obstruction, CE is a very useful diagnostic modality for small bowel Crohn’s disease.

Competing interests None declared.

REFERENCE

PTU-143 QUICKVIEW IN CAPSULE ENDOSCOPY: IS IT ENOUGH?


Introduction Analysis of small-bowel capsule endoscopy (SBCE) is time consuming. QuickView (QV) has been added to the RAPID® software to reduce reading times. Its validity though has been questioned.1 2 We have recently showed that Blue Mode (BM) application provided image improvement for different lesion categories.3 Aim To assess the validity of QV with white light (QVWL) and QV software to reduce reading times. Its validity though has been questioned. QuickView (QV) has been added to the RAPID Analysis of small-bowel capsule endoscopy (SBCE) is compared with the standard (reference) viewing.

Methods Retrospective study; all SBCE for OGIB (August 2008–November 2011), performed with PillCam®SB, with complete small-bowel visualisation were included. A clinician with SBCE experience (>200), unaware of the capsule endoscopy reports, reviewed prospectively the SBCE video streams on RAPID® (ver. 7) platform using QVWL and QVBM. All SBCE were previously reported using standard viewing mode; these reports were taken as reference. Findings were labelled as P0 (non-pathological), P1 (low/intermediate) and P2 (high bleeding potential) lesions. Sensitivity, specificity and positive predictive value (PPV) for QVWL and QVBM, as compared to reference review, for clinically significant (P1/P2) lesions was calculated.

Results A total of 106 SBCE were analysed. Indications were: overt OGIB in 21 and occult OGIB/IDA in 85. With QVWL, 54 [P0 (28), P1 (18), P2 (8)] lesions were detected; 65 [P0 (48), P1 (13), P2 (2)] with QVBM, as compared to 95 [P0 (67), P1 (23), P2 (8)] by standard (reference) reporting. For P1+P2 lesions, the sensitivity, specificity, PPV and NPV for QVWL (as compared to reference reporting) was 92.3, 96.3, 96 and 92.8%, respectively. For QVBM, the above values were 91, 96, 96.2 and 90.6%, respectively. The mean evaluation time (including reading and time to mark thumbnails) was 443 and 453 sec for QVWL and QVBM, respectively.

Conclusion When urgent SBCE analysis is necessary, for further immediate management planning, the QV mode can be trusted to provide an accurate (almost on-the-spot) diagnosis in most cases. In our cohort, the overall diagnostic yield (DY) of SBCE was 30.7% (68/221). The DY for significant pathology and angioectasias was 9% and 21.7%, respectively. In those ≥60 yr (n = 120, 13F/7M, mean age: 65.6 yr), significant pathology was found in 25% (5/20); in the >40 yr group (n = 201, 13F/63M, mean age: 72.2 yr), significant pathology was found in 7.5% (15/201), p = 0.0231. Although none of the patients ≤40 yr had angioectasias, P1 or P2 lesions were found in 48/201 (21.7%) of those >40 yr. The age-range analysis showed angioectasias in 11.1%, 13%, 20% and 42% in the age-groups 41–50, 50–60, 60–70, 70–80 yr, respectively. Interestingly, in those >80 yr (n = 16, 12F/4M, mean age: 82.5 yr) angioectasias were present in 50% of SBCE but no significant pathology was identified.

Conclusion IDA alone is one of the main indications (27%) for referral to the SBCE service of our centre with the majority of referrals coming from the >40 age group. In our cohort, the overall DY of SBCE for IDA is 30.7% and the commonest finding small-bowel angioectasias. The detection rate of significant small-bowel pathology for those ≥40 yr is low decreasing to zero in the >80 age group. In contrast, 25% of patients ≤40 yr had a significant or sinister diagnosis made with SBCE.

Competing interests None declared.

REFERENCES