Effect of Bowel Preparation Volume in Inpatient Colonoscopy: Results of a Prospective, Randomized, Comparative Pilot Study

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Abstract

Background: Inpatient status has been shown to be a predictor of poor bowel preparation for colonoscopy; however, the optimal colon cleansing regimen protocol for hospitalized patients is unknown. Our aim was to compare the efficacy of bowel preparation volume size in hospitalized patients undergoing inpatient colonoscopy.

Methods: This prospective, single blinded (endoscopist), randomized controlled trial was conducted as a pilot study at a tertiary referral medical center. Hospitalized patients undergoing inpatient colonoscopy were assigned randomly to receive a high, medium, or low-volume solution. Data collection included colon preparation quality based on the Boston Bowel Preparation Scale and a questionnaire given to all subjects, in which we evaluated the ability to completely finish bowel preparation and adverse effects (unpleasant taste, nausea, and vomiting).

Results: Twenty-five colonoscopies were performed in 25 subjects. Patients who received low-volume prep averaged a higher mean total BBPS (7.4, SD 1.62), in comparison to patients who received high-volume (6.6, SD 2.19) and medium-volume prep (6.9, SD 1.55), P = 0.64. The low-volume group scored unpleasant taste as 0.6 (0.74), while the high-volume group gave unpleasant taste a score of 2.2 (0.97) and the medium-volume group gave a score of 2.1 (1.36), P < 0.01.

Conclusion: Although not statistically significant, a low-volume colon preparation showed a trend of equivalent quality of bowel preparation measured by BBPS in comparison to traditional volume regimens, with less unpleasant taste, which may contribute to better patient compliance and therefore better bowel preparation in the inpatient setting. Further more robust studies are required to confirm these findings.

Trial registration: clinicaltrials.gov NCT01978509

Background

Colonoscopy examinations are the standard test to evaluate the colon and are frequently performed in hospitalized patients for a number of indications [1]. The quality of colon cleansing directly affects the ability to visualize mucosa which herein affects diagnostic yield and ability to perform therapeutics [1, 2].When bowel preparation is poor, it leads to significant limitations and prevents an endoscopist from performing a high quality examination. This may result in delay of the procedure or earlier interval colonoscopy, which increase costs and decrease patient safety [3–5].

Inpatient status has been shown to be a predictor of poor bowel preparation. This is thought to be due to patient characteristics such as older age, decreased mobility, and more comorbidities, in addition to the need for more emergent evaluation than outpatient populations [6, 7]. The ideal colon purgative method should empty the entire colon from fecal material in a rapid fashion, be as comfortable as possible for patient use, be associated with minimal adverse risks, and be cost efficient. Unfortunately, many of these features are not currently available in bowel preparation solutions [1, 4]. All colonoscopy preparation

regimens may cause adverse effects such as electrolyte and fluid shifts, nausea, vomiting, and abdominal discomfort [8].

Studies in outpatient populations have demonstrated that timing and choice of cathartic medication affects the cleanliness of the bowel preparations [9–11]. However, no standardized (or optimized) bowel preparation regimen exists for inpatient populations undergoing colonoscopy. We hypothesized that low-volume preparation regimen results in better quality of colon preparation in inpatient settings than traditional high or medium-volume regimens. The purpose of this study is to compare the efficacy of a bowel preparation size in hospitalized patients undergoing colonoscopies in the inpatient setting. The primary outcome measured is the quality of bowel preparation scored through the Boston Bowel Preparation Scale (BBPS). Secondary outcomes include patient tolerance and cecal intubation.

Methods

Trial design and setting

This prospective, single-blinded, randomized control trial (clinicaltrials.gov NCT01978509) was Institutional Review Board (IRB) approved and adheres to Consolidated Standards for Reporting Trial (CONSORT) guidelines for reporting clinical trials. It was conducted as a pilot study at Mayo Clinic Arizona between September 2013 and March 2019.

Study population

Eligible subjects included hospitalized patients 18 years or older who were able to provide consent and in whom colonoscopy was deemed medically necessary while hospitalized. Patients who were unable to give consent, were pregnant or breastfeeding, had renal impairment, ileus, ascites, toxic megacolon, evidence of gastrointestinal obstruction, or presence of an allergy to study drug were excluded. Risks and benefits were explained to all subjects and written informed consents were obtained.

Bowel preparation

After informed consent was obtained, patients were randomly assigned to high-volume solution (GoLYTELY®), medium-volume solution (MoviPrep®) or low-volume solution (Prepopik®). All doses were split dose with half of the required preparation being administered the night before the procedure starting at six in the evening and the other half being administered the morning of the procedure starting at three in the morning. All patients were required to complete the liquid purgative two hours prior to their procedure. These are further described in Table 1. All subjects received a clear liquid diet the day before the procedure.

Randomization

Endoscopy physicians were blinded to what type of bowel preparation each patient received. Fellow physicians of gastroenterology department on service at the hospital enrolled participants. The allocation ratio was 1:1:1 for the intervention. Randomization was carried out using a computer-generated random numbers model and performed by a nurse practitioner who then placed bowel preparation orders without informing the inpatient gastroenterology service or endoscopist performing the colonoscopy. Additionally, the patients were told not to speculate or inform their nursing staff, physicians, or performing endoscopist if they were aware which bowel preparation regimen they consumed.

Procedures

Colonoscopy procedures were performed by the inpatient gastroenterology hospital service, which included attending faculty and fellows (under direct supervision of an attending), using Olympus Exera II 180 series colonoscopes in 4 subjects and Olympus 190-series (CF-HQ190AL and PCF-H190L) colonoscopes in the remaining cases (Olympus Corp., Tokyo, Japan). The success of cecal intubation was established by visualization of anatomic landmarks (appendiceal orifice and ileocecal valve). Procedures were performed under conscious sedation (IV fentanyl, IV midazolam) in 21 subjects while 4 patients underwent deep sedation (IV fentanyl, IV midazolam, and IV propofol) with assistance of anesthesia providers.

Therapeutic interventions, such as biopsies, polypectomies, clip placement, argon plasma coagulation, or other electrocoagulation modality were performed as indicated. During the colonoscopy, quality metrics were obtained.

Primary Outcome

To determine quality of bowel preparation among three different volume solutions, we used the Boston Bowel Preparation Scale (BBPS) in the three colon segments (right, transverse and left colon) along with total score.

Secondary outcomes

After colonoscopy, all subjects received a questionnaire about their experiences with the colonoscopy preparation (Table 2), and cecal intubation rate was obtained.

Statistical Analysis

This was a pilot study, in which a modest sample size was achieved. Number of patients enrolled in this study was determined by willingness for participation. The trial ended due to a difficulty of recruiting participants.

Continuous variables are described with their mean and standard deviation while categorical variables are described by count and percentage. The Chi-Square test was used for demographics, indication for colonoscopy, diabetes status, history of constipation, purgative type, and if patient completed bowel preparation. The three groups were compared in terms of BMI, quality of bowel preparation (using Boston Bowel Preparation Scale), and side effects (unpleasant taste, nausea, vomiting, abdominal pain scored in a five-point scale) by the one-way analysis of variance (one-way ANOVA) test. All hypothesis tests were two-sided with $P < 0.05$ considered statistically significant. Analyses were performed using SAS 9.4 (SAS Institute, Inc.; Cary, NC).

Results

A total of 25 inpatient colonoscopies were performed in 25 subjects. Nine patients were assigned to receive GoLYTELY®, eight to receive MoviPrep®, and eight to receive Prepopik®. Demographic data and underlying conditions such as diabetes and chronic constipation are reported in Table 3.

Patients who received Prepopik® achieved a higher total BBPS score (mean 7.4, SD±1.62) than patients who received GoLYTELY® (mean total BBPS score 6.6, SD±2.19) and MoviPrep® (mean total BBPS score 6.9, SD±1.55), although the differences were not statistically significant ($P = 0.64$) (Figure 1). In the GoLYTELY® group, mean of BBPS score for right colon was 2.4 (0.52), for transverse colon was 2.5 (0.53) and for left colon was 2.3 (0.46).

In the MoviPrep® group, mean of BBPS for right colon was 2.4 (0.74), for transverse colon was 2.5 (0.53) and for left colon was 2.1 (0.69).

Finally, in the Prepopik group, BBPS score for right colon, transverse colon and left colon was 2.6 (0.53), 2.7 (0.53), and 2.1 (0.69), respectively. In all cases, cecal intubation was achieved.

With regard to tolerance to colon cleansing, 100% of patients who received Prepopik® reported finishing bowel preparation completely, whereas 77.8% of the GoLYTELY® group and 66.7% of the MoviPrep® group reported accomplishment all purgative intake ($P = 0.24$), shown in the Figure 2.

Unpleasant taste demonstrated a significant difference ($P \leq 0.01$) between Prepopik® group and GoLYTELY®/ MoviPrep® groups. Mean (SD) score for this adverse event informed by patients who had Prepopik® was 0.6 (0.74), while patients who had GoLYTELY® mentioned mean score for the same variable of 2.2 (0.97) and MoviPrep® mean score was 2.1 (1.36). Other parameters analyzed were nausea and vomiting (Table 4).

Discussion

Our pilot study is the first to compare the quality of bowel preparation based on volume in a prospective and randomized manner in hospitalized patients. Our results show that patients who received a low-volume preparation had numerically better BBPS scores than those who received larger-volume preparations. The score differences, however, were not statistically significant likely due to small sample size. Importantly, low-volume preparation was perceived to taste better to patients, which likely plays a factor in patient compliance. Additionally, the low-volume preparation had lower rates of patient reported nausea and vomiting which likely contributed to a higher rate of bowel prep completion in this group.

A poor bowel preparation for colonoscopy has detrimental consequences, such as decreased identification of pathology, increased procedure time, and decreased rates of cecal and terminal ileum intubation. Inadequate bowel preparation also leads to shortened interval colonoscopy duration and increased health care costs, not to mention additional risks to the patient and increased time off of work than would be required otherwise [12, 13]. Furthermore, risk of adverse events such as colon perforation may be increased with inadequate colon cleansing [13].These factors emphasize the importance of prospective studies reviewing the efficacy and quality of bowel cleansing, especially in hospitalized patient cohorts.

Predictors of inadequate bowel preparation for ambulatory colonoscopies cannot be extrapolated to the inpatient setting given the differences between inpatient and outpatient populations. These differences include distribution of age, level of physical activity, prevalence of comorbidities and indication for colonoscopy which are vastly different between the two populations [7].

Some authors have reported better results of inpatient colonoscopy preparation with split-dose administration of 4-liter polyethylene glycol (PEG) [14], based on the outpatient data that shows that split-dose PEG solution is superior to single-dosing [8, 15, 16]. In the outpatient setting, it is known that timing between completion of purgative intake and the colonoscopy is an important factor for bowel-preparation quality, regardless if the procedure is performed in the morning or afternoon [9–11]. In our study, we used split dosing of bowel preparation in all subjects received colon cleansing preparations giving half of the solution starting the evening prior to day of procedure and the remaining half in the morning of the planned procedure.

Physician, nursing, and patient education has also shown to be an efficient tool for colonoscopy cleansing in the inpatient setting [17]. However, Chorev *et al* did not find significant improvement in preparation quality or in colonoscopy success in hospitalized patients after departmental institution of an educational program for healthcare providers [14, 17].

The standard preparation for patient with medical comorbidities of renal failure, congestive heart failure, or liver disease is 4-liter PEG-electrolyte solutions [1, 2, 5]. Nonetheless, it is reported that 1 in 7 patients may not be compliant to bowel preparation regimen mainly due to the volume [18]. Improved results of preparation are achieved with better compliance, which has been shown to be related to decreased bowel cleansing volume, palatability and regimen simplicity [2, 16, 18–20]. We found that 100% of subjects who received Prepopik® finished their bowel preparation completely, in opposition to MoviPrep® (66.7%) and

GoLYTELY® (77.8%). Reasons for this difference may be explained by the lower volume of Prepopik® and perceived better taste ($P \leq 0.01$), both of which can enhance adherence of a colon cleansing regimen.

Our findings are consistent with a prospective study performed by Gu et al with more than 4,300 outpatient colonoscopies that reports better tolerability and cleansing with SuPrep® (low-volume regimen bowel preparation) than GoLYTELY® [16].

A retrospective study by Corliss et al described a rate of 44.1% of inadequate bowel preparation (total BBPS <7) among hospitalized patients receiving standard solution (4-liter of GoLYTELY ®), in comparison to a rate of 22.6% among inpatients receiving SuPrep® (low-volume regimen) in split-dose fashion [21].

Our study has some limitations. First, our small sample size likely affects the statistical significance. Also, some medical conditions as renal impairment and ileus were used as exclusion criteria, which may have provided an inpatient population which is not generalizable.

Conclusions

In summary, in this pilot study, although not statistically significant, a low-volume colon preparation demonstrated a trend of equivalent quality of bowel preparation measured by BBPS in comparison with traditional higher volume regimens. Low-volume preparation also demonstrated lower rate of unpleasant taste. This suggests that low-volume purgative may contribute to better bowel preparation in the inpatient setting. The lack of statistical significance is likely due to small sample size. Further more robust studies are required to confirm these findings.

List Of Abbreviations

BBPS: Boston Bowel Preparation Scale

Declarations

Ethics approval and consent to participate: this study was approved by Institutional Review Board of Mayo Clinic Arizona (13–003983). It was registered at www.clinicaltrial.gov (NCT01978509) in September 2013, and adheres to CONSORT guidelines for reporting clinical trials. Risks and benefits were explained to all patients and written informed consents were obtained. All patients enrolled were older than 18 able to give consent for the procedure and research

Consent to publish: consent for publication of the research results in professional journals without identities revealed was obtained from all patients.

Availability of data and materials: the datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

Competing interests: S. Islam is speaker for Salix Medical.

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Author contributions: JLHS, KR, FCR conceptualized and designed the study. KR, JLHS, NB, MA, SI and DLS collected data. PVH, MRB, ESL, SBU and FCR analyzed data and results. PVH drafted the manuscript. JLHS, DLS, SBU and FCR reviewed the manuscript. All authors read and approved the final manuscript.

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Tables

Table 1 – Bowel preparations regimens

Prep Types	Volumes of Prep	Ingredients	Administration (full dose regimen)
GoLYTELY®	4,000 mL	Polyethylene glycol, sodium sulfate, sodium bicarbonate, sodium chloride, potassium chloride	2 L-solution of water mixed to GoLYTELY® given in the evening before the colonoscopy. This regimen was repeated again the next morning
MoviPrep®	2,000 mL	Polyethylene glycol, sodium sulfate, sodium bicarbonate, sodium chloride, potassium chloride, sedum ascorbate and ascorbic acid	1 L-solution of water mixed to MoviPrep® given in the evening before the colonoscopy. This regimen was repeated again the next morning
Prepopik®	300 mL	Sodium sulfate, potassium sulfate and magnesium sulfate	150 mL-solution of water mixed with Prepopik® given in the evening before colonoscopy. This regimen was repeated again the next morning

Table 2 – Data collection

Variables	Data
Patient demographics	• Sex • Age • BMI • Diabetes status • History of constipation • Indication for colonoscopy • Purgative type
Colonoscopy features	• Colon cleanliness quality, based on the Boston Bowel Preparation Scale • Cecal intubation
Patient questionnaire	• Ability to completely finish bowel preparation • Evaluation of adverse effects (unpleasant taste, nausea, and vomiting) using a five-point scale ranging from 0 (no symptoms) to 4 (severe symptoms)

Table 3 – Patient demographics and indication for colonoscopy

	GoLYTELY® (n=9)	MoviPrep® (n=8)	Prepopik® (n=8)	Total (n=25)	P-value
Female gender, n (%)	3 (33.3%)	3 (37.5%)	2 (25.0%)	8 (32.0%)	0.86
Age (y) Mean (± SD) Range	70.8 (±12.33) 51-86	62.1 (±17.46) 32-85	66.5(±19.79) 35-84	66.6 (±16.34) 32-86	0.57
BMI (kg/m²) Mean (±SD) Range	29.1 (±4.21) 22.9-35.7	25.3 (±3.67) 18.2-29.8	29.8 (±7.59) 23.2-45.6	28.2 (±5.57) 18.2-45.6	0.25
Diabetes, n (%)	2 (±22.2)	2 (±28.6%)	2 (±25.0%)	6 (±25.0%)	0.96
Chronic constipation	1 (11.1%)	1 (14.3%)	2 (25.0%)	4 (16.7%)	0.73
Indication for colonoscopy Abnormal imaging Diarrhea Hematochezia IBD Melena Abdominal pain Anemia	 0 (0.0%) 1 (11.1%) 6 (66.7%) 0 (0.0%) 1 (11.1%) 0 (0.0%) 1 (11.1%)	 1 (12.5%) 2 (25.0%) 3 (37.5%) 0 (0.0%) 0 (0.0)% 1 (12.5%) 1 (12.5%)	 0 (0.0%) 2 (25.0%) 3 (37.5%) 1 (12.5%) 1 (12.5%) 0 (0.0%) 1 (12.5%)	 1 (4.0%) 5 (20.0%) 12 (48.0%) 1 (4.0%) 2 (8.0%) 1 (4.0%) 3 (12.0%)	0.71

Table 4 – Adverse effects of bowel preparation regimens

	GoLYTELY®	MoviPrep®	Prepopik®	P-value
Unpleasant taste Mean (SD) Range	 2.2 (±0.97) 1-3	 2.1 (±1.36) 0-4	 0.6 (±0.74) 0-2	≤ 0.01
Nausea Mean (SD) Range	 0.9 (±1.27) 0-3	 0.5 (±1.07) 0-3	 0 (0.0) 0	0.19
Vomiting Mean (SD) Range	 0.1 (±0.33) 0-1	 0 (0.0) 0	 0 (0.0) 0	0.43

Figures

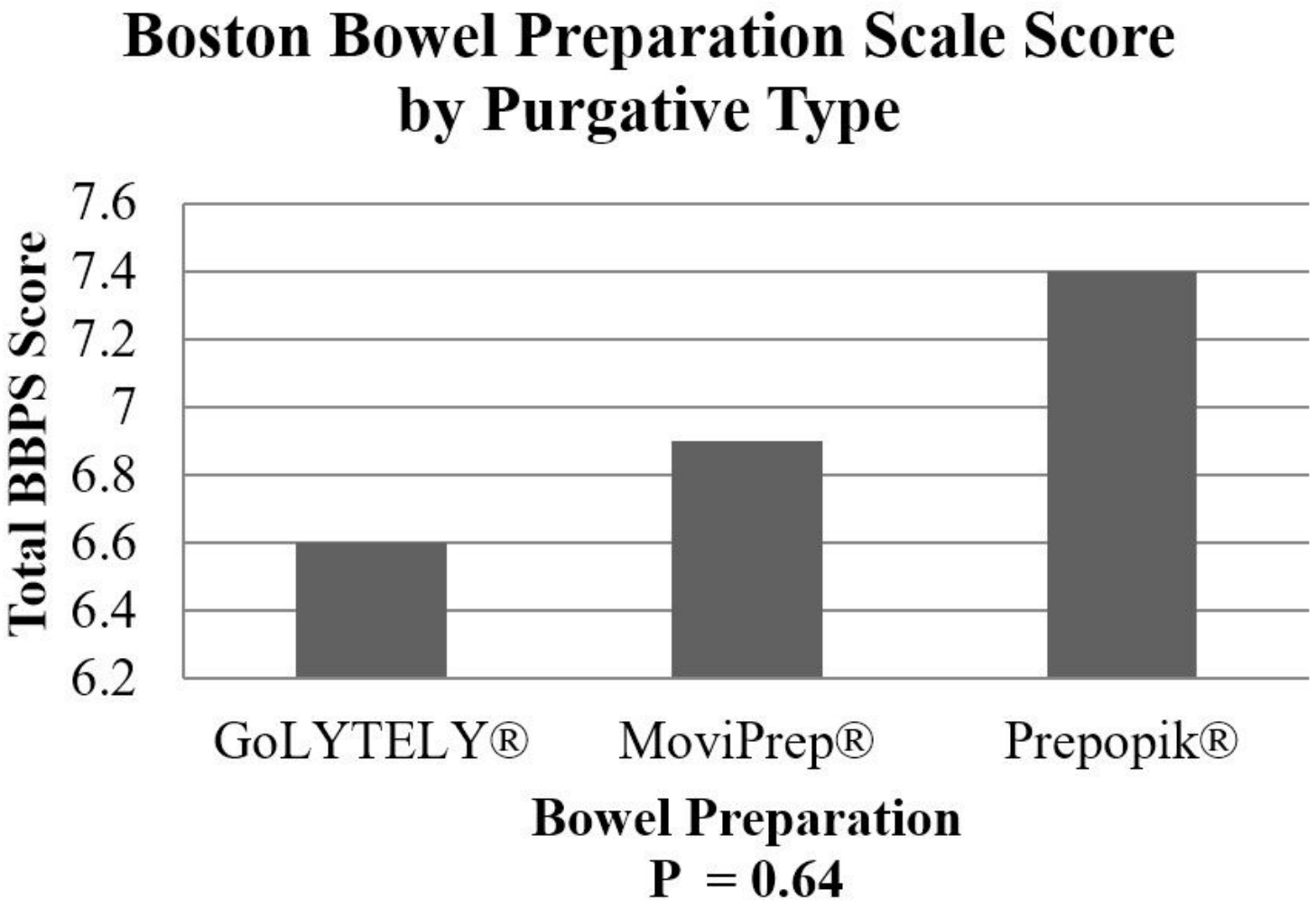

Figure 1

Relation between mean total Boston Bowel Preparation Scale Score (BBPS) and type of purgative

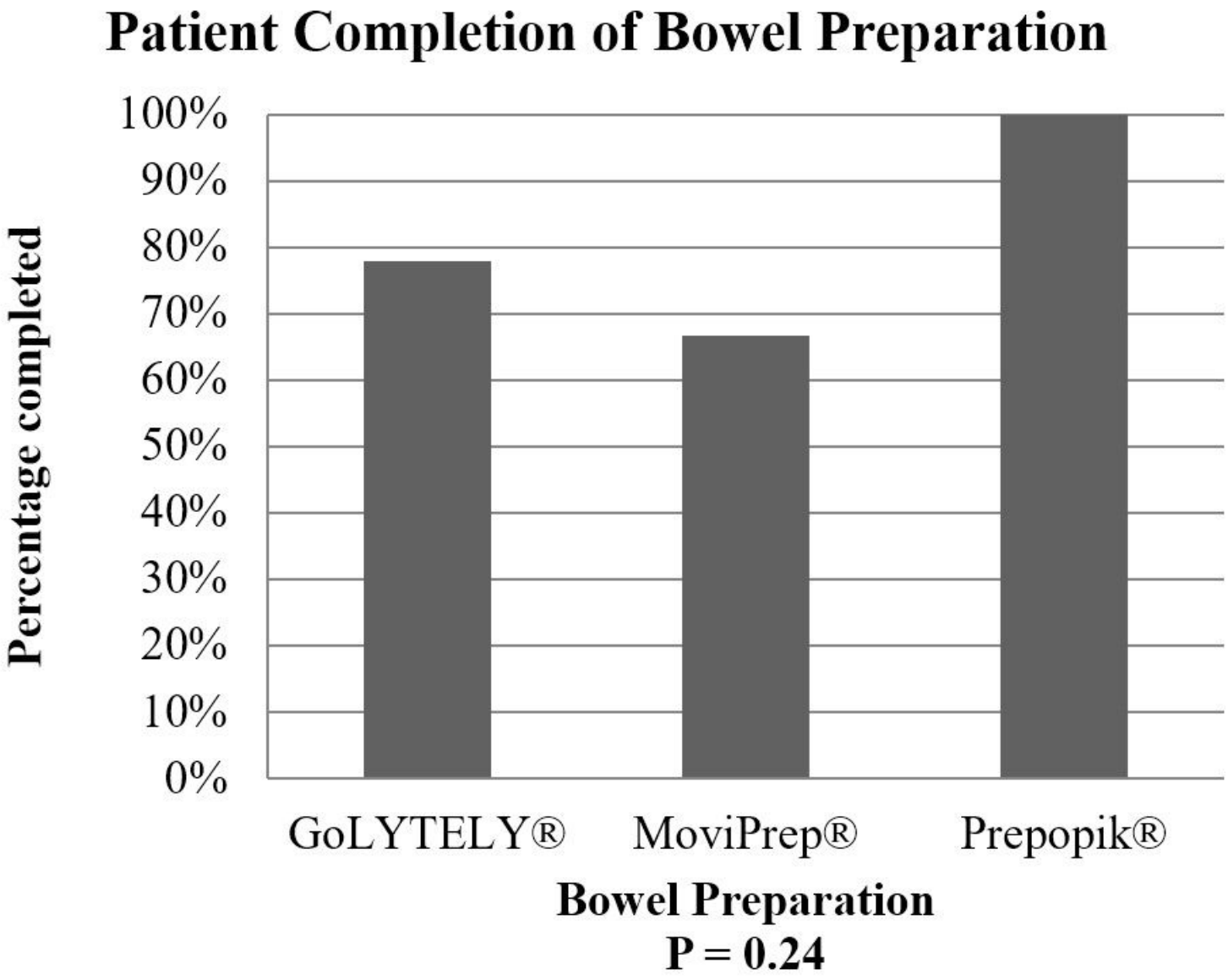

Figure 2

Tolerance and ability to completely finish colon preparation among different colon preparation solutions

Supplementary Files

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