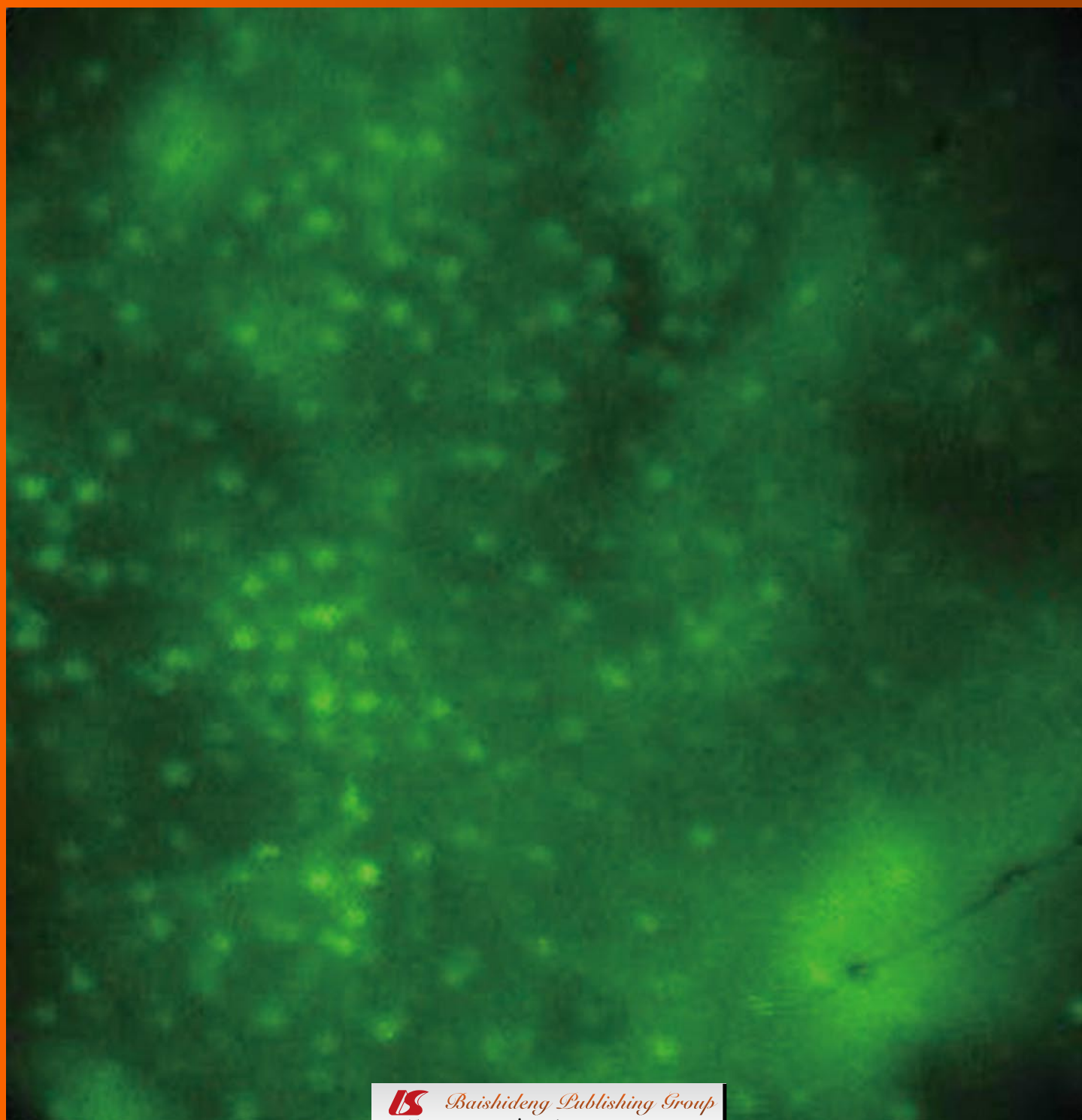


# World Journal of *Gastrointestinal Endoscopy*

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cation and current limitations of these technologies for the early detection of neoplasia in Barrett's esophagus, ulcerative colitis and colorectal cancer.

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### Abstract

Currently, in gastrointestinal endoscopy there is increasing interest in high resolution endoscopic technologies that can complement high-definition white light endoscopy by providing real-time subcellular imaging of the epithelial surface. These 'optical biopsy' technologies offer the potential to improve diagnostic accuracy and yield, while facilitating real-time decision-making. Although many endoscopic techniques have preliminarily shown high accuracy rates, these technologies are still evolving. This review will provide an overview of the most promising high-resolution imaging technologies, including high resolution microendoscopy, optical coherence tomography, endocytoscopy and confocal laser endoscopy. This review will also discuss the appli-

### INTRODUCTION

Endoscopic surveillance is an important tool in the management and detection of many pre-malignant diseases throughout the gastrointestinal (GI) tract, including Barrett's esophagus, ulcerative colitis and atrophic gastritis. The key to the early detection and treatment of GI cancer lies in the ability to detect and delineate intraepithelial neoplasia. Although the endoscopic treatment of many GI mucosal lesions by endoscopic resection or ablation is very effective, dysplasia and neoplasia are not always apparent on conventional white light endoscopy. As such,



it is important to develop technologies that can better define subtle mucosal changes, offering a more targeted approach to current endoscopic surveillance protocols and the potential for real-time decision making [e.g., immediate endoscopic mucosal resection (EMR)]. Many wide-field imaging technologies, such as high-definition white light endoscopy and autofluorescence imaging (AFI), have been shown to enhance diagnostic sensitivity; however, the lack of spatial resolution results in limited specificity and high false-positive rates<sup>[1-3]</sup>. Because of these limitations, there has been emerging interest in the development of complementary technologies that provide a high-spatial resolution, thus enhancing specificity. Examples of these high-resolution technologies include confocal microendoscopy, optical coherence tomography (OCT) and endocytoscopy (EC) (Table 1). By providing subcellular imaging of the epithelial surface, these 'optical biopsy' technologies have the potential to revolutionize our approach to endoscopic surveillance, potentially offering a more targeted, efficient and cost-effective approach to endoscopic surveillance.

## OVERVIEW OF EXISTING TECHNOLOGIES

### Wide-field technologies

Multiple "wide-field" technologies, including narrow-band imaging (NBI), Fujinon Intelligent Color Enhancement system and AFI, have been developed with the goal of highlighting suspicious GI mucosa. These modalities can enhance the macroscopic view of the GI mucosa to theoretically improve diagnostic sensitivity of standard endoscopy. There are no large randomized trials showing an advantage of these technologies over high-definition white light endoscopy. However, these techniques serve an important, complementary role by "red-flagging" suspicious mucosa which can then be better characterized by imaging modalities with greater spatial resolution. This "combination strategy" offers the potential to better identify and characterize lesions at the point of care. Such an approach may enhance detection and treatment strategies by preventing the unnecessary removal of benign lesions and facilitating margin determination during endoscopic therapy.

### High resolution and high magnification endoscopy

Resolution of an image, a separate quality from magnification, is defined as the ability to optically distinguish two closely approximated objects or points<sup>[4]</sup>. High resolution endoscopy augments the ability to perceive detail within an image while magnification endoscopy enlarges an image. For endoscopic video imaging, resolution is a function of pixel density; the higher the pixel density, the better the resolution. At this time, standard definition endoscopes offer a pixel density of 100 000 to 400 000 pixels, meaning that each image is built from 100 000 to 400 000 pixels. High definition or high resolution endoscopes produce images with resolutions ranging from 850 000 to 1 million pixels<sup>[4]</sup>. High resolution endoscopes



**Figure 1** Image of fiber bundle extending through the biopsy port of a standard white-light endoscope<sup>[7]</sup>.

are able to detect objects 10-71 microns in diameter, compared with the naked eye which can discriminate objects 125-165 microns in diameter<sup>[5]</sup>.

Magnification endoscopy usually involves the use of a movable lenses that allows the endoscopist to zoom in on a small area of mucosa and magnify it up to 150 times<sup>[6]</sup>. With greater magnification and resolution, greater image detail can be detected compared to white-light endoscopy. Often, these techniques are used in conjunction with other endoscopic imaging tools, such as chromoendoscopy, to improve detection of mucosal abnormalities. A novel high resolution microscope described by Muldoon *et al*<sup>[7]</sup> involves inexpensive components capable of fluorescence microscopy. This system (Figure 1) consists of a small caliber fiberoptic 3-m image-guide bundle that is made of 30 000 individual fibers and totals to 1 mm in diameter. The center-to-center spacing between the fibers is 4  $\mu\text{m}$ ; this spacing largely determines the resolution of the endoscopic microscope<sup>[8]</sup>.

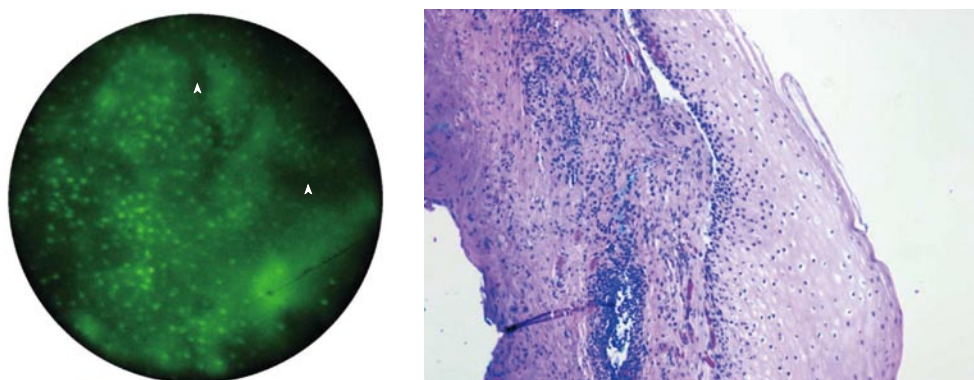
In preliminary studies by the authors, a small amount of acriflavine hydrochloride, a nuclear-specific fluorescent contrast agent, was applied to the tissue surface prior to imaging. Images were produced by placing the distal surface of the fiberoptic bundle in to direct contact with the tissue to be examined. Illumination was provided using a 455 nm blue light emitting diode that produced a light intensity of approximately 1 W. The fluorescent light returning to the bundle is directed to a scientific grade charged-coupled device that transmitted images to a personal computer. This imaging technique allows for *in vivo* visualization of normal mucosa, such as the normal squamous tissue of the esophagus (Figure 2). When used on *in vitro* biopsy and EMR specimens, the device was able to effectively delineate esophageal intraepithelial neoplasia from Barrett's metaplasia and low-grade dysplasia (Figure 3)<sup>[7,8]</sup>.

This microscope is particularly appealing as the cost of the current prototype consists of less than \$3500 in components and uses a 1-2 mm (outer diameter) probe, which can be inserted into the biopsy channel of any endoscope. In addition, the system is capable of fluorescence imaging at a subcellular resolution, thus allowing

**Table 1** Overview of the currently available high-resolution imaging technologies

Technology	Contrast	Field of view	Lateral resolution	Clinical results			
				Trial	Patients (n)	No. of examined areas	Results
Confocal laser endoscopy (Pentax-eCLE)	IV fluorescein Topical acriflavine 0.05%	475 $\mu$ m	0.7 $\mu$ m	Kiesslich <i>et al</i> <sup>[36]</sup>	63	156	Barrett's: Sensitivity 98.1%; Specificity 94% Esophageal neoplasia: Sensitivity 92.9%; Specificity 98.4%
Confocal laser endoscopy (Mauna Kea-pCLE)	IV fluorescein Topical acriflavine 0.05%	240-600 $\mu$ m	1 $\mu$ m	Bajbouj <i>et al</i> <sup>[51]</sup>	39	670	Specificity: 97% (blinded), 95% (on-site); Sensitivity: 28% (blinded), 12% (on-site)
Endocytoscopy (Olympus)	Absorptive contrast (i.e. Methylene Blue or Toluidine Blue)	< 0.5 mm	1.7-4 $\mu$ m	Pohl <i>et al</i> <sup>[33]</sup>	16	166	PPV/NPV (HGIN or cancer in Barrett's patients) -0.29/0.87 ( $\times$ 450) -0.44/0.83 ( $\times$ 1125)
				Sasajima <i>et al</i> <sup>[35]</sup>	60	75	93.3% accuracy in colon cancer detection
HRME	Topical proflavine 0.01%	750 $\mu$ m	< 4 $\mu$ m	N/A $\rightarrow$ Currently going to clinical trial			
Optical coherence tomography	None		Traditional systems: 7-20 $\mu$ m Catheter-based: 1-2 $\mu$ m	Poneros <i>et al</i> <sup>[52]</sup>	121	288	Diagnosis of intestinal metaplasia: 97% sensitive, 92% specific

HRME: High resolution magnification endoscopy; PPV: Positive predictive value; NPV: Negative predictive value.



**Figure 2** Images of normal squamous tissue using the High Resolution Microendoscope. A: Endoscopic microscope image of normal squamous tissue stained with 0.05% acriflavine shows flat arrangement of squamous epithelium with round regularly spaced nuclei. The round clear spaces surrounded by the epithelium represent the papillae (arrowhead). The acriflavine in image A highlights the nuclei; B: Histopathology of same specimen. Scale bar is 100 microns.

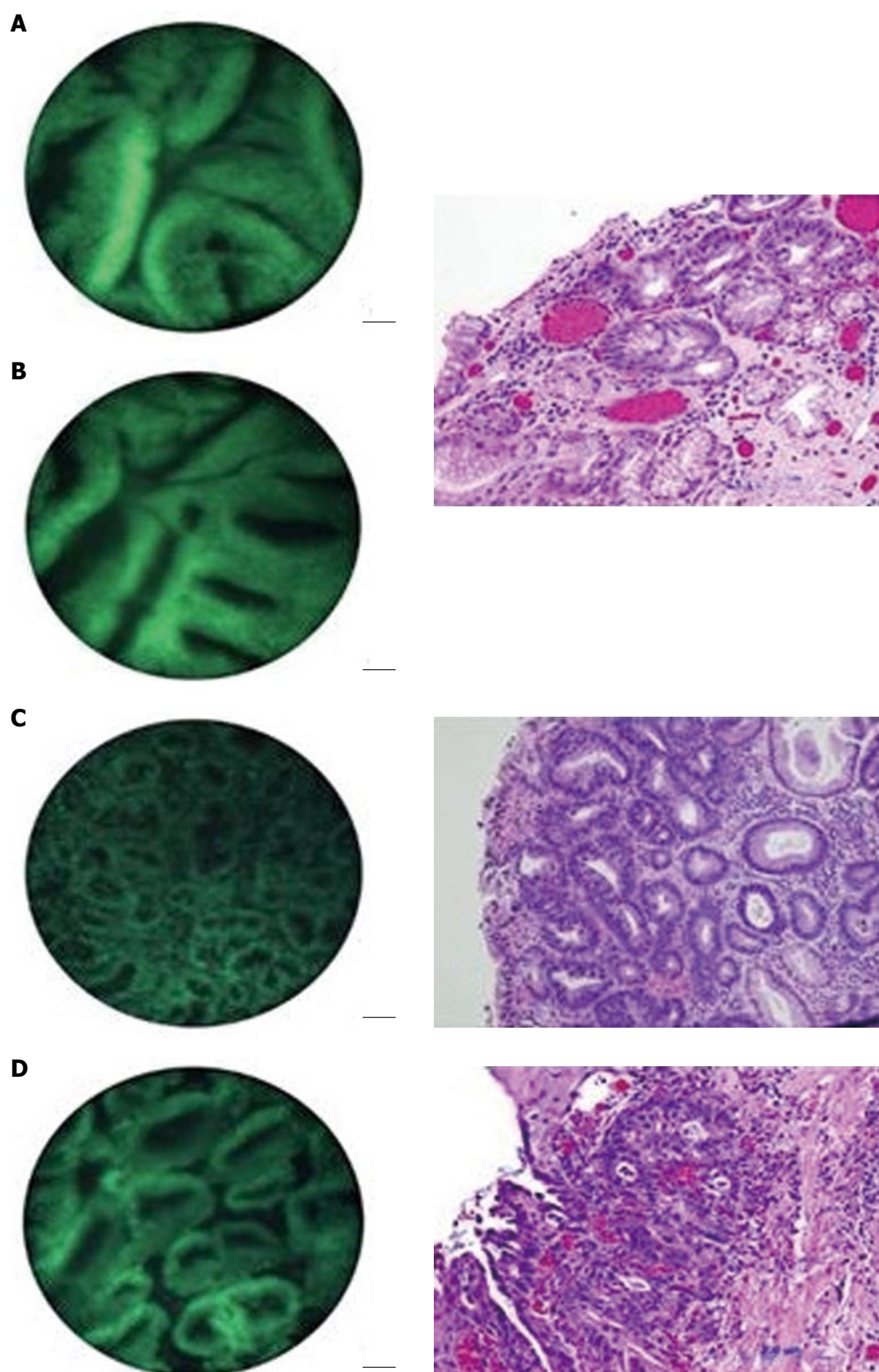
targeted endomicroscopy as more sophisticated molecularly targeted fluorescent contrast agents become available.

### Optical coherence tomography

OCT is the endoscopic, optical analogue of high frequency B-mode ultrasonography<sup>[9]</sup>. However, instead of using sound waves to generate images, OCT uses light waves. OCT is an optical signal acquisition and processing method that can capture high resolution, three dimensional images within any optical scattering media, such as biological tissue. Cross-sectional images are obtained by measuring the intensity of back-scattered light from various depths of tissue using a technique called

low-coherence interferometry. Just as in B-mode ultrasonography, a quantitative measurement of backscattering is performed at each axial depth and these measurements are repeated at different transverse positions. In this manner, a linear or radial two-dimensional map of backscattering strength is acquired and used to produce a high resolution image<sup>[10,11]</sup>. OCT has attracted interest in a variety of medical applications, including ophthalmic scanning<sup>[12]</sup>, diagnosis of epithelial lesions<sup>[13]</sup>, bronchoscopy<sup>[14]</sup> and evaluation of atherosclerosis<sup>[15]</sup>.

OCT is usually performed by introducing a linear or radial catheter into the accessory channel of a standard endoscope, duodenoscope or colonoscope. As in ultrasound, a water interface or tissue contact is not required

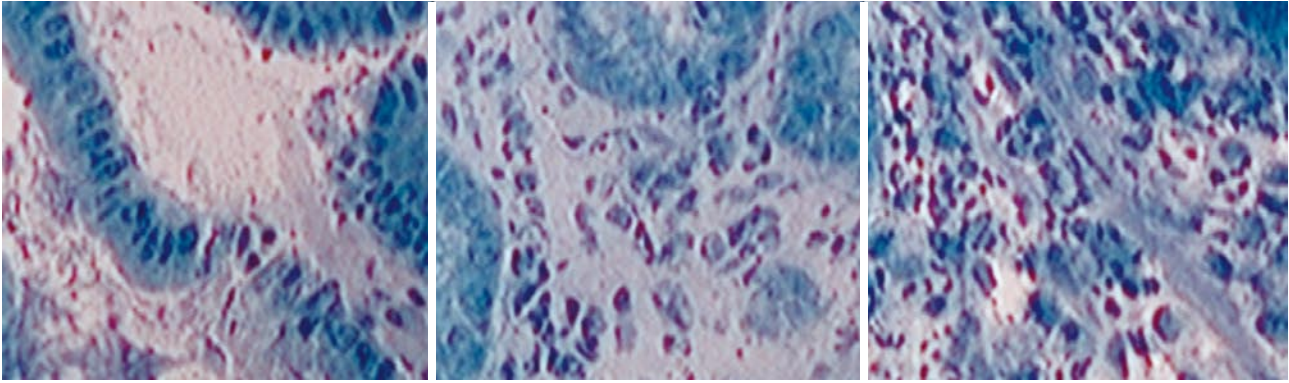


**Figure 3** High resolution microendoscope in Barrett's esophagus: After staining with topical acriflavine, corresponding microendoscopic and histopathological images are shown of Barrett's metaplasia/LGD (A, B) and high grade dysplasia (C, D). The uniformly shaped and spaced glands with intact nuclear polarity can easily be differentiated from the crowded, back-to-back glandular architecture noted in HGD.

to produce an image. Newer OCT systems are capable of producing a  $512 \times 512$  pixel image within one-quarter of a second. Not only are OCT images obtained in real-time, but these images also have a 10-fold greater resolu-

tion (approximately 7 to 20  $\mu\text{m}$ ) than modalities such as endoscopic ultrasound<sup>[16]</sup>. This increased resolution allows for visualization of microscopic mucosal features such as villi, crypts and glands. Although these tissue ele-





**Figure 4** Endocytoscopy enables visualization of different cytological and architectural features, including size, arrangement and density of cells (adapted with permission<sup>[81]</sup>).

ments can be viewed with high resolution, the sampling depth of OCT is limited to 1-2 mm due to scattering of light by tissue. Additionally, the resolution of OCT is not sufficient to visualize abnormalities such as nuclear dysplasia. Characteristics visualized with OCT that may be indicative of dysplasia or regenerative changes include incomplete surface maturation, with a high-surface OCT signal compared with the subsurface signal, and irregular glands<sup>[6]</sup>.

Currently, research is being done to improve the image-acquisition capabilities of OCT. For example, there are reports of a catheter-based OCT system utilizing femtosecond laser pulses to improve imaging capabilities in the GI system; this system can achieve a resolution of approximately 1-2  $\mu\text{m}$ , 10 times better than current OCT systems. In addition to visualizing mucosal structures such as crypts, villi and glands, newer OCT systems are more capable of identifying architectural distortion associated with inflammatory and neoplastic processes. High-resolution OCT also improves the quality of images with sharper images and reduction of image speckling<sup>[17]</sup>.

Other advances in OCT include spectroscopic OCT, which uses the spectrum of back-scattered light to obtain diagnostic tissue information, and doppler OCT, which can potentially be used to detect differences in microvascular networks between dysplastic and non-dysplastic epithelium<sup>[9]</sup>. Recently, Winkler *et al*<sup>[18]</sup> have coupled OCT imaging with laser induced fluorescence imaging (LIF). Their system provides 18  $\mu\text{m}$  OCT resolution while also providing low resolution laser-induced fluorescence. While the LIF component provides little spatial resolution, the addition of fluorescence microscopy allows targeted molecular targets to be used to further characterize dysplastic mucosa. In addition, modifications are being made to their LIF system to increase their resolution.

### Endocytoscopy

EC is based on the principle of light contact microscopy. This imaging technology enables real-time visualization of the cellular structures of the superficial epithelial layer in a plane parallel to the mucosal surface (Figure 4). In order to visualize cellular and subcellular structures (e.g.,

nuclei) with EC, it is necessary to pre-stain the mucosa with an absorptive contrast agent, such as 0.5% to 1% methylene blue, cresyl violet or 0.25% toluidine blue. Often, the mucosa is treated with a mucolytic such as N-acetylcysteine prior to staining. After the stain is applied to the tissue surface, the tip of the endoscope is placed in direct contact with the dye-stained surface mucosa and then the target mucosa is scanned with condensed normal white light. A fixed-focus, high-power objective lens projects highly magnified images from a minute sampling site (< 0.5 mm diameter) on to a charge-coupled device<sup>[19-21]</sup>. With this method, cytological details can be directly visualized, making direct observation of living cells feasible.

The first EC system was utilized in otolaryngology and consisted of a rigid instrument which was not practical for GI use. Now, a novel endocytoscope system, Endocytoscope, has been developed by Olympus instruments (Tokyo, Japan) which consists of two flexible endoscopes with a diameter of 3.2 that can be passed through the accessory channel with a diameter of 3.7 or larger of an endoscope. The Endocytoscope system is comprised of one low-magnification ( $\times 450$ ) endocytoscope and one high-magnification ( $\times 1100$ ) endocytoscope<sup>[20]</sup>. In addition to the probe-based endocytoscope system described above, there are integrated endocytoscope system prototypes available as well.

Endocytoscopic diagnosis is based on the assessment of several cytological and architectural features, such as the density, size and arrangement of cells; the size and shape of nuclei; the nucleus-to-cytoplasm ratio; and the staining pattern. For example, squamous cell carcinoma of the esophagus is distinguished by increased density of cells and marked heterogeneity in staining in nuclear staining and size, as opposed to the orderly cellular arrangement and homogenous staining pattern seen in normal squamous esophageal epithelium<sup>[19,22]</sup>.

### Confocal endomicroscopy

Confocal laser endoscopy (CLE) is one of the newest endoscopic technologies. While some endoscopic techniques such as NBI and chromoendoscopy can be used

effectively to highlight suspicious areas of mucosa for biopsy and histological analysis, CLE offers the endoscopist the ability to make a real-time, *in vivo* histological assessment of GI mucosa. Confocal laser microscopy is based on the excitation of a fluorophore in a specimen using a laser which sequentially scans specific points on the specimen in a raster pattern whereby the focused spot traverses a line rapidly from left to right and the line is swept top to bottom, mapping out a square<sup>[23]</sup>. The emission of the fluorophore at the point of illumination is recorded to create the pixels of an image. Emitted light is also channeled through a pinhole such that light that is not focused at a specific depth is unable to reach the detector. Thus, confocal microscopy is able to scan specific optical depths within the specimen and provide a clear, two-dimensional image of the tissue sample<sup>[9]</sup>.

CLE integrates a confocal laser microscope either in the tip of a video endoscope or as a probe than can be passed through the channel of any endoscope<sup>[5]</sup>. One widely used CLE system consists of an endoscope with embedded CLE technology manufactured by Pentax (Tokyo, Japan). This system is available both for upper GI endoscopy and colonoscopy<sup>[6]</sup>. In the embedded CLE technology (eCLE), a confocal laser microscope is integrated directly into the end of a video endoscope. Images are obtained by using a laser which delivers an excitation wavelength of 488 nm. The pixels are collected every 0.7  $\mu\text{m}$  (to give 0.7  $\mu\text{m}$  lateral resolution) for a total field of view of 475  $\mu\text{m}$  and can be collected through various sections of the mucosa in 7  $\mu\text{m}$  increments to a depth of 250  $\mu\text{m}$ . Current equipment is able to achieve this at a rate of 0.8 to 1.6 frames/s. This system is capable of providing both excellent image clarity and the ability to use the confocal endomicroscope just like a conventional endoscope. In order to produce quality images, image stabilization is necessary; this is achieved using suction. Consequently, a “suction polyp” is created that helps to target tissue biopsy to the imaged area<sup>[24]</sup>.

Alternately, a confocal microscope can be introduced as a mini-probe into the working/accessory channel of the endoscope; a probe-based CLE system (pCLE), Cellvizio-GI, has been created by Mauna Kea Technologies (Paris, France). The advantage of this system is that, unlike the embedded CLE technology, the confocal microscopy probe can be used with any commercial endoscope and, subsequently, a variety of wide-field technologies (Narrow Band Imaging, *etc.*). The probe is placed into the biopsy channel of a standard endoscope and then retracted to allow for tissue biopsy<sup>[24]</sup>. Depending on the system used, pCLE can scan with 1-3.5  $\mu\text{m}$  lateral resolution for a total field of view of 240-600  $\mu\text{m}$ , which does not compare well with the embedded systems. In addition, pCLE systems are unable to vary the depth at which they collect data and thus lack axial resolution. However, these tradeoffs allow the probe based system to operate with a much faster scanning rate (12 frames/s compared to the 0.8-1.2 frames/s in eCLE).

In order to obtain images using either confocal endo-

microscopic tool, the patient must be given a fluorescent contrast agent. This can either be given intravenously or sprayed onto the mucosa directly. The most common contrast agent is IV fluorescein 10%. Fluorescein aptly highlights the vasculature, lamina propria and intracellular spaces, allowing visualization of vessel pattern and cellular architecture<sup>[25]</sup>. Fluorescein and its metabolites are excreted renally. Adverse side effects of fluorescein are rare but may include hypotension without shock (0.5%), nausea (0.39%), injection site erythema (0.35%), diffuse self-limited rash (0.04%) or mild epigastric pain (0.09%). Anaphylaxis has been reported but is uncommon<sup>[23,26]</sup>. Of note, fluorescein does not provide direct nuclear visualization and the appreciation of nucleus-to-cytoplasm ratio cannot be used for the diagnosis and grading of intraepithelial neoplasias.

Acriflavine hydrochloride (0.05% in saline) and cresyl violet (0.13% in acetic acid) are two contrast agents that are applied topically to the mucosa during CLE. Acriflavine is used to stain cellular nuclei which fluorescein is unable to do. However, since acriflavine accumulates in the nuclei, there is a potential mutagenic risk associated with it. Cresyl violet causes cytoplasmic enrichment which in turn leads to negative visualization of nuclear morphology. It also provides pit pattern characterization of mucosal lesions and so can be used for chromoendoscopy as well<sup>[23]</sup>.

## CLINICAL APPLICATIONS OF THE “OPTICAL BIOPSY” TECHNOLOGIES

The aforementioned endoscopic techniques offer a more accurate and in-depth view of GI mucosa. Most studies to date have used these advanced endoscopic techniques in detecting GI lesions to improve early detection of cancer in Barrett's esophagus, colon cancer screening and ulcerative colitis. The advantages of imaging the mucosa are particularly apparent in clinical scenarios where a large number of random biopsies could be replaced with a targeted biopsy of suspicious lesions.

Barrett's esophagus (BE) is the most important risk factor for esophageal adenocarcinoma. The purpose of endoscopic surveillance in monitoring BE is to detect early neoplastic lesions [high grade dysplasia (HGD) or intramucosal cancer] and utilize less invasive, endoscopic treatments. Although guidelines recommend surveillance for Barrett's metaplasia every 3 years, the current practice involves endoscopic white light examination with random four-quadrant biopsy, a procedure that has been shown to miss neoplasia in up to 57% of cases<sup>[27,28]</sup>.

The overall incidence of colorectal cancer (CRC) is increasing in Western populations; CRC now represents the most fatal malignancy in non-smokers in Europe and North America<sup>[29]</sup>. Although CRC carries a high mortality rate, this malignancy can be treated or prevented with early detection. The use of *in vivo* histology may improve our ability to differentiate neoplastic from non-neoplastic lesions and facilitate the detection of cancer at an earlier stage.



### High resolution microendoscopy

In an *ex vivo* study conducted by Muldoon *et al*<sup>[7]</sup>, high resolution microendoscopy (HRME) imaging was conducted on several specimens obtained by EMR after the application of topical acriflavine. The microendoscopic images were compared to histopathological analysis of the same site. The device was able to delineate normal squamous mucosa from Barrett's metaplasia/low-grade dysplasia (LGD) and HGD/cancer (Figure 3).

In another study by the same authors, nine patients with pathologically confirmed Barrett's esophagus underwent endoscopic examination with biopsies or EMR<sup>[8]</sup>. Resected fresh tissue was imaged with fiber bundle microendoscopy/HRME. The images were then analyzed, either visually or with quantitative computer analysis, to predict whether the imaged sites were non-neoplastic or neoplastic. Predictions were compared to the gold standard of histopathology. Subjective analysis of the images by expert clinicians, including two gastroenterologists and two pathologists, achieved average sensitivity and specificity of 87% and 61% respectively. Subjective image analysis, however, was subject to some intra-observer variability.

In the same study, a quantitative, computer-based algorithm was developed to analyze images obtained with HRME. This algorithm was developed using 59 distinct image features as input; this helped to classify an image as neoplastic or non-neoplastic. Histopathology again was used as the gold standard; sites with a pathological diagnosis of Barrett's metaplasia or Barrett's metaplasia with low-grade dysplasia were considered to be non-neoplastic while sites with a pathological diagnosis of Barrett's metaplasia with high-grade dysplasia or esophageal adenocarcinoma were considered to be neoplastic. The best performing quantitative classification algorithm relied on two image textural features, frequency content and pixel-pair correlation, and achieved a sensitivity and specificity of 87% and 85% respectively.

The greatest advantage of the HRME, as mentioned previously, is its cost, portability and flexibility. The limitations are the axial resolution and poor depth penetration. However, to further assess the feasibility of this technology, clinical trials are currently in progress.

### Optical coherence tomography

**OCT and Barrett's esophagus:** OCT has been widely studied for use in examining the esophagus and the esophago-gastric junction. Normal esophageal tissue on OCT imaging shows an easily recognizable horizontal, layered structure. OCT features predictive for the presence of intestinal metaplasia are: (1) the absence of the layered structure of the normal squamous epithelium and the presence of the vertical crypt-and-pit morphology of normal gastric mucosa; (2) a disorganized architecture with inhomogeneous back-scattering of the signal and an irregular mucosal surface; and (3) the presence of submucosal glands characterized at the OCT imaging as pockets of low reflectance below the epithelial surface<sup>[30,31]</sup>. When

these OCT criteria were applied to images acquired prospectively, the criteria were found to be 97% sensitive and 92% specific for specialized intestinal metaplasia, with a PPV of 84%. Use of these simple criteria is limited, however, as the presence of the crypt-and-pit architecture in normal or inflamed gastric mucosa may make it difficult to discriminate between esophageal metaplasia and normal or inflamed gastric mucosa. Also, it is difficult to identify high-grade dysplasia utilizing OCT; the increased nuclear-to-cytoplasmic ratio occurring in dysplasia can alter the light reflection characteristics, giving a more inhomogeneous back-scattering of the signal. Poneros<sup>[30]</sup> were able to improve diagnosis of high grade dysplasia by using two parameters of tissue reflectivity as an indicator of dysplasia. These criteria retrospectively diagnosed high-grade dysplasia with 100% sensitivity and 85% specificity.

**OCT and the colon polyps:** In studies undertaken at Eppendorf Clinic University of Hamburg (Germany) and Cleveland Clinic Foundation (United States), endoscopic OCT was tested as a possible tool for *in vivo* endoscopic differential diagnosis of colon polyps and assessing the need of their removal during colonoscopy<sup>[22]</sup>. OCT features of adenomas and hyperplastic polyps were developed, based on which the diagnostic accuracy of OCT was statistically analyzed. 48 tubular adenomas, 12 tubulovillous adenomas and 56 hyperplastic polyps were studied. It was found that the hyperplastic polyp is characterized by a three-layer "benign" OCT image demonstrating thickening of the upper layer (glandular mucus membrane) and clear border between glandular mucus membrane and submucous layer. Additionally, adenoma is characterized by an image that does not demonstrate layers. This study showed that, of 116 polyps studied, OCT can differentiate adenomas from hyperplastic polyps with good sensitivity (92%) and specificity (84%).

### Endocytoscopy

**EC and Barrett's esophagus:** Pohl *et al*<sup>[33]</sup> conducted a study examining the utility of EC in the surveillance of patients with Barrett's esophagus. In this *in vivo* study, 166 biopsy sites from 16 patients (13 male, mean age 62.1 years) were examined; these patients had no visible lesions and were presenting for Barrett's surveillance endoscopy. EC images were recorded from pre-marked areas in the Barrett's segment using magnification  $\times 1125$  or  $\times 450$ . Biopsies were taken from the same area to allow precise comparison with histology. The images of each area were individually reviewed by both a pathologist and a gastroenterologist in a blinded fashion. In the study, the pathologist noted that features of neoplasia could be evaluated in only 0%-19% of image sequences with magnification  $\times 450$  and in only 4%-41% of sequences obtained with magnification  $\times 1125$ . Conversely, the gastroenterologist noted 74% of low-magnification images as interpretable for neoplasia and 78% of high-magnification images were interpretable for neoplasia. Overall, there was poor inter-observer agreement be-

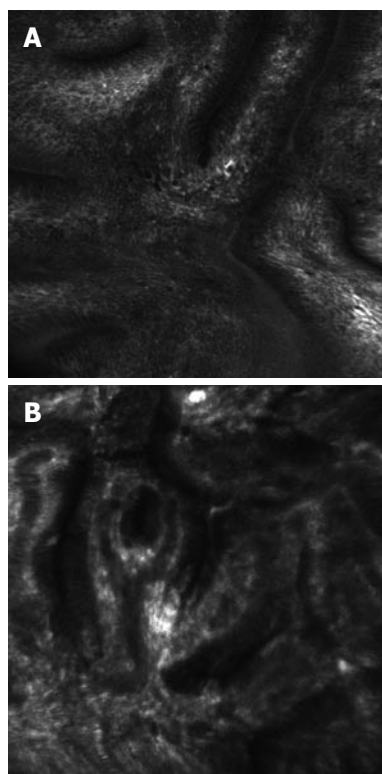
tween the gastroenterologist and pathologist and many images were found to have poor quality or could not be examined at all. Positive and negative predictive values for high grade intraepithelial neoplasia (HGIN) or cancer were 0.29 and 0.87 respectively for magnification  $\times 450$  and 0.44 and 0.83 respectively for magnification  $\times 1125$ .

Although this study did not demonstrate good utility for EC in obtaining endoscopic histology, another study by Eberl *et al.*<sup>[34]</sup> showed that the sensitivity and specificity for the evaluation of 25 patients with neoplastic esophageal lesions by blinded pathologists was 81% and 100% respectively. These improved results are likely due to the presence of identified neoplastic lesions, whereas in the Pohl study there were no visible lesions present. It is important to note that image quality remains an issue with EC. However, advances in this technology are combining EC with other endoscopic tools such as NBI to screen Barrett's esophagus and isolate suspicious areas of the mucosa for evaluation and biopsy.

**EC and colon cancer:** Sasajima *et al.*<sup>[35]</sup> studied the utility of EC in evaluating colorectal lesions; 60 patients were enrolled for examination (43 men, 17 women) and these patients underwent evaluation with EC. The images obtained were compared to histology as the gold standard. A pathologist, who was blinded to the conventional colonoscopic views and the final histological diagnosis, made a diagnosis by assessing the digital EC images. A diagnosis of high-grade adenoma was made by 7 evaluated criteria: (1) disorder of polarity; (2) deformity of nuclei; (3) enlargement of nuclei; (4) various shapes of cells; (5) higher cellular density; (6) increased nuclear:cytoplasmic ratio; and (7) irregular colonic glands. The overall accuracy of EC in this study was 93.3%. According to this study, EC has the capability of providing real-time *in vivo* images which are nearly as accurate as histology. Additionally, in the study conducted by Eberl *et al.*<sup>[34]</sup>, 28 patients with neoplastic colonic lesions were studied with EC and the obtained images were evaluated by a blinded pathologist. The study found a sensitivity and specificity of 61% and 86% respectively in predicting pathological lesions at  $\times 450$  magnification, but increased those results to 83% and 87% respectively at  $\times 1125$ . Clearly, the higher magnification EC was superior in sensitivity compared to the lower magnification.

### Confocal laser endomicroscopy

**CLE and Barrett's esophagus:** Confocal laser endomicroscopy is a new technology that enables the endoscopist to obtain real-time histological information about the examined GI mucosa. Kiesslich *et al.*<sup>[36]</sup> demonstrated that the embedded CLE diagnosed Barrett's-related neoplasia during endoscopy with a sensitivity of 92.9% and a specificity of 98.4%. Additionally, Dunbar *et al.*<sup>[37]</sup> conducted a prospective, randomized, double-blinded, crossover study analyzing the diagnostic yield of CLE-targeted biopsies. This study compared four-quadrant random biopsies with CLE-targeted biopsies in 39 patients. They demonstrated that CLE improved the diagnostic yield for detecting



**Figure 5** Confocal laser endoscopy image of Barrett's metaplasia (A) and high grade dysplasia (HGD) (B) after the intravenous administration of 5 mL of intravenous fluorescein as an exogenous contrast agent. The fluorescein enhances the subepithelial capillary network. HGD can be distinguished from non-neoplastic Barrett's esophagus by the branching, irregular capillary network and irregular, thickened basement membrane.

neoplasia in BE patients, particularly for endoscopically-inapparent neoplastic lesions. CLE detected 33.7% of neoplastic lesions *vs* 17.2% of lesions detected with random biopsies. Additionally, two-thirds of patients in the routine surveillance group did not need any biopsies when examined with CLE due to absence of neoplasia during *in vivo* imaging. The Kiesslich *et al.*<sup>[36]</sup> study also reported a potential reduction in number of mucosal biopsies needed; only 30 of 156 (19.2%) CLE sites in 63 patients examined would have required a mucosal biopsy for confirmation of diagnosis of neoplasia. Ongoing work by us and others continue to study the feasibility of CLE in diagnosing dysplasia in Barrett's esophagus (Figure 5).

**CLE and ulcerative colitis:** In a 2007 study by Kiesslich *et al.*<sup>[10]</sup>, it was demonstrated that chromoendoscopy-guided CLE can be very useful in patients with ulcerative colitis (UC) in detecting neoplasia. The study involved 153 patients who were randomized to undergo conventional colonoscopy or chromoscopy (with 0.1% methylene blue) with endomicroscopy. In the conventional group, random biopsy examinations and targeted biopsy examinations were taken. In the endomicroscopy group, circumscribed mucosal lesions were identified by chromoscopy and evaluated for targeted biopsy examination by endomicroscopy. The results of this study showed

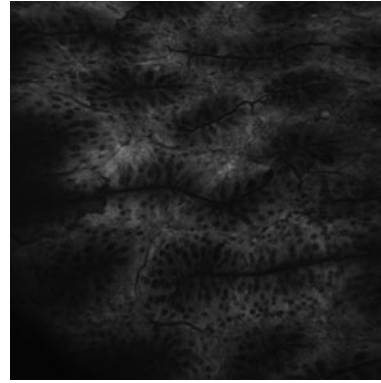
that for grading of UC activity, the endomicroscope assessment agreed with histology 92.5% of the time. By using the confocal pattern classification, the presence of intraepithelial neoplasia (IN), within the endomicroscopy group, was predicted with a sensitivity of 94.7% and a specificity of 98.3%. By using chromoendoscopy with CLE, 4.75-fold more INs was found compared with conventional colonoscopy with random biopsy specimens. Additionally, similar to the results for studies on Barrett's, using chromoscopy-guided CLE allowed for 50% fewer biopsies compared with conventional colonoscopy.

The management of dysplasia-associated lesional mass (DALM) and adenoma-like mass (ALM) in chronic ulcerative colitis is significantly different. With dysplasia-associated lesional mass, the treatment involves total proctocolectomy whereas with adenoma-like mass, the treatment is limited to endoscopic resection and surveillance colonoscopy. Conventional colonoscopy has limited utility in differentiating these two lesions. However, confocal endomicroscopy has been shown to be effective in evaluating these lesions. In a study by Hurlstone *et al.*<sup>[38]</sup>, the accuracy of confocal endomicroscopy for *in vivo* diagnosis of dysplasia-associated lesional mass *vs* adenoma-like mass was 97% (95% CI: 86%-99%). ALM was defined at endomicroscopy as any lesional morphology (Paris criteria 0-II/I) within or outside of an ulcerative colitis zone with no adjacent flat neoplastic architecture. DALM was defined as any lesional morphology (Paris 0-II/I) within a colitis zone accompanied by adjacent mucosal neoplastic criteria. Neoplastic confocal criteria were defined as mucosa demonstrating either dilated/distorted vascular architecture with or without leakage or crypt/goblet cell depletion with or without irregular epithelial "ridge-lined" crypt architecture.

The ability to differentiate ALM and DALM helps to better manage patients clinically, replacing random biopsies with fewer targeted biopsies. As such, there is decreased development of submucosal desmoplasia that almost inevitably complicate multiple biopsies. Also, this technique helps to target biopsies to areas of high suspicion for dysplasia *in vivo*, thereby allowing for rapid, high accuracy diagnosis of dysplasia-associated lesional mass. This leads to more appropriate use of endoscopic resection and directs therapy to pan-proctocolectomy when it is indicated.

**CLE and colon cancer screening:** A study by Polglase *et al.*<sup>[39]</sup> showed that with either topical acriflavine stain or with IV fluorescein stain, the histological correlates of the mucin-containing goblet cells and the columnar epithelial cells, including those vertically oriented across the surface in contact with the confocal imaging window and those radially oriented within crypts, were readily identifiable within the surface of the colonic mucosa<sup>[11]</sup>. Confocal endomicroscopy is useful in identifying normal histology of the colonic mucosa and, in addition, this tool can be used to effectively identify abnormal mucosal patterns.

Kiesslich *et al.*<sup>[10]</sup> described a clinical study aimed at



**Figure 6** Normal colonic mucosa seen with a confocal endomicroscope. Glands are seen longitudinally but are well organized and homogenous. Goblet cells appear black.

evaluating the role of confocal endomicroscopy in predicting histology in screening colonoscopy for CRC, which showed that the presence of neoplastic changes was predicted with high accuracy (97.4% sensitivity, 99.4% specificity and 99.2% accuracy). Additionally, a study by Buchner *et al.*<sup>[40]</sup> compared CLE with virtual chromoscopy (Flexible spectral Imaging Color Enhancement) for classification of colonic polyps. This study demonstrated that when compared to the histopathology, endomicroscopy had a higher sensitivity than virtual chromoscopy in classifying colonic polyps, 91% *vs* 77% respectively. Further multi-center clinical trials are needed to prove the utility of CLE in identifying malignant lesions (Figure 6).

In another study by Kiesslich *et al.*<sup>[41]</sup>, the authors analyzed the predictive power of CLE for diagnosing IN and CRC during ongoing video colonoscopy. In this study, 27 patients underwent CLE evaluation of the colon using either topical acriflavine or IV fluorescein contrast. Additionally, 42 patients underwent observation of standard locations within the colon with CLE (using only IV fluorescein) in addition to CLE observation of specific lesions "unmasked" using adjunctive methylene blue pan-chromoendoscopy. Using both acriflavine hydrochloride and fluorescein sodium, high-quality images were obtained with acriflavine strongly staining the superficial epithelial cells and IV fluorescein permitting deep laminal resolution imaging. Fluorescein-guided CLE was also able to resolve tubular, villous and irregular crypt architecture with an associated loss of goblet cells. Vascular architecture was found to have changed in the context of IN with irregular peri-cryptic vessels (rather than the discrete 'honeycombing' observed surrounding the normal crypt), with an invariable accompanying fluorescein capillary leakage characterized by the neo-angiogenic drive associated with overt neoplasia. These initial data subsequently permitted the creation of the now validated Mainz CLE criteria for IN. Thirteen thousand and twenty CLE images from 390 locations were compared with the histopathological reports (the "gold standard") from 1038 targeted biopsy specimens. IN was subsequently predicted



with a high overall accuracy of 99.2% (sensitivity 97.4%, specificity 99.4%)<sup>[41]</sup>.

**CLE and celiac disease:** Given the great potential to perform *in vivo* histology, it is not surprising that endomicroscopy has been applied to other disease processes besides neoplasia. Venkatesh *et al.*<sup>[42]</sup> recently applied CLE to the diagnosis of celiac disease (CD) in children. Nine patients with suspected CD and 10 matched controls were evaluated with eCLE and a scoring system was developed based on the shape of the villi, distortion of the pattern of surface epithelial enterocytes, decrease in goblet cells, presence of infolding villi and presence of intervillous bridging. Based on the evaluation by two trained confocal endoscopists, eCLE was 100% sensitive and 80% specific compared to the diagnosis by a histopathologist. Further studies using greater number of patients and using the scoring system with untrained endoscopists would have to be done to fully evaluate the applicability of CLE on CD.

## IN VIVO HISTOLOGY: WHERE ARE WE HEADED?

With the advent of the technologies reviewed above, the tools to allow real-time histology have undoubtedly been developed. Many of the techniques reviewed offer very high sensitivity and specificity in detecting histological abnormalities. Whether the technology can be reasonably used in a wide variety of clinical settings, however, is a far more complicated question.

One limitation to subcellular endoscopy is the vast amount of time that would theoretically be required to analyze large sections of mucosa. Many studies have overcome this problem by complementing microscopic endoscopy with so-called “red flag techniques” such as NBI and chromoendoscopy. These systems can highlight areas of suspicion for further, targeted examination by more advanced endoscopic imaging tools.

As reviewed above, endocystoscopy, HRME and CLE all require some kind of contrast agent. Currently we are limited to IV injection of fluorescein and topical application of methylene blue, toluidine blue or acriflavine. These agents rely on the interpretation of the clinician to make the appropriate clinical diagnosis. Thus, one area of development over the next several years will be in the development of more specific, targeted stains and contrast agents.

There are already several studies that have used targeted contrast agents either in *ex vivo* biopsy samples or *in vivo* mouse models. Based on the observation that malignant cells upregulate glucose transport into their cytoplasm<sup>[43-45]</sup>, Thekkek *et al.*<sup>[46]</sup> have used topically applied fluorescent deoxyglucose on *ex vivo* specimens to differentiate normal from neoplastic specimens<sup>[46,47]</sup>. One exciting development is the use of contrast agents that bind specific surface proteins that are overexpressed in malignant cells. Hsiung *et al.*<sup>[48]</sup> have developed a fluorescent heptapeptide isolated from a phage library that binds co-

lonic adenomas with a sensitivity of 81% and specificity of 82%. Foersch *et al.*<sup>[49]</sup> were able to inject fluorescently tagged antibodies against vascular endothelial growth factor (VEGF) in mouse colon cancer models and perform murine *in vivo* confocal endomicroscopy with significantly increased staining of malignant cells and clear delineation of the transition zone. Most recently, a fluorescently labeled VEGF was used to highlight VEGF receptors on the surface of mouse colon cancers<sup>[18]</sup>. Further development of such targeted contrast agents will be needed before opening the realm of endoscopic immunofluorescence.

In addition to a lack of good contrast agents, another significant limitation of these technologies is that they require significant training<sup>[50]</sup>. Each specialized endoscope requires familiarity with the basic operation of the system and technical training to obtain the best pictures. For example, despite measures to stabilize the endoscope against the mucosa in many of the above technologies, the stability of the endoscope remains of crucial importance when looking at subcellular architecture; excessive movements can create distorted pictures. The largest amount of time, however, will likely be spent on training clinicians to interpret the endomicroscopic images. Preliminary studies show that training of clinicians can be done with significantly high accuracy and interobserver agreement. Dunbar *et al.*<sup>[24]</sup> show that after training 11 endoscopists on pCLE using 20 images with known histology followed by a blinded review of 20 unknown images, the overall sensitivity for obtaining the correct diagnosis was 88% and specificity 96%, with substantial interobserver agreement (86%). The conclusions, however, are limited by the small number of endoscopists tested and the presence of clinicians with prior pCLE experience which may have biased the results.

There are several ways the issue of training can be addressed. As mentioned above, Muldoon *et al.*<sup>[8]</sup> offer an interesting quantitative computer-based algorithm that would make interpretation of images from Barrett's esophagus much simpler, with good sensitivity and specificity. Such systems would complement the interpretation of a trained clinician. In addition, the development of new contrast agents, if specific to malignant cells, has the potential to simplify interpretation to merely the differentiation of “bright vs dark”.

Lastly, the most significant limitation of currently available technology is cost. Given some of the sophisticated electronics and engineering involved in these systems, it is not surprising that current systems range from \$150 000-\$300 000. While the cost of unnecessary biopsies and pathological interpretation is saved, the price of these platforms makes real-time histology advantageous only in specific clinical scenarios where large numbers of biopsies are usually performed, as in Barrett's esophagus or familial adenomatous polyposis. Alternatively, these microscopic images could be invaluable in situations where the immediate histological information can significantly change clinical care, such as identifying and delineating the margins of neoplasia for EMR. Finally,

cheaper solutions such as the HRME may provide an adequate degree of resolution to facilitate real-time decision making in lower resource settings where confocal systems may be not be feasible. These are all questions that are in the process of being answered.

## CONCLUSION

The past several years have been marked by the emergence of several exciting and innovative “optical biopsy” technologies that provide real-time subcellular imaging of the GI tract. The ability to make a real-time histopathological diagnosis is potentially invaluable in enhancing the detection of early neoplasia and in facilitating minimally invasive therapies, such as EMR. Widespread application of these technologies, however, is limited by the current cost of these platforms, the lack of targeted contrast agents and the learning curve associated with interpretation of the microendoscopic images. Increased clinical and translational research in these areas will likely ensure that many of these issues are resolved over the next decade, making real-time histology a reality for today’s endoscopist.

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## Appropriateness of outpatient gastrointestinal endoscopy in a non-academic hospital

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### Abstract

**AIM:** To assess the appropriate use and the diagnostic yield of upper gastrointestinal endoscopy and colonoscopy in this subgroup of patients.

**METHODS:** In total, 789 consecutive outpatients referred for gastrointestinal (GI) endoscopy [381 for esophagogastroduodenoscopy (EGD) and 408 for colonoscopy] were prospectively enrolled in the study. The American Society for Gastrointestinal Endoscopy (ASGE) guidelines were used to assess the relationship between appropriateness and the presence of relevant endoscopic findings.

**RESULTS:** The overall inappropriate rate was 13.3%. The indications for EGD and colonoscopy were, respectively, appropriate in 82.7% and 82.6% of the exams, uncertain in 5.8% and 2.4% and inappropriate in 11.5% and 15%. The diagnostic yield was significant higher for

EGDs and colonoscopies judged appropriate and uncertain when compared with those considered inappropriate (EGD: 36.6% vs 36.4% vs 11.4%,  $P = 0.004$ ; Colonoscopy: 24.3% vs 20.0% vs 3.3%,  $P = 0.001$ ). Of the 25 malignant lesions detected, all but one was detected in exams judged appropriate or uncertain.

**CONCLUSION:** This study shows a good adherence to ASGE guidelines by the referring physicians and a significant increase of the diagnostic yield in appropriate examinations, namely in detecting neoplastic lesions. It underscores the importance that the appropriateness of the indication assumes in assuring high-quality GI endoscopic procedures.

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**Key words:** Gastrointestinal endoscopy; Indications; Appropriateness

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### INTRODUCTION

Over the last decade, an increasing demand for gastrointestinal (GI) endoscopy has occurred<sup>[1]</sup>. Unfortunately, the rise in quantity has not always been accompanied by a

parallel rise in quality. Several studies, based on the American Society for Gastrointestinal Endoscopy (ASGE) guidelines<sup>[2]</sup>, showed a substantial rate of inappropriateness of indications for esophagogastroduodenoscopy (EGD) and colonoscopy and a parallel decrease in the diagnostic yield of these endoscopic procedures<sup>[3-10]</sup>. The inappropriate rate is higher in outpatients and in endoscopic units of non-academic hospitals<sup>[5,9]</sup>. These represent the vast majority of patients submitted for GI endoscopy in Portuguese hospitals.

The aims of this prospective study were to assess, according to the ASGE guidelines, the appropriateness of indications and the diagnostic yield of EGD and colonoscopy in outpatients referred to an endoscopy unit of a non-academic hospital in Portugal.

## MATERIALS AND METHODS

The study was performed from October 2005 to June 2006 in an endoscopy unit of a non-academic hospital (São Bernardo Hospital, Setúbal). In Portugal, non-academic hospitals give assistance to 75% of the population. At our hospital, like in most Portuguese hospitals, GI endoscopy can be requested by hospital-based specialists without prior evaluation by a gastroenterologist, but primary care physicians cannot directly refer patients to endoscopy. The population of our geographical area includes around 270 000 inhabitants and is characterized by a high prevalence of gastric and colorectal cancer. Outpatients ( $n = 789$ ) referred for EGD ( $n = 381$ ) and colonoscopy ( $n = 408$ ) were included in this study. All patients gave written informed consent for the endoscopic procedure. Referring physicians were unaware of the study.

Data were collected prospectively and uniformly according to a previously defined protocol. Before beginning the procedure, endoscopists determined the indications for the examination based on the clinical history. The exam was performed regardless of the indication, unless a contraindication was present. The endoscopic examination was carried out using standard, forward-viewing video endoscopes or colonoscopes by gastroenterologists ( $n = 6$ ) or by trainees in gastroenterology ( $n = 3$ ). After the procedure, demographic data, indications and endoscopic findings were reported in the same chart.

The indications were classified, by agreement of two endoscopists, according to the practice guidelines of the ASGE as appropriate, non-appropriate and uncertain (when the data did not allow a correct classification).

Endoscopic findings were classified as “clinically relevant”, when they affected the therapeutic decisions and prognosis, and “not clinically relevant”. Clinically significant findings for EGD included erosive esophagitis, candida esophagitis, Barrett’s esophagus, esophageal cancer, benign esophageal stenosis, achalasia, esophageal varices, Mallory-Weiss tears, gastric ulcer, gastric polyps, gastric cancer, benign gastric stenosis, angiodysplasia (when the indications were hematochezia, fecal occult blood or iron deficiency anemia), duodenal ulcer and duodenal cancer.

**Table 1** Demographic and clinical characteristics of the study population

	EGD	Colonoscopy
Sex (M/F)	191/190	218/190
Age (mean $\pm$ SD, yr)	59.5 $\pm$ 15	61.4 $\pm$ 13.0
Age (< 45 yr/ $\geq$ 45 yr, %)	16.8/83.2	11.3/88.7
Clinical setting (elective/urgent)	94.8/5.2	94.4/5.6

EGD: Esophagogastroduodenoscopy.

Clinically relevant findings for colonoscopy included colorectal cancer, malignant polyps, advanced adenomas (> 1 cm, villous component or high-grade dysplasia), inflammatory bowel disease, angiodysplasia (when the indications were hematochezia, fecal occult blood or iron deficiency anemia) and radiation colitis. When there was more than one endoscopic diagnosis, the most severe one was used for analysis.

To evaluate the association between appropriateness and the presence of clinically relevant endoscopic diagnoses, patients in whom the endoscopic procedure was performed because of an ASGE indication were compared with those in whom an ASGE indication was absent or uncertain.

Statistical analysis was performed with the Chi-Square test and Fisher’s Exact test, using SPSS 11.5 (SPSS Inc.<sup>®</sup>) statistical software. A  $P$  value of < 0.05 was considered significant.

## RESULTS

### Esophagogastroduodenoscopy

Of the 381 outpatients included in the study, 191 (50.1%) were men and 190 (49.9%) were women. The mean age was  $59.5 \pm 15.1$  years (range 13-88 years), with 317 patients (83.2%) being older than 45 years. The exam was electively scheduled in 361 (94.8%) patients and performed urgently in 20 (5.2%) (Table 1).

The indication for EGD was considered appropriate, according to ASGE criteria, in 82.7% of cases, not-appropriate in 11.5% and uncertain in 5.8% (patients whose indication was anemia not otherwise specified). The inappropriate rate was similar in male patients compared with female patients (13.6% *vs* 9.5%,  $P = 0.079$ ), in those younger than 45 years compared with older patients (14.1% *vs* 11.0%,  $P = 0.245$ ) and in the scheduled procedures compared with those performed as an urgent procedure (11.5% *vs* 5.0%,  $P = 0.141$ ). The most common appropriate indications were persistent upper abdominal symptoms despite therapy, associated with alarm symptoms or occurring in patients over 45 years of age (28.3%) and symptoms attributable to gastro-esophageal reflux (12.1%). The most frequent inappropriate indications were surveillance for malignancy in patients with chronic gastritis (2.9%) or a prior gastric operation (2.6%) and follow-up of duodenal ulcer (2.1%) (Table 2).

EGDs were normal in 16.8% of cases. The number

**Table 2** Indications for esophagogastroduodenoscopy and diagnostic yield according to the American Society for Gastrointestinal Endoscopy guidelines *n* (%)

ASGE Indication	Frequency	Relevant lesions (%)	<i>P</i>
Appropriate indication	315 (82.7)	36.6	
Upper abdominal symptoms <sup>1</sup>	108 (28.3)	21.3	0.001
Esophageal reflux symptoms that are persistent or recurrent despite appropriate therapy	46 (12.1)	39.1	0.412
Portal hypertension evaluation	30 (7.9)	80.0	< 0.0001
Follow-up of gastric ulcer	24 (6.3)	33.3	1.0
Iron deficiency anemia	23 (6.0)	13.0	0.018
Endoscopic treatment	18 (4.7)	77.8	< 0.0001
Dysphagia or odynophagia	16 (4.1)	62.5	0.027
Surveillance for malignancy in patients with Barrett's esophagus	11 (2.9)	90.9	< 0.0001
Persistent vomiting of unknown cause	11 (2.9)	18.2	0.346
Active or recent GI bleeding	10 (2.6)	30.0	1.0
For confirmation and specific histologic diagnosis of radiologically demonstrated lesions	8 (2.1)	50.0	0.451
Sampling of tissue or fluid	7 (1.8)	14.3	0.236
Others	24 (6.2)	25.0	0.523
Uncertain indication	22 (5.8)	36.4	
Anemia not otherwise characterized	22 (5.8)	36.4	1.0
Inappropriate indication	44 (11.5)	11.4	
Surveillance for malignancy in patients with chronic gastritis	11 (2.9)	0	< 0.0001
Surveillance for malignancy in patients with prior gastric operation	10 (2.6)	25.0	0.758
Follow-up of duodenal ulcer	8 (2.1)	30.0	1.0
Others	15 (3.8)	0	< 0.0001

<sup>1</sup>Upper abdominal symptoms persistent, despite therapy, associated with symptoms or signs suggesting serious organic disease or occurring in patients > 45 years old. ASGE: American Society for Gastrointestinal Endoscopy; GI: Gastrointestinal.

of normal exams was higher in EGDs performed for a non-appropriate indication when compared with those performed for an appropriate indication (25.0% *vs* 15.2%, *P* = 0.047) and in patients younger than 45 years compared with older patients (42.2% *vs* 11.7%, *P* < 0.0001). The percentage of normal exams in EGDs performed for an uncertain indication was 22.7%.

A clinically relevant diagnosis was detected in 129 EGD (33.9%). The diagnostic yield of appropriate and uncertain EGDs was significantly higher than non-appropriate EGDs (36.6% *vs* 36.4% *vs* 11.4%, *P* = 0.004) (Table 2). This is particularly true for some indications, including surveillance of malignancy in Barrett's esophagus (90.9%, *P* < 0.0001), portal hypertension evaluation (80.0%, *P* < 0.0001), dysphagia/odynophagia (62.5%, *P* = 0.027) and for therapeutic procedures (77.8%, *P* < 0.0001). In contrast, EGDs performed for dyspepsia (21.3%, *P* = 0.001), iron deficiency anemia (13%, *P* = 0.018), surveillance for malignancy in patients with chronic gastritis (0.0%, *P* < 0.0001) and surveillance

**Table 3** Clinically relevant endoscopic findings in esophagogastroduodenoscopies according to appropriateness of the indication

Endoscopic finding	<i>n</i> (%)	ASGE (%)	Uncertain (%)	Non-ASGE (%)	<i>P</i>
Esophageal varices	30 (7.9)	8.9	9.1	0.0	0.119
Erosive esophagitis	27 (7.1)	7.6	4.5	4.5	0.676
Gastric ulcer	21 (5.5)	6.7	0.0	0.0	0.097
Gastric polyps	16 (4.2)	4.1	13.6	0.0	0.033
Barrett's esophagus	17 (4.5)	4.8	0.0	4.5	0.578
Duodenal ulcer	10 (2.6)	2.2	9.1	2.3	0.148
Gastric cancer	9 (2.4)	2.9	0.0	0.0	0.038
Candida esophagitis	5 (1.3)	1.6	0.0	0.0	0.475
Angiodysplasia <sup>1</sup>	2 (0.5)	0.6	0.0	0.0	0.856
Esophageal cancer	1 (0.3)	0.3	0.0	0.0	0.900
Esophageal stenosis	1 (0.3)	0.3	0.0	0.0	0.900
Gastric stenosis	1 (0.3)	0.3	0.0	0.0	0.900
Total	129 (33.9)	36.6	36.4	11.4	0.004

<sup>1</sup>Only angiodysplasias found in exams performed for hematochezia or iron deficiency anemia were considered clinically relevant. ASGE: American Society for Gastrointestinal Endoscopy.

for malignancy in patients with prior gastric operations (0.0%, *P* < 0.0001) had a relatively low diagnostic yield.

A higher number of relevant endoscopic findings was found in patients older than 45 years when compared with younger patients (36.6% *vs* 20.3%, *P* = 0.013), but not in urgent EGDs comparing to elective ones (35% *vs* 33.8%, *P* = 1.0).

The most frequent significant diagnoses were esophageal varices (7.9%), erosive esophagitis (7.1%) and gastric ulcer (5.5%). Ten malignancies (2.7%) were detected, all of them in EGDs with an appropriate ASGE indication (Table 3).

### Colonoscopy

Of the 408 outpatients included in the study, 218 (53.4%) were men and 190 (46.6%) were women. The mean age was 61.4 ± 13 years (range 19-88 years), with 362 patients (88.7%) being older than 45 years. The exam was electively scheduled in 385 (94.4%) patients and performed urgently in 23 (5.6%) (Table 1).

The indication for colonoscopy was considered appropriate, according to ASGE criteria, in 82.6% of cases, not-appropriate in 15% and uncertain in 2.4% (patients whose indication was anemia not otherwise specified). The inappropriate rate was significantly higher in female patients compared with male patients (19.5% *vs* 11%, *P* = 0.038). The inappropriate rate was similar in those younger than 45 years compared with older patients (8.7% *vs* 15.7%, *P* = 0.212) and in the scheduled procedures compared with those performed as an urgent procedure (15.6% *vs* 4.3%, *P* = 0.299). The most common appropriate indications were surveillance after resection of colonic polyps (19.4%), excision of colonic polyps (17.4%) and screening for colonic neoplasia (12.7%). The most frequent inappropriate indications were abdominal pain (12.3%) and chronic constipation (4.4%) (Table 4).



**Table 4** Indications for colonoscopy and diagnostic yield according to the American Society for Gastrointestinal Endoscopy guidelines *n* (%)

ASGE Indication	Frequency	Relevant lesions (%)	<i>P</i>
Appropriate indication	337 (82.6)	24.3	
Follow-up of colonic polyps	79 (19.4)	21.5	0.879
Excision of colonic polyp	71 (17.4)	42.3	< 0.0001
Screening for colonic neoplasia	52 (12.7)	7.7	0.010
Hematochezia	36 (8.8)	30.6	0.197
Follow-up for colorectal cancer	31 (7.6)	9.7	0.166
Diarrhea	30 (7.4)	16.7	0.647
Iron deficiency anemia	20 (4.9)	5.0	0.090
Follow-up for inflammatory bowel disease	12 (2.9)	100	< 0.0001
Evaluation of an imaging study abnormality that is likely to be clinically significant	10 (2.5)	0.0	0.129
Presence of fecal occult blood	9 (2.2)	44.4	0.098
Evaluation for synchronous cancer or neoplastic polyps	4 (1.0)	100	0.002
Uncertain indication	10 (2.4)	20.0	
Anemia not otherwise characterized	10 (2.4)	20.0	1.000
Inappropriate indication	61 (15.0)	3.3	
Abdominal pain	50 (12.3)	6.0	0.005
Chronic constipation	18 (4.4)	5.5	0.006
Unexplained weight loss	6 (1.5)	0.0	< 0.0001
Others	14 (3.4)	0.0	< 0.0001

ASGE: American Society for Gastrointestinal Endoscopy.

**Table 5** Clinically relevant endoscopic findings in colonoscopies according to appropriateness of the indication

Endoscopic finding	<i>n</i> (%)	ASGE (%)	Uncertain (%)	Non-ASGE (%)	<i>P</i>
Adenoma <sup>1</sup>	69 (13.2)	15.7	0.0	1.6	0.005
Colorectal cancer	15 (3.7)	3.6	20.0	1.6	0.755
Inflammatory bowel disease	12 (2.9)	3.6	0.0	0.0	0.272
Angiodysplasia <sup>2</sup>	2 (0.5)	0.6	0.0	0.0	1.000
Radiation colitis	3 (0.7)	1.0	0.0	0.0	1.000
Total	86 (21.1)	24.3	20.0	3.3	0.001

<sup>1</sup>Only malignant or advanced adenomas were considered clinically relevant; <sup>2</sup>Only angiodysplasias found in exams performed for hematochezia or iron deficiency anemia were considered clinically relevant. ASGE: American Society for Gastrointestinal Endoscopy.

Colonoscopies were normal in 33.8% of cases. The number of normal exams was higher in colonoscopies performed for a non-appropriate indication when compared with those performed for an appropriate indication (45.9% *vs* 31.5%, *P* = 0.007) and in patients younger than 45 years compared with older patients (54.3% *vs* 31.2%, *P* = 0.004). The percentage of normal exams in colonoscopies performed for an uncertain indication was 40.0%.

A clinically relevant diagnosis was detected in 86 colonoscopies (21.1%) (Table 5). The diagnostic yield of appropriate and uncertain colonoscopies was significantly higher than non-appropriate colonoscopies (24.3% *vs* 20.0% *vs* 3.3%, *P* = 0.001). This is particularly true for

some indications, including surveillance for colonic neoplasia in inflammatory bowel disease (100%, *P* < 0.0001), screening for synchronous cancer or neoplastic polyps (100%, *P* < 0.0001) and for excision of a colonic polyp (42.3%, *P* < 0.0001). Conversely, referrals for screening for colonic neoplasia (7.7%, *P* = 0.01), for abdominal pain (6.0%, *P* = 0.005) and for chronic constipation (5.5%, *P* = 0.006) had a relatively low diagnostic yield. A higher number of relevant endoscopic findings were also found in urgent colonoscopies compared to elective ones (43.5% *vs* 19.7%, *P* = 0.014) but not in patients older than 45 years when compared with younger patients (21.3% *vs* 19.6%, *P* = 1.0).

The most frequent significant diagnoses were adenomas (13.2%), colorectal cancer (3.7%) and inflammatory bowel disease (2.9%). With regard to malignancies, 12 were detected in exams with an appropriate ASGE indication, 2 in exams with an uncertain indication and 1 in an exam without an appropriate ASGE indication (Table 5).

## DISCUSSION

GI endoscopy plays a central role in gastroenterology as an accurate and safe procedure for diagnosis, follow-up, treatment or exclusion of clinically important gastrointestinal disease<sup>[11,12]</sup>. For this reason, most GI endoscopic centers in Europe and the United States implement some type of open-access service<sup>[10,13,14]</sup>. This has led to an increasing demand for endoscopic procedures and, consequently, an increase in the costs and the waiting lists<sup>[1,10]</sup>. Therefore, adherence to appropriate indications for endoscopic procedures is essential to the rational use of finite resources.

Several studies show a substantial overuse of EGD (12% to 39%) and colonoscopy (15% to 43%) and a parallel decrease in the diagnostic yield of these endoscopic procedures<sup>[3-10]</sup>. The rate of inappropriateness is higher in outpatients and in endoscopic units of non-academic hospitals<sup>[4,5]</sup>. These represent the vast majority of patients submitted to GI endoscopy in Portuguese hospitals.

In order to address this problem, we decided to perform a prospective study in this specific scenario. Overuse of EGD (11.5%) and colonoscopy (15%) was low in this prospective study, compared to other studies conducted in Europe, particularly in this subset of patients. In part, this could be due to the fact that primary care physicians cannot directly refer patients to our endoscopic unit, as many studies have shown that they have a high overuse rate<sup>[4,6]</sup>. The inappropriate rate of colonoscopies was significantly higher in female patients compared with male patients. This probably reflects the higher prevalence of functional gastrointestinal disorders in women<sup>[15,16]</sup>. Like in the study of Hassan *et al*<sup>[4]</sup>, the percentage of not accepted indications was higher in scheduled procedures compared with those performed as an urgent procedure, but it did not reach statistical significance. This was also the case for patients younger than 45 years in EGD. Interestingly, in colonoscopy, the overuse was superior



in patients older than 45 years, a finding similar to that reported by Minoli *et al*<sup>[5]</sup>. The main inappropriate indications for EGD were surveillance for malignancy in patients with prior gastric operations and surveillance of healed benign disease. For colonoscopy, they were abdominal pain and chronic constipation. Special attention should be given to these topics when implementing educational programs for referring physicians.

The other aim of this study was to assess the relationship of the appropriateness of indications with the endoscopic findings. One-third of colonoscopies were normal, twice the number of normal EGDs. In both procedures, the percentage of normal exams was higher in non-appropriate indications and in patients younger than 45 years. More important than the number of normal exams, the efficacy of an endoscopic procedure is usually defined as its diagnostic yield, that is, the ability to detect a finding that is potentially relevant to patient care<sup>[17]</sup>. In our study, clinically significant abnormalities were found in about one-third of EGDs and one-fifth of colonoscopies. These numbers are lower than those reported in most published studies, particularly regarding colonoscopy<sup>[4-9]</sup>. This is mainly due a more restricted criteria applied in this study for the classification of a diagnosis as clinically relevant. In other studies, all adenomas were considered clinically relevant, as well as all angiodysplasias, which was not the case in this study. The probability of detecting a clinically relevant finding was significantly higher when EGDs and colonoscopies were performed for an appropriate as compared to an inappropriate indication, as has been previously reported<sup>[4-9]</sup>. The diagnostic yield of GI endoscopies performed for an uncertain indication (anemia not otherwise specified) were similar to the ones performed for an appropriate indication. This probably reflects the fact that these patients indeed had iron deficiency anemia and should be incorporated in the appropriate examinations group. The probability of detecting a clinically relevant finding was also significantly higher for some specific indications, namely, surveillance of malignancy in Barrett's esophagus, portal hypertension evaluation, dysphagia/odynophagia and for therapeutic procedures in EGD and surveillance for colonic neoplasia in inflammatory bowel disease, screening for synchronous cancer or neoplastic polyps and for therapeutic procedures in colonoscopies. On the other hand, EGDs performed for dyspepsia, iron deficiency anemia, surveillance for malignancy in patients with chronic gastritis and surveillance for malignancy in patients with prior gastric operations and colonoscopies performed for abdominal pain and chronic constipation had a relatively low diagnostic yield. While the latter are inappropriate indications, the former two are indications considered appropriate by the ASGE guidelines. The low diagnostic yield of dyspepsia, found also in other studies<sup>[4]</sup>, probably reflects the contamination of this group by dyspeptic patients younger than 45 years (one-quarter of the total number of dyspeptic patients). The percentage of significant lesions in patients referred for iron deficiency anemia (13.0%) was

low compared to previous published data (40%)<sup>[18-21]</sup>. If we included the patients with anemia not otherwise specified in this group, the percentage of significant lesions would increase to 24.4%, still lower than expected. This can be due in part to a higher number of lesions beyond the reach of EGD in our population where the incidence of colorectal cancer is very high. A higher number of relevant endoscopic findings were also found in EGDs performed in patients older than 45 years when compared with younger patients and in urgent colonoscopies compared to elective ones. The former can be used as a useful parameter in scheduling the exams.

In this study, 25 neoplastic lesions were detected, 10 in EGDs and 15 in colonoscopies. All cancers in EGDs were detected in appropriate exams. This finding is very important because Portugal is a country that has a high prevalence of gastric cancer and because there has been some concern about the efficacy of ASGE guidelines in selecting those patients at risk for upper GI neoplasia from those who are not, following from the studies by Gonvers *et al*<sup>[22]</sup> and Rossi *et al*<sup>[23]</sup> that found a substantial number of cancer in inappropriate EGDs. With regard to colonoscopy, 12 malignancies were detected in exams with an appropriate ASGE indication, 2 in exams with an uncertain indication and 1 in an exam without an appropriate ASGE indication. As previously discussed, the exams performed for anemia not otherwise specified probably correspond to iron deficiency anemia and should be given the same importance of an appropriate indication when scheduling this subgroup of examinations. The single malignancy found at a colonoscopy in the group of patients with inappropriate indications was located in the sigmoid and was detected in a 78-year-old patient with chronic constipation who had never had a colonoscopy. Due to the age of the patient, if we considered this exam as screening for colonic neoplasia consistent with the concept of "colonoscopy once in a life"<sup>[24]</sup>, all neoplastic lesions in this study would be detected in appropriate exams. In addition, only 6 other significant lesions were found in inappropriate examinations, a number much lower than in previous studies<sup>[4-9,24]</sup>.

In conclusion, this study shows a good adherence to ASGE guidelines by referring physicians and a significant increase of the diagnostic yield in appropriate examinations, namely in detecting neoplastic lesions. For this reason, the appropriateness of the indication is critical to the cost-effectiveness of GI endoscopic procedures and must occupy a central role to filter the requests for GI endoscopy whether an open access or a hospital based system is used because we can no longer keep wasting limited resources and money.

## COMMENTS

### Background

Ethical and economical considerations are very important when considering inadequate endoscopic examinations. This study portrays Portugal's general situation in regard to endoscopic practice and gives an account of the activity of an endoscopic unit in a general non-academic hospital.

## Research frontiers

Portugal is a country with a high prevalence of gastric cancer and in our study all cancers in esophagogastroduodenoscopy (EGD) were detected in appropriate examinations. This underlines the efficacy of American Society for Gastrointestinal Endoscopy (ASGE) guidelines in selecting patients at risk for upper gastrointestinal (GI) neoplasia.

## Innovations and breakthroughs

Referral of patients by hospital practitioners opposed to open-access service leads to a decrease of overuse of EGD and colonoscopy, a decrease of health costs and waiting lists. This cannot be overrated in an area of economical restraints. Proper indications lead to an increase of diagnostic yield, that is, the ability to detect a finding that is potentially relevant to patient care.

## Applications

The design of this study revealed great utility for managing an endoscopic unit in Portugal and should be applied to a multicenter evaluation of endoscopic practice in our country.

## Peer review

The high level of appropriateness of endoscopic exams (EGD and colonoscopy) in this study reflected the referral of cases by hospital practitioners as opposed to open-access service. Diagnostic yield related significantly to appropriateness of indications according to ASGE guidelines. This study is important to local doctors and shows the practice for GI exams indications in Portugal.

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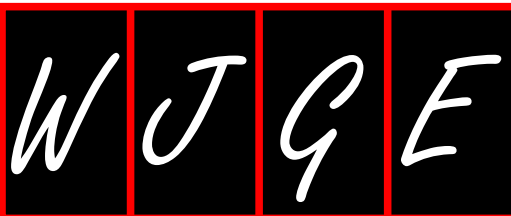
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## Events Calendar 2011

January 14-15, 2011  
AGA Clinical Congress of  
Gastroenterology and Hepatology:  
Best Practices in 2011  
Miami, FL 33101, United States

January 20-22, 2011  
Gastrointestinal Cancers Symposium  
2011  
San Francisco, CA 94143,  
United States

January 28-29, 2011  
9. Gastro Forum München  
Munich, Germany

February 04-05, 2011  
13th Duesseldorf International  
Endoscopy Symposium  
Duesseldorf, Germany

February 13-27, 2011  
Gastroenterology: New Zealand  
CME Cruise Conference  
Sydney, NSW, Australia

February 24-26, 2011  
Inflammatory Bowel Diseases  
2011-6th Congress of the European  
Crohn's and Colitis Organisation  
Dublin, Ireland

February 24-26, 2011  
2nd International Congress on  
Abdominal Obesity  
Buenos Aires, Brazil

February 26-March 1, 2011  
Canadian Digestive Diseases Week  
Westin Bayshore, Vancouver  
British Columbia, Canada

March 03-05, 2011  
42nd Annual Topics in Internal  
Medicine  
Gainesville, FL 32614,

United States

March 14-17, 2011  
British Society of Gastroenterology  
Annual Meeting 2011  
Birmingham, England, United  
Kingdom

March 17-19, 2011  
41. Kongress der Deutschen  
Gesellschaft für Endoskopie und  
Bildgebende Verfahren e.V.  
Munich, Germany

March 17-20, 2011  
Mayo Clinic Gastroenterology &  
Hepatology 2011  
Jacksonville, FL 34234, United States

March 25-27, 2011  
MedicReS IC 2011 Good Medical  
Research  
Istanbul, Turkey

April 07-09, 2011  
International and Interdisciplinary  
Conference Excellence in Female  
Surgery  
Florence, Italy

April 15-16, 2011  
Falk Symposium 177, Endoscopy  
Live Berlin 2011 Intestinal Disease  
Meeting, Stauffenbergstr. 26  
Berlin 10785, Germany

April 18-22, 2011  
Pediatric Emergency Medicine:  
Detection, Diagnosis and Developing  
Treatment Plans  
Sarasota, FL 34234, United States

April 20-23, 2011  
9th International Gastric Cancer  
Congress, COEX, World Trade  
Center, Samseong-dong  
Seoul 135-731, South Korea

April 25-27, 2011  
The Second International Conference  
of the Saudi Society of Pediatric  
Gastroenterology, Hepatology &  
Nutrition  
Riyadh, Saudi Arabia

April 28-30, 2011  
4th Central European Congress of  
Surgery  
Budapest, Hungary

May 07-10, 2011  
Digestive Disease Week  
Chicago, IL 60446, United States

May 12-13, 2011  
2nd National Conference Clinical  
Advances in Cystic Fibrosis  
London, England, United Kingdom

May 21-24, 2011  
22nd European Society of  
Gastrointestinal and Abdominal  
Radiology Annual Meeting and  
Postgraduate Course  
Venice, Italy

May 25-28, 2011  
4th Congress of the Gastroenterology  
Association of Bosnia and  
Herzegovina with international  
participation, Hotel Holiday Inn  
Sarajevo, Bosnia and Herzegovina

June 11-12, 2011  
The International Digestive Disease  
Forum 2011  
Hong Kong, China

June 13-16, 2011  
Surgery and Disillusion XXIV Spige  
II ESYS, Napoli, Italy

June 22-25, 2011  
ESMO Conference: 13th World  
Congress on Gastrointestinal Cancer  
Barcelona, Spain

September 10-11, 2011  
New Advances in Inflammatory  
Bowel Disease  
La Jolla, CA 92093, United States

September 10-14, 2011  
ICE 2011-International Congress of  
Endoscopy, Los Angeles Convention  
Center, 1201 South Figueroa Street  
Los Angeles, CA 90015, United  
States

September 30-October 1, 2011  
Falk Symposium 179, Revisiting  
IBD Management: Dogmas to be  
Challenged, Sheraton Brussels Hotel  
Brussels 1210, Belgium

October 19-29, 2011  
Cardiology & Gastroenterology  
Tahiti 10 night CME Cruise  
Papeete, French Polynesia

October 22-26, 2011  
19th United European  
Gastroenterology Week  
Stockholm, Sweden

October 28-November 02, 2011  
ACG Annual Scientific Meeting &  
Postgraduate Course  
Washington, DC 20001, United  
States

November 11-12, 2011  
Falk Symposium 180, IBD 2011:  
Progress and Future for Lifelong  
Management, ANA Interconti Hotel,  
1-12-33 Akasaka, Minato-ku  
Tokyo 107-0052, Japan

December 01-04, 2011  
2011 Advances in Inflammatory  
Bowel Diseases/Crohn's & Colitis  
Foundation's Clinical & Research  
Conference  
Hollywood, FL 34234, United States



## GENERAL INFORMATION

*World Journal of Gastrointestinal Endoscopy* (*World J Gastrointest Endosc*, *WJGE*, online ISSN 1948-5190, DOI: 10.4253), is a monthly, open-access (OA), peer-reviewed online journal supported by an editorial board of 400 experts in gastrointestinal endoscopy from 45 countries.

The biggest advantage of the OA model is that it provides free, full-text articles in PDF and other formats for experts and the public without registration, which eliminates the obstacle that traditional journals possess and usually delays the speed of the propagation and communication of scientific research results.

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The major task of *WJGE* is to report rapidly the most recent results in basic and clinical research on gastrointestinal endoscopy including: gastroscopy, intestinal endoscopy, colonoscopy, capsule endoscopy, laparoscopy, interventional diagnosis and therapy, as well as advances in technology. Emphasis is placed on the clinical practice of treating gastrointestinal diseases with or under endoscopy. Papers on advances and application of endoscopy-associated techniques, such as endoscopic ultrasonography, endoscopic retrograde cholangiopancreatography, endoscopic submucosal dissection and endoscopic balloon dilation are also welcome.

### Columns

The columns in the issues of *WJGE* will include: (1) Editorial: To introduce and comment on major advances and developments in the field; (2) Frontier: To review representative achievements, comment on the state of current research, and propose directions for future research; (3) Topic Highlight: This column consists of three formats, including (A) 10 invited review articles on a hot topic, (B) a commentary on common issues of this hot topic, and (C) a commentary on the 10 individual articles; (4) Observation: To update the development of old and new questions, highlight unsolved problems, and provide strategies on how to solve the questions; (5) Guidelines for Basic Research: To provide guidelines for basic research; (6) Guidelines for Clinical Practice: To provide guidelines for clinical diagnosis and treatment; (7) Review: To review systemically progress and unresolved problems in the field, comment on the state of current research, and make suggestions for future work; (8) Original Article: To report innovative and original findings in gastrointestinal endoscopy; (9) Brief Article: To briefly report the novel and innovative findings in gastrointestinal endoscopy; (10) Case Report: To report a rare or typical case; (11) Letters to the Editor: To discuss and make reply to the contributions published in *WJGE*, or to introduce and comment on a controversial issue of general interest; (12) Book Reviews: To introduce and comment on quality monographs of gastrointestinal endoscopy; and (13) Guidelines: To introduce consensus and guidelines reached by international and national academic authorities worldwide on basic research and clinical practice in gastrointestinal endoscopy.

### Name of journal

*World Journal of Gastrointestinal Endoscopy*

### ISSN

ISSN 1948-5190 (online)

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All articles published in this journal represent the viewpoints of the authors except where indicated otherwise.



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**Author contributions:** The format of this section should be: Author contributions: Wang CL and Liang L contributed equally to this work; Wang CL, Liang L, Fu JF, Zou CC, Hong F and Wu XM designed the research; Wang CL, Zou CC, Hong F and Wu XM performed the research; Xue JZ and Lu JR contributed new reagents/analytic tools; Wang CL, Liang L and Fu JF analyzed the data; and Wang CL, Liang L and Fu JF wrote the paper.

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There are unstructured abstracts (no more than 256 words) and structured abstracts (no more than 480). The specific requirements for structured abstracts are as follows:

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### Key words

Please list 5-10 key words, selected mainly from *Index Medicus*, which reflect the content of the study.

### Text

For articles of these sections, original articles, rapid communica-

tion and case reports, the main text should be structured into the following sections: INTRODUCTION, MATERIALS AND METHODS, RESULTS and DISCUSSION, and should include appropriate Figures and Tables. Data should be presented in the main text or in Figures and Tables, but not in both. The main text format of these sections, editorial, topic highlight, case report, letters to the editors, can be found at: [http://www.wjgnet.com/1948-5190/g\\_info\\_20100316080002.htm](http://www.wjgnet.com/1948-5190/g_info_20100316080002.htm).

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Figures should be numbered as 1, 2, 3, etc., and mentioned clearly in the main text. Provide a brief title for each figure on a separate page. Detailed legends should not be provided under the figures. This part should be added into the text where the figures are applicable. Figures should be either Photoshop or Illustrator files (in tiff, eps, jpeg formats) at high-resolution. Examples can be found at: <http://www.wjgnet.com/1007-9327/13/4520.pdf>; <http://www.wjgnet.com/1007-9327/13/4554.pdf>; <http://www.wjgnet.com/1007-9327/13/4891.pdf>; <http://www.wjgnet.com/1007-9327/13/4986.pdf>; <http://www.wjgnet.com/1007-9327/13/4498.pdf>. Keeping all elements compiled is necessary in line-art image. Scale bars should be used rather than magnification factors, with the length of the bar defined in the legend rather than on the bar itself. File names should identify the figure and panel. Avoid layering type directly over shaded or textured areas. Please use uniform legends for the same subjects. For example: Figure 1 Pathological changes in atrophic gastritis after treatment. A: ...; B: ...; C: ...; D: ...; E: ...; F: ...; G: ...etc. It is our principle to publish high resolution-figures for the printed and E-versions.

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Three-line tables should be numbered 1, 2, 3, etc., and mentioned clearly in the main text. Provide a brief title for each table. Detailed legends should not be included under tables, but rather added into the text where applicable. The information should complement, but not duplicate the text. Use one horizontal line under the title, a second under column heads, and a third below the Table, above any footnotes. Vertical and italic lines should be omitted.

### Notes in tables and illustrations

Data that are not statistically significant should not be noted. <sup>a</sup>*P* < 0.05, <sup>b</sup>*P* < 0.01 should be noted (*P* > 0.05 should not be noted). If there are other series of *P* values, <sup>c</sup>*P* < 0.05 and <sup>d</sup>*P* < 0.01 are used. A third series of *P* values can be expressed as <sup>e</sup>*P* < 0.05 and <sup>f</sup>*P* < 0.01. Other notes in tables or under illustrations should be expressed as <sup>1</sup>F, <sup>2</sup>F, <sup>3</sup>F; or sometimes as other symbols with a superscript (Arabic numerals) in the upper left corner. In a multi-curve illustration, each curve should be labeled with ●, ○, ■, □, ▲, △, etc., in a certain sequence.

### Acknowledgments

Brief acknowledgments of persons who have made genuine contributions to the manuscript and who endorse the data and conclusions should be included. Authors are responsible for obtaining written permission to use any copyrighted text and/or illustrations.

## REFERENCES

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### Format

#### Journals

*English journal article (list all authors and include the PMID where applicable)*

- 1 **Jung EM**, Clevert DA, Schreyer AG, Schmitt S, Rennert J, Kubale R, Feuerbach S, Jung F. Evaluation of quantitative contrast harmonic imaging to assess malignancy of liver tumors: A prospective controlled two-center study. *World J Gastroenterol* 2007; **13**: 6356-6364 [PMID: 18081224 DOI: 10.3748/wjg.13.6356]

*Chinese journal article (list all authors and include the PMID where applicable)*

- 2 **Lin GZ**, Wang XZ, Wang P, Lin J, Yang FD. Immunologic effect of Jianpi Yishen decoction in treatment of Pixu-diarhoea. *Shijie Huaren Xiaobua Zazhi* 1999; **7**: 285-287

*In press*

- 3 **Tian D**, Araki H, Stahl E, Bergelson J, Kreitman M. Signature of balancing selection in Arabidopsis. *Proc Natl Acad Sci USA* 2006; In press

*Organization as author*

- 4 **Diabetes Prevention Program Research Group**. Hypertension, insulin, and proinsulin in participants with impaired glucose tolerance. *Hypertension* 2002; **40**: 679-686 [PMID: 12411462 PMCID: 2516377 DOI:10.1161/01.HYP.0000035706.28494.09]

*Both personal authors and an organization as author*

- 5 **Vallancien G**, Emberton M, Harving N, van Moorselaar RJ; Alf-One Study Group. Sexual dysfunction in 1, 274 European men suffering from lower urinary tract symptoms. *J Urol* 2003; **169**: 2257-2261 [PMID: 12771764 DOI:10.1097/01.ju.0000067940.76090.73]

*No author given*

- 6 21st century heart solution may have a sting in the tail. *BMJ* 2002; **325**: 184 [PMID: 12142303 DOI:10.1136/bmj.325.7357.184]

*Volume with supplement*

- 7 **Geraud G**, Spierings EL, Keywood C. Tolerability and safety of frovatriptan with short- and long-term use for treatment of migraine and in comparison with sumatriptan. *Headache* 2002; **42** Suppl 2: S93-99 [PMID: 12028325 DOI:10.1046/j.1526-4610.42.s2.7.x]

*Issue with no volume*

- 8 **Banit DM**, Kaufer H, Hartford JM. Intraoperative frozen section analysis in revision total joint arthroplasty. *Clin Orthop Relat Res* 2002; **(401)**: 230-238 [PMID: 12151900 DOI:10.1097/00003086-200208000-00026]

*No volume or issue*

- 9 Outreach: Bringing HIV-positive individuals into care. *HRSA Careaction* 2002; 1-6 [PMID: 12154804]

### Books

*Personal author(s)*

- 10 **Sherlock S**, Dooley J. Diseases of the liver and biliary system. 9th ed. Oxford: Blackwell Sci Pub, 1993: 258-296

*Chapter in a book (list all authors)*

- 11 **Lam SK**. Academic investigator's perspectives of medical treatment for peptic ulcer. In: Swabb EA, Azabo S. Ulcer disease: investigation and basis for therapy. New York: Marcel Dekker, 1991: 431-450

*Author(s) and editor(s)*

- 12 **Breedlove GK**, Schorfheide AM. Adolescent pregnancy. 2nd ed. Wicczorek RR, editor. White Plains (NY): March of Dimes Education Services, 2001: 20-34

*Conference proceedings*

- 13 **Harnden P**, Joffe JK, Jones WG, editors. Germ cell tumours V. Proceedings of the 5th Germ cell tumours Conference; 2001 Sep 13-15; Leeds, UK. New York: Springer, 2002: 30-56

*Conference paper*

- 14 **Christensen S**, Oppacher F. An analysis of Koza's computational effort statistic for genetic programming. In: Foster JA, Lutton E, Miller J, Ryan C, Tettamanzi AG, editors. Genetic programming. EuroGP 2002: Proceedings of the 5th European Conference on Genetic Programming; 2002 Apr 3-5; Kinsdale, Ireland. Berlin: Springer, 2002: 182-191

**Electronic journal** (list all authors)

- 15 Morse SS. Factors in the emergence of infectious diseases. *Emerg Infect Dis* serial online, 1995-01-03, cited 1996-06-05; 1(1): 24 screens. Available from: URL: <http://www.cdc.gov/ncidod/eid/index.htm>

**Patent** (list all authors)

- 16 **Pagedas AC**, inventor; Ancel Surgical R&D Inc., assignee. Flexible endoscopic grasping and cutting device and positioning tool assembly. United States patent US 20020103498. 2002 Aug 1

### Statistical data

Write as mean  $\pm$  SD or mean  $\pm$  SE.

### Statistical expression

Express *t* test as *t* (in italics), *F* test as *F* (in italics), chi square test as  $\chi^2$  (in Greek), related coefficient as *r* (in italics), degree of freedom as *v* (in Greek), sample number as *n* (in italics), and probability as *P* (in italics).

### Units

Use SI units. For example: body mass, *m* (B) = 78 kg; blood pressure, *p* (B) = 16.2/12.3 kPa; incubation time, *t* (incubation) = 96 h; blood glucose concentration, *c* (glucose)  $6.4 \pm 2.1$  mmol/L; blood CEA mass concentration, *p* (CEA) =  $8.6 \pm 24.5$   $\mu$ g/L; CO<sub>2</sub> volume fraction, 50 mL/L CO<sub>2</sub>, not 5% CO<sub>2</sub>; likewise for 40 g/L formaldehyde, not 10% formalin; and mass fraction, 8 ng/g, etc. Arabic numerals such as 23, 243, 641 should be read 23 243 641.

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Standard abbreviations should be defined in the abstract and on first mention in the text. In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Permissible abbreviations are listed in Units, Symbols and Abbreviations: A Guide for Biological and Medical Editors and



Authors (Ed. Baron DN, 1988) published by The Royal Society of Medicine, London. Certain commonly used abbreviations, such as DNA, RNA, HIV, LD50, PCR, HBV, ECG, WBC, RBC, CT, ESR, CSF, IgG, ELISA, PBS, ATP, EDTA, mAb, can be used directly without further explanation.

### Italics

Quantities: *t* time or temperature, *c* concentration, *A* area, *l* length, *m* mass, *V* volume.

Genotypes: *gyrA*, *arg 1*, *c myc*, *c fos*, etc.

Restriction enzymes: *EcoRI*, *HindI*, *BamHI*, *Kbo I*, *Kpn I*, etc.

Biology: *H. pylori*, *E. coli*, etc.

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