Bowel Prep

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VA Caribbean Healthcare System
Conflicts of interest

NO
Bowel Prep: It is important

- 20%–25% of all colonoscopies have inadequate bowel prep
- Inadequate colonic preparation
  - reduced rates of ADRs
  - longer procedural time
  - lower cecal intubation rates
  - economic burden of repeating examinations

AGA SECTION

Optimizing Adequacy of Bowel Cleansing for Colonoscopy: Recommendations From the US Multi-Society Task Force on Colorectal Cancer

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Bowel Prep Rating: Quality Indicator

- GI Societies
  - Documentation in ≥ 98%
    - Regardless of assessment/score scale
    - based on ability to identify polyps after retained fluid or stool has been suctioned
  - Minimum adequate bowel preparation rates of 85%-90%
    - For outpatient's bowel preparation suitable for using recommended surveillance or screening intervals
Topics

• Risk Factors
• Diet prior to bowel cleansing
• Patient Education
• Bowel prep agent
• Dosing and timing of colon cleansing
• Rating Quality of Bowel Preparation during colonoscopy
Risk Factors
Inadequate Bowel Prep

- Constipation < 3 BMs/week
  - OR, 5.2; 95% CI, 1.8-15.2
- Diabetes Mellitus
  - OR, 3.5; 95% CI, 1.4-8.7)
- Medications
  - Opioids: OR, 1.7; 95% CI, 1.4-2.1
  - TCAs: OR, 2.0; 95% CI, 1.4-2.9
- Non-compliance to dosing, timing of preparation or diet
  - OR, 6.7; 95% CI, 3.2-14.2
- Obesity
- Dementia, Parkinson, Spinal Cord
- Cirrhosis
- Male
• Verbal and written instructions

• Read the instructions at least a week prior to the colonoscopy

• GI Nursing Staff phone calls, trained patient navigators
Digital tools have been used to augment bowel preparation instructions.

Smartphone applications

Web-based videos
Diet

- Traditionally, clear liquid
- Hydration - better preparation and fewer adverse events (i.e., nausea) related to the prep
- Low-residue diet for part or all day before colonoscopy
- Evaluate any compromise in efficacy if dietary flexibility is allowed

### Low Fiber Diet for Colonoscopy

<table>
<thead>
<tr>
<th>Foods that are okay</th>
<th>Foods that are not okay</th>
</tr>
</thead>
<tbody>
<tr>
<td>White bread</td>
<td>Whole wheat bread or pasta</td>
</tr>
<tr>
<td>White rice or noodles</td>
<td>Brown or wild rice</td>
</tr>
<tr>
<td>Plain crackers and potato rolls</td>
<td>Whole wheat crackers and Rolls</td>
</tr>
<tr>
<td>Skinless cooked potato</td>
<td>Raw or partially cooked vegetables</td>
</tr>
<tr>
<td>Skinless chicken or turkey</td>
<td>Tough meat or meat items with skin</td>
</tr>
<tr>
<td>Fish and other sea foods</td>
<td>Nuts, seeds, popcorn, and fruits</td>
</tr>
<tr>
<td>Canned fruits without seeds or skin</td>
<td>Milk or milk products</td>
</tr>
<tr>
<td>Eggs</td>
<td>Cereals</td>
</tr>
<tr>
<td>Vanilla wafers, Animal crackers</td>
<td>Granola, Cornbread, Pumpernickel bread</td>
</tr>
<tr>
<td>Items on the clear liquid diet</td>
<td>Items on the high fiber diet</td>
</tr>
</tbody>
</table>
Low-Residue Diet

- (n = 660) 92% male; mean age 64
- LRD menu & Split-dose 2LPEG

- 94% BBPS ≥ 2 in each segment
- Inadequate BP
  - Higher BMI, DM, prior inadequate BP, BP duration of two days, opioid use
- Predictor of inadequate BP
  - BMI ≥ 25 kg/m² (OR 1.06, 95% CI 1.01–1.12, p = 0.03)
  - Every one-unit increase associated with a 6% increased odds
Bowel Prep: Criteria Definition

- No standard criteria or definition exists
  - qualitative terms “adequate”, “inadequate”, “excellent”, “good”, “fair”, or “poor”

- ASGE/ACG Task Force definition of “Adequate”
  - if it allows detection of polyps > 5 mm in size
Bowel Prep Scales
Aronchick Scale

- First bowel preparation quality scale
- Most used in clinical trials and practice
- Performed before washing or suctioning
- % of the total colonic mucosal surface covered by fluid or stool
- No scoring for separate colon segments

Aronchick CA. Gastrointest Endosc 2004
Aronchick CA et al. Validation of an instrument to assess colon cleansing. Am J Gastroenterol 1999
<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>Large volume of clear liquid covering 5–25% of the surface but &gt;90% of surface seen</td>
</tr>
<tr>
<td>Fair</td>
<td>Semi-solid stool that could be suctioned or washed away but &gt;90% of surface seen</td>
</tr>
<tr>
<td>Poor</td>
<td>Semi-solid stool that could not be suctioned or washed away and &lt;90% of surface seen</td>
</tr>
</tbody>
</table>

Interobserver correlation coefficients (ICCs) – kappa coefficients high for cecum (0.76) & total colon (0.77) reduced distal and ascending colon segments
Ottawa Bowel Prep Scale

- Performed before washing or suctioning
- Scoring for separate colon segments
  - right colon, mid-colon, and rectosigmoid
- Scoring for fluid quantity
- Total score (adding scores for each segment + total colon fluid score)

ICCs and consistency ratings were significantly superior for the OBPS vs the Aronchick

Rostom A et al. Gastrointest Endosc 2004
<table>
<thead>
<tr>
<th>Colon Fluid Single Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>0: small amount of fluid</td>
</tr>
<tr>
<td>1: moderate amount</td>
</tr>
<tr>
<td>2: large amount</td>
</tr>
</tbody>
</table>

Scale from 0 (excellent) to 14 (inadequate)

<table>
<thead>
<tr>
<th>OBPS (A)</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>0=Excellent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1=Good</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2=Fair</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3=Poor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4=Inadequate</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LC</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>TC</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>RC</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OBPS (B)</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

| OBPS (A+B) = □ |

Score cutoff of ≥ 8 identified inadequate bowel prep
sensitivity 100%
specificity 91%

Chan et al. Ottawa score of 8 or greater is an optimal cut-off score for inadequate bowel preparation. Am J Gastroenterol 2011
• Performed upon withdrawal and after all flushing & suctioning have been completed
• Score applied by colon segments
• Subjective, qualitative terms are replaced by numbered scores

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
<th>Endoscopic example</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Entire mucosa of colon segment seen well, with no residual staining, small fragments of stool, or opaque liquid</td>
<td><img src="image1.jpg" alt="Image" /></td>
</tr>
<tr>
<td>2</td>
<td>Minor amount of residual staining, small fragments of stool, and/or opaque liquid, but mucosa of colon segment is seen well</td>
<td><img src="image2.jpg" alt="Image" /></td>
</tr>
<tr>
<td>1</td>
<td>Portion of mucosa of the colon segment seen, but other areas of the colon segment are not well seen because of staining, residual stool, and/or opaque liquid</td>
<td><img src="image3.jpg" alt="Image" /></td>
</tr>
<tr>
<td>0</td>
<td>Unprepared colon segment with mucosa not seen because of solid stool that cannot be cleared</td>
<td><img src="image4.jpg" alt="Image" /></td>
</tr>
</tbody>
</table>
BBPS: Adequacy for 10-yr FU

• Validation Studies
  • Median BBPS was 6
    • ICC interobserver total BBPS 0.74
    • Kappa intraobserver total BBPS 0.77

  • 100% raters (12) judged the bowel preparation adequate to exclude polyps > 5 mm with a ≥ 8 BBPS score
    • vs 82% when the score was 6
    • vs 33% when the score was 5

  • Total score of = 6 and all segment scores = 2 should be required as an adequacy standard for 10-year follow-up

  • BBPS segment scores of 2 or 3 (with 2 being noninferior to 3) are adequate bowel preparation for detection of adenomas > 5 mm

Lai EJ et al. Gastrointest Endosc 2009
Calderwood et al. Gastrointest Endosc 2010
Kluge et al. Gastrointest Endosc 2018
Clark et al. Gastroenterology 2016
Other Validated Bowel Prep Scores

- Harefield Cleansing Scale
- Chicago Bowel Preparation Scale

- A standard, fully validated and universally accepted scale for use in clinical practice and trials has not yet been established
Recommended Follow-Up Intervals for Inadequate Prep

Preliminary assessment in sigmoid colon

- Terminate exam & reschedule OR provide additional cleansing without cancelling

If completed to cecum

- Reschedule within a year or shorter interval if advanced neoplasia was detected during exam

Assessment after all appropriate efforts to clear residual debris to detect lesions > 5 mm

Minimum adequate bowel preparation rates of 85%
Dosing of Bowel Prep Agents

• Day before colonoscopy:
  • chyme from the small intestine enters the colon and accumulates, producing a film that coats the proximal colon and impairs detection of flat lesions

• Length of time between the last dose of preparation and the initiation of colonoscopy correlates with the quality of the proximal colon

Siddiqui et al. Gastrointest Endosc 2009
Mormo et al. Gastrointest Endosc 2010
Split-Dose

- Half of the bowel cleansing dose given on the day of the colonoscopy

- Meta analysis studies
  - Superior both efficacy and tolerability compared with day-before dosing
  - Leads to higher ADRs
  - Patient willingness to repeat preparation
  - Decreased incidence of nausea

- Same-day prep during AM for colonoscopy in PM provide similar efficacy to split-dose regimen

Kilgore et al. Gastrointest Endosc 2011
Martel et al. Gastroenterology 2015
Avalos et al. J Clin Gastroenterol 2017
Sharma et al. Endoscopy International 2020
Timing & Dosing

• Split-dose bowel preparation
  • Begin second half dose 4 to 6 hours before procedure time
  • Complete second half dose ≥ 2 to 5 hours before the procedure time

• Same-day preparation as an alternative to 2-day split-dosing for afternoon colonoscopy
Bowel Prep Preparation
Davis GR, Santa Ana CA, Morawski SG et al.
Development of a lavage solution associated with minimal water and electrolyte absorption or secretion.
Gastroenterology 1980; 78: 991–995
Low-volume PEG May 2018

November 2020

February 2010 – 2017 (generic)

November 2018
### Types of Preparations

<table>
<thead>
<tr>
<th>Isosmotic</th>
<th>Hyperosmotic</th>
<th>Combination</th>
</tr>
</thead>
<tbody>
<tr>
<td>• High-volume (4L)</td>
<td>• Sodium sulfate-based</td>
<td>• Sodium picosulfate</td>
</tr>
<tr>
<td>• GoLYTELY &amp; CoLyte</td>
<td>preparations</td>
<td>(stimulant laxative) + magnesium oxide &amp; citric acid</td>
</tr>
<tr>
<td>• NuLytely &amp; TriLyte (sulfate-free)</td>
<td>• SuPrep</td>
<td>(osmotic laxatives)</td>
</tr>
<tr>
<td>• Low-volume PEG (2-3L)</td>
<td>• Sutab</td>
<td>• Prepopik</td>
</tr>
<tr>
<td>• Moviprep &amp; Plenvu (ascorbic acid)</td>
<td>• Sodium phosphate-based</td>
<td>• Clenpiq</td>
</tr>
<tr>
<td>• Gavilyte-H and bisacodyl, PEG-Prep and bisacodyl</td>
<td>preparations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Osmoprep</td>
<td></td>
</tr>
</tbody>
</table>
• **High-volume PEG**
  • Older patient > 65 y/o
  • Chronic constipation
  • Previous inadequate bowel preparation
  • No tolerance to fluid or electrolyte shifts
    • congestive heart failure or hepatic or renal failure
  • Pregnancy (Category C)
  • IBD
  • Bariatric (extended time or low-volume)

• **Low-volume PEG**
  • Better taste - sulfate-free, low potassium
  • Avoid ascorbic acid in glucose-6-phosphate dehydrogenase deficiency

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**Isosmotic**

• **High-volume (4L)**
  • GoLYTELY & CoLyte
  • NuLytely & TriLyte (sulfate-free)

• **Low-volume (2-3L)**
  • Moviprep & Plenvu (ascorbic acid)
  • Gavilyte-H and bisacodyl, PEG-Prep and bisacodyl
• Sodium Sulfate
  • No significant fluid and electrolyte shifts
  • Only tested in patients without comorbidities
  • Effective as PEG preparations

• Sodium Phosphate
  • FDA “black box warning” 2008
    • Seizures, nephropathy, fluid, e-lites imbalance, mucosal damage

Hyperosmotic

• Sodium sulfate-based preparations
  • SuPrep
  • Sutab
  • Sodium phosphate-based preparations
  • Osmoprep
  • Visicol
When doing a double, I’ve been seeing more gastritis on #endoscopy like this when using #Sutab for the #colonoscopy. Anyone else? I don’t have data but would love your thoughts! #GITwitter #medtwitter

The KCl in Sutab is about equal to 30 mEq of KCl divided in 12 aliquots. It may be enough to cause foregut mucosal injury in a minority of people? esp if it lingers in the stomach (not enough water, gastroparesis, etc)
• Sodium picosulfate
  • Avoid in heart failure, renal insufficiency, end-stage liver disease, or electrolyte abnormalities because of the potential for electrolyte shifts
  • Similar efficacy compared with PEG-3350 preparations

Combination
• Sodium picosulfate (stimulant laxative) + magnesium oxide & citric acid (osmotic laxatives)
  • Prepopik
  • Clenpiq
<table>
<thead>
<tr>
<th>Product</th>
<th>Volume</th>
<th>Initial Fluid</th>
<th>Additional Fluids</th>
<th>Total Fluid</th>
</tr>
</thead>
<tbody>
<tr>
<td>PLENVU</td>
<td>32 oz</td>
<td>AT LEAST 32 oz</td>
<td>PLUS ADDITIONAL LIQUIDS TO BE CONSUMED AFTER EACH DOSE</td>
<td>64 oz</td>
</tr>
<tr>
<td>Suprep®</td>
<td>32 oz</td>
<td>AT LEAST 64 oz</td>
<td>WATER ONLY</td>
<td>96 oz</td>
</tr>
<tr>
<td>Sutab®</td>
<td>24 TABS</td>
<td></td>
<td></td>
<td>96 oz</td>
</tr>
<tr>
<td>MoviPrep®</td>
<td>64 oz</td>
<td>AT LEAST 32 oz</td>
<td></td>
<td>96 oz</td>
</tr>
<tr>
<td>Clenpiq®</td>
<td>11 oz</td>
<td>AT LEAST 72 oz</td>
<td></td>
<td>83 oz</td>
</tr>
<tr>
<td>Golytely®</td>
<td>128 oz</td>
<td></td>
<td></td>
<td>128 oz</td>
</tr>
</tbody>
</table>
Other Preparations

• Magnesium Citrate
  • Hyperosmotic preparation (15 oz. in AM and PM)
  • Can cause fluid and electrolyte shifts
    • Renal insufficiency (hypermagnesemia)
    • Heart failure and d-CLD

• Miralax and bisacodyl
  • no clinically significant change in serum electrolytes
    • Hyponatremia
    • Sport drinks – fermentation produce explosive hydrogen gas (as mannitol)
Other Preparations

• Senna
  - High-dose senna (24 tablets of 12 mg each) was as effective as 4 L PEG-ELS in 2 studies (more cramps and abdominal pain)

  - Low-dose senna (3–12 tablets) with 2 L PEG-ELS to increase its cleansing effect
Timing of Bowel Prep Agent

- Suboptimal preparation is increased for colonoscopies scheduled later in the day
  - OR, 1.9; 95% CI, 1.7−2.1
- Length of time between the last dose of preparation and the initiation of colonoscopy
  - good/excellent preparation decreases by 10% for each hour
- Prospective observational study
  - 3 to 5 hours between the last dose of PEG and the start of the colonoscopy provided best prep

Lebwohl et al. Dig Dis Sci 2010
Siddiqui et al. Gastrointest Endosc 2009
Seo et al. Gastrointest Endosc 2012
<table>
<thead>
<tr>
<th>Product-related factors</th>
<th>Patient-related factors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tolerability</strong></td>
<td><strong>Adherence to instructions</strong></td>
</tr>
<tr>
<td>• Low preparation volume</td>
<td>• Patient education</td>
</tr>
<tr>
<td>• Adequate palatability</td>
<td>• Health literacy</td>
</tr>
<tr>
<td><strong>Dosing regimen</strong></td>
<td>• Motivation</td>
</tr>
<tr>
<td>• Split-dosing (2-day or same day of colonoscopy)</td>
<td></td>
</tr>
<tr>
<td><strong>Timing of administration</strong></td>
<td></td>
</tr>
<tr>
<td>• Final dose completed within 2 to 5 hours before the start of the procedure</td>
<td></td>
</tr>
</tbody>
</table>

Intolerance to Bowel Prep Agent

- Allow a fiber-free diet
- Low preparation volume
- Sulfate-free solutions
- Chilling the solution & use a straw
- Sucking on lemon slices, sugar-free menthol candy drops
- Interrupt intake 1-2 hours or slow the rate of consumption
- Inpatients: NGT
Intolerance to Bowel Prep Agent

• History of vomiting
  • ondasetron, promethazine, metoclopramide AND spilt-dose BP
  • 2-3 10 mg bisacodyl tabs q 6-8 hours the day prior to the exam & large volume tap water enemas until clear in the unit

• Vomiting de novo – ensure vomiting has stopped
  • 1st split dose: 10 mg of bisacodyl and/or 10 oz. magnesium citrate; antiemetic as needed
  • 2nd split dose: ask about color of effluent, 10 mg of bisacodyl and magnesium citrate
History of Inadequate Bowel Prep

• Check for compliance with diet, timing and dosing of prep agent

• Two days of clear liquids & AM procedure, split-dosing 4L PEG
  • Miralax week before
  • magnesium citrate if there are no contraindications

• Repeating bowel prep agent administration
  • In tandem over a two-day period
  • 3 days apart under clear diet
Simethicone, flavored electrolyte solutions, prokinetics, spasmolytics, bisacodyl, senna, olive oil, and probiotics

No improved efficacy, safety, or tolerability of bowel prep

Agents may be useful in select circumstances, at the discretion of the prescribing physician
Salvage Options for Inadequate Preparation

There is insufficient evidence to recommend a single salvage strategy for those patients encountered with a poor preparation that precludes effective completion of the colonoscopy. The following options can be considered in such cases:

Recommendations

1. Large-volume enemas can be attempted for patients who, presenting on the day of colonoscopy, report brown effluent despite compliance with the prescribed colon-cleansing regimen (Weak recommendation, very low quality evidence)

2. Through-the-scope enema with completion colonoscopy on the same day can be considered, especially for those patients who receive propofol sedation (Weak recommendation, very low quality evidence)

3. Waking the patient entirely from sedation and continuing with further oral ingestion of cathartic with same-day or next-day colonoscopy has been associated with better outcomes than delayed colonoscopy (Weak recommendation, low-quality evidence)
Inability to tolerate preparation

Slow bowel transit

Immobilization

Acute illness  MICU/CCU

Motility altering medications
A safe and effective multi-day colonoscopy bowel preparation for individuals with spinal cord injuries

Shawn H. Song @1,2, Jelena N. Svircev1,2, Brandon J. Teng3, Jason A. Dominitz3,4, Stephen P. Burns1,2

1Spinal Cord Injury Service, Veterans Affairs Puget Sound Health Care System, Seattle, Washington, USA, 2Department of Rehabilitation Medicine, University of Washington, Seattle, Washington, USA, 3Department of Internal Medicine, University of Washington, Seattle, Washington, USA, 4Division of Gastroenterology, Harborview Medical Center, Seattle, Washington, USA

• Rectal exam as needed to facilitate complete evacuation following each bowel movement

• 89% of patients (53) had adequate bowel cleansing at colonoscopy
Feasibility study of minimal prepared hydroflush screening colonoscopy

Menachem Moshkowitz,1,2,3 Ahmad Fokra,1,3 Yoseph Itzhak,4 Nadir Arber,21,2,3 and Erwin Santo2,3

ClearPath® (Easy-Glide, Kfar Truman, Israel)
• Single use, disposable oversleeve fits over the scope and connected to a workstation
• System generates a mixture of water and air that creates a high intensity pulsed vortex
• Fecal matter and fluids are simultaneously removed through two suction ports
Bubbles!!
Colonic Bubbles

- Described in 30 to 40% of colonoscopies
- Validated bowel prep scales do not address the problem or possible actions
- Low-volume PEG solution containing ascorbic acid
Bubble Score

• Degree of obscuration by bubbles, bile, or debris as follows:
  • 0: < 50% of mucosa seen, severe obscuration
  • 1: 50% – 75% of mucosa seen, moderate obscuration
  • 2: (80% – 95% of mucosa seen, mild obscuration)
  • 3: (> 95% of mucosa seen, no obscuration)

• CEBuS
  • CEBuS-0: no or minimal bubbles covering < 5% of the surface
  • CEBuS-1: bubbles covering 5%–50%
  • CEBuS-2: bubbles covering > 50%
    - ICC 0.83 (0.73-0.89) and 0.90 (0.86-0.94)
  • Reporting clinical action (do nothing; wash with water; wash with simethicone)
    • ICC 0.63 (0.43-0.78) in Phase 1 and 0.77 (0.68-0.84) in Phase 2

Yoo et al Improving of bowel cleansing effect for polyethylene glycol with ascorbic acid using simethicone. Medine (Baltimore) 2016
Simethicone

• Dosage of 120 - 240 mg, or 45 mL of a 30% solution

• Through-the-scope may result in residue and persistent contamination in the endoscopic channels despite utilizing HLD and adherence to reprocessing methods

• Concerns about transmitting infection through contaminated endoscopes

• No confirmed cases of infection related to simethicone use
High or low-volume prep, split-dose

Assessment after all appropriate efforts to clear residual debris to detect lesions > 5 mm

Minimum adequate bowel preparation rates of 85% (BBP > 6) & document

Recommended Follow-Up Intervals for Inadequate Prep