Feasibility, Safety and Diagnostic Yield of Omom CE, a New Capsule Endoscopy System: The First Experience in Caucasian Patients

Flaminia Cavallaro1, Gian Eugenio Tontini1, Rosamaria Bozzi2, Nicoletta Nandi3, Domenico Cattaneo2, Federica Villa3, Sergio Cadoni4, Paolo Gallitru5, Emanuele Rondonotti5 and Maurizio Vecchi1,6

1Gastroenterology & Digestive Endoscopy Unit, IRCCS Policlinico San Donato, Milano, Italy
2Surgery & Digestive Endoscopy Unit, V. Monaldi Hospital, Naples, Italy
3Gastroenterology & Digestive Endoscopy Unit, C. Cantù Hospital, Ao Legnano, Abbiatogrosso, Italy
4Digestive Endoscopy Unit, Santa Barbara Hospital, Iglesias, Italy
5Gastroenterology Unit, Valduce Hospital, Como, Italy
6Department of Biomedical Sciences for Health, University of Milan, Milano, Italy

Abstract
Capsule endoscopy, since its FDA approval in 2001, has dramatically changed the study of the small bowel. However, one of the main limitations to its diffusion is the relatively high cost it has. More recently, a new video capsule system (OMOM CE) has been developed in China and obtained the CE mark. Aim of the study was to assess the feasibility, safety and diagnostic yield of OMOM CE. 118 consecutive patients with suspected small bowel disease underwent OMOM CE. Indications to the exam were obscure gastrointestinal bleeding, known or suspected Crohn’s disease, suspected small bowel tumor, familial adenomatous polyposis. All patients ingested the capsule easily. Visualization of the entire small bowel was achieved in 114 patients (97%). The overall diagnostic yield was 48%. In our series, the overall diagnostic yield was similar to that reported in the literature. OMOM CE appears to be a practical, safe, easy to perform procedure, providing a similar diagnostic yield and an even superior observation of the small bowel compared to other systems. Its lower cost might also encourage its diffusion.

Patients and Methods

Patients
The total recruited patients were 118 (61 men, 57 women, mean age 53 years, range 18-86 years), all with suspected small bowel pathology. Patients underwent OMOM CE in one of the three Gastroenterology Unit involved in the study (Gastroenterology & Digestive Endoscopy Unit, IRCCS Policlinico San Donato - University of Milan; Surgery & Digestive Endoscopy Unit, V. Monaldi Hospital, Naples; Santa Barbara Hospital, Iglesias). Indications to perform the exam were obscure gastrointestinal bleeding, known or suspected Crohn’s disease, suspected small bowel tumor and familial adenomatous polyposis. The distribution of patients for each diagnostic subgroup is reported in table 1. All the included subjects had previously performed other investigations, such as esophagogastroduodenoscopy, colonoscopy, small bowel follow through, enteroclysis, abdominal computed tomography or magnetic resonance.

<table>
<thead>
<tr>
<th>Indications Of Patients For Capsule Endoscopy</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obscure gastrointestinal bleeding</td>
<td>55</td>
</tr>
<tr>
<td>Known or suspected Crohn’s disease</td>
<td>57</td>
</tr>
<tr>
<td>Familial adenomatous polyposis</td>
<td>3</td>
</tr>
<tr>
<td>Suspected small bowel tumor</td>
<td>3</td>
</tr>
<tr>
<td>Total patients</td>
<td>118</td>
</tr>
</tbody>
</table>

Methods
The device used in all the enrolled patients was the OMOM capsule endoscopy (Jinshan Science & Technology Company, Chongqing, China). The system is composed of three parts: a disposable capsule, an image recorder jacket and an image workstation.
In the recorder jacket, there are 14 receiver elements placed close to the abdomen and waist. The images acquired are transmitted from the capsule to the recorder via a digital radio frequency communication channel. Moreover, it is included a portable real-time monitor device that allows the endoscopist not only to follow the progression of the capsule, but also to send possible commands to the OMOM system to modify the rate of frame (2, 1 or 0.5 fps), the flash intensity and the capsule state (sleep or awake). The recorder is later connected to the workstation, in order to download and process the images.

OMOM capsule endoscopy differs from the other available capsule endoscopy systems in dimensions, as the OMOM CE is slightly bigger, the presence of an antenna-carrying jacket, the possibility to modify the image acquisition rate up to 58 %. The diagnostic yield observed in the different subgroups is shown in table 2. Diagnostic yield in patients with OGIB was 76 % (when counting both positive and suspicious findings), which is greater if compared to that of the non-OGIB subgroup. This finding further confirms that OGIB is the most important indication for capsule endoscopy. When patients were divided according to the type of bleeding (overt vs. occult), the diagnostic yield of OGIB was similar (p = 0.7) to that of non-OGIB as reported in table 3.

### Table 2: Diagnostic yield

<table>
<thead>
<tr>
<th>Indication</th>
<th>Nr</th>
<th>Positive</th>
<th>Suspicious</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obscure GI bleeding</td>
<td>55</td>
<td>33 (60%)</td>
<td>9 (16%)</td>
<td>13 (24%)</td>
</tr>
<tr>
<td>Suspected or known Crohn’s disease</td>
<td>57</td>
<td>20 (35%)</td>
<td>3 (5%)</td>
<td>34 (60%)</td>
</tr>
<tr>
<td>FAP</td>
<td>3</td>
<td>1 (33%)</td>
<td>0 (0%)</td>
<td>2 (67%)</td>
</tr>
<tr>
<td>Suspected small bowel tumor</td>
<td>3</td>
<td>2 (67%)</td>
<td>0 (0%)</td>
<td>1 (33%)</td>
</tr>
<tr>
<td>Total</td>
<td>118</td>
<td>56 (48%)</td>
<td>12 (10%)</td>
<td>50 (42%)</td>
</tr>
</tbody>
</table>

Complete visualization of the small bowel was achieved in 114 patients (97%). Capsule retention without obstruction occurred in only 1 patient (0.8%) due to a previously undiagnosed Crohn’s disease stricture at the terminal ileum, in a patient with diarrhoea and without any obstructive symptom. This patient underwent surgical treatment of the stricture and capsule recovery. In 4 patients the capsule did not reach the cecum within the time of recording. In 3 of them the capsule failed to reach the cecum because of the impact with a lesion (a jejunal stricture due to a previously unknown Crohn’s disease in one patient, an ileal mass in another one and a duodenal substenosis in the last case); in the fourth patient, an actual cause could not be found, as the only pathological finding was angiodysplasia. Anyway, they all spontaneously expelled the capsule in 10 days, except for the patient with the jejunal stricture, whom experienced symptomless retention and had to undergo surgical treatment, allowing also for capsule retrieval.

Additionally, in one of the three centres, in the first hour of examination, the real-time monitor was used to assess capsule location. If the capsule, after 60 minutes from ingestion, did not pass the pylorus reaching the small bowel, then metoclopramide 10 mg was administered to the patient intravenously. The acquired images were reviewed by two expert gastroenterologists that according to the findings classified the videos as diagnostic, suspicious or negative.

### Statistical analysis

Quantitative variables were expressed as mean ± SD values. Fisher’s test was used to compare occult OGIB and overt OGIB diagnostic yield.

### Results

All patients ingested the OMOM CE very easily and no complications were observed. All data analyzed were normally distributed. The recording time was 420 to 580 minutes (mean time 514 min, SD 39). Surprisingly, the mean pyloric transit time -defined as the recorded time at the first image of duodenum- was 78 minutes (SD 44) in patients who received metoclopramide while in those not receiving it, was 27 minutes (SD 16). For what concerns the mean small bowel transit time – defined as the time from the first duodenal image to the time of the first cecal image- was 241 minutes (SD 123) in patients who received metoclopramide and 235 minutes (SD 73) in those who did not receive it. Cases in which the capsule was not able to reach the cecum were excluded from analysis of small bowel transit time.

The overall diagnostic yield, when considering only positive findings, was 48%. If suspicious findings were included as well, the diagnostic yield increased up to 58 %. The diagnostic yield observed in the different subgroups is shown in table 2. Diagnostic yield in patients with OGIB was 76 % (when counting both positive and suspicious findings), which is greater if compared to that of the non-OGIB subgroup. This finding further confirms that OGIB is the most important indication for capsule endoscopy. When patients were divided according to the type of bleeding (overt vs. occult), the diagnostic yield of OGIB was similar (p = 0.7) to that of non-OGIB as reported in table 3.

### Table 3: Diagnostic yield in OGIB

<table>
<thead>
<tr>
<th>Indication</th>
<th>Nr</th>
<th>Positive</th>
<th>Suspicious</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>OGIB Occult</td>
<td>34</td>
<td>20 (59%)</td>
<td>6 (18%)</td>
<td>8 (23%)</td>
</tr>
<tr>
<td>OGIB Overt</td>
<td>21</td>
<td>14 (67%)</td>
<td>1 (5%)</td>
<td>6 (21%)</td>
</tr>
</tbody>
</table>
Angiodysplasias were the most common findings [8], being observed in all subjects in the OGIB subgroup. Other possible associated findings included ulcers, erosions, polyps, active bleeding with no recognizable lesion and small-bowel tumors. All the findings are reported in table 4. The main findings are shown in figures 4-7.

**Discussion**

Since the development of the first model of capsule endoscopy, there has been a continuous technological progress and consequent technical advancement that has allowed capsule endoscopy to become a powerful tool for the evaluation of suspected or known small bowel disease conditions. However, in times of strict cost containment, the high cost of this procedure has represented one the main limitations on its use. Recently, a relatively low-cost capsule endoscopy was developed and has been used in large patients’ population studies in China. This is the first study evaluating the overall performance of OMOM capsule endoscopy in a group of patients of Caucasian origin.

In our hands, the system proved to be easy to use and safe. Indeed, retention without obstruction occurred in only 1 patient and it was due to a previously undiagnosed Crohn’s disease stricture at the level of the terminal ileum. Retention was symptomless and the patient underwent surgical treatment of the stricture and capsule recovery. Some of the features of the OMOM system have revealed to be extremely useful in making the procedure more adjustable and tailored to the many potential clinical settings. In particular, the possibility of modulating the flash intensity and the ON/OFF status of the capsule are unique of this system. While the first one might be convenient in conditions of low visibility (in the stomach or if there are residues or blood in the lumen); the second one may be helpful in saving battery life when a distal lesion has to be reached. Another important feature is the possibility of monitoring the pyloric transit in order to decide whether or not to use a prokinetic to fasten up the process and achieve exam completion; indeed, it is known that delayed gastric time is one of the most frequent causes of failure to reach the cecum [9, 10].

In our series, OMOM capsule endoscopy reached the cecum in most of patients (97%). Our result is much higher than the figures so far reported in literature for all the other capsule systems [11-13]. Even though the use of prokinetics may explain this result [10, 14] this does not seem to be the case in our study. In fact, when are considered patients from the centers neither utilizing prokinetics injection nor real-time viewer, the proportion of capsule reaching the cecum was even higher (37/38 patients, 97%). Therefore, the role of these factors can be easily ruled out. The OMOM CE is slightly bigger and heavier than the other capsules and this may favor a relatively faster progression along the small bowel. Moreover, our patient series was characterized by a relatively large proportion of patients with clinical conditions, such as diarrhea and overt OGIB, possibly associated with accelerated peristalsis and a short small bowel transit time. As a matter of fact, the small bowel transit time observed in the present study is quite short but substantially similar to that reported in the literature.

This might be explained considering that transit speed can be affected by multiple variables, such as the completion rate, the definition of the small bowel transit time used (many Authors include also patients in whom the capsule never reached the cecum), the age of patients, the comorbidities and drugs assumption that may affect bowel peristalsis (like diabetes or neuropathies, and opioids or prokinetics, respectively), the in-patient or out-patient settings, etc. Another possible explanation for this result could be the relatively longer lifespan of OMOM capsule endoscopy battery that allows for prolonged recording. In any cases, a more complete visualization of the small bowel could be crucial to obtain an even higher diagnostic yield than that achieved by currently available devices.

In our series, the diagnostic yield was assessed considering only positive
findings (see table 2); the results were similar to those reported in literature, with an overall detection rate of 48%. In particular, it was 60% in OGIB and 35% in known or suspected Crohn’s disease. In agreement with previously described studies, the diagnostic yield of capsule endoscopy varies depending on the indication for which it is performed, being about 50% for OGIB in a recent series [11,15-16] while, for suspected Crohn’s disease, widely ranges between 33-70% [16-18]. The results of the present study are quite encouraging, as they show diagnostic figures at least equal to those reported in the literature, despite the fact that a statistical comparison is not feasible due to the relatively small number of patients evaluated in our study.

Conclusion

In our series, OMOM capsule endoscopy appears to be a practical, safe and easy to perform procedure in the evaluation of small bowel disorders. Compared to the other capsule systems on the market, OMOM capsule provides similar overall diagnostic yields and longer time of observation of the small bowel.

Furthermore, its significantly lower cost, with respect to all other systems available in Europe, should encourage its diffusion because of the superior cost/effectiveness ratio.

References

