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Rev.	Author	Date:	Description	ECO*
01	Sharon Goldfarb	28.Aug.2016	First Issue	n/a
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*If applicable

Clinical Investigational Plan			
Protocol ID	**934CLD**	**Sponsor**	**GI View Ltd.**
Revision	**03**	**Investigational Device**	**Aer-O-Scope® Colonoscope System**

1 GENERAL

1.1 Introduction

The Aer-O-Scope® Colonoscope System is a joystick operated self-propelled, disposable colonoscope designed to improve visualization behind folds, eliminate the possibility of disease transmission and be safe and easy to use. The Aer-O-Scope has a unique omni-directional 360˚ view optics, that provide the operator with a 360° field of view.

There is no perfect gold standard for colorectal cancer detection. Conventional colonoscopy, which is an imperfect gold standard, frequently misses polyps and even large tumors, especially those that are located behind colonic folds. The Aer-O-Scope Colonoscope System, with its omni-directional 360° view capability, was designed to view behind folds and lower the rates of missed polyps. Preclinical animal trials demonstrated that the Aer-O-Scope Colonoscope System was superior to conventional colonoscopy in visualizing polyps[i]. This current clinical investigation is intended to compare the visualization of the Aer-O-Scope Colonoscope System to that of conventional colonoscopes commonly used in GI practices today.

1.2 Identification of the Clinical Investigation Plan

Clinical Investigation	Post Market Evaluation of Aer-O-Scope™ Visualization
Reference Number	934CLD
Version of the CIP	Rev. 02
Amendments	n/a
Version/Issue Number and Reference Number	n/a

1.3 Sponsor

Sponsor	GI View Ltd. 5 Shoham St. 5251001 Ramat Gan Israel
Representative	Israel: Sharon Goldfarb; +972-54-6454034; sharon@giview.com USA: TBD – To be added prior to USA IRB submission

1.4 Principal Investigator, Coordinating Investigator and Investigation Site(s)

See Appendix 1: Participating Investigators

1.5 Overall Synopsis of the Clinical Investigation

Inclusion/Exclusion Criteria	**Inclusion Criteria:** 1. Subject is indicated for screening, diagnostic (minor complaints such as rectal bleeding or minor abdominal pain) or surveillance colonoscopy 2. Subject willing to undergo tandem colonoscopies with Aer-O-Scope Colonoscope and a conventional colonoscope (including a single colon preparation bowel cleansing) 3. Subject between the ages of 45 and 75 (patients between the ages of 45 and 50 must have a family history of a first degree relative with onset of colon cancer before the age of 60). 4. Subject is able to understand and willing to sign informed consent form **Exclusion Criteria:** 1. *Personal history* of colorectal neoplasia including familial adenomatous polyposis or hereditary nonpolyposis, colon cancer (HNPCC). 2. Diagnosis of active (flaring) inflammatory bowel disease (active ulcerative colitis or Crohn's colitis), bowel obstruction, or acute diverticulitis, or known severe diverticulosis, fecal incontinence or any known large-bowel disease that would require a predetermined therapeutic colonoscopy (non-screening, non-diagnostic or non-surveillance cases) 3. Severe gastrointestinal tract-related symptoms, or complaints, suggesting performance of a pre-determined therapeutic colonoscopy (non-screening, non-diagnostic or non-surveillance cases) 4. History of colonic resection 5. Clinically significant cardiovascular or pulmonary disease. 6. Cancer or other life threatening disease or significant chronic condition that puts the subject at risk. 7. Blood-clotting disorders and/or current anticoagulant therapy (Subjects taking up to 100mg aspirin for prophylactic treatment are acceptable for this study) 8. Pregnancy 9. Previous radiation therapy to the abdomen 10. Morbid Obesity (BMI > 40 kg/m2) 11. Drug abuse or alcoholism 12. Subject is bed-ridden and/or unable to adequately communicate 13. Subject is under custodial care 14. Subject has a history of psychiatric disorders which would prevent compliance with study instructions 15. Participation in a clinical study within the previous 30 days

Number of Subjects	Three hundred and 10 (310): Up to ten (10) training cases per investigator per site) plus eighty (80) study subjects per site (between one hundred (100) and one hundred and ten (110)subjects per site (dependent on the number of investigators including training cases) Each site will have three (3) study cohorts: ✓ **Training cohort** (up to the first 10 cases per investigator) Aer-O-Scope colonoscopy followed by conventional colonoscopy (not part of the statistical evaluation for visualization) ✓ **Aer-O-Scope colonoscopy** followed by conventional colonoscopy ✓ **Conventional colonoscopy** followed by Aer-O-Scope colonoscopy
Study Duration	One (1) Year
Study Objectives	1. Primary Objectives: 1.1. To measure the adenoma miss rate (AMR) (based on histology) for the Aer-O-Scope colonoscopy as compared to the AMR for conventional colonoscopy in a tandem back-to-back study. The AMR is defined as the percentage of adenomas missed per cohort (either by the Aer-O-Scope colonoscope or a conventional colonoscope) and is measured by the number of missed adenomas (detected in the second pass colonoscopy) divided by the total number of adenomas detected per cohort. See **Number of Subjects** above for cohort group definitions 1.2. To demonstrate the Aer-O-Scope Colonoscope System is safe for the performance of screening, diagnostic (minor cases such as rectal bleeding and/or abdominal pain) and polyp surveillance colonoscopy. 2. Secondary Objectives: 2.1. To measure the polyp miss rate (PMR) for the Aer-O-Scope colonoscopy as compared to the PMR for conventional colonoscopy in a tandem back-to-back study. The PMR is defined as the percentage of polyps missed per cohort (either by the Aer-O-Scope colonoscope or a conventional colonoscope) and is measured by the number of missed polyps (detected in second pass colonoscopy) divided by the total number of polyps detected per cohort. (See **Number of Subjects** above for cohort group definitions). 2.2. To measure the advanced adenoma (≥10mm with villous histology or with high grade dysplasia based on histology) miss rate (AAMR) for the Aer-O-Scope colonoscopy as compared to the AAMR for conventional colonoscopy in a tandem back-to-back study. The AAMR is defined as the percentage of advanced adenomas missed per cohort (either by the Aer-O-Scope colonoscope or a conventional colonoscope) and is measured by the number of missed advanced adenomas (detected in second pass colonoscopy) divided by the total number of polyps detected per cohort.

	It should be noted that the expected number of advanced adenomas will be significantly lower than the number of polyps and the number of adenomas. The evaluation of this objective will most likely not reach statistical significance due to the small expected sample size of advanced adenomas. 2.3. To define and document the learning curve for the operation of the Aer-O-Scope Colonoscope System and use of therapeutic access using the Aer-O-Scope Colonoscope System – Using a 5 point Likert Scale (for perceived physician proficiency). The first ten (10) cases will be training for system operation. The first twenty (20) therapeutic interventions per physician will be training for therapeutic access. 2.4. Colonoscopy timing for both Aer-O-Scope and conventional colonoscopy will be documented for the following properties: 2.4.1. Cecal intubation time (not including therapeutic intervention times) 2.4.2. Withdrawal time (not including therapeutic intervention times) 2.4.3. Total procedure time (not including therapeutic intervention times) 3. Tertiary Objectives: 3.1. Timing of therapeutic interventions (see Appendix 3: Therapeutic Accessories Used in This Study) performed with the Aer-O-Scope Colonoscope System will be documented for the purpose of data collection only
Study Endpoints	1. Primary 1.1. Adenoma miss rates (AMR) for each study cohort 1.2. No serious adverse events or serious adverse device effects using the Aer-O-Scope Colonoscope System. 2. Secondary 2.1. Polyp miss rates (PMR) for each study cohort 2.2. Advanced adenoma miss rates (AAMR) for each study cohort 2.3. Perceived proficiency in Aer-O-Scope operation, mean Likert score between1-3. 2.4. Cecal intubation time (not including therapeutic intervention times) 2.5. Withdrawal times (not including therapeutic intervention times) 2.6. Total procedure time (not including therapeutic intervention times) 3. Tertiary 3.1. Therapeutic intervention metrics (time, tool, success rate)

2 IDENTIFICATION AND DESCRIPTION OF THE INVESTIGATIONAL DEVICE

Manufacturer	GI View Ltd.
Model/Type	Aer-O-Scope Colonoscope System (MASA 0101-0202)
Traceability	Work station will be identified by Catalog number and serial number. Aer-O-Scope Disposable Scanner will be identified by serial number and lot number.

	Released software will be identified by SW number and revision. All systems will be traced using a specific device traceability form in accordance with GI View SOP 690CLP Device Inventory and Accountability or equivalent ISO 14155:2011 compliant SOP from the company's CRO.
Intended Purpose	The Aer-O-Scope Colonoscope System is intended to provide panoramic (360°) visualization (via a video monitor) and diagnostic/therapeutic access to the adult lower gastrointestinal tract, (including but not limited to, the anus, rectum, sigmoid colon, transverse colon, cecum and ileocecal valve) for endoscopy. The Aer-O-Scope Scanner (colonoscope component of the Aer-O-Scope System) is a single use, disposable device. The Aer-O-Scope Scanner cannot be reprocessed.
Populations	The Aer-O-Scope Colonoscope System is intended for adult populations indicated for screening, diagnostic (minor complaints such as rectal bleeding or minor abdominal pain) or polyp surveillance colonoscopy.
Investigational Device Description	The Aer-O-Scope Colonoscope System provides panoramic (360°) visualization (via an external video monitor) and diagnostic/therapeutic access to the adult lower gastrointestinal tract for endoscopy (including but not limited to, the anus, rectum, sigmoid colon, transverse colon, cecum and ileocecal valve). The system has two main components: • **The Aer-O-Scope Workstation** – Facilitates the operation of the Aer-O-Scope Disposable Scanner. This includes supply and control over CO_2, water, suction, air pressure, and the power supply for the camera and illumination. The Aer-O-Scope Workstation receives and processes data sent to and from the Aer-O-Scope Disposable Scanner including pneumatic controls, video signals from the camera and the pressure measurements utilized by the Aer-O-Scope propulsion system to manage navigation within the colon. The Workstation features an ergonomic joystick for the control of the Aer-O-Scope Disposable Scanner optical imaging head steering to streamline navigation. • **The Aer-O-Scope Disposable Scanner** – Is the colonoscope component of the System. The Aer-O-Scope Disposable Scanner is a single-use, self-propelled device that incorporates a CMOS chip that facilitates the introduction of the highly sophisticated visualization system, featuring 360° panoramic omni-view capabilities. The scanner moves through the entire colon and into the cecum. The Scanner captures high-resolution video images of the colon mucosa, transmitted in real-time, to the workstation and then video monitor and is digitally recorded for future reference. The propulsion mechanism uses a series of soft pliable polyurethan balloons and CO_2 gas to propel the optical imaging head into and then out of the colon. Two working channels for the provision of therapeutic access are incorporated in the scanner. The Scanner is disposable and cannot be reprocessed.
Training	For the purpose of this study, the operators will be expert GI endoscopists. Each operator will undergo 2-3 day(s) of training including didactic

	presentations regarding the operation of the Aer-O-Scope. Hands on experience operating the system in a model will also be provided prior to initiating the study. Training procedures for general operation of the system will be included in up to the first ten (10) procedures in the study – the exact number to be determined by the physician's perceived proficiency based on a Likert Scale questionnaire. Up to the first twenty (20) therapeutic interventions will be considered therapeutic training procedures – the exact number to be determined by the physician's perceived proficiency based on a Likert Scale questionnaire. Up to the first 10 training procedures will not be analyzed in the final statistical analysis for polyp visualization.
Medical Procedure	The Aer-O-Scope Disposable Scanner like any conventional colonoscope is inserted into the rectum and then maneuvered to the cecum. The Aer-O-Scope has an incorporated propulsion system to advance the optical imaging head through the colon. The propulsion system utilizes soft pliable balloons and CO_2 gas to gently propel the optical imaging head inwards on intubation and outwards upon retraction. The operator gently eases the multi-luminal cable inward towards the cecum during the insertion phase and gently pulls the cable during retraction scan phase both while steering the optical imaging head with the ergonomic joystick. If pathology of any type is detected during the procedure, a standard therapeutic accessory (at least 230cm in length and ≤1.8mm in diameter) is inserted through one of the Aer-O-Scope two (2) working channels (2.1mm diameter each) and the polyp is removed or biopsied. In the event that the pathology cannot be removed due to size, shape and/or location, the area adjacent to the pathology is tattooed to mark for later therapeutic intervention. In this study, subjects will undergo tandem colonoscopy with the Aer-O-Scope Colonoscope System and a conventional colonoscope (see Appendix 2: Conventional Colonoscopes Used in this Investigation). Subjects will be randomized in blocks to begin either with the Aer-O-Scope Colonoscope System or with the conventional colonoscope. The same endoscopist will perform both procedures. Because the physicians will see which device they are using to perform the colonoscopies, blinding will not be possible. Each subject will undergo colonoscopy in tandem with each device. All pathologies will be removed (or tattooed) during the procedures. Data will be documented on Case Report Forms (973CLD). Data related to adenomas will be retrieved from histology reports.

3 JUSTIFICATION FOR THE DESIGN OF THE CLINICAL INVESTIGATION

Pre Clinical Testing/ Assessment	This post marketing study is intended to demonstrate the ability to better visualize colonic abnormalities using the Aer-O-Scope Colonoscope System. During the course of the last decade, several major visualizations studies have been performed and it has become common practice to use the "second-pass" method for determining visualization methods[ii,iii,iv]. This study is intended to demonstrate a significantly lower adenoma miss rate using the Aer-O-Scope Colonoscope System as compared to a conventional colonoscope. GI View performed a comparative visualization study in swine during the course of 2013 and 2014 and demonstrated a superior ability to visualize pathologies as compared to an Olympus CF140L colonoscope[v]. GI View performed an ex vivo study using harvested swine colons with implanted pseudo-polyps to demonstrate the ability of the Aer-O-Scope Colonoscope System to provide therapeutic access for therapeutic interventions. Following an extensive review of the published biomedical literature, GI View designed this study to be the same as similar studies in the published literature. The population in this study is the same population indicated for screening, diagnostic and surveillance colonoscopy as seen in the published professional literature. A list of articles can be found in Appendix 4: Bibliography.

4 INVESTIGATIONAL DEVICE AND CLINICAL INVESTIGATION RISKS & BENEFITS

Risks	The risks associated with the Aer-O-Scope Colonoscope are similar to those risks associated with conventional optical colonoscopy. As with all procedures related to colon screening, there are some associated risks. Risks associated with both colonoscopy and the Aer-O-Scope Colonoscope may include but are not limited to the following: • Lower digestive tract bleeding, • Colon perforation (that may result in inflammation of the peritoneum (peritonitis) or need for emergency medical treatment), • Excessive insufflation of the colon, • Erosion of the colon mucosa, • Sepsis • Venous thrombosis, • Vasovagal events, • Pain, • Ano-rectal Fissures, • Bloating and • Discomfort. Anticipated adverse device effects include bloating, flatulence mild in nature, ano-rectal fissures and minor discomfort. These symptoms are all transient and do not pose a potential risk to the subjects' health. The Aer-O-Scope Colonoscope system has been designed to minimize

	these adverse effects.
Benefits	Colonoscopy is the gold standard for colon inspection and is a safe and effective procedure. Previous studies of colonoscopy have proven beneficial in the prevention of colon cancer. The Aer-O-Scope Colonoscope may allow a simpler and faster examination, potentially resulting in increased capacity and thus shorter waiting periods for the colon examination. The Aer-O-Scope Colonoscope's unique video system with both forward and omni-directional (360° panoramic) cameras allows greater visualization of the colon both in front and behind the colonic folds as compared to conventional forward-viewing colonoscopy. This was demonstrated in the comparative animal study. A higher detection rate has been shown to lead to lower rates of interval cancers. In addition, the Aer-O-Scope Colonoscope Disposable Scanner is a single use device. As such, each subject receives a new, unused, clean device, eliminating the risk of infectious disease transmission from improper or inadequate high level disinfection. This also reduces the amount of toxic chemicals needed for high-level disinfection. The Aer-O-Scope Colonoscope design is intended to potentially lower the risk of colonic perforation by using a soft and very flexible multi-lumen cable – rather than the more rigid tube used with standard colonoscopes. This design has the potential for substantially reducing the risk of colonic perforation, which can be life threatening.

5 HYPOTHESES OF THE CLINICAL INVESTIGATION

Hypotheses	1. Primary Hypotheses: 1.1. Colonoscopy with the Aer-O-Scope Colonoscope System will have lower AMR than the conventional forward-viewing colonoscopes. The mean adenoma miss rate for conventional colonoscopy as found in the published literature is between 15-40%. The number missed adenomas (NMA) (based on histology) for each of the two cohort groups in back-to-back tandem colonoscopy will be measured. The NMA is defined as the number of adenomas (based on histology) detected during the second pass colonoscopy that were not detected and removed (or tattooed) during the first pass colonoscopy. The AMR will be measured by the NMA divided by the total number of adenomas detected (for each cohort). 1.2. Colonoscopy with the Aer-O-Scope Colonoscope System is safe for screening, diagnostic and surveillance colonoscopy. 2. Secondary Hypotheses: 2.1. Colonoscopy with the Aer-O-Scope Colonoscope System will have a lower PMR than the conventional forward-viewing colonoscopes. The number missed polyps (NMP) for each of the two cohort groups in back-to-back tandem colonoscopy will be measured. The NMP is defined as the number of polyps detected during the second pass colonoscopy that were not detected and removed (or tattooed) during the first pass colonoscopy. The PMR will be measured by the NMP divided by the total number of adenomas detected (for each cohort). 2.2. Colonoscopy with the Aer-O-Scope Colonoscope System will have lower AAMR than the conventional forward-viewing colonoscopes. The number missed advanced adenomas (NMAA) (based on histology) for each of the two cohort groups in back-to-back tandem colonoscopy will be measured. The NMAA is defined as the number of advanced adenomas (based on histology) detected during the second pass colonoscopy that were not detected and removed (or tattooed) during the first pass colonoscopy. The AAMR will be measured by the NMAA divided by the total number of adenomas detected (for each cohort). Because approximately only 6% of all adenomas are considered advanced adenomas, the evaluation of this objective will most likely not

reach statistical significance due to the small expected sample size of advanced adenomas.

2.3. Physicians will be proficient in operation of and visualization with the Aer-O-Scope Colonoscope System within the first ten (10) cases. Perceived proficiency will be measured using the five (5) point Likert Scale shown below. Physicians will be asked to grade their performance proficiency of intubation, maneuverability, scanning (withdrawal) and visualization using the Aer-O-Scope Colonoscope System throughout the study. For the purpose of this study, the Likert Scale will be used only for Aer-O-Scope colonoscopies.

Physicians will be proficient in the achievement of therapeutic access for the purpose of therapeutic interventions within the first 20 therapeutic interventions (per physician). Perceived proficiency will be measured using the five (5) point Likert Scale shown below. Physicians will be asked to grade their performance proficiency of tool insertion, maneuverability and ability to perform therapeutic intervention via the Aer-O-Scope colonoscope. For the purpose of this study, the Likert Scale will be used only for the Aer-O-Scope colonoscopies. An overall score between 1 and 3 will be considered proficient.

LIKERT SCALE	USABILITY
1	Easy to perform
2	Slightly complicated to perform
3	Neutral (Neither easy nor difficult)
4	Complicated to perform
5	Very Complicated to perform

2.4. Colonoscopy timing with the Aer-O-Scope Colonoscope System and conventional forward-viewing colonoscopes will be documented for data collection only for the following properties:

2.4.1. Time to cecal intubation – procedures will be timed using a stopwatch. The time spent on therapeutic interventions will be deducted from the intubation time. The Aer-O-Scope and conventional colonoscopes will be equivalent.

2.4.2. Withdrawal time - procedures will be timed using a stopwatch. The time spent on therapeutic interventions will be deducted from the withdrawal time. The Aer-O-Scope and conventional colonoscopes will be equivalent.

2.4.3. Total procedure time – The total procedure time will be recorded from initial intubation through final retraction. The time spent on therapeutic interventions will be deducted from the overall time. The Aer-O-Scope and

	conventional colonoscopes will be equivalent.
Claims and Performance	The Aer-O-Scope Colonoscope System will have a lower overall number of missed adenomas as compared with conventional forward-viewing colonoscopy. An interim analysis will be performed upon completion of each study site.
Risks and Adverse Effects	All serious adverse events and unexpected adverse events as well as adverse device effects will be evaluated in the course of this study.

6 DESIGN OF THE CLINICAL INVESTIGATION

6.1 General

This will be a prospective multi-center, multi-national comparative non-blinded clinical investigation. Each subject will undergo back-to-back tandem colonoscopies with the Aer-O-Scope Colonoscope System and a conventional colonoscope (for a list of scopes to be used, see Appendix 2) since this is a tandem colonoscopy study, each subject will serve as their own control. The 1st procedure will be randomized, half to Aer-O-Scope Colonoscope System and half to conventional colonoscope. The same investigator will perform both procedures on each subject. All pathologies found will be either removed or tattooed. Unmarked pathologies found on second pass will represent those missed during the 1st pass, thus making the subject and the control one and the same. Tattooed pathologies that can be removed endoscopically will be removed in an additional colonoscopy. This may occur if a large polyp cannot be removed for any reason with the Aer-O-Scope, but can be removed with conventional colonoscopy.

Subjects will be randomized in blocks of twenty (20) for either Aer-O-Scope or conventional colonoscopy as the first procedure. Physicians will be notified of the procedural order immediately prior to first colonoscopy. Up to the first ten (10) cases for each physician (system operation training cases) will all begin with the Aer-O-Scope colonoscopy as the first procedure.

The primary endpoint of AMR was chosen as this measure appears to be related to the performance of colonoscopy and reduction in colorectal cancer incidence. During the course of the last decade, several major visualizations studies have been performed and it has become common practice to use the “second-pass” method for measuring colonoscopy visualization methods[iii,iv]. In the “second-pass” method, during the course of the first colonoscopy, all visualized lesions are removed (or tattooed in the event that they cannot be removed for any reason.). Any unmarked abnormalities discovered during the second pass colonoscopy are considered to be missed pathologies for the first pass colonoscopy.

All endpoints related to timing will be measured using a stopwatch and overall time stamp from the Aer-O-Scope or conventional colonoscope. Time to perform therapeutic interventions with Aer-O-Scope as well as a description of said interventions will also be recorded. The same instruments will be used to measure all procedures and will be calibrated as dictated by the manufacturer.

All equipment used during the course of this clinical investigation will undergo calibration and testing as per the manufacturing instructions. The Aer-O-Scope Colonoscope System has an automated calibration system and diagnostic test that run daily. Conventional colonoscopes will be maintained as per hospital/manufacturer protocol.

Recruited subjects who are withdrawn as a result of poor bowel prep or any other medical determination leading to the inability to undergo colonoscopy and/or tandem colonoscopy *will be*

replaced. A poor prep is defined as having a score of score of 0 or 1 in the Boston Bowel Preparation Scale (BBPS). The BBPS scores are as follows:

0 = Unprepared colon segment with mucosa not seen due to solid stool that cannot be cleared.
1 = Portion of mucosa of the colon segment seen, but other areas of the colon segment not well seen due to staining, residual stool and/or opaque liquid.
2 = Minor amount of residual staining, small fragments of stool and/or opaque liquid, but mucosa of colon segment seen well.
3 = Entire mucosa of colon segment seen well with no residual staining, small fragments of stool or opaque liquid.

Any subject withdrawn as a result of physician discretion due to concomitant medical issues will be withdrawn prior to the actual colonoscopic procedures. Patients with a large polyp (>20mm) removed during the first pass with a conventional colonoscope will be withdrawn. Patients who receive treatment during the first pass with clips (no other option available) will be withdrawn.
Coagulation therapy should be performed either with Argon Plasma Coagulation (APC) or another cautery tool or contact thermal device as per clinical protocol. For the purpose of this clinical investigation, clips should not be used unless there is no alternative. Patients treated with clips *prior to their final pass colonoscopy*, will be withdrawn from the investigation.
Physicians may also withdraw any patient due to medical causes if deemed appropriate, including patients that have undergone at least one (1) procedure.

6.2 Investigational Device(s) and Comparator(s)

Each subject will undergo back-to-back tandem colonoscopies, which could last approximately up to one (1) hour each. It is possible that procedures that have multiple therapeutic interventions may go beyond the expected time frames.
The Aer-O-Scope Colonoscope System will be compared to standard conventional colonoscopes that are normally used at the study sites (see Appendix 2 for the exact scope models). This study is intended to compare visualization properties of the currently used technologies; therefore, the standard colonoscope was chosen as the comparator.
During the course of this investigation, subjects will undergo the standard (split) bowel preparation used for colonoscopy at the clinic. This may include but may not be limited to one of the following medications:

- MoviPrep
- Picolax
- Miralax
- Motilium
- Laxadine
- Golytely

During the course of this investigation, subjects will undergo the standard sedation given for colonoscopy. This may include but is not limited to the following medications:

- Biatryl/Fentanyl
- Dormicum/Medazolam
- Propofol

During the course of this investigation, subjects who have findings during their colonoscopies will undergo polypectomies and/or biopsies and/or tattooing using standard therapeutic tools. This may include but is not limited to the following therapeutic tools and medications:

Biopsy forceps – both hot and cold

- Snare – both hot and cold
- Needle – for tattooing or injecting
- Saline solution
- Tattooing ink
- Epinephrine
- Argon plasma coagulation
- Cautery forceps/needles

The number of polyps detected during the second pass colonoscopy (that were not removed or tattooed during the first pass) will represent the overall number of missed polyps for the first colonoscopy. The number of detected polyps is defined as the number of polyps detected during colonoscopy. Each polyp removed (regardless of first or second pass colonoscopy) will be sent to histology as a singular specimen. Histology will determine if the lesion removed is an adenoma, hyperplastic polyp, serrated adenoma, cancer etc.

Patients with polyps ≥20mm detected during 1st pass with conventional colonoscopy will be withdrawn from the study. Patients with polyps ≥20mm detected during 1st pass with the Aer-O-Sco^{pe} will be tattooed for polyp resection during the 2nd pass with a conventional colonoscope.

Patients with polyps ≥20mm that were missed during a 1st pass with a conventional colonoscope and detected with the Aer-O-Scope will be tattooed and undergo a 3rd pass with a conventional colonoscope for polypectomy/EMR (endoscopic mucosal resection).

Upon determination of polyp histology, the NMA will be calculated for each procedure. The NMA is defined as the number of adenomas detected during the second pass colonoscopy and confirmed histologically, that were not removed (or tattooed) during the first pass colonoscopy. The NMA will be calculated for both cohorts alike. The AMR will then be calculated for each cohort.

In the event pathology that is too large to remove or in a location preventing endoscopic removal is visualized during the course of any procedure, the pathology will be marked using tattooing. In the event a lesion is too large to remove during second pass colonoscopy with the Aer-O-Scope Colonoscope System but can be removed endoscopically with a conventional colonoscope, the pathology will be tattooed and the subject will undergo a third procedure with a conventional colonoscope using the same bowel prep and sedation, to remove the said pathology. Pathologies of this type will not be considered missed by the Aer-O-Scope.

The Aer-O-Scope Disposable Scanner is a single use disposable device. Each subject will undergo a colonoscopy with a single Aer-O-Scope Disposable Scanner (heretofore “scanner”). In the event of a technical malfunction, the scanner will be replaced with a new one. The expected number of Aer-O-Scope Disposable Scanners to be used is 310 but more may be used in the event of device malfunction. Each subject will undergo a conventional colonoscopy with a conventional colonoscope. The conventional colonoscope is a reusable device that undergoes high level disinfection / reprocessing between procedures. Each clinic generally uses three (3) scopes per procedure room. One (1) scope in use, another awaiting the next procedure and the third in reprocessing. Three (3) sites will be participating in this clinical investigation; therefore, the number of conventional colonoscopes to be used is expected to be 9; however, more or less may be used according to the sites’ standard operational procedures.

Disposable and reusable therapeutic instruments will be used as needed.

An interim analysis will be performed upon completion of each study site.

6.3 Subjects

Subject Selection	**Inclusion Criteria:** 1. Subject is indicated for screening, diagnostic (minor complaints such as rectal bleeding or minor abdominal pain) or surveillance colonoscopy 2. Subject willing to undergo tandem colonoscopies with Aer-O-Scope Colonoscope and a conventional colonoscope (including a single colon preparation bowel cleansing) 3. Subject between the ages of 45 and 75 (patients between the ages of 45 and 50 must have a family history of a first degree relative with onset of colon cancer before the age of 60). 4. Subject is able to understand and willing to sign informed consent form **Exclusion Criteria:** 1. *Personal history* of colorectal neoplasia including familial adenomatous polyposis or hereditary nonpolyposis, colon cancer (HNPCC). 2. Diagnosis of active (flaring) inflammatory bowel disease (active ulcerative colitis or Crohn's colitis), bowel obstruction, or acute diverticulitis, or known severe diverticulosis, fecal incontinence or any known large-bowel disease that would require a predetermined therapeutic colonoscopy (non-screening, non-diagnostic or non-surveillance cases) 3. Severe gastrointestinal tract-related symptoms, or complaints, suggesting performance of a pre-determined therapeutic colonoscopy (non-screening, non-diagnostic or non-surveillance cases) 4. History of colonic resection 5. Clinically significant cardiovascular or pulmonary disease 6. Cancer or other life threatening disease or significant chronic condition that puts the subject at risk. 7. Blood-clotting disorders and/or current anticoagulant therapy (Subjects taking up to 100mg aspirin for prophylactic treatment are acceptable for this study) 8. Pregnancy 9. Previous radiation therapy to the abdomen 10. Morbid Obesity (BMI > 40 kg/m2) 11. Drug abuse or alcoholism 12. Subject is bed-ridden and/or unable to adequately communicate 13. Subject is under custodial care 14. Subject has a history of psychiatric disorders which would prevent compliance with study instructions 15. Participation in a clinical study within the previous 30 days

Withdrawal	Subjects will be removed from the study whenever it is necessary to safeguard their welfare. Non-compliance with the protocol or occurrence of serious adverse events may also necessitate discontinuation from the

	study. When a patient is removed from the study, a final physical examination must be performed. Subjects removed from the study because of an adverse event will be followed-up until the adverse event has resolved. Additional reasons for removing a patient from the study: 1 Subjects who express a desire to withdraw from the study. 2 Any medical condition that, in the opinion of the investigator, warrants discontinuation from the study for the safety of the patient. 3 Poor colonic bowel cleansing that prevents proper visualization and intubation of the colon. 4 A large (≥20mm) polyp removal during first pass colonoscopy with a conventional colonoscope 5 Use of clips during first pass colonoscopy with a conventional colonoscope
Point of Enrollment	Subjects will meet with the physician or physician appointed representative (such as a clinical coordinator) and be given ample opportunity to read and review the provided informed consent form and will be asked to sign prior to the beginning the bowel cleansing regimen. Subjects will be given the opportunity to ask the physicians questions prior to signing the informed consent. Subjects unable to sign prior to the day of procedure will be asked to sign the patient informed consent prior to entering the procedure room. A signed copy of the form will be provided for each patient.
Duration	This multi-center, multi-national study is expected to last no longer than twelve (12) months. Each subject will be enrolled, undergo Aer-O-Scope Colonoscopy and conventional colonoscopy and be followed 24-48 hours via telephone post procedure. Subjects undergoing therapeutic interventions will be followed until the final histological results and only then will be terminated from the study.
Number of Subjects	This study will include a total of 310 subjects in three (3) sites. Each site will study up to between 100 and 110 subjects (depending on the number of sub-investigators undergoing training). Subjects will be enrolled over a three (3) month period at each site and will undergo procedures over a three (3) month period at each site.

6.4 Procedures

Procedures	Subjects indicated for screening, diagnostic (for minor complaints such as rectal bleeding or minor abdominal pain) or polyp surveillance colonoscopy will meet with the physician or clinical coordinator prior to the procedure for a standard pre-procedure evaluation. Following a preliminary evaluation of eligibility, the patient will be informed of the clinical study and offered the opportunity to participate if he/she is an acceptable candidate. Should the subject agree to join the study, they will be provided a copy of the patient informed consent form and provided ample time to review the form. The point of enrollment will be upon signing the patient informed consent form. Subjects who sign the consent form but do not undergo any procedure will be recorded as screen

	failures on a separate log, and removed from the enrollment roster. The duration of this multi-national study is expected to be twelve (12) months, three (3) months per site. Each enrolled subject will participate for up to seven (7) days which will include the day of the informed consent signature, the bowel preparation and the day of procedures (Aer-O-Scope Colonoscopy and colonoscopy) with a 24-48 hour follow-up period. Up to 200 subjects will be enrolled in the USA and up to 110 subjects will be enrolled in Israel with a total of up to 310 Subjects overall.

6.5 Monitoring plan

General Outline Details	A full monitoring plan *935CLD Clinical Investigation Monitoring Plan* will be provided separately.

7 STATISTICAL CONSIDERATIONS

Measurements	The pass criteria for the study objectives are rejecting the Null hypotheses as presented below.
Primary Hypothesis:	Colonoscopy with the Aer-O-Scope Colonoscope System will have lower AMR than the conventional forward-viewing colonoscopes.
Statistical Analysis **Assumptions:**	• The Adenomas rate within the sample will be 50% (see Appendix 4: Bibliography). • The adenoma rate in the sample, for patients with Adenomas, will be 200% (average of 2 adenomas per person). (see Appendix 4: Bibliography) • The differences in AMR between the two groups will be 15% (see Appendix 4: Bibliography) • The expected AMR of the two groups will be 0.10 vs 0.25 (see Appendix 4: Bibliography) • The drop-out rate will be 10%.
Statistical Analysis Plan: **Hypotheses testing based calculations**	• For testing the hypothesis that the Aer-O-Scope Colonoscope System will have lower AMR and PMR than the conventional forward-viewing colonoscopies we will perform the Z-tests for comparing two proportions. The tests will be two-sided with significant level of 5%. • To demonstrate the physicians proficiency in operation of (including therapeutic interventions) and visualization with the Aer-O-Scope Colonoscope descriptive statistics will be performed using the Likert Scale questionnaire. A mean score between one (1) and three (3) will denote proficiency.
Sample Size Calculation:	The sample size calculation based on the independence AMR between the two groups. A total of 240 patients are needed to compare the AMR between the groups using Z-test for two proportions comparisons. This number enables a 10% dropout, and does not include 70 patients (20-30 training subjects per site (sub-investigator dependent) for learning qualification. This sample size based on a significant level of 5% and a power of 80% to prove a difference in AMR between the groups.

8 DATA MANAGEMENT

Procedures Description	*SOP CLP688 Processing Paper CRF Received from Investigational Sites* describes activities related to data processing and data management. Overall responsibilities as stated in the SOP are as follows: The **Sponsor** of the clinical investigation is responsible for: • Maintaining records to document the compliance of all parties involved in the clinical investigation • Ensuring that the clinical investigation is correctly monitored at the investigation site according to the monitoring plan The **Monitor** is responsible for: • Monitoring the clinical investigation at the investigation site, according to 934CLD Clinical Investigation Monitoring Plan and SOP 633CLP Monitoring Clinical Investigations, ensuring that: o CRFs and queries are complete, recorded in a timely manner, and consistent with source documents o Appropriate corrections, additions or deletions are made to the CRFs, dated, explained if necessary and initialed by the principal investigator or by his/her authorized designee • Maintaining detailed shipping records for transmission of completed paper CRFs to Sponsor / CRO The **Principal investigator (PI)** for the clinical investigation is responsible for: • Ensuring the accuracy, completeness, legibility and timeliness of the data reported to the sponsor in the CRFs and in all required reports during the clinical investigation • Supporting the sponsor or CRO and responding to questions during monitoring and close-out of the clinical investigation at the investigation site The **Site Clinical Coordinator** for the clinical investigation is responsible for: • Maintaining all of the study related hospital files o This includes maintaining all logs such as: ▪ Clinical Investigation Plan (CIP) Deviation Log ▪ Subject Informed Consent (SIC) Signature Log ▪ Investigation Team Log ▪ Device Accountability Log ▪ Investigation Site Team Training Log ▪ Clinical Investigation Document Approval Log ▪ CIP Amendment Log • Correct filling of the CRFs based on source documentation and live documentation • Maintaining contact with study subjects, and coordinating visits to the hospital for signing documents and undergoing treatment • Providing the subjects with the bowel cleanse preparation medications (sponsor provided)

	• Instructing subjects on proper diet and other study related issues • Ensuring 24-48 hour follow-up phone calls are made • Maintaining contact with the sponsor for all reportable incidents and general updates The **Data Manager** is responsible for: • Managing CRF receipt and reconciliation of any discrepancies prior to data entry • Performing manual review of the CRF to verify completeness and legibility, data content and consistency • Ensuring that all SAEs have been reported to the Sponsor • Performing CRF data entry into the clinical data base • Maintaining the CRF Tracking Form (689CLP), recording data receipt & reconciliation, manual review, data changes, data queries and data entry
Retention Period	All original copies of CRFs and completed forms will be stored in the Trial Master File in accordance with *674CLP Trial Master File Management* for a period of no less than five (5) years.

Clinical Quality Assurance	**Study File Monitoring**
	• Prior to study implementation, a monitoring schedule will be set and logged into the *642CLP Monitoring Schedule Form*. Tracking of planned and actual visits will also be performed using this form.
	• At the start of the clinical study, the Clinical Monitor will monitor the study files for the following:
	  ○ IRB/EC/Helsinki Committee Documents
	  ▪ All IRB Correspondence is on file
	  ▪ The study staff are IRB approved prior to performing any study procedures
	  ▪ Adverse events and deviation procedures for reporting to IRB per current guidelines are in place
	  ▪ All versions of the IRB protocols and informed consent forms are on file
	  ○ FDA
	  ▪ Signed Good Clinical Practice compliance form, financial disclosure and CV for the PI and sub investigators
	  ▪ All FDA correspondence, if applicable
	  ▪ Procedures of documentation of serious adverse events that are unexpected and related for reporting to FDA within 7 calendar days are in place
	• Other documents:
	  ○ CVs for all study staff are on file and updated within the last 2 years
	  ○ Medical licenses for the Sub-Investigators are on file and updated prior to expiration
	  ○ Delegation Log is updated and procedures for updating the log with new staff are in place
	  ○ All other essential documents have been prepared and

completed as appropriate

Before, during and at the close of the study period, study documentation will be monitored by the Clinical Monitor for the following:

- Informed Consent
- Ensure that subject identification is on all pages of the ICF, if applicable
- Documentation of subject receiving a copy of the consent form is present
- Clinic note documents informed consent process
- The subject and study representative signed and dated the consent form for him/herself
- The subject initialed and dated all appropriate pages on the informed consent form, if applicable
- Note to file completed for any informed consent deviations.
- Ensure a valid (current version date) copy of the consent form was used

Protocol:

- Confirm that the study staff is conducting the study in compliance with the protocol approved by IRB/CE/Helsinki Committee and if applicable, FDA.
- The protocol deviations (exceptions and violations) are documented in the subject chart and reported to IRB/CE/Helsinki Committee as required.
- Ensure any deviations are logged in FORM *638CLP CIP Deviations*

Source Documents:

- Review subject charts to ensure accuracy, completeness and legibility of the data
- Any correction made to the source documents is dated, initialed, and explained. The original entry should not be obscured.
- The protocol specific source documents are on file.
- Source documents are completed in ink.
- Note to files are generated for missing or incomplete data, and to explain any discrepancies or additional comments.

Case Report Forms:

- Ensure that the data reported on the CRF is consistent with the source documents.
- Discrepancies between the source documents and CRF are explained in a note to file or captured in a comment in the CRF.

Query Management

Queries may be generated by the PI, Sub-investigators, Sponsor, Monitor or Data Center.

Query management will be handled by the Clinical Monitor using the *639CLP CRF & Query Monitoring Log*.

The Clinical Monitor will create a Monitoring Report using the *637CLP*

	Monitoring Report FORM. Samples of data queries are as follows: • Non-compliance to protocol • Missing data • Out-of-range data • Unplanned patient visits • Data inconsistent with the source documents • Data clarification

9 AMENDMENTS TO THE CIP

Amendments	All subsequent amendments to the CIP must also be agreed and approved by the sponsor, the coordinating investigator and all principal investigators. The Sponsor / CRO will ensure that 9.1 Amendments to the Clinical Investigation Plan are documented, using form *698CLP 'CIP Amendment and Revision Sheet'* 9.2 approval is documented, using form 693CLP 'Clinical Investigation Document Approval Log'' *9.3* the amended CIP is sent to all investigators and the IRB / EC after approval

10 DEVIATIONS FROM CLINICAL INVESTIGATION PLAN

Deviations	Neither the Principal Investigator nor any of the sub-investigators are authorized to deviate from the CIP, except as specified in 4.5.4 b of ISO 14155:2011 and 21 CFR 812.150 (a)(4), specifically requests for deviations, and reports of deviations, if the deviation affects subject's rights, safety and wellbeing, or the scientific integrity of the clinical investigation. Under emergency circumstances, deviations from the CIP to protect the rights, safety and well-being of human subjects may proceed without prior approval of the sponsor and the EC/IRB/Helsinki Committee. Such deviations shall be documented and reported to the sponsor and the EC/IRB/Helsinki Committee as soon as possible.
Procedures	According to 633CLD Monitoring Clinical Investigations, after completion of the monitoring visit, the monitor will prepare the EC/IRB /Helsinki Committee Notifications letter using form *644CLP EC Notification Form* if any reportable serious deviations or adverse events were recorded, and send them to the Ethics Committee/Institutional Review Board/Helsinki Committee and Principal Investigator, according to this CIP.
Notifications	All notifications will be carried out within the time frames specified by local regulatory authorities or as noted in *934CLD Clinical Investigation Monitoring Plan* (for this CIP)

Other	Investigational site activities will be monitored prior to, throughout, and following the conduct of the clinical investigation to ensure that all criteria are met as per this Clinical Investigation Plan. In the event that responsibilities are not met by participating personnel, the sponsor reserves the right to disqualify the specific parties involved, specifically the Principal Investigator, as follows: • Accuracy, completeness, legibility and timeliness of the data reported to the sponsor in the CRFs and in all required reports during the clinical investigation are not carried out or are compromised • Resources are not provided in order to facilitate the operation of the investigational study • Any unethical actions related to the investigation and/or serious deviations from the CIP and/or written procedures In the event that monitoring activities reveal any areas of concern, the PI will be notified in writing and corrective actions will be established. Should the event occur repeatedly, the PI/Site may be disqualified.

11 DEVICE ACCOUNTABILITY

procedures for accountability of investigational devices	*690CLP Device Inventory & Accountability* describes all procedures for device shipping, accountability, storage, use and return. Responsibilities are as follows: The **Sponsor** of the clinical investigation is responsible for: • Maintaining records to document the compliance of all parties involved in the clinical investigation • Keeping records to document the physical location of all investigational devices from shipment of investigational devices to the investigation sites until return or disposal • Monitoring clinical activities at the investigation site according to the monitoring plan, to ensure that investigational device accountability records are accurate and complete The **Principal investigator (PI)** for the clinical investigation is responsible for: • Keeping records documenting the receipt, use, return and disposal of the investigational devices at the site • Supporting the sponsor or CRO and responding to questions during monitoring and close-out of the clinical investigation at the investigation site

12 STATEMENTS OF COMPLIANCE

12.1 This clinical investigation will be conducted in accordance with ethical principles stated in the Declaration of Helsinki and in compliance with all national and local regulatory requirements for the safety and protection of human subjects.

12.2 This clinical investigation will be implemented only upon receiving all final notification/authorizations from local and national regulatory and Helskinki/EC/IRB authorities, as appropriate.

12.3 This clinical investigation will comply with any additional requirements set forth by the Helsinki/EC/IRB and/or regulatory authorities.

12.4 This clinical investigation provides clinical study medical insurance for study participants as required by local and national regulatory authorities.

13 INFORMED CONSENT PROCESS

General process	Subjects interested in participating in the clinical investigation will be screened by the clinical coordinator or participating physician. Subjects who meet the criteria will then be given a copy of the Patient Informed Consent prior to receiving the medication for the bowel prep, with ample time to read and review the document and ask questions prior to signing. Subjects will meet with one of the investigators or the clinical coordinator to discuss investigational participation and any questions they may have regarding the investigation, the investigational device and the informed consent. The informed consent will be signed during the meeting with one of the participating investigators. A photocopy of the signed patient informed consent form will be provided to the patient prior to the procedure. Subjects requesting to withdraw consent will be disqualified from the investigation at no cost or consequence.
Unable subject	Subjects unable to provide consent on their own behalf will not be recruited into the study.
Emergency treatment	In the event of an emergency resulting from the clinical investigation, all emergency treatment will be provided at no cost to the patient. Clinical Investigation Insurance has been provided to ensure all costs be covered if necessary.

14 ADVERSE EVENTS, ADVERSE DEVICE EFFECTS AND DEVICE DEFICIENCIES

Definitions	An **adverse event** is any undesirable or unintentional or unexpected event (sign, symptom, illness, abnormal laboratory value, or other medical event) that occurs during the course of the study, whether or not considered related to the device. This definition includes events related to the investigational medical device or the comparator and also includes events related to the procedures involved.
	Regardless of the relationship to the investigational device, all moderate to serious adverse events occurring from the time that the informed consent is signed must be recorded in the patient's CRF. Mild expected adverse events such as flatulence, nausea, diarrhea, bloating, mild abdominal cramping, anal discomfort, minor rectal bleeding (specifically if therapeutic intervention is performed), headache, dizziness, thirst, tenesmus or any other symptoms not requiring treatment will not be recorded. These events are common and expected. For device operators, this definition is restricted to the events related to the investigational medical device.
	A **mild adverse event** is one that the symptoms are barely noticeable to the patient. It does not influence performance, require drug treatment or prevent the patient from carrying on with normal life activities.
	A **moderate adverse event** is one that the symptoms make the patient uncomfortable and causes some impairment to normal life activities and requires treatment for symptom(s).
	A **serious adverse event** an adverse event that:
	• Led to death,
	• Led to serious deterioration in the health of the subject, that either resulted in
	  ○ A life-threatening illness or injury, or
	  ○ A permanent impairment of a body structure or body function, or
	  ○ In-patient or prolonged hospitalization, or
	  ○ Medical or surgical intervention to prevent life-threatening illness or injury or permanent impairment to a body structure or a body function
	An **adverse device effect (ADE)** is an event related to the use of an investigational medical device. This includes any adverse event resulting from the insufficiencies or inadequacies in the instructions for use, the deployment, the implantation, the installation, the operation or any malfunction of the investigational medical device. This also includes user error or intentional misuse of the investigational medical device.
	A **device deficiency** is an inadequacy of a medical device related to its identity, quality, durability, reliability safety or performance, such as malfunction, misuse or use error and inadequate labeling.
	An **unanticipated serious adverse device effect (USADE)** is a serious adverse device effect which by its nature, incidence, severity or outcome has not been identified in the current version of the risk analysis report / Investigator's Brochure.

Principal Investigator	The principal investigator will notify the sponsor immediately (within 24 hours) of any serious adverse event or serious adverse device effect and

	within 48 hours for any other adverse device effect. All reports to the appropriate authorities will be made by the principal investigator as set forth in the standard clinical practices outlined in the 21 CFR (§ 812.150(a)(1), § 812.46(b) and § 812.150(b)(1))/ MEDDEV 2.7/3 Dec 2010 and ICH-GCP Guidelines.
Adverse Events Report	Adverse Events will be reported and treated as per the standard clinical practices outlined in the 21 CFR (§ 812.150(a)(1), § 812.46(b) and § 812.150(b)(1))/ MEDDEV 2.7/3 Dec 2010 and ICH-GCP Guidelines.
Device Deficiencies Report	All device deficiencies related to the identity, quality, durability, reliability, safety or performance of the investigational medical device shall be documented throughout the clinical investigation and appropriately managed by the sponsor.
Foreseeable Adverse Events and Anticipated Adverse Device Effects	Anticipated adverse events include minor bloating, stomach ache, flatulence, nausea, vomiting, light headedness, minor mucosal erosions and rectal fissures. Anticipated adverse device effects include problems related to the suction system that may hinder visualization, temporary irrigation problems due to kinks in the tubing resulting from a tortuous colon etc.
Emergency Contact Details	In the event of a serious adverse event and/or a serious adverse device effect, the following sponsor representative should be contacted immediately: Sharon Goldfarb-Albak VP Regulatory and Clinical Tel: +972-54-6454034 (24hours a day, 7 days a week) Email: Sharon@giview.com Fax: +972-73-2539666/7
Data Monitoring Committee DMC	An independent data safety emonitoring board (DSMB) of at least three (3) gastroenterologists will review any and all adverse events and device deficiencies. Chairing the committee will be Dr. TBD.

15 VULNERABLE POPULATION

15.1 This clinical investigation will be conducted on adult populations only. No vulnerable populations such as children and/or pregnant females etc. will be included in the study population.

16 EARLY TERMINATION OR SUSPENSION OF THE CLINICAL INVESTIGATION

Suspension or Premature Termination	Grounds for suspension or premature termination of the clinical investigation include but are not limited to: Non compliance of the investigational site personnel to the CIP and or investigational procedures Severe Adverse Events that demonstrate danger to the patient population Unethical performance on the part of any of the investigators Device Adverse Effects that demonstrate danger to the patient population or severe flaw in investigational device design Failed audit of investigation with serious flaws to study design,

	performance or outcomes Business/Financial issues that cannot be resolved Other unforeseen events that give the PI/Sponsor reasonable doubts to the safety and/or performance of the system which will be referred to the Data Safety Monitoring Committee for review prior to determination of suspension or termination.
Blinding/Masking Technique	This clinical investigation does not include any blinding or masking.
Follow-Up	Patients will be followed up 24-48 hours post procedure via telephone by the clinical coordinator at each site. Patients who undergo therapeutic interventions will only be terminated from the study upon receiving the histology results.

17 PUBLICATION POLICY

The results of this clinical investigation may be published in a mainstream peer reviewed professional journal pending prior written approval from GI View Ltd.

18 BIBLIOGRAPHY

Bibliographic References	A detailed bibliography can be found in Appendix 1 of the Investigator's Brochure (936CLD Rev 01). Articles mentioned in this CIP can be found in the endnotes at the end of this document.

Appendix 1: Participating Investigators

1. Dr. Erwin Santo
2. Dr. Nathan Gluck
3. Dr. Sharon Levy (potential sub-investigator)[1]
4. Dr. Mati Shnell (potential sub-investigator)
5. Dr. Adam Philips (potential sub-investigator)
6. Dr. Guy Rosner (potential sub-investigator)
7. Dr. Roi Dekel (potential sub-investigator)
8. Dr. Yami Shapira (potential sub-investigator)

[1] There will be two (2) sub-investigators at the TLVMC site. This list contains the potential candidates for participating as sub-investigators in this study, pending final agreements.

Appendix 2: Conventional Colonoscopes Used in this Investigation

All colonoscopes used in the TLVMC site will be of the latest models and have HD visualization systems

Appendix 3: Therapeutic Accessories Used in This Study

See IMOH Form 1B

Appendix 4: Bibliography

[i] N Gluck et al; A novel colonoscope with panoramic visualization detected more simulated polyps than conventional colonoscopy in a live swine model; Endoscopy International Open 2015

[ii] IM Gralnek et al; Standard forward-viewing colonoscopy versus full-spectrum endoscopy: an Internation, multicentre, randomized, tandem colonoscopy trial; Lancet Oncol 2014; 15: 353–60

[iii] Siersema PD et al. Retrograde-viewing device improves adenoma detection rate; World J Gastroenterol 2012 July 14; 18(26): 3400-3408

[iv] AM Leufkens et al; Effect of a retrograde-viewing device on adenoma detection rate during colonoscopy: the TERRACE study; Gastrointest Endosc 2011;73:480-9

[v] Gluck Nathan et al. A novel colonoscope with panoramic visualization detected more simulated polyps than conventional colonoscopy in a live swine model;Endoscopy International Open; DOI http://dx.doi.org/10.1055/s-0034-1393080; Published online: 2015