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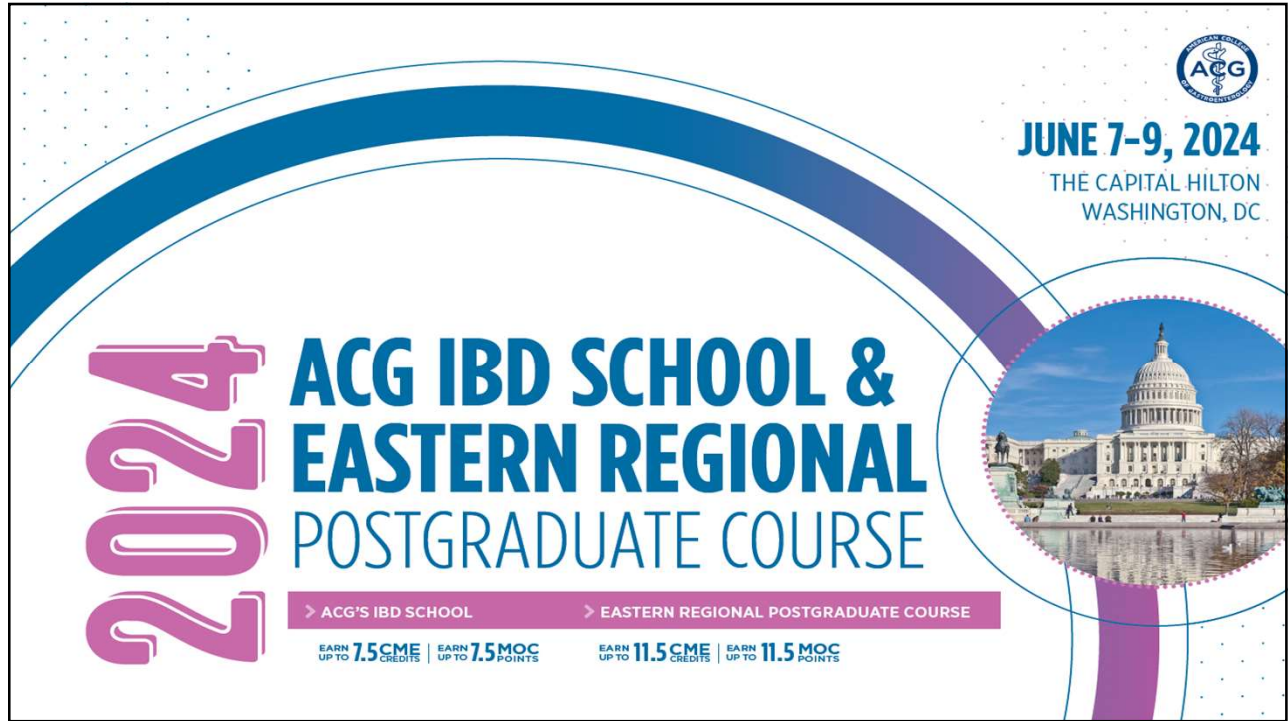
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Special Issue:
WELL-BEING

JOY AND WELL-BEING IN THE PRACTICE
OF MEDICINE - THE IMPORTANCE OF THE
HUMAN CONNECTION

ACG MAGAZINE
BIT.LY/ACG-MAG-WELLBEING

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ACG
JUNE 7-9, 2024
THE CAPITAL HILTON
WASHINGTON, DC

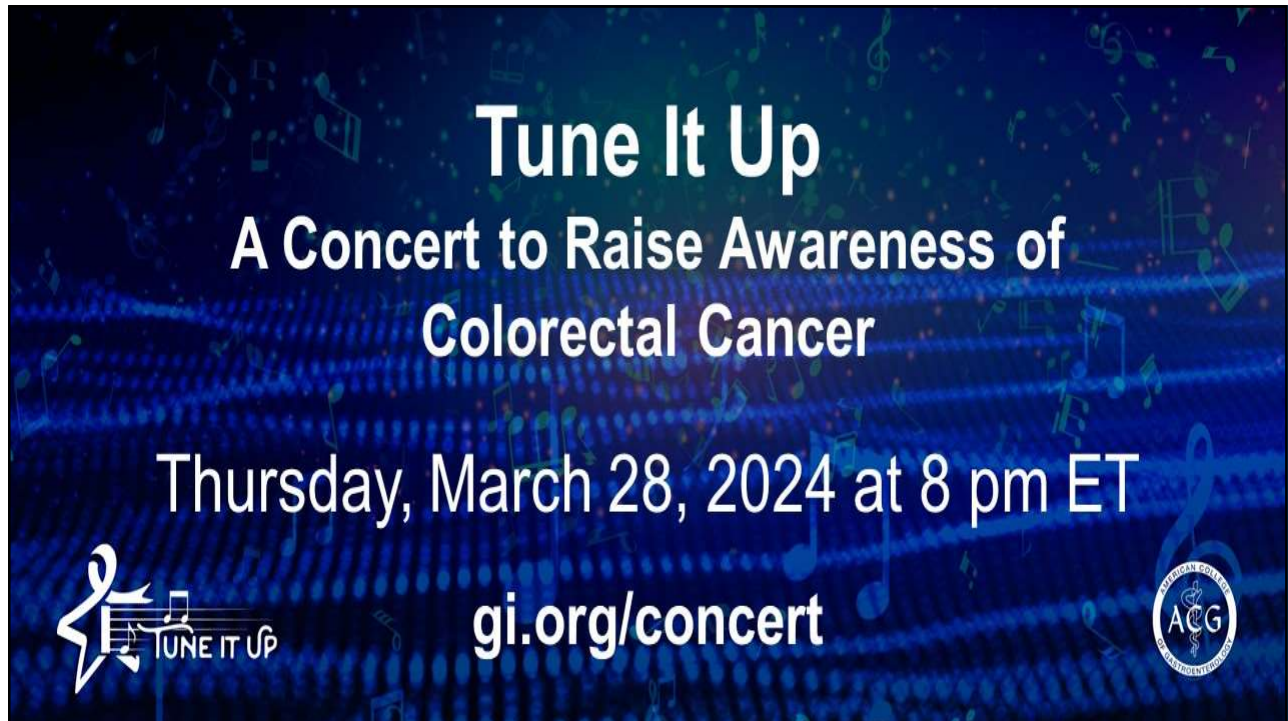
2024 ACG IBD SCHOOL & EASTERN REGIONAL POSTGRADUATE COURSE

> ACG'S IBD SCHOOL > EASTERN REGIONAL POSTGRADUATE COURSE

EARN UP TO 7.5 CME CREDITS | EARN UP TO 7.5 MOC POINTS EARN UP TO 11.5 CME CREDITS | EARN UP TO 11.5 MOC POINTS



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Tune It Up

A Concert to Raise Awareness of Colorectal Cancer

Thursday, March 28, 2024 at 8 pm ET

gi.org/concert



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AJG The American Journal of GASTROENTEROLOGY

ACG MONOGRAPH ON MICROBIOME THERAPEUTICS

→ Currently available online and in print

Wolters Kluwer

ACG INSTITUTE FOR CLINICAL RESEARCH AND EDUCATION

Unrestricted educational grants to support the monograph have been provided to the ACG Institute for Clinical Research and Education from Nestlé Health Science and Seres Therapeutics and Ferring Pharmaceuticals Inc.

The advertisement features a blue background with abstract, glowing green and red shapes. On the right, there is a smaller image of the monograph cover, which includes the AJG logo, the title 'ACG MONOGRAPH ON MICROBIOME THERAPEUTICS', and the ACG Institute logo.

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Virtual Grand Rounds

universe.gi.org

Participating in the Webinar

All attendees will be muted and will remain in "Listen Only Mode"

Type your questions here so that the moderator can see them. Not all questions will be answered but we will get to as many as possible.

A handout with the slides and room to take notes can be downloaded from your control panel.

Moderator: Philip N. Okafor, MD, MPH, FACG

Exit

The interface is a blue-themed virtual meeting room. On the left, there is a portrait of the moderator, Philip N. Okafor, MD, MPH, FACG. On the right, there is a control panel with several icons: a microphone (muted), a hand (listen only), a question mark (questions), and a document (handout). Three yellow callout boxes with arrows point to these icons, providing instructions for participants. The top left corner shows the 'Virtual Grand Rounds' logo, and the top right corner shows the URL 'universe.gi.org' and a 'G' logo.

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ACG Virtual Grand Rounds

Join us for upcoming Virtual Grand Rounds!




Week 12 – Thursday, March 21, 2024
 I See a Large Polyp During Routine Colonoscopy: How Do I Deal With It?
 Faculty: Mohit Girotra, MD, FACP
 Moderator: James Tabibian, MD, PhD, FACP
At Noon and 8pm Eastern

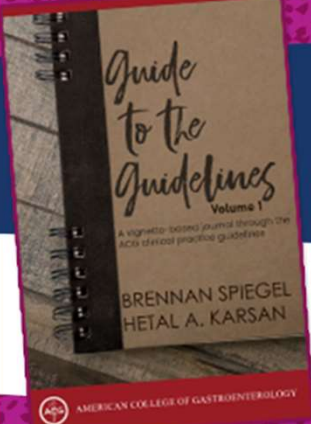





Week 15 – Thursday, March 14, 2024
 Exocrine and Endocrine Complications of Pancreatitis
 Faculty: Ari Grinspan, MD, FACP
 Faculty: Olga Aroniadis, MD, MSc, FACP
 Moderator: Neil H. Stollman, MD, FACP
At Noon and 8pm Eastern

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Disclosures





Philip S. Schoenfeld, MD, MEd, MScEpi, FACG:
 AbbVie: Advisory board, Consultant, Speaker Bureau; Ardelyx: Advisory board, Consultant, Speaker Bureau; Ironwood: Advisory board, Consultant, Speakers Bureau; Phathom: Advisory board, Speakers Bureau; Salix: Advisory board; Sanofi: Advisory board.

Philip N. Okafor, MD, MPH, FACG:


**All of the relevant financial relationships listed for these individuals have been mitigated*

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The Poor Bowel Prep: Effective Strategies to Optimize the Boston Bowel Prep-Score in High-Risk Patients

Philip Schoenfeld, MD, MEd, MSc (Epi), FACG
 Editor-in-Chief, Evidence-Based GI: An ACG Publication
 Chief (Emeritus)-Gastroenterology Section
 John D. Dingell VA Medical Center, Detroit, MI



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Poor Bowel Preps: A Daily Frustration!



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Remember the Basics

- Per multi-society position statement on Quality Indicators for Colonoscopy:
 - Should Get Adequate Bowel Prep in 85% + (European Society for GI Endoscopy Recommends 90%+)
 - *Remember: If You Don't Measure It, Then You Can't Improve It!*



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Remember the Basics

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 - Should Get Adequate Bowel Prep in 85% + (European Society for GI Endoscopy Recommends 90%+)
 - Remember: If You Don't Measure It, Then You Can't Improve It!
- **When Splitting the Prep, "Runway Time" Should Not Be Longer than 5 Hours**



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Runway Time: Time Between Finishing the Bowel Prep and Actually Starting the Colonoscopy

Ideal Runway Time: 3-4 Hours

Runway Time No More than 5 Hours

Patient Starts Drinking 2nd Half of Bowel Prep 4-6 Hours Before Arrival Time & Finishes Prep 2-4 Hours Before Arrival at Unit

Johnson DA, et al. *Am J Gastroenterol* 2014;109:1528
Oldfield EC, et al. *Am J Gastroenterol* 2023;118:761

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Remember the Basics

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 - Remember: If You Don't Measure It, Then You Can't Improve It!
- When Splitting the Prep, "Runway Time" Should Not Be Longer than 5 Hours
- Preferable to use low-volume bowel prep in average-risk patients



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Consuming Bowel Preparation...

Large-volume PEG-ELS is tough to drink!



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Consuming Bowel Preparation...

Large-volume PEG-ELS is tough to drink!



Patients more willing to drink low-volume prep and no difference in head-to-head outcomes in average-risk patients.

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Table 1. Available FDA-approved PEG-based bowel preparation agents

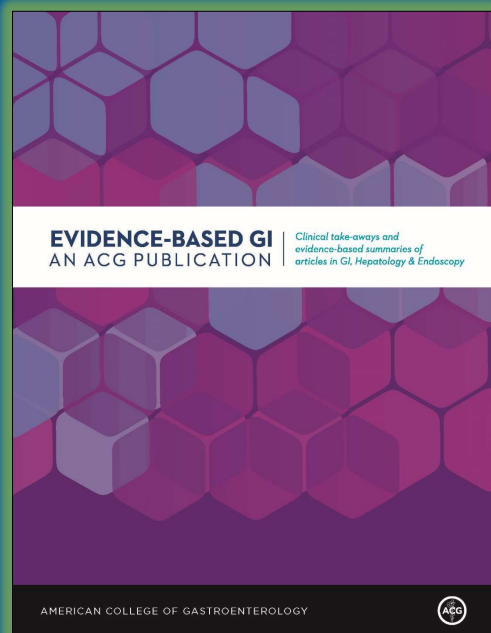
Generic name	Brand name	Formulation	Volume
PEG-ELS ^{a,b}	GoLYTELY CoLyte	PEG-3350, sodium sulfate, sodium bicarbonate, sodium chloride, and potassium chloride	4 L
SF-PEG-ELS ^{c,d}	NuLyteLy TriLyte	PEG-3350, sodium bicarbonate, sodium chloride, and potassium chloride	4 L
Low-volume PEG-ELS with ascorbic acid ^e	MoviPrep	PEG-3350, sodium sulfate, sodium chloride, potassium chloride, and ascorbic acid	2 L 16 oz of clear liquids with each dose (500 mL)
Low-volume PEG-3350 ^f	PLENVU	PEG-3350, sodium sulfate anhydrous, sodium ascorbate, and ascorbic acid	1 L 16 oz of clear liquids with each dose (500 mL)
Oral sodium sulfate ^g	SUPREP	Sodium sulfate, potassium sulfate, and magnesium sulfate	12 oz; 2.5 L of water
Oral sodium sulfate ^h	SUTAB	Sodium sulfate, magnesium sulfate, and potassium chloride	24 tablets; 2 L of water
Sodium picosulfate, magnesium oxide, and anhydrous citric acid ⁱ	CLENPIQ	Sodium picosulfate, magnesium oxide, and anhydrous citric acid	10 oz; 2 L of water
Sodium phosphate tablets ^j	OsmoPrep	Monobasic and dibasic sodium phosphate	32 tablets; 2 L of water

Oldfield EC, Johnson DA, Rex DK. Am J Gastroenterol 2023; 118: 761-64

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And... when consuming additional clear liquids, drink at least total of 2.5-3.0 liters

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CRC SCREENING

A New "Pill Prep" for colonoscopy- An effective alternative for individuals who won't drink GoLytely®



Philip N. Okafor, MD, MPH
Clinical Assistant Professor of Medicine, Division of Gastroenterology, Stanford University School of Medicine, Stanford, California

This article reviews: DiPalma JA, Bhandari R, Cleveland M, et al A Safety and Efficacy Comparison of a New Sulfate-Based Tablet Bowel Preparation Versus a PEG and Ascorbate Comparator in Adult Subjects Undergoing Colonoscopy. Am J Gastroenterol 2021; 116: 319-28 PMID: 33165006

Correspondence to Philip N. Okafor, MD, MPH, Associate Editor. Email: EBGI@gi.org

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Is this dangerous?



238 gram
Bottle of MiraLAX

+



64 oz.
Bottle of Gatorade

...and 10 mg of Bisacodyl (Dulcolax®)

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Does it cleanse the bowel adequately?

Retrospective Endoscopic Database Analysis: PEG-3350 + Gatorade + Bisacodyl vs. 4-L GoLYTELY (PM only dosing)

Preparation	Percentage
MiraLAX/Gatorade	93%
GoLYTELY	89%

n = 778 patients referred for CRC screening

Shieh F, Gunaratnam N, Schoenfeld P. *J Clin Gastroenterol* 2012; 46: e96-e100.

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A

Study or subgroup	Favors 4L split dose Events Total	Favors comparator Events Total	Weight	Odds ratio M-H, random, 95% CI	Odds ratio M-H, random, 95% CI
1.1.1 Excellent - good prep					
Enestvedt B, et al, 2011	85 103	59 87	44.4%	2.24 [1.14, 4.42]	
Hjelkrem, et al, 2011	49 101	54 302	55.5%	4.33 [2.65, 7.06]	
Subtotal (95% CI)			389 100.0%	3.40 [2.28, 5.06]	
Total events	134	113			
Heterogeneity: Chi ² = 2.36, df = 1 (P = .12); I ² = 58% Test for overall effect: Z = 6.03 (P < .00001)					

B

Study or subgroup	Favors 4L split dose Events Total	Favors comparator Events Total	Weight	Odds ratio M-H, random, 95% CI	Odds ratio M-H, random, 95% CI
1.1.1 Excellent - good prep					
Abdul-Baki H, et al, 2008	92 107	78 183	24.3%	8.26 [4.44, 15.34]	
Acun E, et al, 2005	52 68	41 73	22.0%	2.54 [1.23, 5.24]	
Marmo R, et al, 2010	160 218	95 215	29.1%	3.48 [2.33, 5.22]	
SS Park, et al, 2010	61 80	95 152	24.5%	1.93 [1.05, 3.55]	
Subtotal (95% CI)			623 100.0%	3.47 [1.96, 6.14]	
Total events	365	309			
Heterogeneity: Tau ² = 0.25; Chi ² = 11.83, df = 3 (P = .008); I ² = 75% Test for overall effect: Z = 4.26 (P < .00001)					

Figure 3. Post hoc subgroup meta-analyses showing a higher number of excellent or good bowel preparations with 4-L split-dose PEG than for (A) MiraLAX/Gatorade or (B) single-dose 4-L PEG preparations. (A) A 4-L split-dose PEG vs MiraLAX/Gatorade. (B) A 4-L split-dose PEG vs single-dose PEG.

Enestvedt BK, et al. *Clin Gastro Hepatol* 2012; 10: 1225

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A

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Hjeltnes, et al, 2011	49	101	54	302	55.5%	4.33 [2.65, 7.06]	
Subtotal (95% CI)		204		389	100.0%	3.40 [2.28, 5.06]	
Total events	134		113				
Heterogeneity: Chi ² = 2.36, df = 1 (P = .12); I ² = 58% Test for overall effect: Z = 6.03 (P < .00001)							

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Study or subgroup	Favors 4L split dose		Favors comparator		Weight	Odds ratio M-H, random, 95% CI	Odds ratio M-H, random, 95% CI
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Aoun E, et al, 2005	52	68	41	79	22.0%	2.54 [1.23, 5.24]	
Marmo R, et al, 2010	160	218	95	215	29.1%	3.48 [2.33, 5.22]	
SS Park, et al, 2010	61	80	95	152	24.5%	1.93 [1.05, 3.55]	
Subtotal (95% CI)		473		623	100.0%	3.47 [1.96, 6.14]	
Total events	365		309				
Heterogeneity: Tau ² = 0.25; Chi ² = 11.83, df = 3 (P = .008); I ² = 75% Test for overall effect: Z = 4.26 (P < .00001)							

Figure 3. Post hoc subgroup meta-analyses showing a higher number of excellent or good bowel preparations with 4-L split-dose PEG than for (A) MiraLAX/Gatorade or (B) single-dose 4-L PEG preparations. (A) A 4-L split-dose PEG vs MiraLAX/Gatorade. (B) A 4-L split-dose PEG vs single-dose PEG.

OR = 3.40 (2.28-5.06) for Excellent/Good Bowel Cleansing with 4l of Golytely (split-dose) vs MiraLax-Gatorade (split prep) ...

Enestvedt BK, et al. Clin Gastro Hepatol 2012; 10: 1225

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Electrolytes in Sports Drinks May Be Insufficient

Although sports drinks can aid in rehydrating and replacing electrolytes lost during sweating as a result of physical exertion, the electrolyte load may be insufficient for patients undergoing a purgative regimen for colonoscopy


	Sports drink, g/2 L*	PEG + ELS, g/2 L	Ratio (PEG + ELS:Sports drink)
Sodium	0.88	8.35	9:1
Potassium	0.24	1.06	4:1
Chloride	0.72	4.23	6:1

PEG + ELS = polyethylene glycol electrolyte lavage solution.
*Traditional Gatorade®.
Cohen et al. *Gastroenterol Hepatol*. 2009;5(11; suppl 20):1-11.


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**Making Bowel Preparation Palatable: Efficacy
of a Novel Sports Drink Flavor-Optimized
PEG and Sulfate Bowel Preparation**

 **Ahmad Abu-Heija, MBBS**

*Consultant Gastroenterologist, Oak Ridge Gastroenterology
Associates, Oak Ridge, TN.*

Dr Ahmad Abu-Heija
Associate Editor

This summary reviews Bhandari R, Goldstein M, Mishkin DS, et al. Comparison of a novel, flavor-optimized, polyethylene glycol and sulfate bowel preparation with oral sulfate solution in adults undergoing colonoscopy. *J Clin Gastroenterol*; 2023;57(9):920-927.

Correspondence to Ahmad Abu-Heija, MBBS, Associate Editor. Email: EBGI@gi.org


ENDOSCOPY

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Remember the Basics

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 - Should Get Adequate Bowel Prep in 85%+ (European Society for GI Endoscopy Recommends 90%+)
 - Remember: If You Don't Measure It, Then You Can't Improve It!
- When Splitting the Prep, "Runway Time" Should Not Be Longer than 5 Hours
- Preferable to use low-volume bowel prep in average-risk patients
- Assess quality of bowel prep with Boston Bowel Prep Scale (BBPS)



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How do you Determine if the Prep is Adequate? It's a Subjective Assessment

The Boston Bowel Prep Scale is my preferred tool. Validated for test-retest reliability and inter-observer reproducibility. Easily learned through online program. Makes a separate assessment for three segments of colon.



A	Unprepared colon segment with mucosa not seen because of solid stool that cannot be cleared	0
B	Portion of mucosa of the colon segment seen, but other areas of the colon segment not well seen because of staining, residual stool, and/or opaque liquid	1
C	Minor amount of residual staining, small fragments of stool and/or opaque liquid, but mucosa of colon segment seen well	2
D	Entire mucosa of colon segment seen well with no residual staining, small fragments of stool and/or opaque liquid.	3

Lai EJ et al. *Gastrointest Endosc* 2009;69:620

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Prep Is Inadequate If The BBPS Is Less than 2-2-2

Clark B, Protiva P, Nagar A, et al. *Gastroenterology* 2016; 150: 396-405
Oldfield EC, et al. *Am J Gastroenterol* 2023;118:761

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Prep Is Inadequate If The BBPS Is Less than 2-2-2

If BBPS is 3 or 2, then miss rate for adenomas > 5mm is 5%. When BBPS in a segment worsens to 1, then miss rate for adenomas > 5mm increases to 16%!

Clark B, Protiva P, Nagar A, et al. *Gastroenterology* 2016; 150: 396-405
Oldfield EC, et al. *Am J Gastroenterol* 2023;118:761

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When Should Repeat Colonoscopy Be Performed If The BBPS Is 1-2-2... or a "Fair" Prep?

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Fair bowel prep is commonly associated with recommendation to do “early” colonoscopy

- Retrospective Database Study of patients with normal colonoscopy
- Compared to pts with “*excellent/good*” prep, pts with “*fair*” prep were more likely to be told to return in < 10 yrs: $OR = 18.0$ (95% CI: 12.0-28.0) ←

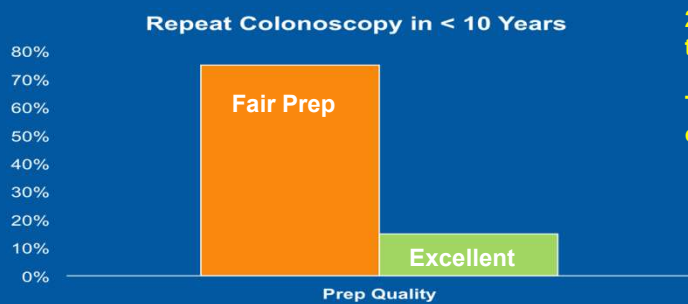
Menees SB, Schoenfeld P, et al. *Am J Gastroenterol* 2014, 109(2):148-154

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24% of ALL patients told to return in < 10 yrs.

This is prior to institution of split-prep at UM.

Menees SB, Schoenfeld P, et al. *Am J Gastroenterol* 2014, 109(2):148-154

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Fair bowel prep is commonly associated with recommendation to do “early” colonoscopy

Retrospective Database Study of patients with normal colonoscopy

Compared to pts with “*excellent/good*” prep, pts with “*fair*” prep were more likely to be told to return in < 10 yrs: *OR = 18.0 (95% CI: 12.0-28.0)* ←

Repeat Colonoscopy in < 10 Years

Prep Quality	Repeat Colonoscopy in < 10 Years (%)
Fair Prep	~75%
Excellent	~15%

Prep Quality

24% of ALL patients told to return in < 10 yrs.

This is prior to institution of split-prep at UM.

If fair prep, most frequent recommended interval for repeat colonoscopy: **5 YEARS**

Menees SB, Schoenfeld P, et al. *Am J Gastroenterol* 2014, 109(2):148-154

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Prep Is Inadequate If The BBPS Is Less than 2-2-2

This is an “Inadequate” Bowel Prep and Should Recommend Repeat Colonoscopy ≤ 12 months.

Calderwood A, et al. *Gastrointest Endosc* 2022; 95: 360-67
Oldfield EC, et al. *Am J Gastroenterol* 2023;118:761

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Prep Is Inadequate If The BBPS Is Less than 2-2-2

This is an "Inadequate" Bowel Prep and Should Recommend Repeat Colonoscopy \leq 12 months.

GIQuic Database of 672 sites from 2011-18. Among 260,000+ colonoscopies by 4000+ endoscopists, only 32% of inadequate preps told to return < 12 months.

Calderwood A, et al. *Gastrointest Endosc* 2022; 95: 360-67
Oldfield EC, et al. *Am J Gastroenterol* 2023;118:761

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We're all worried that the patient with a normal screening colonoscopy....



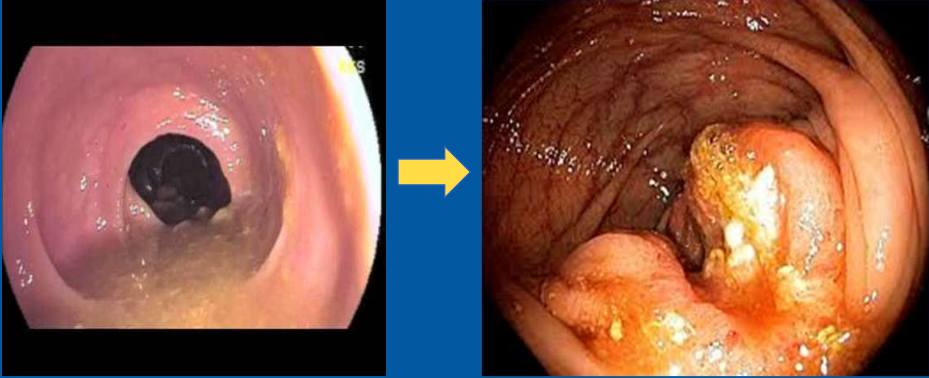
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The Greatest Fear of Endoscopists is the Patient with a “Missed” Colon Cancer

We’re all worried that the patient with a normal screening colonoscopy....

Comes back in with a “missed” CRC



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Why and When Does Post-Colonoscopy CRC Occur?

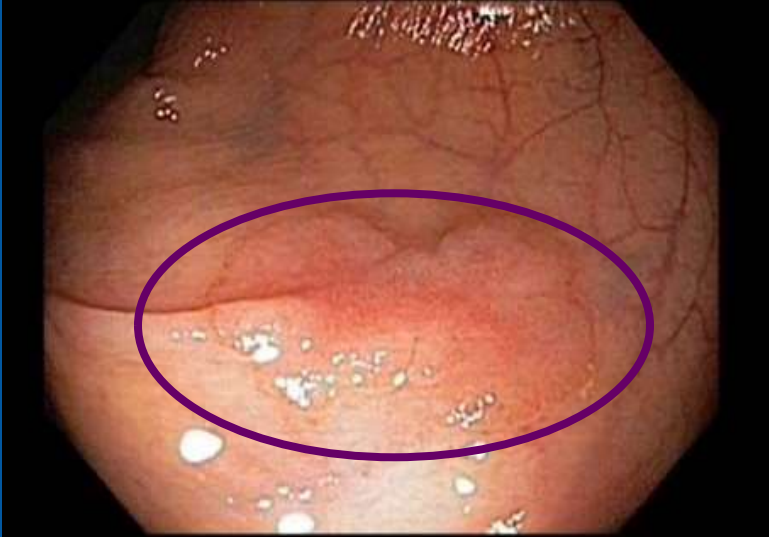


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Why and When Does Post-Colonoscopy CRC Occur?

Missed a flat adenoma or serrated polyp. Common in right side of colon.

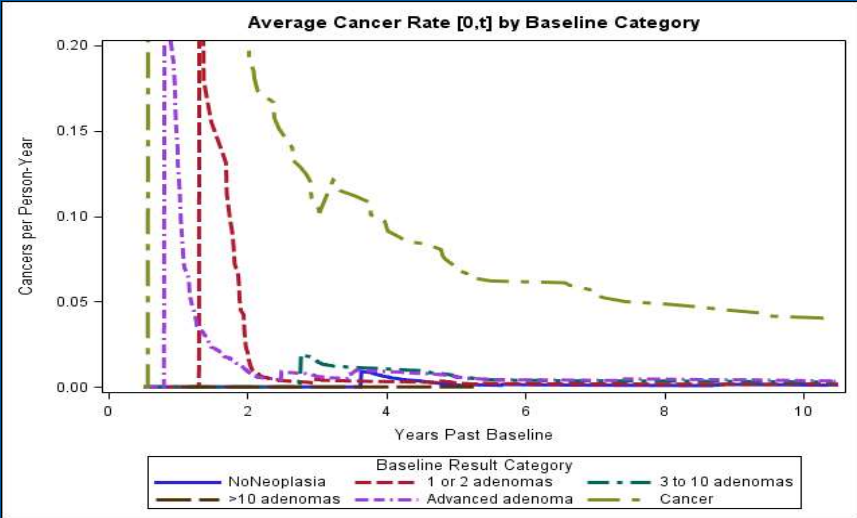


The image shows an endoscopic view of the colon mucosa. A purple oval highlights a flat adenoma, which is a type of precancerous polyp that is often missed during colonoscopy. The surrounding mucosa appears normal with some minor inflammation and mucus.

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Risk of Colorectal Cancer in 10-Year Period After Normal Screening Colonoscopy: The VA 380 Study Data

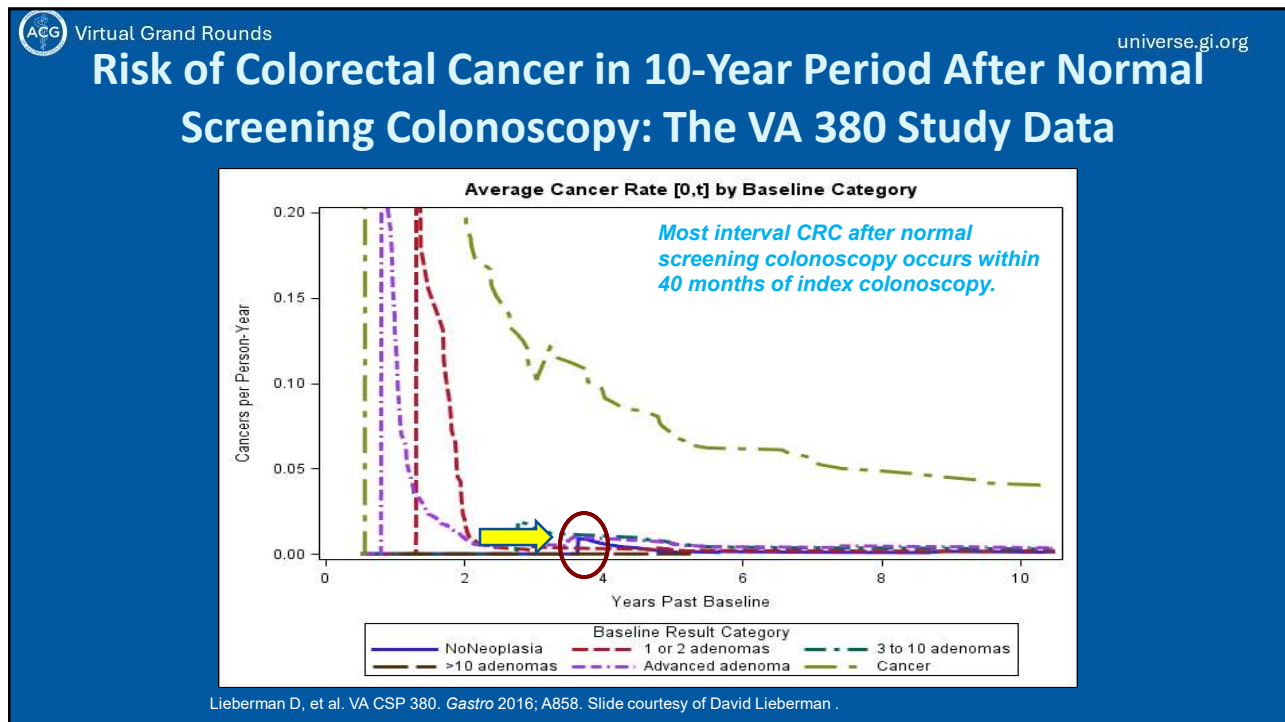


The graph displays the average cancer rate per person-year over a 10-year period following a baseline colonoscopy. The y-axis represents 'Cancers per Person-Year' (0.00 to 0.20), and the x-axis represents 'Years Past Baseline' (0 to 10). The legend indicates five baseline result categories: NoNeoplasia (solid blue), 1 or 2 adenomas (dashed red), 3 to 10 adenomas (dashed green), Advanced adenoma (dotted purple), and Cancer (dashed yellow). The cancer rate is highest for the 'Cancer' category at baseline (0.20) and decreases over time. The '3 to 10 adenomas' category shows a significant increase in cancer rate over the 10-year period, starting at approximately 0.19 and ending at 0.04. The 'Advanced adenoma' category starts at 0.19 and drops to 0.01. The '1 or 2 adenomas' category starts at 0.19 and drops to 0.01. The 'NoNeoplasia' category shows a very low cancer rate throughout the 10-year period.

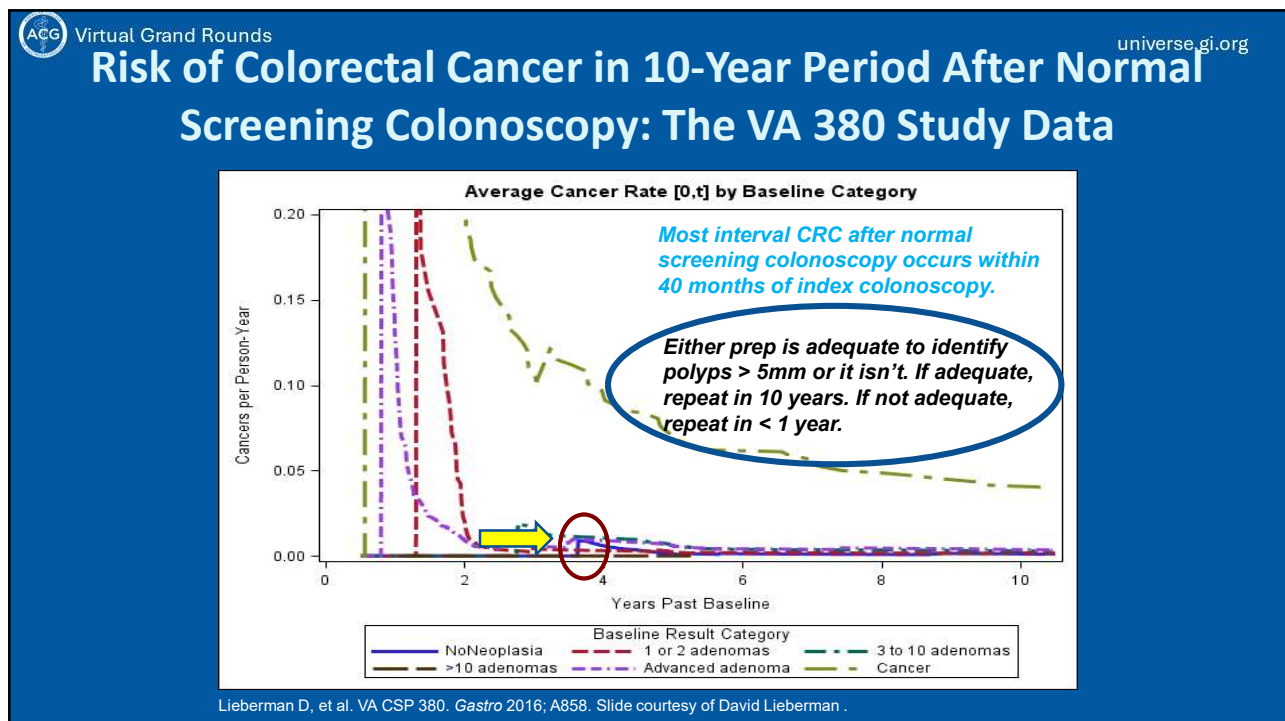
Baseline Result Category	Year 0	Year 1	Year 2	Year 4	Year 6	Year 8	Year 10
NoNeoplasia	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1 or 2 adenomas	0.19	0.13	0.01	0.01	0.01	0.01	0.01
3 to 10 adenomas	0.19	0.19	0.19	0.12	0.06	0.05	0.04
Advanced adenoma	0.19	0.19	0.03	0.01	0.01	0.01	0.01
Cancer	0.20	0.19	0.19	0.12	0.06	0.05	0.04

Lieberman D, et al. VA CSP 380. *Gastro* 2016; A858. Slide courtesy of David Lieberman .

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Why Do Patients Have Poor Bowel Prep?

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Why Do Patients Have Poor Bowel Prep?

- **Risk Factors for colonic dysmotility and inadequate bowel preparation despite compliance**
- Obesity
- Current opioid use
- Diabetes mellitus
- History of using constipation treatments
- Current use of anticholinergics (including TCA)
- Prior colonic resection
- Neurologic disease
- GLP-1 Receptor Agonist Use (e.g., semaglutide)
- ***Prior history of inadequate prep!***

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Why Do Patients Have Poor Bowel Prep?

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- Prior colonic resection
- Neurologic disease
- GLP-1 Receptor Agonist Use (e.g., semaglutide)
- ***Prior history of inadequate prep!***

Note: In non-compliant patient, additional patient education is probably more beneficial than prescribing supra-therapeutic bowel prep regimen.

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Prior RCTs of Compliant Patients with Inadequate Bowel Preparations

Gimeno-Garcia et al. *Am J Gastroenterol* 2017;112:951-58.

- RCT of 256 patients. Virtually all failed with low-volume (2 liter) bowel prep.
- All patients took 10 mg bisacodyl on the day before the procedure + a low-residue diet for 3 days pre-procedure.
- 4L PEG-3350 as split-prep vs 2L PEG + ascorbic acid as split-prep

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Prior RCTs of Compliant Patients with Inadequate Bowel Preparations

Gimeno-Garcia et al. *Am J Gastroenterol* 2017;112:951-58.

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- 4L PEG-3350 as split-prep vs 2L PEG + ascorbic acid as split-prep

**4L PEG-3350-superior for adequate bowel cleansing
(81.1% vs 67.4%, $P < 0.01$, ITT analysis)**

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- All patients took 10 mg bisacodyl on the day before the procedure + a low-residue diet for 3 days pre-procedure.
- 4L PEG-3350 as split-prep vs 2L PEG + ascorbic acid as split-prep

**4L PEG-3350-superior for adequate bowel cleansing
(81.1% vs 67.4%, $P < 0.01$, ITT analysis)**


→ *Doesn't address need for suprathreshold purgative regimens*

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EVIDENCE-BASED GI
AN ACG PUBLICATION

*Clinical take-aways and
evidence-based summaries of
articles in GI, Hepatology & Endoscopy*



It's a Bad "Prep" Even Though the Patient Took It Correctly: Consider 15 mg Bisacodyl plus 4-Liter PEG Split Prep Before Next Colonoscopy




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This article reviews Sey MSL, Von Renteln D, Sultanian R, et al. A Multicenter Randomized Controlled Trial Comparing Bowel Cleansing Regimens for Colonoscopy After Failed Bowel Preparation. Clin Gastroenterol Hepatol 2022; In Press.


Philip Schoenfeld, MD, MEd, MSc (Epi)
Editor-in-Chief

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Virtual Grand Rounds

EVIDENCE-BASED GI
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- No prior RCT assessing patients who successfully completed 4L PEG split-prep but still had inadequate cleansing.
- Multi-center, single-blind RCT
- Intervention: 4L PEG split prep + 15mg bisacodyl (taken at 2pm on day before scope) vs 6L PEG split prep + 15mg bisacodyl
- Outcome: Adequate bowel prep based on BBPS >6 with >2 in each segment
- Patient Demographics: 37% obese, 41% with IBS-C or CIC, 10% on opioids. Prior bowel prep: 35% used 4L PEG; 38% used 2L PEG; 12% used sodium picosulfate

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It's a Bad "Prep" Even Though the Patient Took it Correctly: Consider a 15 mg Bisacodyl plus 4-Liter PEG Split Prep Before Next Colonoscopy

Outcome		Split-dose 4L + bisacodyl (n = 97)	Split-dose 6L + bisacodyl (n = 99)	P-value
Adequate cleansing	Defined as BBPS ≥ 6	83 (91.2%)	78 (87.6%)	0.44
	Defined as adequate to identify polyps > 5mm	82 (91.1%)	76 (85.4%)	0.24
Secondary endpoints	Cecal intubation rate, n (%)	87 (96.7%)	82 (92.1%)	0.19
	Adenoma detection rate, n (%)	34 (37.4%)	28 (31.5%)	0.41
Adherence	Diet + consumed 100% of prep	67 (81.7%)	53 (68.0%)	0.05
	Diet + consumed 80% of prep	71 (86.6%)	57 (73.1%)	0.03

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My Practice

- For patients with history of poor bowel preparation or 2 risk factors for poor prep >>>>
- Prescribe 4 liters PEG split-prep + 15 mg bisacodyl at 2pm on day before procedure

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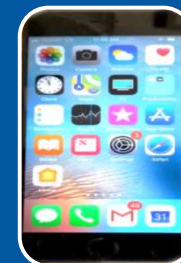
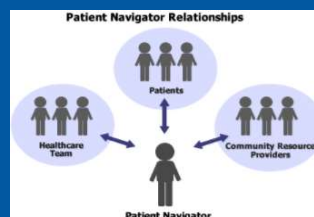
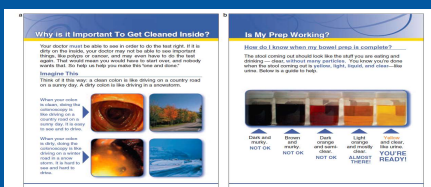
Why Do Patients Have Poor Bowel Prep?

- **Risk Factors for colonic dysmotility and inadequate bowel preparation despite compliance**
- Obesity
- Current opioid use
- Diabetes mellitus
- History of using constipation treatments
- Current use of anticholinergics (including TCA)
- Prior colonic resection
- Neurologic disease
- *Prior history of inadequate prep!*
- **Risk Factors for Non-Compliance**
- Non-English Speaker
- Poor Health Literacy
- Lower Education/ Reading Level

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Patient Navigation Improves Quality of Bowel Preparation: Cannot Rely on Paper Instructions Alone

- Provide written instructions in multiple languages if your patient population includes non-English speakers. Instructions written at 8th grade level. Use cartoons, video aids, etc.
- Provide oral instructions in patients native language. Phone call follow-up 3-5 days before colonoscopy. Supplement with phone apps.



Spiegel BM, et al. *Am J Gastroenterol.* 2011;106:875-883.

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Enhanced Instruction Improves Likelihood of Adequate Bowel Preparation

Usual instruction + additional tools

- Visual aids (booklet, cartoon, etc)
- Telephone, text message
- Smartphone, social media apps

Significantly better prep quality

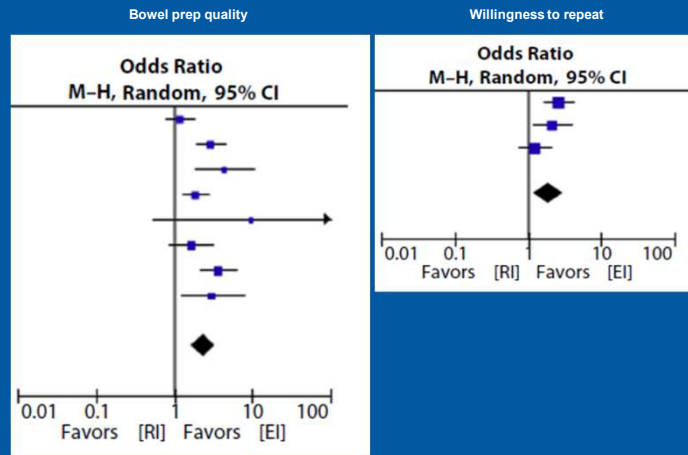
- OR, 2.35; P < .001

Greater willingness to repeat prep

- OR, 1.91; P = .006

Meta-analysis 8 RCTs (N = 3795)

Guo X, et al. *Gastrointest Endosc.* 2017;58:90-97.



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Bowel Prep “Bottom Lines”

- Always record quality of bowel preparation. Target is 100%
- Get an adequate bowel prep in at least 85% of screening/surveillance colonoscopies.
- Most interval or “missed” CRC after “normal” screening colonoscopy occurs by 3.5 years or sooner.
- If bowel prep is inadequate, repeat < 12 months. If bowel prep is adequate, repeat in 10 years.

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- Most interval or “missed” CRC after “normal” screening colonoscopy occurs by 3.5 years or sooner.
- If bowel prep is inadequate, repeat < 12 months. If bowel prep is adequate, repeat in 10 years. **Target for this is 90%**

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Questions



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