

## Does the sentence “less is more” apply to bowel preparation?



I read with interest the editorial by Soriani et al [1]. We were happy to see that our experience [2] has been replicated by other Authors. Our belief, in fact, hinges on the timing rather than the type of laxative. Back in 2014, we responded with conviction to the cry, “Split the dose!” convinced that the “golden 5 hours” rule was the right way [3]. Thus, we thought it was more effective to stay within 5 hours from the end of preparation than to administer high-dose laxatives. With this letter, I would also like to thank Prof. Riccardo Marmo, who suggested us to pursue this approach. It should be supported even more, considering that in our studies, we enrolled patients at high risk of complications and who had inadequate preparation. Today, with the advent of very-low-dose intestinal preparations specially designed for colonoscopy bowel preparation, the split-dose approach is particularly safe [4]. Paradoxically, the reported complications, hypernatremia and dehydration [5], are also better managed in hospitalized patients.

The cases reported by Soriani et al [1] reinforce our work and the conviction that administering bowel preparation with a correct protocol and timing can lead to an early diagnosis and a shorter hospitalization. For inpatients, who often do not have a sufficient level of bowel preparation, the goal should be shifted to a level of preparation that allows the endoscopist to make a diagnosis and offer treatment, rather than classifying according to the adenoma detection rate. Because there are no very-low-dose bowel preparations, in our study, we used 1 L of a polyethylene glycol-based preparation (Macrogol 4000 + anhydrous sodium sulphate + sodium bicarbonate + sodium chloride + potassium chloride). Despite this was 25% of a high-dose laxative, the results were encouraging [2].

The results in the patients who used the 1-L preparation (including 11 who were hemorrhagic) were comparable to the group for whom the split high-dose preparation was used. However, the waiting time to perform the endoscopic examination and the fast diagnosis/treatment received significantly impacted hospitalization time.

In conclusion, bowel preparation in critically ill patients is always underestimated. Unfortunately, it is common to think that fasting together with the cathartic effect of bleeding is sufficient to complete the endoscopic examination and bowel preparation is the exclusive target of the endoscopist.

Studies such as that of Soriani et al [1] are oxygen for all endoscopists who treat critical patients, where the negative impact on colonoscopy effectiveness and hospitalization time, particularly in hemorrhagic patients, is underestimated.

### Competing interests

The authors declare that they have no conflict of interest.

### The author

#### Stefano Pontone

Department of Surgical Sciences, “Sapienza” University of Rome, Rome, Italy

### Corresponding author

#### Prof. Stefano Pontone

Department of Surgical Sciences, “Sapienza” University of Rome, V.le Regina Elena 324, 00161, Rome, Italy  
 Fax: +390649975503  
 stefano.pontone@uniroma1.it

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