GASTRO PRACTICE

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GUIDE: COLONOSCOPY page 1

On the day before the exam the patient will take their prescribed bowel preparation which acts as a powerful laxative as we need the colon to be as clean as possible. On the day of the test you arrive at the day unit or ward and a nurse asks you to change and checks all your details and measures your blood pressure and places a wrist band on you with your details on it. When the doctor, such as myself, arrives he will go through the consent form with you. This is a legal document which a patient and doctor need to sign if the patient would like to go ahead with the procedure. The main risks of a colonoscopy are:

- Patient discomfort as air is inflated and stretches the bowel wall, but a sedative and intravenous painkiller help to reduce this
- Bleeding can occur especially if polyps are snipped off, but this is uncommon and less than 1% of patients will encounter this complication and in most cases the bleeding will stop on its own
- A bowel perforation or hole is a potentially serious but infrequent complication affecting about 1 in 1000 and this may require a surgical procedure to repair the hole or remove part of the colon
- Even when the bowel preparation is really good, since the colon has many natural twists and turns with folds and dark corners there is a risk, the doctor might miss something even a small cancer and this risk can be up to 5%. However, the colonoscopy is still the best test we have to look at the colon in detail. Remember nothing in medicine is ever really 100%.

Once the consent form is signed the patient can either walk into the endoscopy room or they are pushed in on a bed. In the room a small drip is placed in a vein and a peg is placed on the finger to measure the oxygen blood saturation. A small tube is placed at the nose to provide a flow of oxygen. An intravenous drug can then be given and midazolam, and fentanyl are most commonly used. Some colonoscopies are done under general anaesthetic for example in children and in some adults who request for this, it can be arranged.

The patient lies on their left side with their knees bent up and the doctor does a rectal exam with jelly on his gloved index finger. During the procedure the patient can view what is going on by looking at the monitor if they so wish. After the rectal exam a bendy colonoscope is inserted into the rectum which has a bright light on the end. The whole scope is over 120cms long. Gradually it is passed along the colon and sometimes patients are asked to turn on their back with their knees bent up to get past some tricky corners. Eventually the end of the colon is reached and this is called the caecum. The small bowel or terminal ileum enters the caecum here and the doctor passes the scope into the ileum to inspect it as this is the most common place to pick up Crohn's inflammation. Now the doctor can begin to remove the camera and this may take up to 10 minutes. As the camera is withdrawn, the doctor may need to take tiny biopsies which the patient does not feel as there are no sensory receptors on the inner lining of the colon. There is a channel down the side of the endoscope through which instruments are inserted to take biopsies and remove polyps. Most polyps are painlessly removed by places a loop or snare around their base and cutting them off.

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Bleeding is usually minimal but if the polyp is large a hot snare is used as this cauterises the blood vessels in the polyp hence preventing them from bleeding afterwards and the polyp burnt scar will just heal up on its own. The medical term for removing polyps is polypectomy.

The endoscope is then removed from the patient who can go to recovery room. Once awake the patient can go home but is not allowed to do so alone and patients cannot drive a car that day. It is important the patient has someone to collect them after the examination. If you experience the passage of a large amount of blood and feel unwell you may need to return to a hospital or contact your doctor or hospital where the procedure was done for urgent advice. In addition abdominal pain that does not go away or gets worse means you need to seek further medical advice. The same applies to patients who develop a fever and shakes, vomiting and/or rigors.

Days or weeks after the doctor has carried out a review at the clinic, a decision is made as to whether further colonoscopies are required. Usually if you have no family members with colon polyps or bowel cancer and at your colonoscopy your bowel was clean enough and no polyps were seen the next colonoscopy would be in 10 years' time. Of course as patients get older the risks of undertaking another colonoscopy must be weighed against the benefits and in older patients who may not be fit enough to undergo another procedure with sedation alternative tests such as a virtual or CT scan colonoscopy can be used to inspect the colon.

ALTERNATIVES TO COLONOSCOPY

There are other ways we can investigate the colon and each has its own advantages and disadvantages.

A barium enema is quite an old test and we do not really use it anymore. Instead a more up to date investigation is called a virtual colonoscopy using a CT scan. The advantage is that this is a non-invasive test that requires no sedation and to capture the X ray images does not take as long as a colonoscopy. However if a polyp is seen it cannot be removed and the patient may then require a colonoscopy anyway. The CT or virtual colonoscopy is not so good at picking up small polyps or adenomas for example those measuring less than 5mm.

Stool tests - large polyps and colon cancers may release tiny amounts of blood or even DNA into the stool which of course the human eye would not pick up. One type of stool test looks for blood and if this is found then the patient needs a colonoscopy. About 2 to 5% of patients with a positive stool test end up being diagnosed with a colon cancer. Of course these stool tests do not pick up early polyps as these rarely bleed and often we want to detect these early lumps and bumps to prevent them advancing in later years to anything more serious.

Flexible sigmoidoscopy - this test it is very similar to a colonoscopy procedure but usually no bowel preparation is used and instead an enema is given to the patient 30 minutes before the test so they open their bowels leaving the left side of their colon clear, and thereby allowing the doctor to see any polyps. This form of endoscopy only examines the bottom third of the colon. Having a flexible sigmoidoscopy has been shown to reduce the risk of getting colon cancer but it is still not as good a test as a high quality colonoscopy. The risk of a serious complication at flexible sigmoidoscopy is very low indeed at less than 2 per 10,000. Usually if polyps are found the patient will need a colonoscopy on another day anyway to examine the remainder of the colon for any other polyps which may be there.