Body Positions for Colonoscopy: Value of the Trendelenburg position

To the Editor:

Although the review of techniques for the very difficult colon by Dr. Rex is excellent (1), further discussion of the value of position changes is warranted. Many gastroenterologists maintain the left lateral position changing only when difficulty is encountered. In the supine position, loops are better palpated and after the scope is withdrawn with straightening maneuvers; external pressure often helps.

The benefits of right lateral positioning are best known for advancing from the proximal ascending colon into the cecum in a redundant colon (1,2). I find two additional benefits: advancement beyond the hepatic flexure in a redundant colon and cleansing the cecum of residual material by gravity. Efficiency of this maneuver is further improved by having the technician pull the mid-abdomen downwards.

The prone position was recently shown to decrease insertion time in obese patients (3). However, this is an awkward position and airway control could be problematic.

I have had success advancing past the angulated sigmoid with brief use of a 20-30 degree Trendelenburg prone position if changing to a pediatric colonoscope and straightening maneuvers fail. When the body is tilted, the colon descends from the pelvis and the rectosigmoid angle straightens (4,5). In my experience this decreases: time of insertion, air insufflation, looping, and pressure applied to the sigmoid but has the potential risk of regurgitation. During deep, prolonged, intra-operative Trendelenburg intraocular pressure increases (which also occurs in the left lateral position) and there is reduced arterial oxygen pressure in obese men during laparoscopy with pneumoperitoneum (6-8). A history of ischemic optic neuropathy is a contraindication to Trendelenburg otherwise these risks do not apply to colonoscopy. Formal study of this maneuver for colonoscopy is warranted.

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References

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