Results: Sixty-seven studies were compared. There were no visible lesions that were not detected. There were 29 overcalls of abnormalities that were normal findings in 12 patients. Examples of overcalls included calling a normal vessel an AVM or a fold a polyp. There were 14 mislabeled abnormalities in 13 patients. Examples of mislabelling included calling lymphoid hyperplasia or Brunner's glands as small bowel polyps. This tendency to miss-term findings decreased with feedback.
Conclusions: An appropriately trained physician extender can detect abnormalities at wireless capsule endoscopy. Physician extenders may be used efficiently for cataloging findings of wireless capsule endoscopy.

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LANSOPRAZOLE EFFECTIVELY REDUCES THE RISK OF GI SYMPTOM OCCURRENCE IN ULCER FREE PATIENTS WHO CONTINUE CHRONIC NSAID USE

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Purpose: A12-wk study assessed the risk reduction of gastroduodenal ulcers and gastrointestinal (GI) related symptoms in patients treated with lansoprazole, misoprostol or placebo while continuing chronic NSAID therapy. In addition, upper and lower GI symptoms were evaluated by investigator assessment at 4, 8, and 12 weeks. Composite and individual NSAID associated upper GI symptoms were evaluated post hoc.
Methods: Five hundred and thirty-five patients on chronic NSAID therapy with a documented history of gastric ulcer (GU) but no evidence of active GU, duodenal ulcer, erosive esophagitis or *H. pylori* infection and fewer than 25 gastric/duodenal erosions by endoscopy were randomized to receive 12 wks of either lansoprazole 15 mg QD (L15), lansoprazole 30 mg QD (L30), misoprostol 200 mcg QID (Miso) or placebo. Of 535 patients, 345 were free from moderate or severe NSAID associated upper GI symptoms which included abdominal pain, heartburn, belching, fullness/bloating/early satiety, and abdominal distension at baseline and comprised the post hoc study cohort. The percentage of patients remaining free from moderate or severe symptoms at 12 wks was calculated by Life-Table methods. The development of individual symptoms during NSAID therapy was also assessed.
Results: Compared to placebo (44%) and Miso patients (39%), a significantly greater proportion of L15 (64%; p=0.011 and 0.003, respectively) and L30 patients (65%; p=0.037 and 0.007, respectively) remained free from moderate or severe composite NSAID associated GI symptoms at the end of 12 weeks (Table 1). Of the individual symptoms evaluated, a higher proportion of lansoprazole treated patients remained free from moderate or severe abdominal pain and heartburn compared to placebo-treated patients and remained free from heartburn compared to Miso-treated patients.

(%) of Subjects Free from Moderate/Severe Symptoms at 12 Weeks

	Placebo	Miso	L15	L30
Composite Symptoms	44*	39*	64	65
Abdominal Pain	57*	63	74	77
Heartburn	68*	65*	89	86

* $p<0.05$ compared to LAN 15 and LAN 30

Conclusions: Lansoprazole 15 mg and 30 mg were significantly superior to placebo in reducing the risk of upper GI symptom occurrence in patients taking chronic NSAIDs. Reducing the risk of abdominal pain and heartburn occurrence in patients taking lansoprazole largely drove this result. Funded by TAP.

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PROPOFOL VERSUS MIDAZOLAM/FENTANYL FOR OUTPATIENT COLONOSCOPY: ADMINISTRATION BY NURSES SUPERVISED BY ENDOSCOPISTS

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Purpose: To compare nurse-administered propofol to midazolam/fentanyl for outpatient colonoscopy.
Methods: One hundred patients undergoing outpatient colonoscopy were randomized to receive either propofol or midazolam plus fentanyl, administered by a nurse and supervised by an endoscopist. There was no involvement of an anesthesia specialist. Endpoints were patient satisfaction, procedure and recovery times, neuropsychological function, and complications.
Results: The mean dose of propofol administered was 277 mg; mean doses of midazolam and fentanyl were 7.2 mg and 117 ucg, respectively. Mean time to sedation was faster with propofol (2.1 min vs. 6.1 min; $p < 0.0001$) and depth of sedation was greater ($p < 0.0001$). Patients receiving propofol reached full recovery sooner (16.5 vs. 27.5 min; $p = 0.0001$) and were discharged sooner (36.5 vs 46.1 min; $p = 0.01$). Patients in the propofol and midazolam and fentanyl groups reported similar degrees of overall satisfaction using a 10-point visual analog scale (9.3 vs 9.4, $p > 0.5$). After recovery, the propofol group scored better on tests reflective of learning, memory, working memory span, and mental speed. Six minor complications occurred in the propofol group; 4 episodes of hypotension, 1 episode of bradycardia, and 1 rash. Five complications occurred with the use of midazolam and fentanyl; one episode of oxygen desaturation requiring mask ventilation and 4 episodes of hypotension.
Conclusions: For outpatient colonoscopy, propofol administered by nurses and supervised by endoscopists resulted in faster sedation, recovery, and discharge times and better neuropsychological function following recovery compared to midazolam/fentanyl. Patients reported similar degrees of overall satisfaction. Nurse-administered propofol offers several advantages for outpatient colonoscopy, but did not improve patient satisfaction compared to midazolam and fentanyl sedation.

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SELECTION OF ENDOSCOPY PATIENTS FOR NURSE-ADMINISTERED PROPOFOL SEDATION (NAPS)

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Purpose: NAPS supervised by endoscopists (without an anesthesiologist or nurse anesthetist present) has been used at our center in more than 5,000 cases to date. The safety of NAPS can only be understood in the context of how patients are excluded from NAPS. The purpose of this study is to decribe the percent of patients excluded from NAPS and the reasons.
Methods: Patients undergoing unsedated procedures were excluded. 749 consecutive cases undergoing sedation for non-ERCP, non-EUS endoscopic procedures at a single tertiary care hospital endoscopy unit were prospectively evaluated with regard to selection of NAPS versus narcotic/benzodiazepines (N/B). More than 4,000 NAPS cases had been performed at our center at the start of this study.
Results: Of the 749 patients, 621 were sedated with propofol and 128 with N/B. The percentage of patients receiving propofol was higher for outpatients vs inpatients (84.5% vs 63.9%; $p<.001$), colonoscopy vs EGD (92.0% vs 73.3%; $p<.001$), patients without an absolute or relative contraindication to NAPS (listed below) vs patients with a relative NAPS contraindication (99.6% vs 40.3%; $p<.001$). Among the 128 patients receiving N/B, the specific exclusion criteria (some patients had more than 1) were: ASA status of III/IV unless based only on liver or renal disease