Domain	Performance Measure	Statement ID	PICO/CQ ID	Statement - Final version	Population	Intervention	Comperator	Outcome	Group	Round 1. Results [%]	Round 2. Results [%]	Round 3. Results [%]	Agreement reached in Round:
Pre-procedure	Indication for SBCE **Key PM**	**1.1**	**1.1**	The percentage of small bowel examinations procedures performed by indication should be audited. Studies performed for indications not included in a published standard list of appropriate indications approved by an internationally recognized endoscopy professional society should be documented and reviewed.	Patients having CE	Indications for CE		Compliance with indication	% of examinations according to indications	**81.8**			1
Pre-procedure	Rate of adequate bowel preparation **Minor PM**	**17.2**	**14.1a**	Visualization is probably higher in patients who received purgative agents.	Patients having CE small bowel	Preparation	No preparation	Increased visualization	Use of peparation CE	**81.8**			1
Pre-procedure	Rate of adequate bowel preparation **Minor PM**	**17.1**	**14.1**	The mucosal visualisation obtained for a capsule endoscopy should be adequate or good in greater than 95% of cases using accepted bowel preparation methods.	Patients having CE small bowel	Preparation	No preparation	Increased diagnostic yield	Use of peparation CE	63.6	63.6	90	3
Pre-procedure	Patient selection **Minor PM**	**7.1**	**3.1**	High risk groups having capsule endoscopy have a greater risk of retention	Subgroups of patients having CE (NSAID users/abdominal radiation/previous Small Bowell surgery/IBD (inflammatory bowel disease, Chron)/abdominal symptoms (pain , diarrhoea, sub occlusive symptoms)	CE		Capsule retention, need for surgery /endoscopic removal	capsule retention per indications	**90.9**			1
Pre-procedure	Patient selection **Minor PM**	**11.1**	**8.1**	The use of patency capsule can reduce the incidence of capsule retention in high risk patients.	Patients having CE	Patency capsule	No Patency capsule	Lower incidence of capsule retention	Patency capsule	**90.9**			1
Completeness of procedure	Complete cecal or stomal visualization **Key PM**	**4.1**	**1.4**	Incomplete study rate (failure to reach colon or stoma bag) should be less than 20%	Patients having CE	Colonic visualization CE		Cecum visualization	% of examinations according to indications-	**100**			1
Completeness of procedure	Complete cecal or stomal visualization **Key PM**	**5.1**	**2.1**	In call cases of an incomplete study (capsule failing to reach colon or stoma bag) the patient should be asked to confirm excretion. If excretion is not confirmed after 15 days then all patients should have an abdominal xray.	Patients having CE	Ask the patient for CE excretion verification	No verification	Morbidity/retention	capsule excretion	**63.6**	**90.9**	**100**	3
Detection of pathology	Lesion detection rate **Key PM**	**2.1**	**1.2**	The overall diagnostic yield of capsule endoscopy depends on the referral population, and adherence to ESGE guidelines. Current available data does not support a single optimal diagnostic yield per indication as such regular audit is required to ensure adherence with ESGE guidelines on capsule use and >95% compliance achieved.	Patients having CE	Positive significant findings		Diagnostic yield	% of examinations according to indications-	**45.5**	**63.6**	**100**	
Detection of pathology	Timing of SBCE for overt bleeding **Key PM**	**16.1**	**13.1**	Early Capsule Endoscopy achieves a higher diagnostic yield in patients with overt OGIB. The timing of capsule endoscopy should be regularly audited against ESGE guidelines and >95% compliance achieved.	Patients having CE	Early CE (<15 days)	delayed CE (>15 days)	Improved lesion detection rates of bleeding lesions	Capsule timing	**100**			1

Domain	Performance Measure	Statement ID	PICO/CQ ID	Statement - Final version	Population	Intervention	Comperator	Outcome	Group	Round 1. Results [%]	Round 2. Results [%]	Round 3. Results [%]	Agreement reached in Round:
Detection of pathology	Use of standard terminology **Minor PM**	**15.1**	**12.1**	Structured and standardised reporting improves the consistency of image interpretation and the description of findings and hence patient management and fascilitates study databases. It does not improve diagnostic yield	Patients undergoing CE	Standardised reporting	None	Yield of pathology	Standardised report of procedure and findings	**63.6**	**81.8**	**100**	3
Detection of pathology	Reading speed of SBCE **Minor PM**	**14.6**	**11.3**	For all indications and in all cases, the video reading speed should be in accordance with ESGE guidelines. Reading speed should be appropriate such that lesion detection is not compromised and sufficient diagnostic yields are achieved on regular audit.	Endoscopists	High Reeding speed	Low reading speed	Improved quality of CE in particular lesion detection	Reading procedue	**63.6**	**72.7**	**80**	3
Detection of pathology	Reading speed of SBCE **Minor PM**	**14.1**	**11.1**	Reading time is significantly reduced when software is utilised to eliminates duplicate images when compared to unmodified viewing.	Reading	Software mode/speed	Standard reading	Improved reading time and reliable quality (diagnostic yield) of CE in particular lesion detection	Reading procedue	**81.8**			1
Management of pathology	Appropriate referral for DAE **Key PM**	**10.1**	**7.1**	The use of small bowel capsule endoscopy with device assisted enteroscopy improves the diagnostic yield. Prior capsule endoscopy is associated with an increased diagnostic and therapeutic yield during device assisted enteroscopy.	Patients having enteroscopy post CE	Triage with small bowel capsule	Enteroscopy without capsule triage	Improved lesion detection rates /reduced missed rates when enteroscopy is performed after CE	Enteroscopy post CE	**81.8**			1
Complications	Capsule retention rate **Key PM**	**7.2**	**3.2**	Retention rates should be audited in all cases against known rates. Variations from expected rates suggest suboptimal patient selection and procedure quality	Endoscopist	Capsule retention	Published capsule retention rates per indication	Improved quality of capsule endoscopy performance, in particular patient selection, reduced risk of complications	capsule retention per indications	**63.6**	**63.6**	**80**	3

Statement ID	PICO/QM ID	Topic area (Evaluative Text)	Statement Round 3 (final)	Statement Round 2	Statement Round 1	Editorial Comment	Population	Intervention	Comperator	Outcome	Group	Round 1. Results [%]	Round 2. Results [%]	Round 3. Results [%]
2.1	1.2	Overall detection rate	The overall diagnostic yield of capsule endoscopy depends on the referral population, and adherence to ESGE guidelines. Current available data does not support a single optimal diagnostic yield per indication as such regular audit is required to ensure adherence with ESGE guidelines on capsule use and >95% compliance achieved.	The overall diagnostic yield of capsule endoscopy depends on the referral population and how strict are the criteria to select patients for capsule endoscopy. When considering all the indications the diagnostic yield of capsule endoscopy should be at least 50%.	The overall detection rate for patients having capsule endoscopy and positive significant findings is at least 51.55% (range 6.2 to 83%).	Notes: Descriptive	Patients having CE	Positive significant findings		Diagnostic yield	% of examinations according to indications	45.5	63.6	100
5.1	2.1	capsule excretion	In call cases of an incomplete study (capsule failing to reach colon or stoma bag) the patient should be asked to confirm excretion. If excretion is not confirmed after 15 days then all patients should have an abdominal xray.	If the capsule does not enter the colon, capsule excretion should be verified by asking patients to verify excretion. If capsule excretion is not confirmed, capsule excretion should be confirmed by x-ray in all cases.	Capsule excretion should be verified, by asking patients to verify excretion.	Notes: Should we verify capsule excretion? When and how? Always: 1) if CE is incomplete, to check-out retention and 2) if CE is complete, to avoid contamination/pollution. If the CE is incomplete and the patient did not recover the capsule, an x.ray should be done?. If the CE is complete and the patient did not recover the capsule, no problem, nothing to do (the risk of CE retention in the colon is very low).	Patients having CE	Ask the patient for CE excretion verification	No verification	Morbidity/retention	capsule excretion	63.6	90.9	100
6.1	4.1	capsule retention	In all cases of capsule retention within the small bowel a management plan to promote natural excretion or to retrieve the capsule should be agreed with the patient; this may be observation and/or medical therapy in cases of asymptomatic capsule retention, device assisted enteroscopy or, when clinically indicated (i.e. in case of obstructive symptoms or malignancy), surgical intervention.	In case of retention, the capsule excretion should be attempted in all patients, even if asymptomatic. In case of failure, the capsule should be retrieved in all patients.	A retained capsule in an asymptomatic patient should be retrieved.	Notes: Should a retained capsule in an asymptomatic patient be retrieved? Should we select the retrieval method depending on the retention ethiology; tumor (surgery), IBD (medical therapy/DBE), unknown (DBE)	Asymptomatic patients with CE retention	Endoscopic/surgical retrieval	Wait and watch (no invasive approach)	Morbidity, mortality, rate of obstruction/perforation/progress of underlying disease	capsule retention	63.6	54.5	100
7.2	3.2	capsule retention per indications /Endoscopist (DMcN)	Retention rates should be audited in all cases against known rates. Variations from expected rates suggest suboptimal patient selection and procedure quality	Capsule retention rates by indication per endoscopist reflect procedure quality.	Capsule retention rates by indication per endoscopist reflect procedure quality.	Notes: Can capsule retention rates by indication per endoscopist reflect procedure quality?	Endoscopist	Capsule retention	Published capsule retention rates per indication	Improved quality of capsule endoscopy performance, in particular patient selection, reduced risk of complications	capsule retention per indications	63.6	63.6	80
14.6	11.3	Detection rates by reading speed	For all indications and in all cases, the video reading speed should be in accordance with ESGE guidelines. Reading speed should be appropriate such that lesion detection is not compromised and sufficient diagnostic yields are achieved on regular audit.	The optimal reading speed that is able to enhance lesion detection is unknown.	There is no known as safe or optimal reading speed to enhance lesion detection.	Notes: Is there a safe or optimal capsule reading speed to enhance lesion detection?	Endoscopists	High Reeding speed	Low reading speed	Improved quality of CE in particular lesion detection	Reading procedue	63.6	72.7	80
15.1	12.1	Standardised report of procedure and findings including indication, reader, speed, preparation quality, landmarks, (completeness), all relevant findings including image and time notes, recommendations (see below for details); management	Structured and standardised reporting improves the consistency of image interpretation and the description of findings and hence patient management and fascilitates study databases. It does not improve diagnostic yield	Standardised reporting in small bowel capsule endoscopy homogenizes and improves the interpretation/description of findings, facilitates study databases, and impacts on consective patient management. It does not improve the diagnostic yield.	Standardised reporting in small bowel capsule endoscopy improves diagnostic yield and interpretation.	Notes: Does inclusion of a standardised reporting in small bowel capsule endoscopy improve interpretation?	Patients undergoing CE	Standardised reporting	None	Yield of pathology	Standardised report of procedure and findings	63.6	81.8	100

Statement ID	PICO/QM ID	Topic area (Evaluative Text)	Statement Round 3 (final)	Statement Round 2	Statement Round 1	Editorial Comment	Population	Intervention	Comperator	Outcome	Group	Round 1. Results [%]	Round 2. Results [%]	Round 3. Results [%]
17.1	14.1	Use of preparation (any)	The mucosal visualisation obtained for a capsule endoscopy should be adequate or good in greater than 95% of cases using accepted bowel preparation methods.	Diagnostic yield of capsule endoscopy is improved in patients who received laxative agents.	Diagnostic yield is significantly higher in patients who received purgative agents.		Patients having CE small bowel	Preparation	No preparation	Increased diagnostic yield	Use of peparation CE	63.6	63.6	90

Statement ID	PICO/QM ID	Topic area (Evaluative Text)	Statement for Round 2	Editorial Comment	Population	Intervention	Comperator	Outcome	Group	Round 1. Results [%]
2.1	1.2	Overall detection rate	The overall diagnostic yield of capsule endoscopy depends on the referral population and how strict are the criteria to select patients for capsule endoscopy. When considering all the indications the diagnostic yield of capsule endoscopy should be at least 50%.	Notes: Descriptive	Patients having CE	Positive significant findings		Diagnostic yield	% of examinations according to indications	**45.5**
3.2	1.3a	Detection rate by indication	In properly selected patients, the median detection rate of small bowel capsule endoscopy performed for obscure gastrointestinal bleeding should account for 58%.		Patients having CE	Lesions detections rates	Minimum published diagnostic yield for OGIB	Improved lesion detection rates /reduced missed rates	% of examinations according to indications	**54.5**
5.1	2.1	capsule excretion	If the capsule does not enter the colon, capsule excretion should be verified by asking patients to verify excretion. If capsule excretion is not confirmed, capsule excretion should be confirmed by x-ray in all cases.	Notes: Should we verify capsule excretion? When and how? Always: 1) if CE is incomplete, to check-out retention and 2) if CE is complete, to avoid contamination/pollution. If the CE is incomplete and the patient did not recover the capsule, an x-ray should be done?. If the CE is complete and the patient did not recover the capsule, no problem, nothing to do (the risk of CE retention in the colon is very low).	Patients having CE	Ask the patient for CE excretion verification	No verification	Morbidity/retention	capsule excretion	**63.6**
6.1	4.1	capsule retention	In case of retention, the capsule excretion should be attempted in all patients, even if asymptomatic. In case of failure, the capsule should be retrieved in all patients.	Notes: Should a retained capsule in an asymptomatic patient be retrieved? Should we select the retrieval method depending on the retention etiology; tumor (surgery), IBD (medical therapy/DBE), unknown (DBE)	Asymptomatic patients with CE retention	Endoscopic/surgical retrieval	Wait and watch (no invasive approach)	Morbidity, mortality, rate of obstruction/perforation/progress of underlying disease	capsule retention	**63.6**
7.2	3.2	capsule retention per indications /Endoscopist (DMcN)	Capsule retention rates by indication per endoscopist reflect procedure quality.	Notes: Can capsule retention rates by indication per endoscopist reflect procedure quality?	Endoscopist	Capsule retention	Published capsule retention rates per indication	Improved quality of capsule endoscopy performance, in particular patient selection, reduced risk of complications	capsule retention per indications	**63.6**
11.2	8.2	Patency capsule Usage / Rates per Indication	In patients with Crohn's disease the routine, non-selective strategy use of patency capsule does not result in significative difference in terms of capsule retention when compared to a selective strategy use of patency capsule.	Notes: Should patency capsule be indicated only in a selected group of patients or routinely in every patient indicated to CE?	Patients having CE small bowel	Utilisation in selected patients only (Crohn)	Routine utilisation / no utilisation	Risk avoidance: retention	Patency capsule	**54.5**
12.1	9.1	Satisfaction	Patients report more discomfort and less willingness to repeat the procedure with the use of preparations compared to fasting alone.	Notes: Does the use of laxatives reduce patients' satisfaction during CE?	Patients having CE	Preparation	Fasting alone	Patients satisfaction, willingness to repeat the procedure, complaints	Patient experience	**72.2**
14.4	11.2	Detection rates by reading procedure	Electronic chromo endoscopy modes do not improve the reading time. There is no difference in reading time between white light and FICE or blue mode.	Notes: Does speed and the use of colour selection modes (FICE / blue mode / NBI) for detection of lesions at CE reading influence diagnostic accuracy (sensitivity and specificity) and or reading times?	Patients/Endoscopists	Reading time according to selection modes (FICE, blue mode)	Standard reading	Improved diagnostic yield / reduction in unnecessary intervention	Reading procedue	**72.7**
14.6	11.3	Detection rates by reading speed	The optimal reading speed that is able to enhance lesion detection is unknown.	Notes: Is there a safe or optimal capsule reading speed to enhance lesion detection?	Endoscopists	High Reeding speed	Low reading speed	Improved quality of CE in particular lesion detection	Reading procedue	**63.6**

Statement ID	PICO/QM ID	Topic area (Evaluative Text)	Statement for Round 2	Editorial Comment	Population	Intervention	Comperator	Outcome	Group	Round 1. Results [%]
15.1	12.1	Standardised report of procedure and findings including indication, reader, speed, preparation quality, landmarks, (completeness), all relevant findings including image and time notes, recommendations (see below for details); management	Standardised reporting in small bowel capsule endoscopy homogenizes and improves the interpretation/description of findings, facilitates study databases, and impacts on consecutive patient management. It does not improve the diagnostic yield.	Notes: Does inclusion of a standardised reporting in small bowel capsule endoscopy improve interpretation?	Patients undergoing CE	Standardised reporting	None	Yield of pathology	Standardised report of procedure and findings	**63.6**
17.1	14.1	Use of preparation (any)	Diagnostic yield of capsule endoscopy is improved in patients who received laxative agents.		Patients having CE small bowel	Preparation	No preparation	Increased diagnostic yield	Use of peparation CE	**63.6**

Statement ID	PICO/QM ID	Topic area (Evaluative Text)	Statement Round 1	Editorial Comment	Population	Intervention	Comperator	Outcome	Group
1.1	1.1	Adherence to ESGE/ASGE recommendations OR Percentage of small bowel examinations procedures performed for an indication that is included in a published standard list of appropriate indications approved by an internationally recognized endoscopy professional society and the indication is documented.	The percentage of small bowel examinations procedures performed for an indication that is included in a published standard list of appropriate indications approved by an internationally recognized endoscopy professional society should be documented.	Notes: Descriptive	Patients having CE	Indications for CE		Compliance with indication	% of examinations according to indications
1.2	1.1a	Adherence to ESGE/ASGE recommendations OR Percentage of small bowel examinations procedures performed for an indication that is included in a published standard list of appropriate indications approved by an internationally recognized endoscopy professional society and the indication is documented.	The median percentage of small bowel capsule endoscopy performed for obscure gastrointestinal bleeding should account for at least 57.6% (ranging between 14.3% to 83.3%)		Patients having CE	Indication: OGIB		Compliance with indication	% of examinations according to indications
1.3	1.1b	Adherence to ESGE/ASGE recommendations OR Percentage of small bowel examinations procedures performed for an indication that is included in a published standard list of appropriate indications approved by an internationally recognized endoscopy professional society and the indication is documented.	The median percentage of small bowel capsule endoscopy performed for anemia should account for at least 23.9% (ranging between 1.4% to 67.9%)		Patients having CE	Indication: anemia		Compliance with indication	% of examinations according to indications
1.4	1.1c	Adherence to ESGE/ASGE recommendations OR Percentage of small bowel examinations procedures performed for an indication that is included in a published standard list of appropriate indications approved by an internationally recognized endoscopy professional society and the indication is documented.	The median percentage of small bowel capsule endoscopy performed for Crohn's disease (suspected and established CD) should account for at least 11.5% (ranging between 1.3% and 27.2%)		Patients having CE	Indication: CD		Compliance with indication	% of examinations according to indications
1.5	1.1d	Adherence to ESGE/ASGE recommendations OR Percentage of small bowel examinations procedures performed for an indication that is included in a published standard list of appropriate indications approved by an internationally recognized endoscopy professional society and the indication is documented.	The median percentage of small bowel capsule endoscopy performed for suspected small bowel tumor and celiac disease should account for about 3.4% each (ranging between 0.8% to 8.4%)		Patients having CE	Indication: tumors and celiac		Compliance with indication	% of examinations according to indications
1.6	1.1e	Adherence to ESGE/ASGE recommendations OR Percentage of small bowel examinations procedures performed for an indication that is included in a published standard list of appropriate indications approved by an internationally recognized endoscopy professional society and the indication is documented.	The median percentage of small bowel capsule endoscopy performed for polyposis should account for about 2.6 % (ranging between 0.4% to 13.8%)		Patients having CE	Indication: polyposis		Compliance with indication	% of examinations according to indications
2.1	1.2	Overall detection rate	The overall detection rate for patients having capsule endoscopy and positive significant findings is at least 51.55% (range 6.2 to 83%).	Notes: Descriptive	Patients having CE	Positive significant findings		Diagnostic yield	% of examinations according to indications
3.1	1.3	Detection rate by indication	Individual endoscopist lesion detection rates by indication predict reading quality in capsule endoscopy.	Notes: Descriptive. Do individual endoscopist lesion detection rates by indication predict reading quality in capsule endoscopy?	Patients having CE	Lesions detections rates	Minimum published diagnostic yield per indication	Improved lesion detection rates /reduced missed rates	% of examinations according to indications
3.2	1.3a	Detection rate by indication	Median detection rate of small bowel capsule endoscopy performed for obscure gastrointestinal bleeding should account for 57.7% (ranging from 9.7% to 81.8%)		Patients having CE	Lesions detections rates	Minimum published diagnostic yield for OGIB	Improved lesion detection rates /reduced missed rates	% of examinations according to indications
3.3	1.3b	Detection rate by indication	Median detection rate of small bowel capsule endoscopy performed for anemia should account for 55.35% (ranging from 4% to 84.4%)		Patients having CE	Lesions detections rates	Minimum published diagnostic yield for anemia	Improved lesion detection rates /reduced missed rates	% of examinations according to indications
3.4	1.3c	Detection rate by indication	Median detection rate of small bowel capsule endoscopy performed for Crohn's Disease should account for 40.5% (ranging from 0% to 75%)		Patients having CE	Lesions detections rates	Minimum published diagnostic yield for CD	Improved lesion detection rates /reduced missed rates	% of examinations according to indications
3.5	1.3d	Detection rate by indication	Median detection rate of small bowel capsule endoscopy performed for small bowel tumors should account between 15.4% and 21.7% (see the comment)	Suspected small bowel tumors: only two studies reported this results which were 15.4% and 21.7%.	Patients having CE	Lesions detections rates	Minimum published diagnostic yield for tumors	Improved lesion detection rates /reduced missed rates	% of examinations according to indications

Statement ID	PICO/QM ID	Topic area (Evaluative Text)	Statement Round 1	Editorial Comment	Population	Intervention	Comperator	Outcome	Group
3.6	1.3e	Detection rate by indication	Median detection rate of small bowel capsule endoscopy performed for polyposis should account 60% (ranging from 50% to 77.4%)		Patients having CE	Lesions detections rates	Minimum published diagnostic yield for polyposis	Improved lesion detection rates /reduced missed rates	% of examinations according to indications
4.1	1.4	Colonic visualization	The ideal colonic visualisation rate (caecum visualization) in patients having capsule endoscopy is at least 80%	Notes: Descriptive	Patients having CE	Colonic visualization CE		Cecum visualization	% of examinations according to indications
5.1	2.1	capsule excretion	Capsule excretion should be verified, by asking patients to verify excretion.	Notes: Should we verify capsule excretion? When and how? Always: 1) if CE is incomplete, to check-out retention and 2) if CE is complete, to avoid contamination/pollution. If the CE is incomplete and the patient did not recover the capsule, an x.ray should be done?. If the CE is complete and the patient did not recover the capsule, no problem, nothing to do (the risk of CE retention in the colon is very low).	Patients having CE	Ask the patient for CE excretion verification	No verification	Morbidity/ retention	capsule excretion
6.1	4.1	capsule retention	A retained capsule in an asymptomatic patient should be retrieved.	Notes: Should a retained capsule in an asymptomatic patient be retrieved? Should we select the retrieval method depending on the retention ethiology; tumor (surgery), IBD (medical therapy/DBE), unknown (DBE)	Asymptomatic patients with CE retention	Endoscopic/surgical retrieval	Wait and watch (no invasive approach)	Morbidity, mortality, rate of obstruction/perforation/progress of underlying disease	capsule retention
6.2	4.1a	capsule retention	The retrieval method should be selcted depending on the retention etiology; tumor (surgery), IBD (medical therapy/DBE), unknown (DBE)		Asymptomatic patients with CE retention	Endoscopic/surgical retrieval	Wait and watch (no invasive approach)	Morbidity, mortality, rate of obstruction/perforation/progress of underlying disease	capsule retention
7.1	3.1	capsule retention per indications	There are high-risk groups of patients having capsule endoscopy (state high risks).	Notes: Descriptive. Are there groups of patients with increased risk for capsule retention?	Subgroups of patients having CE (NSAID users/abdominal radiation/previous Small Bowell surgery/IBD (inflammatory bowel disease, Chron)/abdominal symptoms (pain , diarrhoea, sub occlusive symptoms)	CE		Capsule retention, need for surgery /endoscopic removal	capsule retention per indications
7.2	3.2	capsule retention per indications /Endoscopist (DMcN)	Capsule retention rates by indication per endoscopist reflect procedure quality.	Notes: Can capsule retention rates by indication per endoscopist reflect procedure quality?	Endoscopist	Capsule retention	Published capsule retention rates per indication	Improved quality of capsule endoscopy performance, in particular patient selection, reduced risk of complications	capsule retention per indications
8.1	5.1	clear (and type of) instructions with regard to diet, fasting and restrictions (Iron ...)	There is no evidence about the relationship between modality of information (diet fasting and restrictions) and compliance.	Notes: Modality of information (oral, written, doctor or nurse...). Is there any evidence that who provides the information and the type of information have an impact on compliance?	Patients referred for CE	Provision of information regarding fasting and diet		Compliance with provided indications	Clear Instructions with regard to diet, fasting and restrictions

Statement ID	PICO/QM ID	Topic area (Evaluative Text)	Statement Round 1	Editorial Comment	Population	Intervention	Comperator	Outcome	Group
9.1	6.1	completeness of procedure	Both the use of prokinetics and of real-time viewer improves completion rate	Notes: Are there other factors influencing completenss of SB visualization (chewing gum, right lateral position after swallowing the capsule etc). The main factors influencing the completeness rate are those that you have included. Rate pf gastric retention should be defined. Does general use of real time viewer with endoscopic transport of the capsule to the duodenum or application of prokinetics in case of delayed gastric transport increase completeness of CE?	Patients having CE and risk factors for not completeness (Diabetes, neurological diseases, hospitalisation, immobilisation, previous abdominal surgery, IBD)	Use of promotility agents, use of real time viewer	No promotility agents, no real time viewer	Rate of complete bowel visualisation	Completness of procedure
10.1	7.1	Rate of post CE referral to enteroscopy (DAE), Angiography, Surgery, Chemo-therapy etc	The use of small bowel capsule endosocpy with device assisted enteroscopy improved the diagnostic yield. Prior capsule endoscopy is associated with an increased diagnostic and therapeutic yield during device assisted enteroscopy.	Notes: Is CE able to select patients to improve the quality of enteroscopy? Is there a minimum concordance rate between CE and enteroscopy? Does a low diagnostic yield at enteroscopy (post CE) mean a low CE quality? in other terms, is enteroscopy directly influenced by the quality of the CE report (i.e: lesion location, size ...)?	Patients having enteroscopy post CE	Triage with small bowel capsule	Enteroscopy without capsule triage	Improved lesion detection rates /reduced missed rates when enteroscopy is performed after CE	Enteroscopy post CE
11.1	8.1	Capsule retention	The use of patency capsule can reduce the incidence of capsule retention in high risk patients.	Notes: Can the use of Patency capsule reduce the incidence of capsule retention in high risk patients?	Patients having CE	Patency capsule	No Patency capsule	Lower incidence of capsule retention	Patency capsule
11.2	8.2	Patency capsule Usage / Rates per Indication	No significant difference has been found between the non-selective and selective strategy use of patency capsule in patients with Crohn's disease in capsule retention.	Notes: Should patency capsule be indicated only in a selected group of patients or routinely in every patient indicated to CE?	Patients having CE small bowel	Utilisation in selected patients only (Crohn)	Routine utilisation / no utilisation	Risk avoidance: retention	Patency capsule
12.1	9.1	Satisfaction	Patients report more discomfort and less willingness to repeat the procedure with the use of preparations compared to fasting alone.	Notes: Does the use of laxatives reduce patients´satisfaction during CE?	Patients having CE	Preparation	Fasting alone	Patients satisfaction, willingness to repeat the procedure, complaints	Patient experience
13.1	10.1	Detection rates and training	Participation in formal training course increases competence.	Notes: Do formal capsule endoscopy training standards improve quality of capsule endoscopy reading and reporting?	Endoscopists	Mandatory formal training course/training period	No formal training	Detection Rate	Procedure numbers and training
13.2	10.2	CE procedures per year	Competence increases with number of readings performed. The minimum number of readings to achieve competence is 20 -25.	Notes: Is there a minimum number of capsule endoscopy procedures that should be performed regularly to maintain reading proficiency?	Endoscopists/Unit	Minimum capsule	None	Improved quality of capsule endoscopy in particular lesion detection	Procedure numbers and training
13.3	10.3	Prior endoscopy experience	Prior endoscopy experience is required to ensure competency as a capsule endoscopist.	Notes: Is prior endoscopy experience required to ensure competency as a capsule endoscopist?	Endoscopists	Prior endoscopy experience	None	Improved quality of capsule endoscopy in particular lesion detection and interpretation	Procedure numbers and training
14.1	11.1	Reading	Reading time is significantly shorter with software which eliminates images than conventional viewing.	Notes: Does the use of software mode (Quick view / express select / overview) reduce reading times, allowing a reliable sensitivity? Does a standardised reading speed improve interpretation?	Reading	Software mode/speed	Standard reading	Improved reading time and reliable quality (diagnostic yield) of CE in particular lesion detection	Reading procedue
14.2	11.1a	Reading	Diagnostic yield of automatized fast-reading software is unknown.	Notes: However it should be noted that none of the studies used a valid reference standard: some studies used the standard view as a reference standard, while other used a consensus diagnosis made by expert	Reading	Software mode/speed	Standard reading	Improved reading time and reliable diagnostic yield of CE in particular lesion detection	Reading procedue

Statement ID	PICO/QM ID	Topic area (Evaluative Text)	Statement Round 1	Editorial Comment	Population	Intervention	Comperator	Outcome	Group
14.3	11.1b	Reading	Miss rates of automatized fast-reading software ranged from 2.5% to 13%. Sensitivity ranged from 70% to 100%; specificity ranged from 84.7% to 100%.	Notes: However it should be noted that none of the studies used a valid reference standard: some studies used the standard view as a reference standard, while other used a consensus diagnosis made by expert	Reading	Software mode/speed	Standard reading	Improved reading time and reliable accuracy of CE in particular lesion detection	Reading procedue
14.4	11.2	Detection rates by reading procedure	There is no difference in reading time between with light and FICE or blue mode.	Notes: Does speed and the use of colour selection modes (FICE / blue mode / NBI) for detection of lesions at CE reading influence diagnostic accuracy (sensitivity and specificity) and or reading times?	Patients/Endoscopists	Reading time according to selection modes (FICE, blue mode)	Standard reading	Improved diagnostic yield / reduction in unnecessary intervention	Reading procedue
14.5	11.2a	Detection rates by reading procedure	Blue mode has equal or worse values of sensitivity and specificity when compared to white light.		Patients/Endoscopists	Reading accuracy according to selection modes (FICE, blue mode)	Standard reading	Improved diagnostic yield / reduction in unnecessary intervention	Reading procedue
14.6	11.3	Detection rates by reading speed	There is no known as safe or optimal reading speed to enhance lesion detection.	Notes: Is there a safe or optimal capsule reading speed to enhance lesion detection?	Endoscopists	High Reeding speed	Low reading speed	Improved quality of CE in particular lesion detection	Reading procedue
15.1	12.1	Standardised report of procedure and findings including indication, reader, speed, preparation quality, landmarks, (completeness), all relevant findings including image and time notes, recommendations (see below for details); management	Standardised reporting in small bowel capsule endoscopy improves diagnostic yield and interpretation.	Notes: Does inclusion of a standardised reporting in small bowel capsule endoscopy improve interpretation?	Patients undergoing CE	Standardised reporting	None	Yield of pathology	Standardised report of procedure and findings
16.1	13.1	Delay to capsule endoscopy procedure and effect on detection rates- Capsule timing	Earlier timing of CE achieves a higher diagnostic yield for patients with overt OGIB	Notes: bleeding	Patients having CE	Early CE (<15 days)	delayed CE (>15 days)	Improved lesion detection rates of bleeding lesions	Capsule timing
17.1	14.1	Use of preparation (any)	Diagnostic yield is significantly higher in patients who received purgative agents.		Patients having CE small bowel	Preparation	No preparation	Increased diagnostic yield	Use of peparation CE
17.2	14.1a	Use of preparation (any)	Visualization is probably higher in patients who received purgative agents.		Patients having CE small bowel	Preparation	No preparation	Increased visualization	Use of peparation CE