Colonoscopy completion may occasionally prove tricky, and many tricks of the trade have been reported to this end, albeit mostly on an individual basis [1]. Among the myriad rescue techniques when encountering difficult sigmoid intubation is gastroscope-directed guidewire insertion followed by over-the-wire scope insertion after wire backloading onto a colonoscope [2]. Here, a variant technique designated “alongside-the-stiff-guidewire” was pioneered and successfully applied without complications in five consecutive patients over the last 12 months (two patients referred and three in-patients, each with sigmoid intubation failures using the conventional colonoscopy approach) (Table 1).

The technique implies switching to a standard-size gastroscope to intubate the sigmoid with its sharp angulations, which, given the increased tip flexibility and shorter bending section length, proved easily successful in all individuals. Note the mucosal injury where colonoscope advancement failed (Fig. 1a). In the next step, a stiff Savary-type guidewire with a flexible tip routinely used for esophageal bougienage was inserted carefully to the higher sigmoid (up to about 40 cm) and the gastroscope withdrawn (Fig. 1b). Instead of backloading the guidewire onto the colonoscope, e.g., using an endoscopic retrograde cholangiopancreatography (ERCP) catheter, the previously used colonoscope was re-inserted “alongside” the stiff guidewire, speeding up the procedure and reducing related accessory consumption. Owing to the straightening of the anatomy with the guidewire in place, sharp angulations were easily navigated (Fig. 1c), and the guidewire was withdrawn after advancement up to its tip to exclude procedure-related mucosal and/or transmural injury, which, indeed, was avoided in all patients. All procedures were completed safely (Fig. 1d, Video 1).

Relative to previously reported rescue techniques, this variant “alongside-the-stiff-guidewire” approach represents an attractive simplification owing to the potential benefits of reduced time and accessory consumption and its reliance on ubiquitously available scope technology even in office-based endoscopy services.

### Table 1

<table>
<thead>
<tr>
<th>Gender</th>
<th>Age</th>
<th>Colonoscopy indication</th>
<th>External referral</th>
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<tbody>
<tr>
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<td>Post-polypectomy surveillance</td>
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<tr>
<td>2</td>
<td>Female</td>
<td>87</td>
<td>Exclusion of obstruction</td>
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<td>Female</td>
<td>69</td>
<td>Cancer screening</td>
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<td>Female</td>
<td>62</td>
<td>Diarrhea</td>
</tr>
<tr>
<td>5</td>
<td>Female</td>
<td>82</td>
<td>Abdominal pain</td>
</tr>
</tbody>
</table>

**Competing interests**

The authors declare that they have no conflict of interest.
The author

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Endoscopy 2022; 54: E32–E33
DOI 10.1055/a-1353-4358
ISSN 0013-726X
published online 19.2.2021
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Georg Thieme Verlag KG, Rüdigerstraße 14, 70469 Stuttgart, Germany

Video 1 Dynamic illustration of the "alongside-the-stiff-guidewire" technique in patient 5.

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