

**TABLE 14-2**  
**SUGGESTED APPROACH TO UPPER ENTEROSCOPY**  
**WITH JEJUNAL ASPIRATION TO IDENTIFY**  
**SMALL INTESTINAL BACTERIAL OVERGROWTH**

	<b>PROCEDURE DETAILS</b>
Preparation before test	<ol style="list-style-type: none"> <li>1. No colon cleansing prep for 1 month.</li> <li>2. No antibiotics or probiotics for 2 weeks.</li> <li>3. Stop prokinetics and opiates for 48 hours.</li> <li>4. Fast for 12 hours before test.</li> <li>5. Rinse patient's mouth with about 30 cc of antiseptic mouthwash before endoscopy to minimize oral flora contamination.</li> <li>6. If patient is on proton pump inhibitors, patient can continue.</li> <li>7. If patient has gastroparesis, patient should be on full liquid diet for 3 days before test to avoid gastric food bezoars during endoscopy.</li> </ol>
Test methods	<ol style="list-style-type: none"> <li>1. Upper enteroscopy is performed with a pediatric colonoscope or small bowel enteroscope.</li> <li>2. Endoscope is advanced to proximal jejunum without attaching the suction tubing to minimize contaminating suction channel.</li> <li>3. Aspiration catheter (at least 180 cm) is inserted through the endoscope into the proximal jejunum.</li> <li>4. Aspiration catheter is attached to a suction trap, which is attached to wall suction, to collect at least 2 cc of luminal liquids in the suction trap.</li> </ol>
Laboratory handling	<ol style="list-style-type: none"> <li>1. Aspiration sample is placed immediately into an anaerobic transport device (free of oxygen) for quantitative anaerobic bacteria culture.</li> <li>2. Remaining sample is sent for quantitative aerobic bacteria culture.</li> <li>3. Samples are delivered to the microbiology lab to be plated for culture within 1 hour of collection.</li> </ol>
Criteria for SIBO	<ol style="list-style-type: none"> <li>1. Growth of <math>&gt; 10^4</math> colony forming units/mL of coliform bacteria in 48 hrs, such as <i>Escherichia</i>, <i>Klebsiella</i>, <i>Proteus</i>, <i>Acinetobacter</i>, <i>Enterobacter</i>, <i>Neisseiria</i>, <i>Citrobacter</i>, <i>Bacteroides</i>, or <i>Clostridium</i> species.</li> </ol>

quiescent phase with only minimal spontaneous contractile activity. Phase II is variable with irregular contraction frequency and amplitude. Phase III generates the migrating motor complex (MMC) coordinated contractions that allow for the downstream propagation of luminal content (Figure 14-2).

Abnormal antroduodenal and small bowel manometric patterns lack the specificity to diagnose CIPO. However, it is helpful when the underlying cause of CIPO is unclear. Visceral myopathy is typically associated with hypomotility with low-amplitude contractions ( $< 10$  mm Hg) in the small bowel. On the other hand, visceral neuropathy has normal contraction strength, but is identified