Chapter 7

COLONOSCOPY TIPS AND TRICKS

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GENERAL INFORMATION

Colonoscopy was defined in 1971 and the imaging capacity was significantly increased over the years. However, colonoscopy still requires good dexterity and concentration. Intubation rate of cecum is reported as 90-95% even in experienced hands (1).

Adequate training and experience are required for accurate diagnosis and therapeutic procedures. In particular, a moving and long sigmoid colon or a transfer colon may present major difficulties in colonoscopy.

Colonoscopy not only evaluates the mucosa macroscopically but also provides microscopic evaluation with biopsy. It provides the evaluation of the mucosa with the methods of magnification and staining. It allows us to carry out advanced therapeutic procedures such as polypectomy, ESD, EMR. Colonoscopy should be performed especially in cancer screening, but it should be done with indication.

Table 1. Colonoscopy indications	
Diagnostic Purpose	**Therapeutic**
Suspected inflammatory bowel disease	Polypectomy, ESD, EMR
Unspecified iron deficiency anemia	Removal of foreign body
Unexplained gis bleeding, secret blood positivity	Stenting
Chronic diarrhea	Hemorrhoid band ligation
Cancer Screening	Balloon Dilatation
To determine the efficacy of IBH treatment	Ulceration, neoplasia, vascular malformation, treatment of bleeding from the polypectomy (electrocoagulation, argon, heater probe, injection)
Follow-up of malignancy	Correction of sigmoid volvulus
Stenosis in barium examination	Marking of the location of neoplasms
Unexplained abdominal pain	Reduction of intussusception

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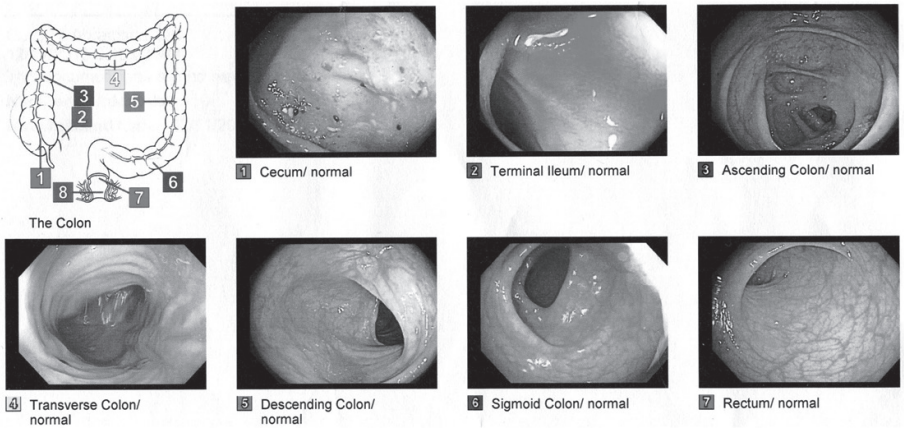
The typical triangular-looking transverse colon, the hepatic flexure, and the assendan colon, the cecum base with the characteristic morphology occurs. The cecum base is characterized by a folding pattern and an appendix orifice formed by a combination of three taenias. If it is still undetectable, it can be understood by touching the right lower dial.

The ileocecal valve is localized above the base of the cecum, and its morphology and orientation varies widely, but it is usually seen from the proximal assendan colon. The ileocecal valve may be recognized by the yellowish, thickened, slightly raised bulge in the lumen. If the valve opening cannot be entered distally from its location, the endoscope tip is inserted into the cecum and is slowly retracted in the direction of the valve.

After the valve is delivered, the air is aspirated and the endoscope is pushed into the terminal ileum. Aspiration of air at the base of the cecum can sometimes make the valv mouth visible.

You must see every side on the way out, at least 6 minutes patiently reviewing something should not be missed.



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