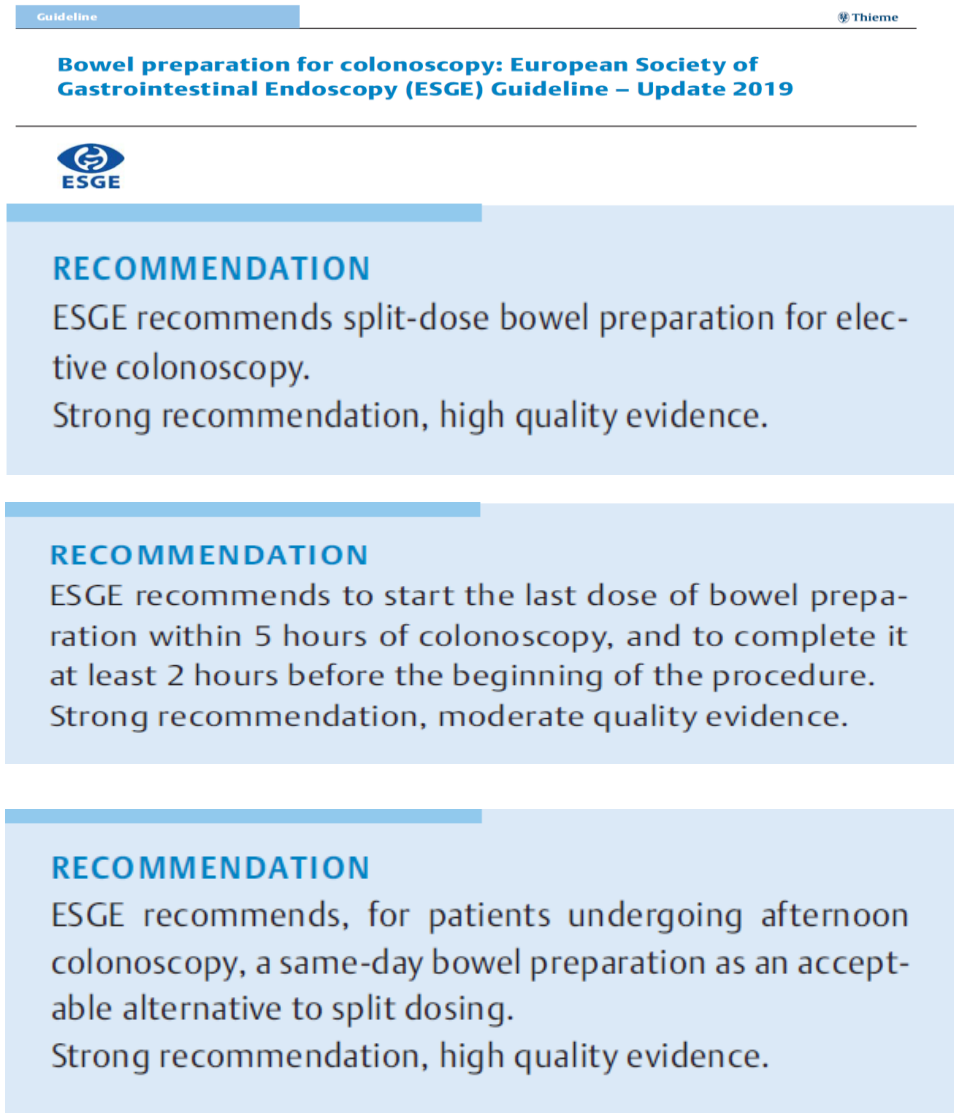
TEMPI E REGIMI PER LA PREPARAZIONE INTESTINALE: SPLIT!!



Guideline

Thieme

Bowel preparation for colonoscopy: European Society of Gastrointestinal Endoscopy (ESGE) Guideline – Update 2019

ESGE

RECOMMENDATION

ESGE recommends split-dose bowel preparation for elective colonoscopy.
Strong recommendation, high quality evidence.

RECOMMENDATION

ESGE recommends to start the last dose of bowel preparation within 5 hours of colonoscopy, and to complete it at least 2 hours before the beginning of the procedure.
Strong recommendation, moderate quality evidence.

RECOMMENDATION

ESGE recommends, for patients undergoing afternoon colonoscopy, a same-day bowel preparation as an acceptable alternative to split dosing.
Strong recommendation, high quality evidence.

- Elemento chiave per ottimizzare l'efficacia dei regimi di preparazione indipendentemente dal lassativo utilizzato
- Incremento del 30-40% del tasso di pazienti con preparazione adeguata
- Significativo aumento del tasso di diagnosi di lesioni neoplastiche
- Miglioramento della tollerabilità della preparazione

BARRIERE ALL'IMPLEMENTAZIONE DELLA DOSE SPLIT

Rischio di fermata/ incontinenza

- *Raro (< 5%)*
- *Non significativamente diverso che per full-dose nei RCTs*

Split dose e rischio di aspirazione

- Volume gastrico residuo simile a quello delle preparazioni «full-dose day before»
- Sicuro per i pazienti
- Consente di mantenere le ore di digiuno richieste per la sedazione secondo ASA.

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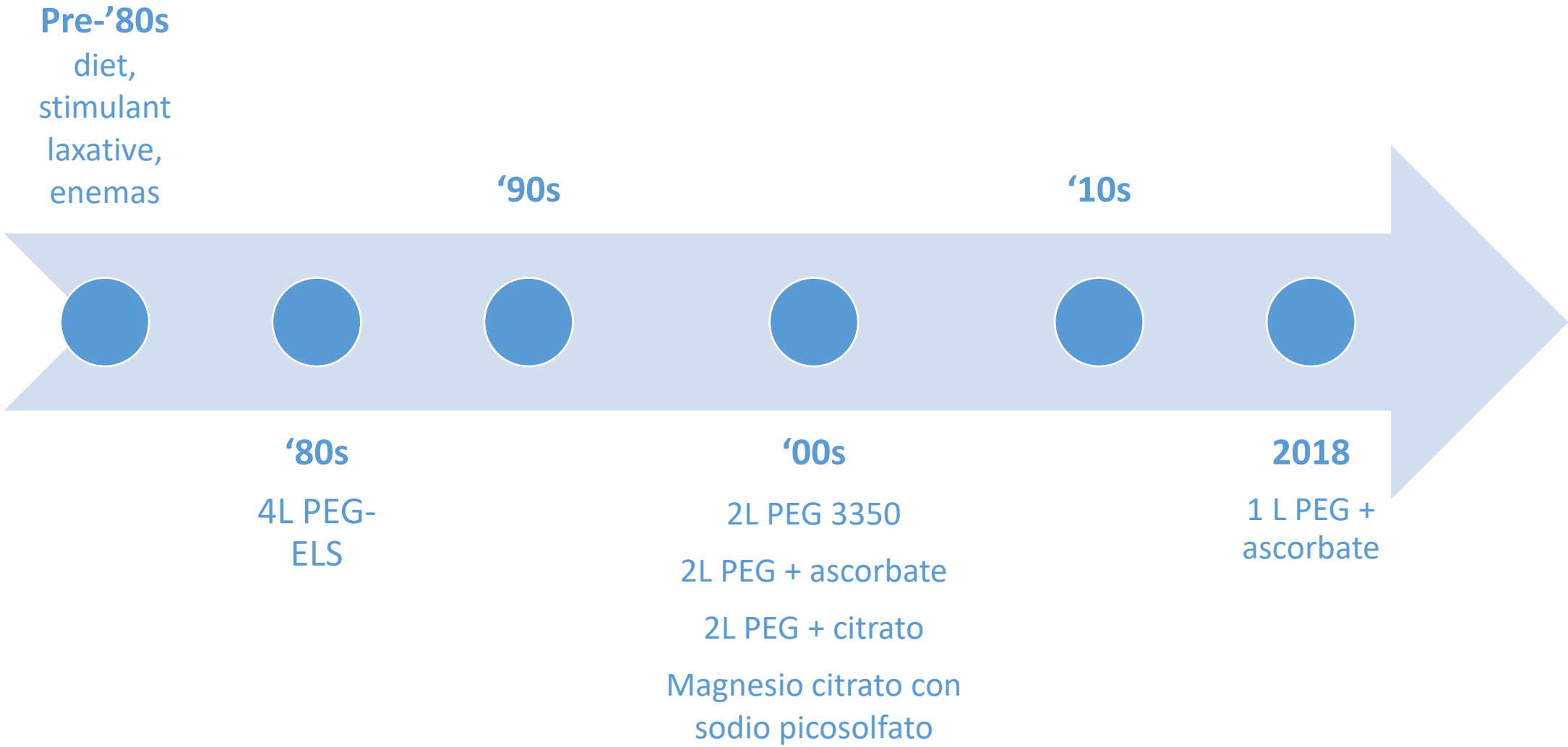
STORIA DELLE PREPARAZIONI INTESTINALI



ALTO O BASSO VOLUME?

▶ **Table 1** Summary data on efficacy and safety of validated laxatives for routine bowel preparation.

Agent	Efficacy (split/same-day regimen)	Safety
High volume polyethylene glycol (PEG)	Noninferior or superior to low volume PEG or non-PEG regimens	Not recommended in: ▪ Patients with congestive cardiac failure (NYHA class III or IV).
Low volume PEG plus adjuvants		
▪ 2 L PEG + ascorb	Noninferior to high volume PEG and non-PEG regimens	Not recommended in patients with: ▪ Severe renal insufficiency (creatinine clearance < 30 mL/min); ▪ Congestive heart failure (NYHA III or IV); ▪ Phenylketonuria; or ▪ Glucose-6-phosphate dehydrogenase deficiency.
▪ 2 L PEG + citrate	Noninferior to high volume PEG or 2 L PEG + ascorbate	Not recommended in patients with: ▪ Severe renal insufficiency (creatinine clearance < 30 mL/min): ▪ Congestive heart failure (NYHA III or IV) ▪ Unstable angina; or ▪ Acute myocardial infarction. No long-term data available. Limited post-marketing data available.
▪ 1 L PEG + ascor	Noninferior to 2 L PEG + ascorbate, oral sulfate solution (OSS), and magnesium citrate plus picosulphate (MCSP). No comparison with high volume PEG.	Not recommended in patients with: ▪ Severe renal insufficiency (creatinine clearance < 30 mL /min); ▪ Congestive heart failure (NYHA III or IV); ▪ Phenylketonuria; or ▪ Glucose-6-phosphate dehydrogenase deficiency. Adequate hydration must be maintained. Limited post-marketing data available.
▪ 2 L PEG + bisac	Noninferior to high volume PEG or 2 L PEG + ascorbate	Occasional reports of ischemic colitis with high dose bisacodyl. Not recommended in: ▪ Patients with congestive cardiac failure (NYHA class III or IV).
Magnesium citrate plus picosulphate (MCSP)	Noninferior to high volume PEG or 2 L PEG + ascorbate	Not recommended in patients with: ▪ Congestive heart disease; ▪ Hypermagnesemia; or ▪ Severe kidney insufficiency. Not recommended in patients at risk for: ▪ Hypermagnesemia; or ▪ Rhabdomyolysis.
Trisulfate (magnesium sulfate, sodium sulfate, and potassium sulfate), also called oral sulfate solution (OSS)	Noninferior to high volume PEG, 2 L PEG ascorbate Superior to MCSP in a single RCT	Not recommended in patients with: ▪ Severe renal insufficiency (creatinine clearance < 30 mL/min); ▪ Congestive heart failure; or ▪ Ascites.

NYHA, New York Heart Association; RCT, randomized controlled trial.

RECOMMENDATION

ESGE recommends the use of high volume or low volume PEG-based regimens as well as that of non-PEG-based agents that have been clinically validated for routine bowel preparation. In patients at risk for hydroelectrolyte disturbances, the choice of laxative should be individualized.

Strong recommendation, moderate quality evidence.

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SIMETICONE (200-400 mg)

- Miscela detergente capace di ridurre la tensione superficiale delle bolle,
- Effett
- Incre
- Miglic

RECOMMENDATION

ESGE suggests adding oral simethicone to bowel preparation.

Weak recommendation, moderate quality evidence.

- Riduce significativamente il gonfiore addominale con migliore compliance del paziente

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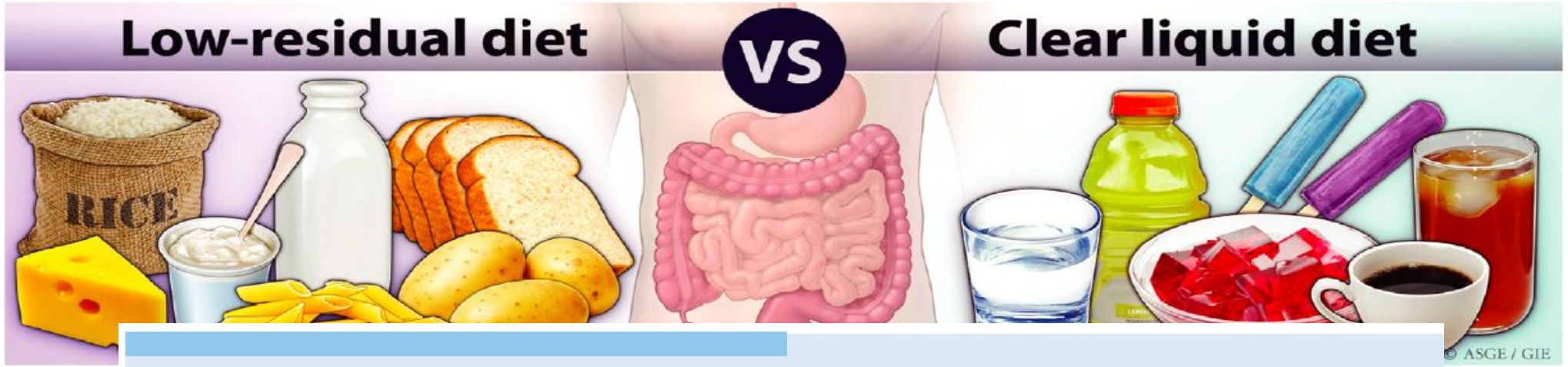
DIETA: PER QUANTO TEMPO?

- Storicamente raccomandata per 3 giorni.
- Tuttavia più lunga è la restrizione dietetica, più bassa è la compliance dei pazienti.
- Nessuna differenza di efficacia in termini di pulizia intestinale quando limitata alle 24 h precedenti l’esame piuttosto che per tempi maggiori.



RECOMMENDATION

ESGE recommends a low fiber diet on the day preceding colonoscopy.

Strong recommendation, moderate quality evidence.

- LRD non … trasparenti procedura … preparazic … ente o cecale. … mperatura
- Limiti: def … definiscono come una dieta con un apporto giornaliero di fibre < 10-15 g.

- Limiti: scarso apporto energetico, poco appetibile. Oltre il 50% dei pazienti si mostra riluttante a ripetere la colonscopia.

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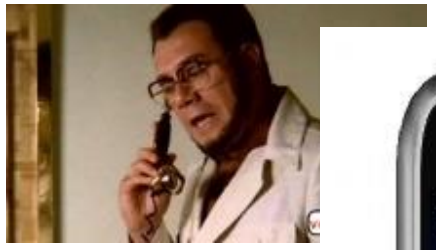
INFORMARE/EDUCARE IL PAZIENTE



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LA PREPARAZIONE ALLA COLONSCOPIA SENZA FATICA

1. ***«SPLIT!»***
2. ***Basso volume***
3. ***Simeticone***
4. ***Dieta a basso contenuto di fibre il giorno prima***
5. ***Educare/Informare***

GRAZIE PER L'ATTENZIONE!