

## EDITORIAL

### Does it matter how long the small bowel is?

The small bowel (SB) is a very long organ hardly accessible to conventional endoscopy. The revolution entailed by its complete diagnostic exploration with capsule endoscopy (CE) has led to a change in traditional surgical management and its related gold standard – intraoperative enteroscopy. CE is currently the first-line diagnostic strategy for the SB. An emergent technique in its wake has played a key role in the management of patients with SB conditions: to wit, device-assisted enteroscopy (DAE). Thus were developed first double-balloon enteroscopy (DBE) (1), then single-balloon enteroscopy, and most recently motorized spiral enteroscopy (2).

When accessing the SB via the oral route (OR), how do we know our location in such a long portion of the gut? Only if we go past Bauhin's valve and identify the cecum shall we know (3), but this is uncommon in clinical practice. To answer this question, therefore, I would pose another one: how long is your SB? But there is no answer to the latter question based on imaging modalities, nor with CE. In CE the capsule does not move at a constant speed but may come to a halt, aim to the rear, even move backwards carried away by antiperistaltic waves. It is an "awesome voyage," but one that may double back.

Let us estimate distances then. For all practical purposes the method developed by May et al. (4) for measuring depth in DBE has been validated in our setting (5), and provides quite an acceptable estimation. This is important in clinical practice since DBE may be a lengthy procedure using up plenty assets, particularly human resources (HR).

Bringing the subject into focus, let it be pointed out first that seeing the whole SB is not always necessary, although we should be ready to do so. The decision to finish an OR DAE procedure must be based on evidence consistent with the previously acquired diagnostic images. Should the length investigated be considered inadequate, a second DAE should be indicated using the anal route (AR). The exam would be complete if the tattoo made during the initial DAE via the OR is now identified in the second, AR procedure.

Furthermore, in our setting, Juan Manuel Herreras-Gutiérrez (Seville, Spain) and Miguel Mascarenhas-Saraiva (Porto, Portugal) opened up the path of the Iberian meetings on SB CE back in 2003, to which DAE would be added in Murcia 2007. These meetings between Spain and Portugal are still ongoing on a yearly basis, alternating between both countries.

It is precisely this year, in 2020, when we shall be celebrating the Fifth Centenary of a great feat shared by both countries, namely the first complete circumnavigation of Planet Earth by Juan Sebastián Elcano (Getaria, Gipuzkoa, Spain) and Fernão de Magalhães (usually in English, Ferdinand Magellan) (Sabrosa, Porto, Portugal), whom historians recognize as the key leading figures in finding such a long route in the then-known world.

It might be safely said that we are now on another journey with the same desire for discovery but a novel goal: the SB. Hence, it seems only logical that both countries joined forces to develop a clinical practice guide for DAE, which E. Pérez-Cuadrado Robles, R. Pinho, et al. (6) now publish in this issue of our *centenarian The Spanish Journal of Gastroenterology (Revista Española de Enfermedades Digestivas)*, simultaneously with *GE - Port J Gastroenterol*, the official voice of the Sociedade Portuguesa de Gastrenterologia.

Also in this monographic issue on DAE, P. Esteban et al. (7) bring to completion a number of prior institutional papers on conventional endoscopy (8-10) using DAE quality indicators and procedure. They suggest 9 process indicators, among which an appropriate indication stands out. This is useful to measure what we do and the way we do it.

As an added value to the technique, enteroscopes are also useful for organs other than the SB in selected cases – for instance, for ERCP in patients with altered SB anatomy (11) or for rescue colonoscopy (12).

Lastly, Soria et al. (13) also provide a rapid review of training for DBE, which is inseparable from skills acquisition for this technique. They are a team of veterinarians and physicians with drawn-out experience in DBE research and training with enteroscopes for animal use exclusively.

Back in our Iberian Peninsula, we estimate that hundreds of CE devices are now being used. However, the number of DAE equipments seems to fall short of fifty.

Even bearing in mind the high diagnostic yield of CE in the right indications, more DAE devices are probably needed. Indeed, if a lesion is identified by CE in the SB that needs to be treated or biopsied, the patient will require a DAE via the route suggested by CE. Thus arises another question: now you have CE, is DAE also available at your site?

All our actions should be for a cause and purpose: if a relevant lesion is revealed by CE, we must act accordingly.

There are limitations – no official benchmark centers (CSUR) exist in Spain for DAE, patient referrals, sometimes to other Autonomous Communities, may be challenging, and medicalized transportation is always expensive. This is particularly relevant in case of mid-gastrointestinal bleeding, a major indication for DAE (14).

Longer procedures such as DAE are certainly HR-consuming at a time when conventional techniques may have delays in our endoscopy units; even so, however, DAE should be furnished with infrastructure, as the technique, when used for appropriate indications, is clearly cost-effective. This is feasible in our setting with training, quality, and measurable health outcomes, and above all also with dedication.

This Editor thinks that the three aforementioned articles (6,7,13) included in this monographic issue on enteroscopy are important not only for knowledge updating but also because of their usefulness for clinical practice and for setting up the technique at any endoscopy unit in our setting.

From all the above, I encourage from these lines the agencies responsible for health care management to modulate the desirable proportionality between CE and DAE equipments in SB endoscopy units, and to facilitate and streamline the circuits involved. To hospital administrators I would explain that DAE is cost-effective, and reduces surgeries, hospital stays, etc. Furthermore, when rightly indicated the technique should be used for the benefit of patients.

Therefore, the answer to the title question is that how long the small bowel is does indeed matter, and we should be ready about it.

Even if we cannot assess its length before a DAE procedure, we certainly can improve our clinical decisions and circuits, and systematize the procedure to obtain high clinical and technical success rates. And we also can measure it, which does matter.

This monographic issue was made with that purpose.

The way is long and tortuous, but if J.S. Elcano, F. Magellan, et al. were successful, then maybe...

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