

Low-residue versus clear liquid diet before colonoscopy:

a meta-analysis of randomized,
controlled trials

Gastrointestinal Endoscopy 2016;83:499-507

106.08.29 Journal club

引言人：營養室魏賓慧

BACKGROUND

- Colonoscopy is extremely important for the identification and removal of precancerous polyps.
- Bowel preparation before colonoscopy is essential for adequate visualization.
- Bowel preparation: (difficult to comply ?)(inadequate education)
 - clear liquids diet (traditionally)(the day before a colonoscopy)
 - ingest a large volume of preparation solution before colonoscopy.
- The goal of this meta-analysis :
evaluate the effects of bowel-preparation protocols
with an LRD compared with the standard CLD before colonoscopy.

低渣飲食

Low-residue diet

- 定義：每日粗纖維攝取量在4公克以下。

- 食物選擇應：

瓜類TDF含量
蔬菜 1g /100g
水果 0.6g /100g

- (1) 減少纖維質

(可吃精製穀類、瓜類蔬菜、過濾蔬菜汁、去皮水果、過濾果汁)

- (2) 避免動物筋膠
- (3) 避免奶類及其製品
- (4) 軟質(避免油炸)
- (5) 避免刺激

清流飲食

clear liquid diet

- 定義：完全無渣、不產氣或刺激腸道蠕動、室溫下清澈或液化流質飲食

- 食物選擇：

米湯、去油清湯、過濾後之果汁、蜂蜜水….

| | 腸鏡檢查(一般檢查) | |
|-------------|----------------------------|----------------------------|
| | 上午 | 下午 |
| 傳統瀉藥 | 前晚7PM服用瀉藥 | 檢查當日7AM服用瀉藥 |
| Dulcolax | 檢查前一日喝大量開水1000-1500cc | 檢查前一日喝大量開水1000-1500cc |
| Castor oil | | |
| FLEET 2瓶 | 第一瓶前晚6PM, 再補充1500cc以上開水 | 第一瓶前晚7PM, 再補充1500cc以上開水 |
| | 第二瓶檢查當日6AM, 再補充1000cc以上開水 | 第二瓶檢查當日7AM, 再補充1000cc以上開水 |
| | | |
| 克見清1包或耐福力2包 | 檢查當日5AM服用瀉藥, 第一次喝400CC, | 檢查當日9AM服用瀉藥, 第一次喝400CC, |
| 泡2000CC開水 | 之後每15分喝200CC, 直到2000CC喝完為止 | 之後每15分喝200CC, 直到2000CC喝完為止 |
| | (需在8AM前喝完) | (需在12點前喝完) |
| | | |

步驟 2：系統性文獻回顧的品質如何？(FAITH)

F - 研究是否找到 (Find) 所有的相關證據？

最好的狀況是？

良好的文獻搜尋至少應包括二個主要的資料庫(如：Medline, Cochrane 考科藍實證醫學資料庫, EMBASE 等)，並且加上文獻引用檢索(參考文獻中相關研究、Web of Science, Scopus 或 Google Scholar)、試驗登錄資料等。文獻搜尋應不只限於英文，並且應同時使用 MeSH 字串及一般檢索詞彙(text words)。

我可以在哪裡找到這些資訊？

在文章的方法(Methods)章節，可以找到詳細搜尋策略的說明，包括使用的名詞，結果(Results)章節中可以找到本篇系統性文獻回顧評估的摘要及全文文獻數目、文獻納入與排除的數量及原因。資料可能會以圖表或 PRISMA 的流程圖呈現。

評讀結果：☒是 ☐否 ☐不清楚

說明：

Methods - Literature search

Search terms and Formula

- Search Results =
“ low-residue diet and colonoscopy, ” +
“ fiber-free diet and colonoscopy, ” +
“ diet liberalization and colonoscopy. ”
- Databases Searched (February 2015):
Scopus / MEDLINE/PubMed
Cochrane databases / CINAHL
- Abstracts Searched (2004–2014):
Digestive Disease Week
United European Gastroenterology
American College of Gastroenterology

| Source | Initial Articles Identified |
|-------------------------------------|-----------------------------|
| Scopus | 46 |
| MEDLINE/PubMed | 29 |
| Cochrane databases | 20 |
| CINAHL | 0 |
| Abstracts for major conferences | 24 |
| Total number of articles identified | 119 |

Results- Study selection

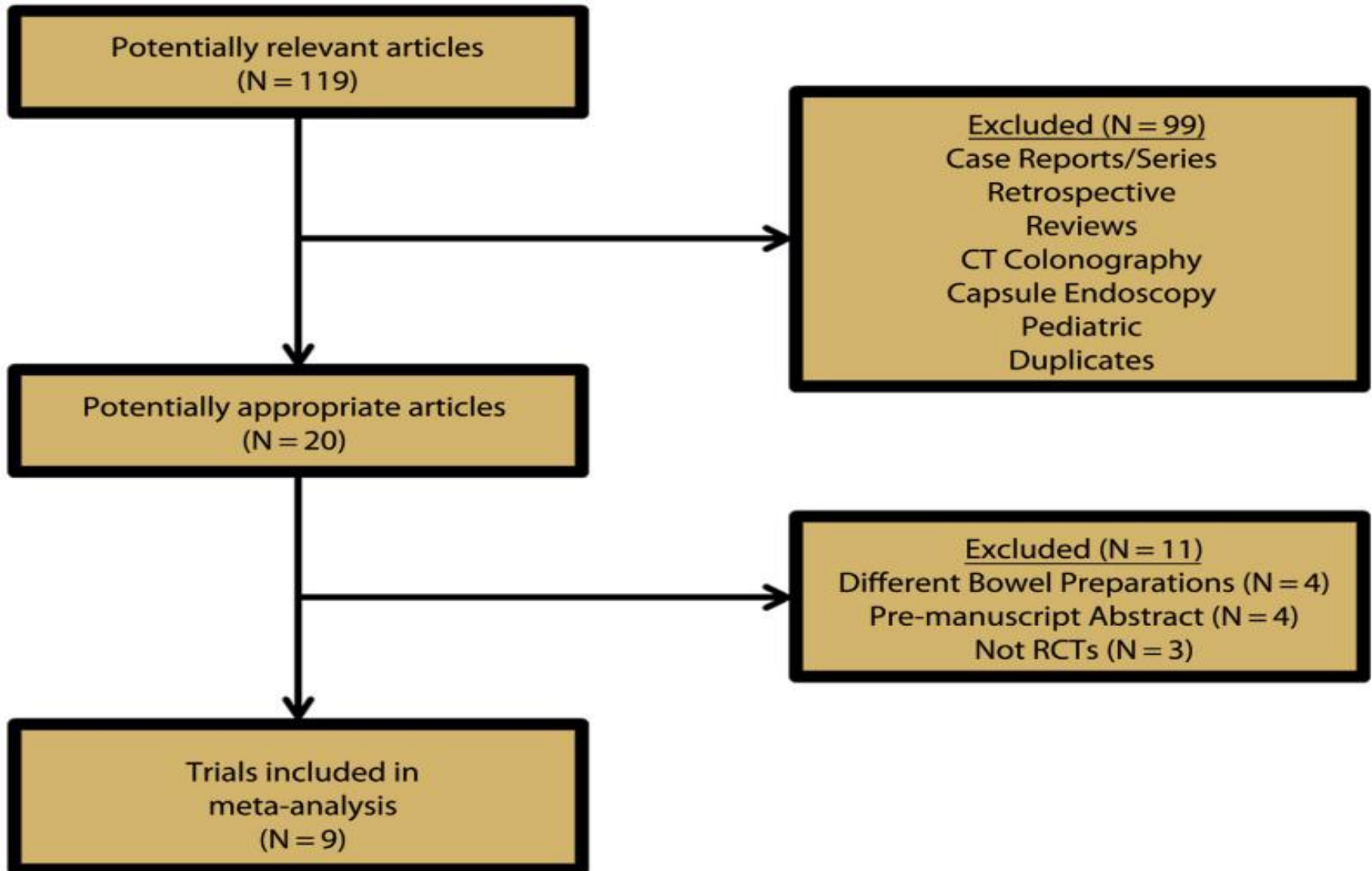


Figure 1. Algorithm demonstrating article search. *RCTs*, randomized, controlled trials.

A - 文獻是否經過嚴格評讀 (Appraisal) ?

最好的狀況是？

應根據不同臨床問題的文章類型，選擇適合的評讀工具，並說明每篇研究的品質(如針對治療型的臨床問題，選用隨機分配、盲法、及完整追蹤的研究類型)。

我可以在哪裡找到這些資訊？

在文章的方法章節，可以找到所使用的文獻品質評讀標準的描述，而結果章節則會列出每篇研究品質的評讀結果。

評讀結果：☒是 ☐否 ☐不清楚

說明：

Methods - Study quality assessment

- Use 2 tools, the Cochrane 's Collaboration Risk of Bias Tool and the Jadad scale.
- The Jadad scoring scale ranging from 0 (low quality) to 5 (high quality), critiques each study on various potential mechanisms of bias.

A score of ≤ 2 (Low- or low-to-moderate quality studies)

A score of ≥ 3 (high-quality studies)

- The grade is described as high, moderate, low, or very low based on *the assessment of limitations* within included studies, *consistency of results* , *precision*, *effect magnitude*, and *publication* and other forms of bias.

Results - Study details(1)

TABLE 2. Quality assessment of studies included in the meta-analysis based on Cochrane's Collaboration Risk of Bias Tool and Jadad Scale

| Study | Study design | Random sequence generation | Allocation concealment | Blinding | Blinding outcome assessment | Incomplete outcome data | Selective reporting | Other bias | Jadad score | Quality assessment |
|---|--------------|----------------------------|------------------------|--------------|-----------------------------|-------------------------|---------------------|------------|-------------|--------------------|
| Park et al 2009 ¹⁹ | RCT | Adequate | Adequate | Single blind | Adequate | None | None | None | 3 | Moderate |
| Rapier et al 2006 ²⁰ | RCT | Adequate | Adequate | Single blind | Adequate | None | None | None | 3 | Moderate |
| Scott et al 2004 ²² | RCT | Inadequate | Adequate | Single blind | Adequate | None | None | None | 2 | Low-to-moderate |
| Sipe et al 2013 ²⁵ | RCT | Adequate | Adequate | Single blind | Adequate | None | None | None | 3 | Moderate |
| Soweid et al 2010 ²¹ | RCT | Adequate | Adequate | Single blind | Adequate | None | None | None | 3 | Moderate |
| Melicharkova et al 2013 ²⁴ | RCT | Adequate | Adequate | Single blind | Adequate | None | None | None | 3 | Moderate |
| Stolpman et al 2014 ²³ | RCT | Not described | Not described | Single blind | Adequate | None | None | None | 2 | Low to moderate |
| Butt et al 2014 ²⁷ Abstract | RCT | Not described | Not described | Single blind | Adequate | None | None | None | 2 | Low to moderate |
| Walter et al 2013 ²⁶ Abstract | RCT | Not described | Not described | Single blind | Adequate | None | None | None | 2 | Low to moderate |

Randomized, controlled trial.

patients not
blinded to bowel preparation

I - 是否只納入 (included) 具良好效度的文章？

最好的狀況是？

我可以在哪裡找到這些資訊？

僅進行文獻判讀是不足夠，系統性文獻回顧只納入至少要有一項研究結果是極小偏誤的試驗。

在文章的**方法**章節，可以找到文章評估的方式，以及是由誰完成評估的，在**結果**章節則會提供審查者意見一致性的程度。

評讀結果：☒是 ☐否 ☐不清楚

說明：

Methods - Data extraction

- Each study was required to **have at least 1 low-residue meal the day before a colonoscopy and used the same bowel preparation for both diet groups.**
- Two re-viewers (E.T.N. and D.L.N.) extracted the data independently with any disagreements being settled by a third party (M.L.B.) or consensus decision.

T - 作者是否以表格和圖表「總結」(total up) 試驗結果？

最好的狀況是？

我可以在哪裡找到這些資訊？

應該用至少 1 個摘要表格呈現所納入的試驗結果。若結果相近，可針對結果進行統合分析(meta-analysis)，並以「森林圖」(forest plot)呈現研究結果，最好再加上異質性分析（見後文）。

在文章的**結果**章節，可以找到摘要的圖表，以及作者對系統性文獻回顧結果的解釋。

評讀結果：☒是 ☐否 ☐不清楚

說明：

Paul Glasziou et al. (2007) Evidence-based Practice Workbook (2nd edit)

Results - Study details(2)

TABLE 1. Details of included studies

| Author | Study type | Location | No. of patients | Demographics | Definition of adequate bowel preparation | Diet during bowel preparation phase | Type bowel preparation solution |
|---------------------------------|------------|------------------------------------|-----------------|--|--|--|---|
| Park et al 2009 ¹⁹ | RCT | Seoul, South Korea | 214 | Male: 120 (56.1%) Female: 94 (43.9%) Mean age: 53.1-55.2 y | Ottawa Scale no. reported cutoff for adequate preparation | Prepackaged low-residue diet all day vs clear liquid diet all day | 4 L PEG with electrolytes on day of colonoscopy |
| Rapier et al 2006 ²⁰ | RCT | San Diego, Calif, USA | 75 | Male: 44 (58.7%) Female: 31 (41.3%) Mean age: 61.0 y | Aronchick Scale Adequate bowel preparation was excellent or good | Prepackaged low-residue diet all day vs clear liquid diet all day | Magnesium citrate and bisacodyl (oral and rectal) |
| Scott et al 2005 ²² | RCT | Norfolk, Va and Asheville, NC, USA | 185 | Male: 82 (44.3%) Female: 103 (55.7%) Mean age: 56.9-57.0 y | Aronchick Scale Adequate bowel preparation was excellent or good | Regular breakfast then low-residue diet lunch, then clear liquids rest of day vs light breakfast then clear liquid rest of day | Sodium phosphates oral solutions Split dose |
| Sipe et al 2013 ²⁵ | RCT | Indianapolis, Ind, USA | 196 | Male: 93 (47.4%) Female: 103 (52.6%) Mean age: 56.9-57.8 y | Boston Bowel Preparation Scale No reported cutoff for adequate preparation | Low-residue diet for breakfast, lunch, snack, then clear liquids rest of day vs clear liquid diet all day | Oral sulfate solution Split dose |
| Soweid et al 2010 ²¹ | RCT | Beirut, Lebanon | 200 | Male: 105 (52.5%) Female: 95 (47.5%) Mean age: 55.5-56.6 y | Aronchick Scale Adequate bowel preparation was excellent or good | Low-residue diet for breakfast, lunch, dinner vs clear liquid diet all day | 4 L PEG with electrolytes the evening before |

Results - Study details (3)

| Author | Study type | Location | No. of patients | Demographics | Definition of adequate bowel preparation | Diet during bowel preparation phase | Type bowel preparation solution |
|---|------------|---------------------------|-----------------|---|---|---|--|
| Melicharkova et al 2013 ²⁴ | RCT | Kingston, Ontario, Canada | 213 | Male: 109 (51.2%) Female: 104 (48.8%) Mean age: 56.5-57.1 y | Ottawa and Aronchick Scales Adequate bowel preparation was excellent or good | Low-residue diet for breakfast, then clear liquids the rest of day vs clear liquid diet all day | Sodium picosulfate + magnesium citrate + bisacodyl evening before for morning procedures and day of for afternoon procedures |
| Stolpman et al 2014 ²³ | RCT | Minneapolis, Minn, USA | 201 | Male: 114 (56.7%) Female: 87 (43.3%) Mean age: 60 y | Boston Bowel Preparation Scale Adequate bowel preparation was score ≥ 6 | Low-residue diet for breakfast and lunch, then clear liquids rest of day vs clear liquid diet all day | Oral sulfate solution Split dose |
| Butt et al 2014 ²⁷ Abstract | RCT | Melbourne, Australia | 226 | Male: 118 (52.2%) Female: 108 (47.8%) Mean age: 53 y | Harefield Cleansing Scale Adequate bowel preparation was score of A or B | Low-residue diet all day (white diet) vs clear liquid diet all day | 2 L PEG + ascorbic acid evening before for morning procedures and split dose for afternoon procedures |
| Walter et al 2013 ²⁶ Abstract | RCT | Philadelphia, Pa, USA | 140 | Male: 60 (52.5%) Female: 80 (47.5%) Mean age: NA | Boston Bowel Preparation Scale Adequate bowel preparation was score ≥ 6 | Low-residue diet for breakfast and lunch, then clear liquids rest of day vs clear liquid diet all day | 2 L PEG + ascorbic acid Split-dose |

RESULTS

- Adequate bowel preparations
- Tolerability of bowel preparation with assigned diet
- Willingness to repeat bowel preparation with assigned diet
- Overall adverse effects
- Publication bias

Adequate bowel preparations

- Definition (each study)
 - (1) excellent and good preparation
for the Aronchick scale,
6 for the Boston Bowel Preparation Scale (BBPS),
scores of A or B for the Harefield Cleansing Scale.
- Exclude 1 study (Park et al)-
 - did not record the absolute number of patients
achieving adequate bowel preparation in the 2
dietary groups, but did demonstrate that the total
Ottawa scores were statistically similar in the 2
dietary groups.

Adequate bowel preparations

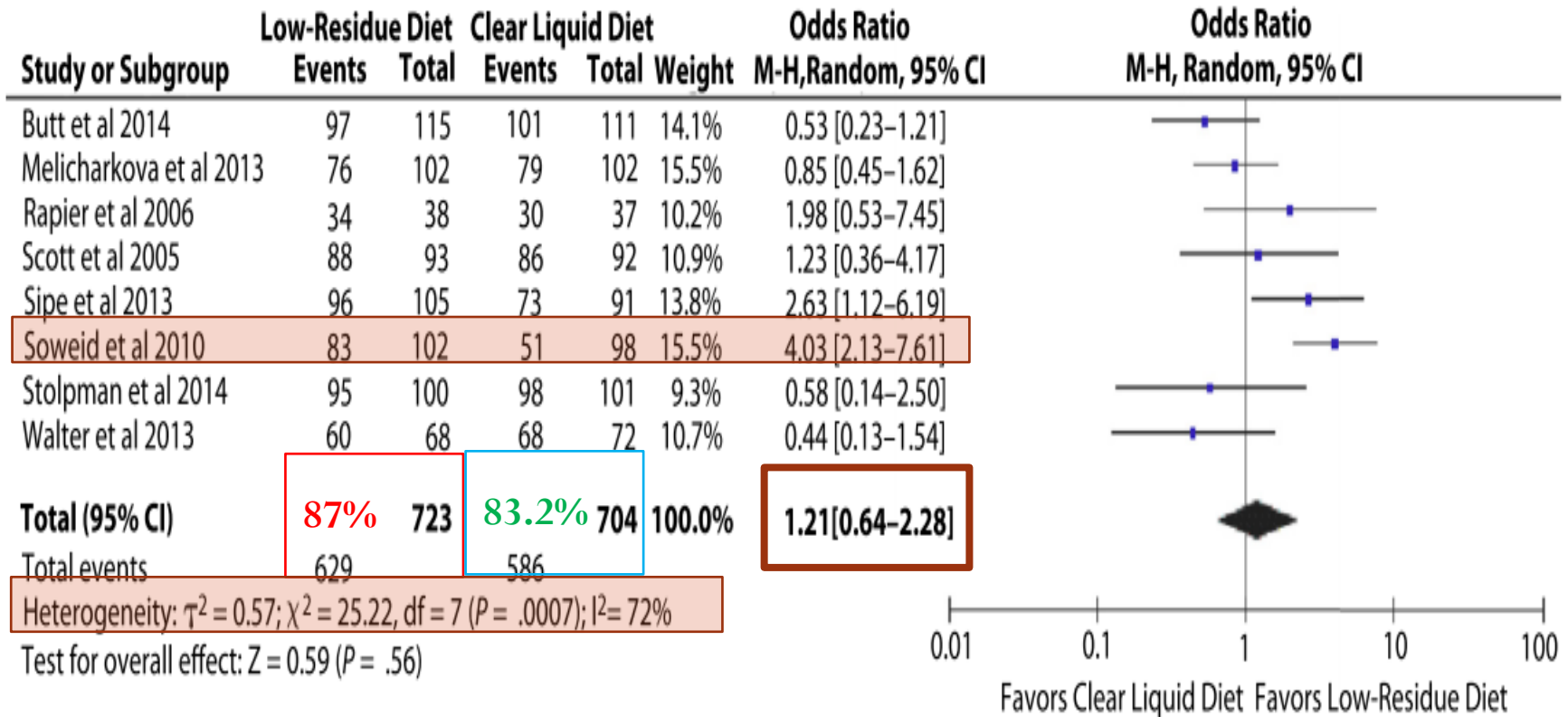


Figure 2. Forest plot comparing the frequency of adequate bowel preparations while on a low-residue diet compared with a clear liquid diet the day before colonoscopy. *CI*, confidence interval; *M-H*, Mantel-Haenszel.

The grade of evidence for this outcome was deemed moderate.

The I^2 measure of inconsistency ($P < .10$ or $I^2 > 50\%$ was significant) was used to assess heterogeneity.

Sensitivity analysis

- eliminate the Soweid et al study and demonstrated similar results without significant heterogeneity (OR 0.97; 95% CI, 0.68-1.38; $P = .88$; $I^2 = 44\%$; $P = .10$).
- Heterogeneity was likely due to the very small number of patients with adequate bowel preparation in the CLD group by Soweid et al.
(only 52% of those consuming a CLD had adequate bowel preparation.)
- The Soweid et al study was selected for elimination, which did not affect the overall results.

Tolerability of bowel preparation with assigned diet

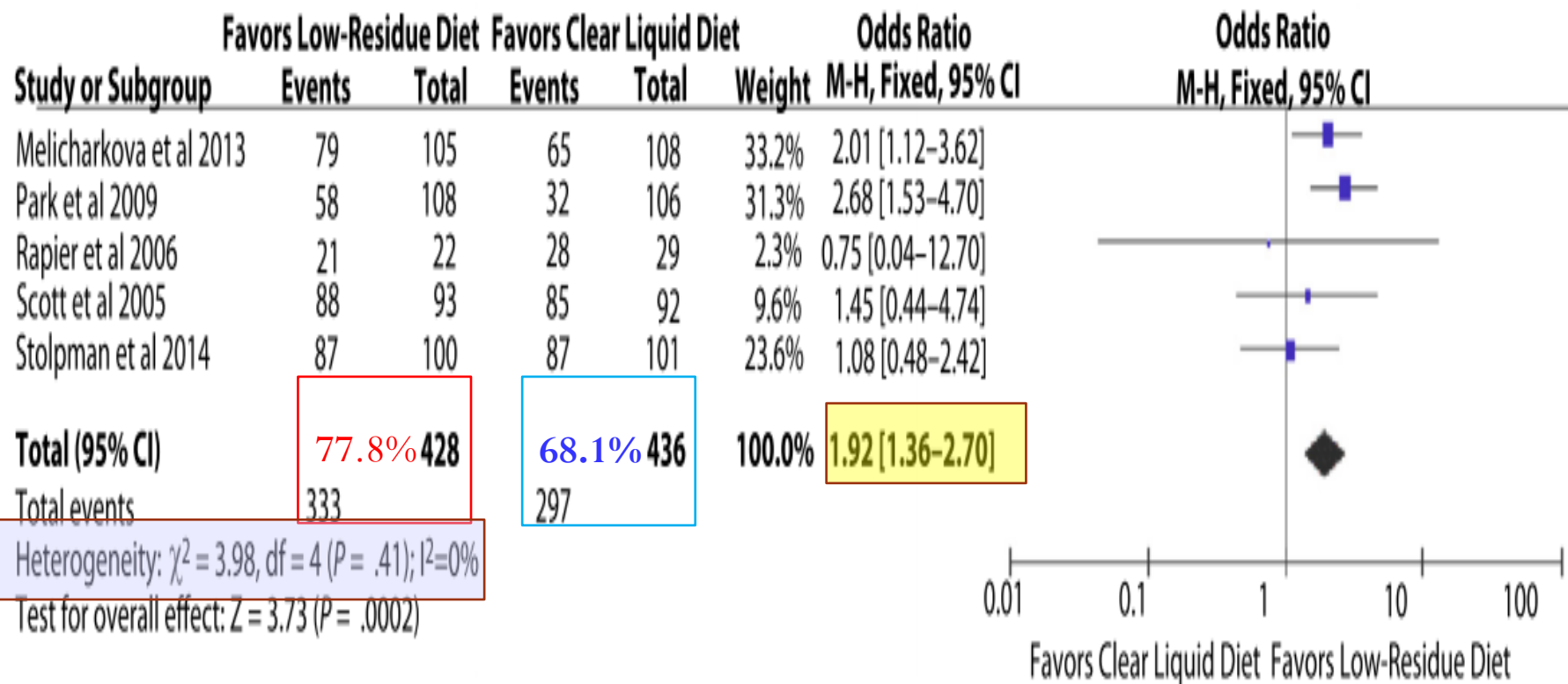


Figure 3. Forest plot comparing patient reported tolerability of bowel preparation and diet while on a low-residue diet compared with a clear liquid diet the day before colonoscopy. *CI*, confidence interval; *M-H*, Mantel-Haenszel.

Willingness to repeat bowel preparation with assigned diet

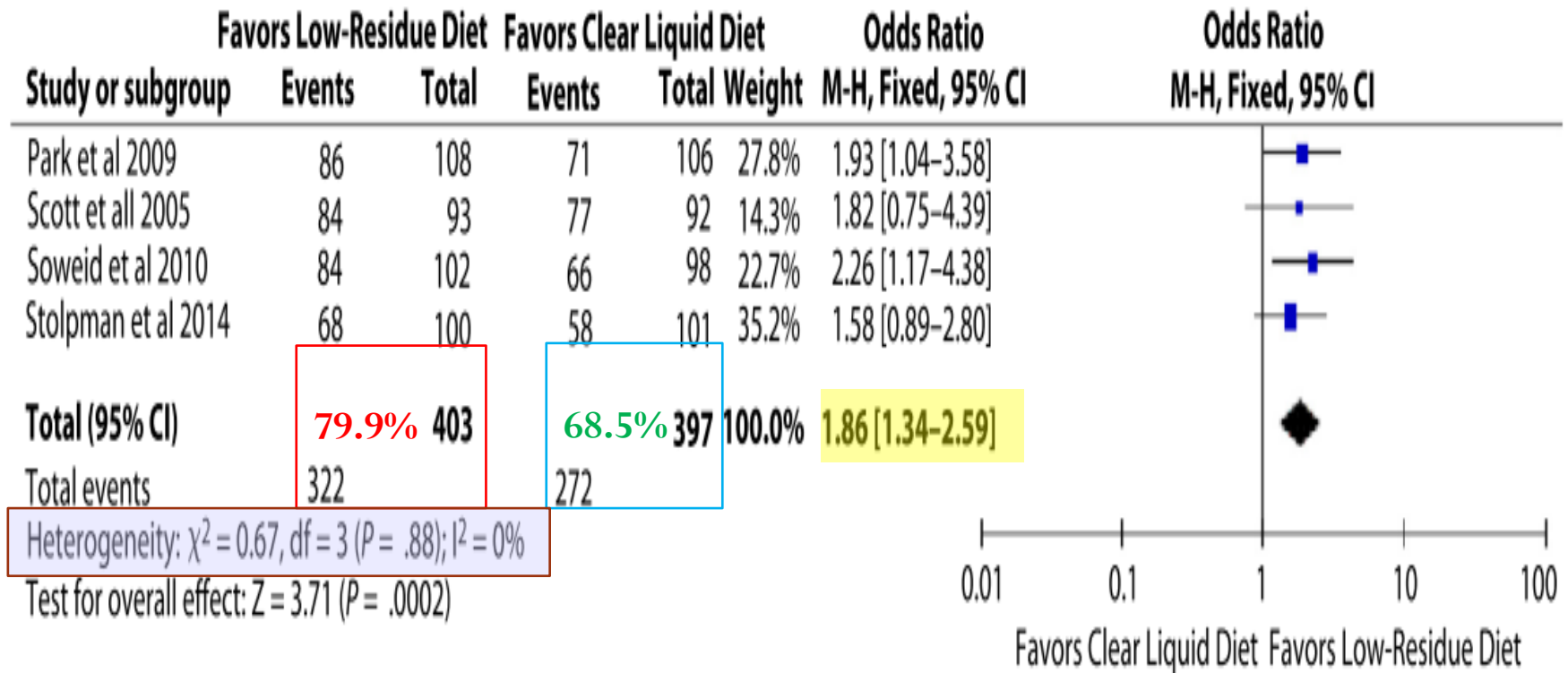


Figure 4. Forest plot comparing patient willingness to repeat bowel preparation and diet while on a low-residue diet compared with a clear liquid diet the day before colonoscopy. *CI*, confidence interval; *M-H*, Mantel-Haenszel.

Overall adverse effects

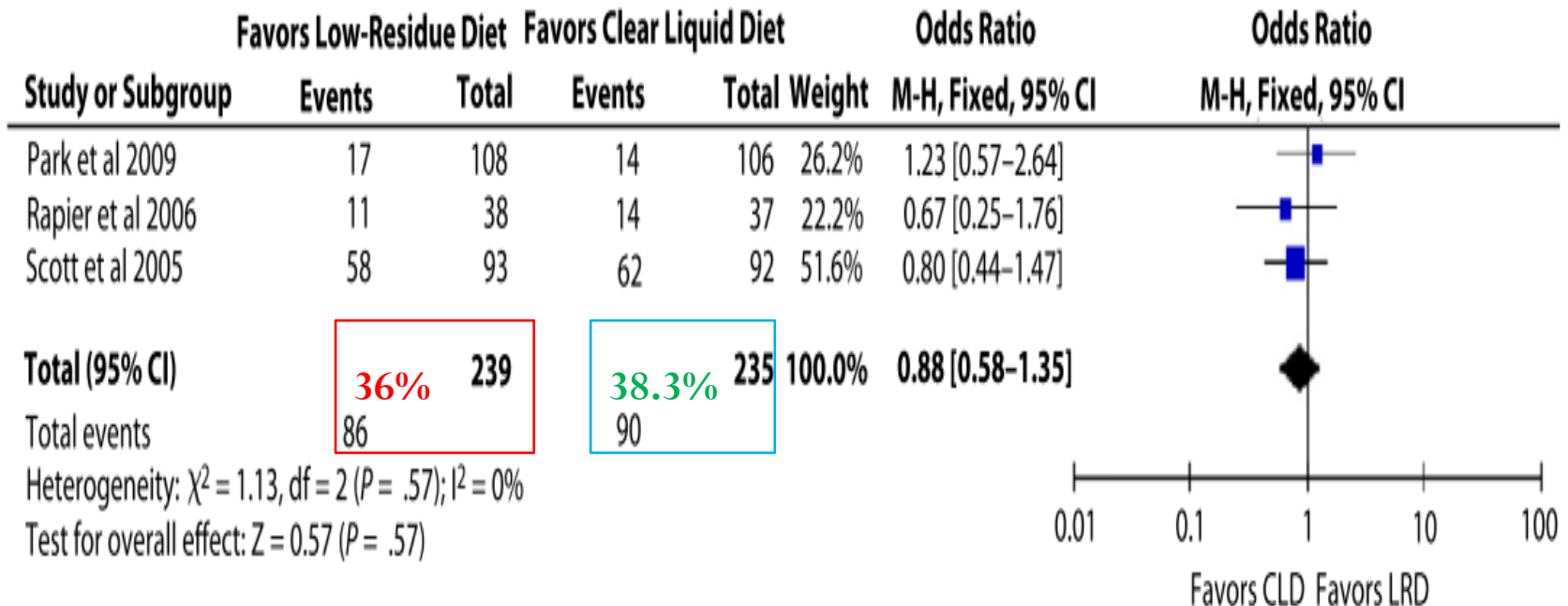


Figure 5. Forest plot comparing patient adverse effects of bowel preparation and diet while on a low-residue diet compared with a clear liquid diet the day before colonoscopy. *CI*, confidence interval; *M-H*, Mantel-Haenszel.

The grade of evidence for this outcome was deemed moderate.

Publication bias

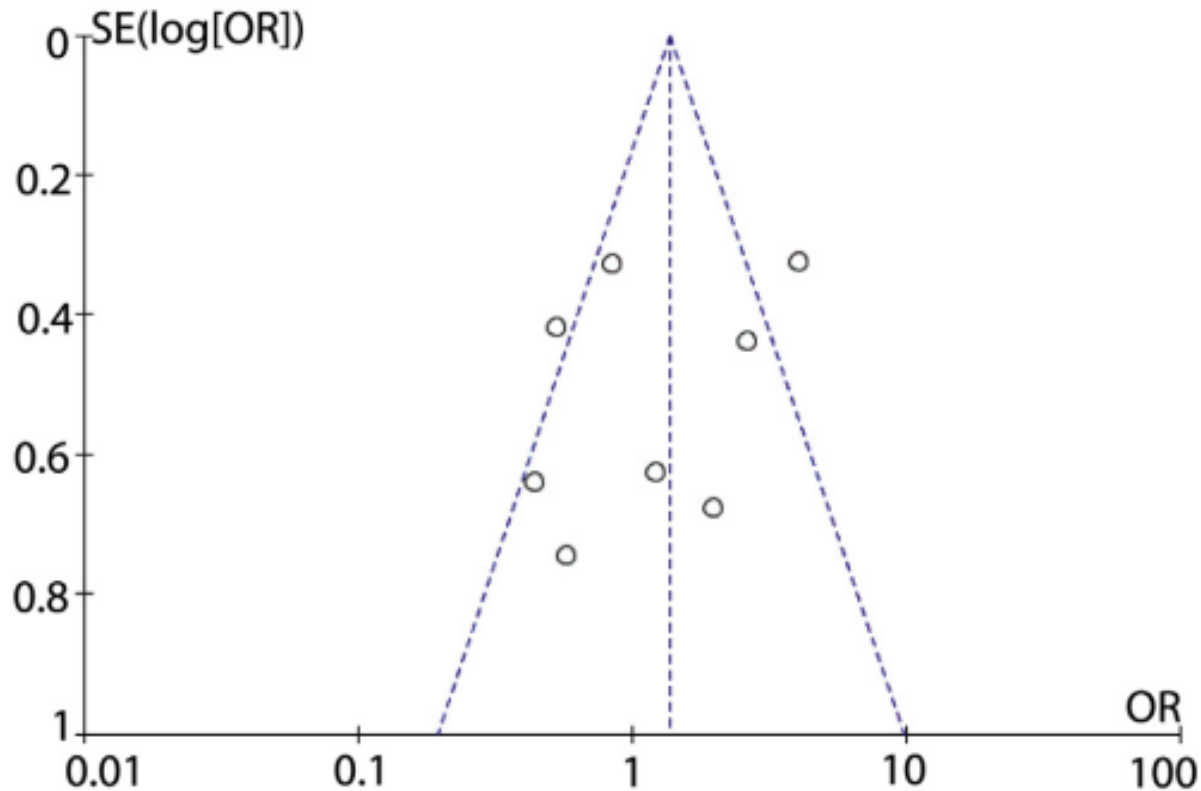


Figure 6. Funnel plot showing no publication bias. *OR*, odds ratio; *SE*, standard error.

H - 試驗的結果是否相近 - 異質性 (Heterogeneity) ?

最好的狀況是？

在理想情況下，各個試驗的結果應相近或具同質性，若具有異質性，作者應評估差異是否顯著(卡方檢定)。根據每篇個別研究中不同的 PICO 及研究方法，探討造成異質性的原因。

我可以在哪裡找到這些資訊？

在文章的結果章節，可以找到研究結果是否具異質性，及造成異質性可能的原因探討。森林圖中可以找到異質性的卡方檢定結果。

評讀結果：☒是 ☐否 ☐不清楚

說明：

DISCUSSION

The study's strengths

| | | |
|---|---|--|
| 1 | only randomized, controlled trials. (the included randomized, controlled trials used the same bowel preparation for both the CLD group and the LRD group.) | This reduces the bias of different bowel preparations, which could significantly affect results. |
| 2 | used an extensive 3-phase search algorithm to identify potential studies. | |
| 3 | varied in location, including South Korea, Lebanon, Australia, Canada, and various states in the United States. | |
| 4 | various bowel preparations were used, including polyethylene glycol with electrolytes, oral sodium solution, , phospho-soda, magnesium citrate with bisacodyl, and low-volume polyethylene glycol with ascorbic acid. | This demonstrates that results may be applicable to various commonly used bowel preparations. |

The study's limitations (1)

| | |
|---|---|
| 1 | <p>Varied low-residue diet (LRD)</p> <p>(1) prepackaged LRD produced by companies (2 studies: Park et al, Rapier et al)</p> <p>(2) specially designed LRD plan created by dietitians</p> |
| 2 | <p>the amount of meals on the day before the colonoscopy differed among studies.</p> <ul style="list-style-type: none"> - LRD for all 3 meals of the day - Regular breakfast, LRD for lunch (latest at 2 pm), clear liquids rest of day - LRD for breakfast, lunch, and a snack, clear liquids rest of day - LRD for breakfast, lunch (up to 1 PM), clear liquids rest of day - LRD for breakfast, CLD for the rest of the day <p>** Subgroup analysis : no statistically significant difference in adequate bowel preparations between the LRD all day and CLD all day. (3 papers) (OR 1.63; 95% CI, 0.41-6.45; P = .49).</p> |
| 3 | <p>the bowel preparation differed among the studies.</p> <ul style="list-style-type: none"> - all studies used the same bowel preparation in both groups, leading to a minimal effect on outcomes. - the results were consistent among multiple bowel preparations, suggesting more generalizability with common practice. |
| 4 | <p>studies were limited in some outcomes, eg, only 3 studies evaluated the adverse events; however, these are all the studies date on the subject.</p> |

The study's limitations (2)

| | |
|---|---|
| 5 | <p>the bowel preparation scales differed among studies.</p> <p>However, based on strict definitions by the authors of the individual studies, adequate bowel preparation was easily defined in all studies but one because of the use of only the mean score on the Ottawa Bowel Preparation Scale without dichotomous data to pool.</p> |
| 6 | <p>significant heterogeneity was noted for adequate bowel preparation.</p> <p>- based on the Cochrane Handbook, the random-effects model was used, and a sensitivity analysis was conducted with the elimination of 1 study with similar results without heterogeneity.</p> |
| 7 | <p>tolerability was based on categorical data in a dichotomous fashion of tolerable or not tolerable.</p> <p>Due to the inability to appropriately pool the data from the various scales used across the studies, only the categorical data were pooled.</p> <p>- tolerability may be assessed further in the future with an increased number of publications with more consistent scales enabling appropriate data pooling.</p> |
| 8 | <p>4 of the studies were of low to moderate quality based on an inappropriate randomization technique or lack of a description of randomization.</p> <p>When these studies were excluded in the sensitivity analysis, the results for adequate bowel preparation were similar (OR 2.05; 95% CI, 0.92-4.57; P =.08).</p> |

Conclusion

- An LRD on the day before colonoscopy seems to be as effective for quality of bowel preparation but demonstrates higher patient tolerability and willingness to repeat bowel preparation.
- This suggests that a CLD before colonoscopy should be replaced with an LRD.

Bowel preparation for colonoscopy: European Society of Gastrointestinal Endoscopy (ESGE) Guideline

Endoscopy 2013 ;45 : 142-150

(1) The ESGE recommends **a low-fiber diet on the day preceding colonoscopy** (weak recommendation, moderate quality evidence).

(2) The ESGE recommends a split regimen of 4 L of polyethylene glycol (PEG) solution (or a same-day regimen in the case of afternoon colonoscopy) for routine bowel preparation.

A split regimen (or same-day regimen in the case of afternoon colonoscopy) of 2 L PEG plus ascorbate or of sodium picosulphate plus magnesium citrate may be valid alternatives, in particular for elective outpatient colonoscopy (strong recommendation, high quality evidence).

In patients with renal failure, PEG is the only recommended bowel preparation. The delay between the last dose of bowel preparation and colonoscopy should be minimized and no longer than 4 hours (strong recommendation, moderate quality evidence).

(3) The ESGE advises against the routine use of sodium phosphate for bowel preparation because of safety concerns (strong recommendation, low quality evidence).

Diet During Bowel Cleansing

Recommendation

1. By using a split-dose bowel cleansing regimen, diet recommendations can include either low-residue or full liquids until the evening on the day before colonoscopy (*Weak recommendation, moderate-quality evidence*)

- The diet regimens in these trials were variable and included a regular diet until 6 PM, regular breakfast, low-residue breakfast, lunch and snack, a soft diet, and a semiliquid diet (heterogeneity: $P = .008$; $I^2=62\%$).
- With this degree of heterogeneity we are reluctant to recommend a regular diet the day before colonoscopy.
- A low-residue diet for part or all of the day before colonoscopy can be considered for patients without other identifiable preprocedural risks for inadequate colon preparation.
- colonoscopists carefully should evaluate any compromise in efficacy if dietary flexibility is allowed.

OPEN

Regime for Bowel Preparation in Patients Scheduled to Colonoscopy: Low-Residue Diet or Clear Liquid Diet? Evidence From Systematic Review With Power Analysis

Guo-Min Song, BSc, Xu Tian, MN, Li Ma, MN, Li-Juan Yi, MN, Ting Shuai, MN, Zi Zeng, MN, and Xian-Tao Zeng, MD

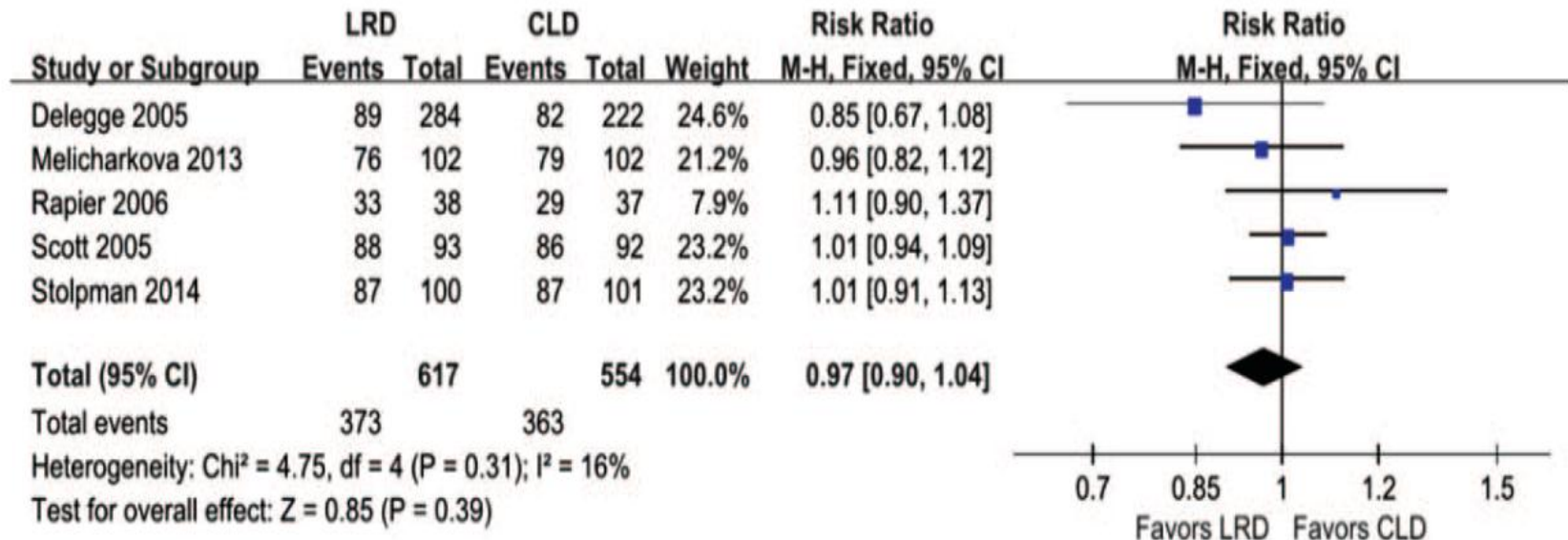


FIGURE 3. Meta-analysis on the quality of bowel preparation (excellent—good preparation): 5 eligible studies including 1171 participants were included and no significant difference for this given outcome was identified based on a fixed-effect model.

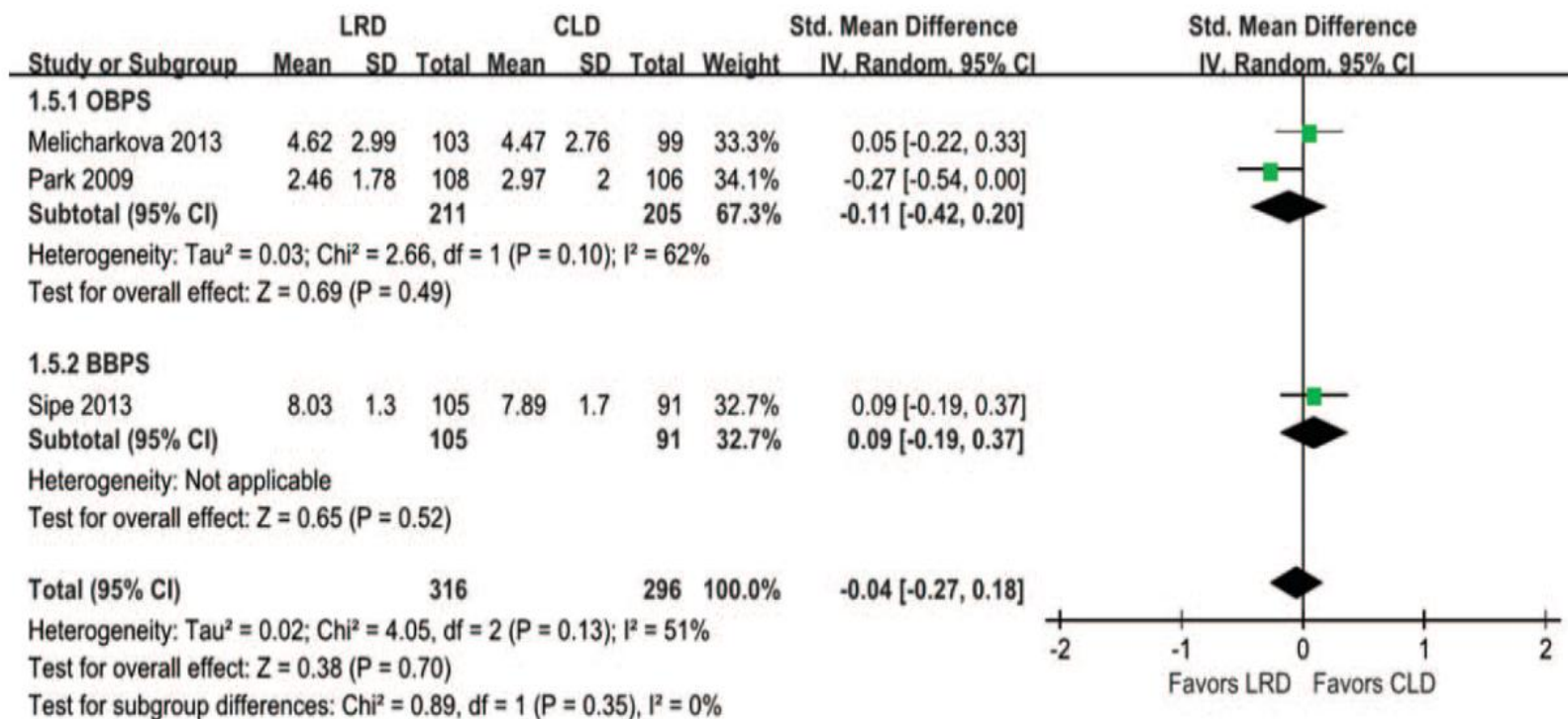


FIGURE 4. Meta-analysis on the efficacy of colon cleansing: subgroup analyses according to OBPS and BBPS were not statistically significant. BBPS = Boston Bowel Preparation Scale, OBPS = Ottawa Bowel Preparation Scale.

Medicine Volume 95, Number 1, January 2016

Outcomes of Interest

Hunger
Bloating
Abdominal pain
Nausea
Vomiting
Headache

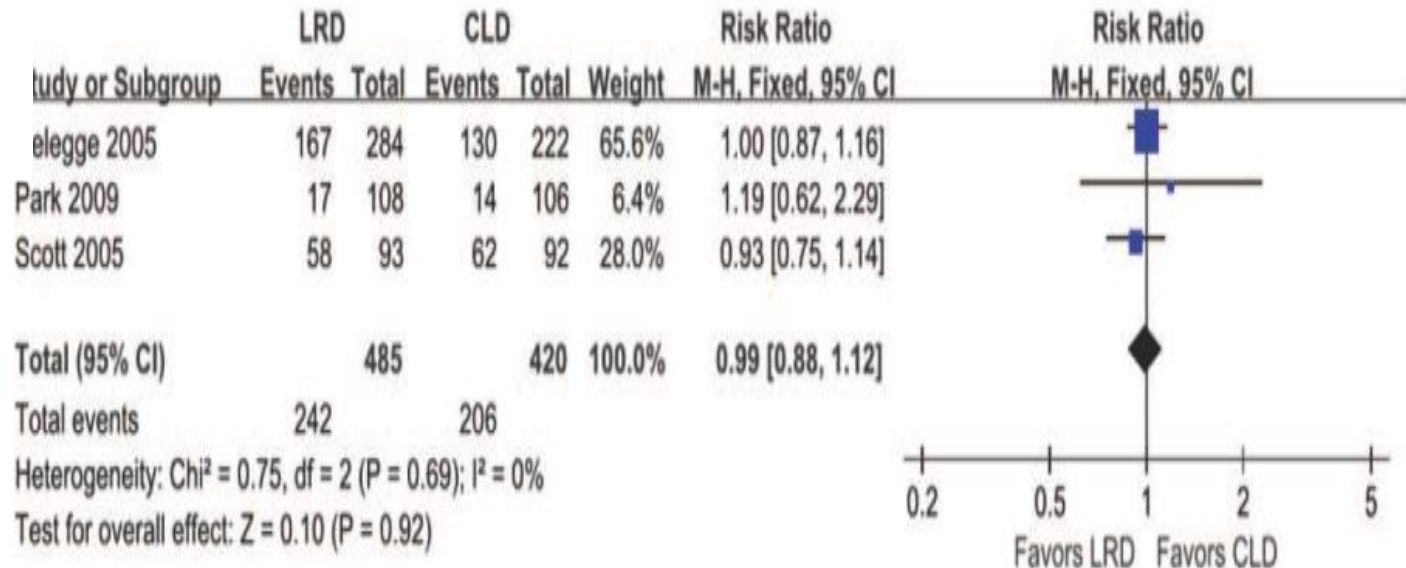


FIGURE 8. Meta-analysis on overall AEs: 3 studies including 905 were eligible for the inclusion criteria prespecified in our study and the synthesis analysis with fixed-effect model did not indicate statistically significant difference.

Medicine Volume 95, Number 1, January 2016

Effect of Diet Liberalization on Bowel Preparation

Danny J. Avalos, MD, Daniel A. Sussman, MD, MSPH, Luis F. Lara, MD, Faye S. Sarkis, MD, Fernando J. Castro, MD

DOI: 10.14423/SMJ.0000000000000662

399-407

VOLUME: 110 ISSUE: 6 JUNE, 2017

ABSTRACT

ARTICLE

IMAGES

REFERENCES

CME

DISCUSS

SDC

Abstract:

Objectives: Precolonoscopy dietary regimens often are restricted to clear liquids; however, the superiority of a clear liquid diet (CLD) for bowel preparation quality is ambiguous. We performed a meta-analysis of randomized trials comparing bowel preparation outcomes between a low-residue diet (LRD) or regular diet (RD) compared with a CLD.

Methods: MEDLINE, clinicaltrials.gov, Cochrane Central Register, Scopus, Embase, Cumulative Index to Nursing and Allied Health Literature, and the Web of Science databases were used to conduct a search for randomized controlled trials from 1976 to March 2015. Of 122 relevant references, 12 studies met our inclusion criteria, 7 studies of which were classified as being of high quality. Pooled estimates of bowel preparation quality were defined as adequate versus inadequate. Secondary outcomes included tolerability, willingness to

Conclusions:

An LRD/RD provided no difference in bowel preparation quality as compared with a CLD. As such, it may be reasonable for patients without risk factors for poor preparation to undergo an **LRD until lunch the day before their colonoscopy** given that bowel preparation tolerability and willingness to repeat were greater among groups with a liberalized diet.

大腸鏡檢查 【Colonscopy】

一、何謂大腸鏡檢查？

用一條細長且能彎曲內視鏡潤滑後從肛門進入，直接觀察大腸的病患。

二、檢查的適應症：

如：解血便、便秘、下痢、下腹痛、慢性大腸疾病、診斷惡性腫瘤或大腸憩室症、或經X光檢查後發現有異常，但又無法確定診斷者，或者經內視鏡預行息肉切除術等都是大腸鏡檢查的適應症。

三、檢查注意事項：

(一) 檢查前：大腸鏡檢查前首要任務為清淨腸道。

1. 檢查前一天採清流質飲食，如：米湯、過濾後之果汁、蜂蜜水等完全無渣食物。

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(二) 檢查中：

1. 檢查過程前會給予注射胃腸鬆弛劑，減少腸蠕動以利作檢查，副作用口渴、腹脹、心跳加快等。

大腸鏡檢查準備方法(粉末瀉劑)

1. 檢查前一天照常飲食，但須避免食用含有種子的食物(例如：西瓜、

香瓜、百香果、蕃茄....等)，服用鐵劑者於三天前開始暫停使用。

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- (2) 下午做檢查者：當天早上9點開始喝，第一次先喝400cc，接著

每隔15分鐘喝200cc，直到2000cc喝完為止。

※開始喝粉末瀉劑後，應繼續日常活動且要多走動，大約1小時以

後，會有腹瀉情形。(開始腹瀉時間因人而異，若喝完2000cc仍未

排便，請和胃鏡室醫護人員聯絡)。

※如果有任何疑問或不適之處請和胃鏡室醫護人員聯絡。

※聯絡電話：(02)-29307930 轉 1541 (早上8點~下午5點例假日除外)

舉牌囉！

- 大腸鏡檢查前腸道準備， 前一天可吃低渣飲食！
同 意 (綠牌) 40 位 不同意 (紅牌) 0
待評估 (黃牌) 4 位

