

TITLE

Fitting balloon overtube assisted colonoscopy (BOAC) into the difficult or failed colonoscopy algorithm

AUTHORS

Malcolm Tan¹

James E. East²

INSTITUTIONS

1. Department of Gastroenterology and Hepatology, Changi General Hospital, Singapore, Singapore.
2. Translational Gastroenterology Unit, John Radcliffe Hospital, University of Oxford, Oxford, United Kingdom.

ADDRESS FOR CORRESPONDENCE

Dr. James E. East, Translational Gastroenterology Unit, Experimental Medicine Division, Nuffield Dept of Clinical Medicine, University of Oxford, John Radcliffe Hospital, Headley Way, Headington, Oxford, OX3 9DU, United Kingdom

Telephone: +44 [0]1865 228753

Fax: +44 [0]1865 228763

E-mail: james.east@ndm.ox.ac.uk

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Dear Editor,

We thank Koukias and colleagues for highlighting the recent paper from their group which supports our view that balloon overtube assisted colonoscopy (BOAC) should be available in major endoscopy units as an option for technically challenging colonoscopies¹.

In their randomized control trial, patients who were predicted to have difficult colonoscopies by using a novel scoring system underwent either a double balloon colonoscopy (DBC) or a conventional colonoscopy (CC) without the use of ancillary equipment. Cecal intubation rate (CIR) was 100% in the DBC group, compared to 59% in the CC group, although the CIR increased to 86% when magnetic endoscopic imaging or a pediatric colonoscope was utilized. Underwater colonoscopy, use of a gastroscope, or cap-assisted colonoscopy were not tested. With these ancillary devices, there may not have been a detectable difference between both groups. Importantly, patients and operators were more satisfied with DBC than CC.

In our meta-analysis² of patients who had incomplete CC, the average age was 66.1 years and there was a slight preponderance towards women (53.4%). About half (45.6%) of our patients had a history of abdomino-pelvic surgery and using the novel colonoscopic difficulty scale described by Despott et al, a significant number of our patients would have been eligible to participate in their trial.

A recently published prospective cohort study by Rogers et al³ looked at 175 patients with prior incomplete colonoscopy. An algorithm was derived with an initial cohort of 50 patients and using the first suggested endoscope (adult or pediatric colonoscope, or gastroscope +/- water immersion) selected by the algorithm, a CIR of 90% could be achieved. Therefore, a key question for endoscopists is where BOAC fits in their personal and unit's algorithm for difficult or failed colonoscopy. It seems clear that alternative scopes, devices, techniques or endoscopists can bring CIR close to 90%, though this remains short of the 97% (95% CI 95-99%) reported in our meta-analysis and supported by Despott et al. randomized data.

As the use of a disposable overtube is required in BOAC, the added cost may be a prohibitive factor in using it as a first-line tool for patients who are suspected to have technically difficult colonoscopies, though this needs to be balanced against a repeat failure. We suggest in units without a balloon enteroscopy service, the algorithm proposed by Rogers et al³ may be considered, with referral to a unit for BOAC if complete optical examination and biopsy or therapy is clinically mandated. However, if BOAC is immediately available endoscopists should perhaps go directly for the most effective and comfortable technique for difficult or failed cases.

References

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