**Module 3: Updates in Endoscopy**

**Dr. Lightdale**

**Question 1:**

How do you deal with very uncooperative patients that need anesthesia? Ketamine? Premedication with anxiety lowering drugs?

**Answer:** A patient centered approach to uncooperative patients prior to procedure is best. At times, premedication with oral midazolam (Liacouras et al., GIE, 1998.) or Ketamine IM may be appropriate depending on the situation and the patient.

**Question 2:**

In a patient with Osteogeneis Imperfecta (OI) and EOE, do you do repeated endoscopies?

**Answer:** Patients with OI are indeed high risk for iatrogenic complications. As such, a risk/benefit analysis when planning each "repeated" procedure that takes into account the goals of the procedure is important. It may also be helpful to define what you are hoping to gain from doing each procedure, as well as the degree to which you believe performing the procedure will guide clinical management.

**Question 3:**

Are other hypermobility patients other than E.D. also at risk for perforations?

**Answer:** Technically, any connective tissue disorder can 1) be associated with joint laxity/hypermobility and 2) be associated with decreased mucosal wall strength. However, only "vascular type" EDS (with mutation of COL5A1) has been associated with particularly high risk for perforation.

**Dr Barth:**

**Question 1:** Should clips be applied/avoided after epi injection

**Answer:** Would not worry. The clips grab tightly and will remain in place even after swelling from the epi subsides

**Question 2:** Biclip vs. Triclip?

**Answer:** I avoid the triclip as it does not approximate tissue with as much force and is more difficult to apply unless absolutely "en face" (due to its design, it can't be applied at an angle)

**Question 3:** Use of elective clipping in larger polyps?

**Answer:** I don't do this unless the stalk bleeds. It's very easy to apply clips to polyp stalks if they bleed post polypectomy.

**Question 4:** Use of clips in bulb or cecum, risks or concerns?

**Answer**: Not really. Angles can be tough in bult. I think clips are safer in these thin walled areas than thermal methods.

**Question 5**: Why would you remove a clot if average risk of bleeding is only 20% (8-35%)?

**Answer:** 20% is too high for me to sleep at night and I would much rather control the situation than leave it to chance.

**Dr. Shub:**

**Question 1:** Is there a role for surveillance if <5 juvenile polyps are detected at colonoscopy?

**Answer:** There is no consensus on this so I would say no.

**Question 2:** In asymptomatic patients with a parent with a polyposis syndrome, can genetic testing be used instead of surveillance endoscopy/colonoscopy?

**Answer**: If the gene is identified in the index case, then siblings can be screened. If negative for the gen, they do not need surveillance. However, if no gene identified and especially if they have any extraintestinal findings, then would recommend screening with scope.

**Question 3:** Are the recommendations for frequency of surveillance endoscopies the same in children with IBD regardless of if they are on infliximab or not?

**Answer:** The effect of infliximab is not known on whether the risk of cancer is modified.

**Question 4**: Pathology departments charge based on number of biopsy containers for review. In surveillance endoscopies, and to avoid charging patients extra thousands of dollars in pathology charges, do you ever "pool" biopsy specimens of normal looking tissue?

**Answer**: Yes and no for the following reasons:

1) In Barrett's, you want to know the location of dysplasia
2) For polyposis, could batch together because any polyp dysplasia would warrant colectomy
3) In IBD, would be helpful to do in separate bottles so can focus on that specific location for future surveillance.

**Dr. Gilger**

**Question 1:** When is it appropriate to defer to interventional radiology for stricture dilatation? Do you dilate with fluoroscopy control?

**Answer:** Interventional radiology is a reasonable choice if you cannot perform the dilatation. And yes, fluoroscopy assistance is helpful.

**Question 2**: Are you seeing patients with TEF/esophageal atresia repair AND Eosinophilic esophagitis and recurrent strictures?  Do you treat these patients differently?

**Answer:** Yes, many do overlap and most need dilatation.  There is no difference for the dilatation.

**Question 3:** Is there a role for Kenalog before or after dilatation?

**Answer:** Yes, 1-2 times then no more as it “thins” mucosa with repeated use.