

Abstracts of the 10TH ESGENA CONFERENCE

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Best Free Paper 2004 - Category: Oral Presentation
- presented on 22 October 2006 in Berlin

Telephone Follow up Clinic for Patients with Coeliac Disease

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Introduction: Coeliac disease is a condition in which the lining of the small intestine is damaged by gluten, a protein found in wheat, barley, rye and possibly oats. This damage impairs absorption of vital nutrients. Life long adherence to a strict gluten free diet is essential to avoid long term complications. For this reason, the British Society of Gastroenterology (2002) and the Primary Care Society for Gastroenterology (2006) recommend annual follow up on patients with coeliac disease to monitor compliance and known complications of the disease such as osteoporosis, lymphoma and hyposplenism. With an estimated prevalence of 1% in the UK, this represents a large commitment of out patient resources.

Aims/Objectives: To establish a nurse-led telephone follow up clinic to provide an annual review of clinical progress and ongoing education, information and support of patients at different stages of life. This initiative will 'free up' outpatient clinics and will have several advantages to patients. Travel costs, time, as well as inconvenience to patients are avoided and importantly patients are secure in the knowledge that their condition is regularly reviewed.

Method: Patients who are stable on a gluten free diet are transferred to an annual telephone follow up clinic. This clinic can be delegated to a competent, appropriately trained nurse who has specialist knowledge of coeliac disease and this group's dietary requirements. Each patient is contacted annually by post and given the date and time of the telephone clinic. Appropriate blood tests are requested via their local surgery. The consultation involves evaluation of dietary compliance, symptomatic review and review of blood tests, assessment of bowels and joints, together with education and support in conjunction with any changes in general health/lifestyle which may impact on management of the disease.

Results: The telephone clinic has now recruited 67 patients. The clinic is awaiting a full audit, but feedback from patients and clinicians has been very positive.

Conclusions: Coeliac disease is a permanent intolerance to gluten. Continued adherence to a strict gluten free diet is required if patients are to avoid serious malabsorption problems together with other life threatening complications. Nurse led telephone clinics are ideal to provide life long follow up on these patients by giving continued support and confidence to manage their chronic disease. Preliminary feedback from such a clinic has yielded positive responses from both patients and clinicians.

Learning Outcomes:

1. Annual life long follow up of all coeliac patients is recommended by the British Society of Gastroenterology and Primary Care Society for Gastroenterology to monitor compliance and long term complications of the disease.
2. Follow up for these patients does not have to be done in a hospital setting. They can be monitored successfully and safely by an appropriately trained, competent nurse.

References:

British Society of Gastroenterology (2002) Guidelines for the management of patients with coeliac disease.
Primary Care Society for Gastroenterology (2006) The management of adults with celiac disease in primary care.

Best Free Paper 2004 - Category: Poster Presentation
- presented on 22 October 2006 in Berlin

Pre-assessment of patients on the wards having an endoscopic procedure.

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Introduction.

A persistent problem facing the Endoscopy Unit is the unexpected or late cancellation of endoscopic procedures due to inpatients not being properly or adequately prepared. Consequently Endoscopy procedures that are often critical to patient care are postponed with subsequent wastage of patient slot and blocking of inpatient beds.

Aim.

The aim of this project was to identify the reasons for inpatient cancellation and then formulate a strategy to tackle the problem. The overall aim was to reduce the number of inpatient cancellations, improve communication between wards, patients and the endoscopy unit to promote patients autonomy.

Objective.

The objective was;

To provide informed consent through the education of inpatients about their endoscopy and the care they would receive throughout the procedure.

Improve the efficiency of the endoscopy unit and facilitate the smooth diagnosis and treatment of inpatients by educating the ward staff about the procedures and the necessary preparations.

Method.

A monthly audit was done to identify the number of patients' cancellations and reasons given. A pilot study was also undertaken by a questionnaire to see whether inpatients knew the procedure they were having and the risks factors, prior to giving consent.

The results of these two studies were then used to formulate a pre op / procedural assessment form which included the check list and care plan.

A letter was sent to all the wards informing the staff that the endoscopy team would be undertaking pre-assessment of inpatients attending the endoscopy unit.

An experienced endoscopy nurse would visit the ward patients and pre assess the patient with the date and approximate time of procedure. The nurse would give patient an explanation of procedure, gather pertinent information and answer any questions pertaining to the procedure and also to allay patients' fears. Information leaflets of the procedure will be given to patient and informed consent obtained. The nurse looking after the patient will be asked to sit in on the pre-assessment

All documentation will be filed into patient's notes.

Close liaison was carried out with the Unified Assessment Project manager to implement this change

Results.

A pilot study carried out at the unit identified that 30% of inpatients considered that they were not given sufficient chance to ask questions before their endoscopy. 60% of the patients were not given any literature and 75% of patients said they would prefer an endoscopy nurse to visit them on the ward prior to their procedure.

A pilot study has been undertaken to design the care plan to its full potential. Teaching sessions have been implemented for the ward staff and endoscopy staff on how the documentation works.

Conclusion.

The study has shown that there is a need for a pre procedure visit incorporating pre-assessment of ward patients. To improve the demand and capacity of the endoscopy unit. All the endoscopy team have been very enthusiastic and motivated, to be part of the pre-assessment team

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Abstracts of Free Papers and Poster Sessions

Investigating the efficiency of manual cleaning and endoscope washers using adenosine triphosphate hygiene monitoring system

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Introduction:

It has been known that Adenosine triphosphate (ATP) is a universal molecule found in all animal, plant, bacteria, and yeast and mould cells. The gut and the bowel are believed to contain contaminants which will contain evidence of ATP. During endoscopy, ATP will adhere to the channels of a flexible endoscope, however, after manually cleaning the scopes and disinfecting them in an Automatic Endoscopy Reprocessor (AER), all sources of ATP should be significantly reduced.

Aims/Objectives:

The general aim of the study is to improve the clinical practice in the process of decontamination of endoscopes by measuring evidence of ATP present in the scopes. The study has attempted to answer the following null hypothesis;

- A. there is no significant difference in the reduction of ATP from post manual cleaning to post AER of gastroscopes and the colonoscopes.
- B. there is no significant difference in the reduction of ATP from pre manual cleaning to post manual cleaning.

Methods:

- A. Subject. The endoscopes were randomised. There were 9 gastroscopes and 6 colonoscopes investigated.
- B. Apparatus. The equipment used for this purpose is a handheld luminometer called the ATP Hygiene Monitoring System, which detects the amount of ATP present in the scopes.
- C. Procedure. The study involves swabbing of the biopsy channel of endoscopes and these are categorised as pre- manual cleaning, post manual cleaning, and post AER. Using the portable ATP monitor the scores of each scope are taken before they are clean, after cleaning, and after they finish a cycle from the AER. The authors had set the parameters from 0 to 5 as a fail-safe system. Above 5 will not be considered as pass, 5 will be a caution. Scopes that did not pass the set parameters would be decontaminated again.
- E. Experimental design. A quasi-experimental design was used in the study and the statistical analysis used was a parametric related t test. The level of significance for a one-tailed test used in the experiment was 0.05.

Results:

All scopes were found to have a huge amount of ATP after they were used. After manual cleaning ATP contamination of the biopsy channel was significantly reduced. The ATP contamination of the biopsy channel was nil on the colonoscopes after decontamination from the AER. The gastroscopes showed there was also a reduction of ATP in the biopsy channel, however one of the gastroscopes showed that there was an increase in post AER with a score of 3, compared to post manual cleaning which was 2, and this was within the set parameters.

Conclusion:

The results corresponded well with the theoretical predictions, that there will be a reduction of ATP in the biopsy channel of the endoscopes after cleaning and disinfection. However, the efficacy of cleaning depends on the number of factors which includes;

- a. nature of the device being processed.
- b. the extent and nature of the soiling to be removed
- c. the temperature
- d. mechanical energy (time, output, duration)
- e. detergent
- f. the nature, volume, concentration and temperature of the disinfectant solution.

It is hoped that this study will stimulate further work in the field.

References:

ATP Hygiene Monitoring System SURE II. Northavon business centre, Bristol, Health edge solutions limited.
Rider et al. (2003). B Cell-based sensor for rapid identification of pathogens. Science, 301:213-215.

Double balloon enteroscopy: Implementing a new examination method in an endoscopy unit

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Introduction

In the autumn of 2004 we started, as the first hospital in Scandinavia, to offer double balloon enteroscopy. By offering this examination, we are now able to treat the findings we get from capsule endoscopy. We receive patients from all over Denmark. The patients are referred to us after having had a capsule endoscopy. Most of our patients are 60 years old or more, and many of them have intestinal bleeding so severe that they need blood transfusions every week. If possible, we perform the examination under general anaesthesia, due to the long examination time, of up to two hours, and the amount of air used.

Implementing a new examination method

Implementing the double balloon enteroscopy was different from how we usually work when implementing something new. Normally one learns from a more experienced nurse; this time, we had to gather the experience ourselves.

We had three main areas to work with:

1. Care for the patient before, during, and after the examination
2. Information to patients and colleagues
3. The endoscope and examination procedure

1. The care does not differ very much from what we do at other examinations, but with an examination time of up to 2 hours, special care has to be taken of the patient. When implementing a new examination method, there will be things that have to be changed. The most important change we have made, is changing from doing the procedure as an outpatient procedure, to having all the patients admitted to hospital the day before the examination. On admission to the ward, the patient is seen by a surgeon and an anaesthesiologist. The haemoglobin is checked, and if needed, the patient is given a blood transfusion. If the examination is performed through the colon, the patient is given a bowel cleansing with dinatriumphosphate.

2. In order to inform our patients as well as possible before the examination, we have produced information leaflets, which are sent to the patients when they are referred to us.

To ensure that the nursing staff on the wards know about the examination method, we have produced an information paper together with a short checklist.

In the endoscopy unit we now have a detailed description of the examination, and a written teaching plan, to ensure that the nurses who are going to learn the procedure have all the information necessary. In May 2006, we were invited by the hospital to give a lecture at a nursing symposium about double balloon enteroscopy

3. We were introduced to the endoscope and the examination procedure by Dr. P. Vilmann, who performs the examination, and by the Danish representative of Fujinon, the manufacturing company. After working

with the double balloon enteroscope for a year we visited VU medisch centrum in Amsterdam, and had two very inspiring days.

Conclusions

Implementing double balloon enteroscopy as a new examination method, has been an interesting challenge. No matter how simple a new procedure seems, it is always more complicated than you can imagine. Demand that you have time to prepare before starting something new, and if you do not have nurses in your own area/country to discuss with, don't be afraid of contacting nurses in other countries. That is what we are going to do next time.

References:

- 1) Yamamoto H, Kita H. Double-balloon endoscopy: from concept to reality. In: *Gastrointest Endosc Clin N Am.* 2006 Apr; 16(2):347-61.
 - 2) May A, Nachbar L, Wardak A, Yamamoto H, Ell C.: Double-balloon enteroscopy: preliminary experience in patients with obscure gastrointestinal bleeding or chronic abdominal pain. In: *Endoscopy.* 2003 Dec; 35(12):985-91.
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Implementation of a computerised nursing care plan for standardised care in inflammatory bowel disease.

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Introduction

A total of 420 patients with inflammatory bowel disease (IBD) (250 Ulcerative Colitis (UC) and 170 Crohn's Disease (CD) are presently under treatment at our centre, representing 2-3% of total admissions. In October 2003, a computer programme with standardized care was implemented for patients admitted to our centre with the diagnosis of IBD.

Aims

To evaluate this computerised nursing care plan for IBD patients and to identify the quantity and quality of the nursing records concerning nursing diagnosis and recommendations given at discharge.

Methodology

We performed a descriptive retrospective study in 15 patients who met the inclusion criteria for IBD (5 UC and 10 CD) between January 2004 and January 2005 (6 men and 9 women, mean age 42 y (20-96)). All the nurses' notes included in the computerised programme over 24 hours from all 3 work shifts on the 3rd day of admission were studied. These notes consisted of data inserted by nurses on 4 screens: confirmed interventions, graphs, progress charts, and recommendations at discharge. We evaluated nursing diagnosis notes in the following areas; elimination, pain/analgesia, nutrition/fluids, perianal hygiene, rest/sleep, and information about their disease.

Results

Elimination: Confirmed interventions (CI): 87.7%; Graphs (G): 39.9%; Progress Charts (PC): 48.8%.

Pain/analgesia: CI: 89.9%; G: 75.5%; PC: 66.6%.

Nutrition/fluids: CI: 93.28%; G: 84.4%; PC: 35.5%

Perianal hygiene: CI: 22.2%; G: 0%; PC: 0%.

Rest/sleep: CI: 81.1%; G: 0%; PC: 0.4%.

Information: CI: 71.1%; G: 0%; PC: 0.2%.

Recommendations at discharge: 14 of 15 patients (93.3%) were given the recommendations at discharge.

Conclusions:

We observed that the present computerised nursing care plan for standardised care in our IBD patients: 1) Aids nurses determine how, when and what care should be given in accordance with a standardised plan. 2) Shows a trend to repeat information. 3) Indicates a lack of correlation between the CI screen with the graphs and progress charts.

Although our computerised nursing care plan for standardised care has facilitated nursing care and records, the results obtained have evidenced the need to modify the programme.

References

- 1.- Diagnósticos Enfermeros por necesidades. Virginia Henderson
- 2.- Guia de práctica clínica . M.A. Campos Osaba y cols. Fundación Jordi Gol
- 3.- Proceso de Enfermería y Valoración. M.A. Campo Osaba

Two things the delegates could learn from the presentation.

Nurse records. Nursing care plans IBD.

A structured approach to nurse education: endomucosal resection (emr) and the development of nursing practice in endoscopy.

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Introduction Endoscopy is constantly responding to changes in demand for and access to services, and to advances in technology and therapeutic interventions. These can have a significant impact on the role of the endoscopy nurse. EMR is one such therapeutic intervention. Since EMR was first performed it has become recognised as a viable alternative to the surgical removal of many larger polyps and for the routine removal of some sessile polyps and early cancers in both the upper and lower GI tract (Ono H et al 2001, Hurlstone DP et al 2004).

Aim Our aim in developing EMR practice was to have an approach inclusive of nursing and junior medical staff. To this end we initially focused on three areas:

- What is EMR?
- When/why is it performed?
- How is it performed?

Objective It was clear that a focused development in practice was required. The drivers for this included:

- New techniques and accessories
- Need to extend limited knowledge base for this procedure
- Practice beyond the routine diagnostic and therapeutic work
- Increasing demand for EMR
- Nurses accountability
- Quality assurance
- Patient satisfaction

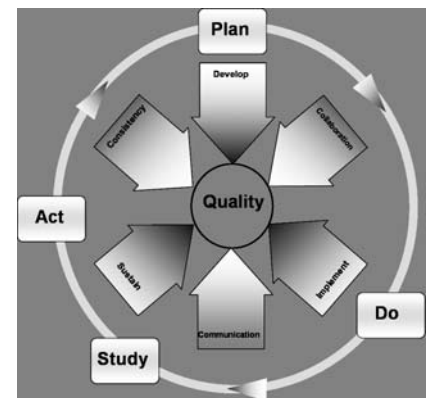
Method A model for practice development has been created within the unit to guide the introduction of advances in service provision such as EMR. A combination of a collaborative approach to the development and implementation of change and a desire to create consistent and sustainable changes in practice has led to the successful adoption of EMR into our repertoire of advanced endoscopic services. The model is represented right.

Outcomes The outcomes have been motivating. All qualified nurses are trained in the technique with specific competencies included in their induction. We have held several national symposia on EMR in Leeds with international faculty to promote dissemination of the skills required. Ultimately patients have benefited from a high quality, specialised service.

Learning Objectives

- (1) A standardised approach to service delivery promotes quality and patient satisfaction.
- (2) Collaborative practice development encourages and supports multidisciplinary working.

References (1) Ono H, Kondo H, Gotoda T, Shirao K, Yamaguchi H, Saito D, Hosokawa K, Shimoda T and Yoshida S (2001) Endoscopic mucosal resection for treatment of early gastric cancer. *Gut*;48;225-229. (2) Hurlstone DP, Sanders DS, Cross SS, Adam I, Shorthouse AJ, Brown S, Drew K and Lobo AJ (2004) Colonoscopic resection of lateral spreading tumours: a prospective analysis of endoscopic mucosal resection. *Gut*;53;1334-1339.



Nurse endoscopy training at ersta hospital, Sweden – the initial experience

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With a steadily increasing demand for GI endoscopy, Nurse Endoscopy has become widely accepted as a valuable adjunct. Sweden has been slow in adopting this concept. We report the experience with the first two formally trained Swedish Nurse Endoscopists. Both nurses had previous experience as endoscopy nurses for at least 10 years.

Clinical training. The clinical training programme was a stepwise introduction to the necessary skills in gastro- and colonoscopy; handling of the instrument; retraction of the instrument; intubation; recognition of important anatomical landmarks; detection of pathological findings; tutored complete endoscopic procedures; and finally, writing full examination reports. Analysis of the performance of the two nurses suggested that about 75 patients had to be examined before they could enter the last steps of a complete endoscopy followed by an adequately written report about the findings. The entire training period was 1.5 years and during this time each nurse performed about 300 upper and 300 lower GI endoscopies, all of which were supervised.

Current clinical practice. Each of the nurses runs a list of their own. As they are proficient in both upper and lower GI endoscopy, the list can be composed to balance the incoming referrals and current waiting list. They can also replace a physician endoscopist in case of unexpected absence. A patient group directive (PGD) has been issued which also allows the administration of drugs used for conscious sedation. Furthermore, a senior consultant is always present as back up within the endoscopy unit. The referrals are allocated to the nurse lists as deemed suitable based on the information provided in the referral notes. Since managing own lists, the nurses have performed some 700 endoscopies during a period of 6 months. Their practice involves biopsy of pathological findings and removal of polyps.

Conclusion and future direction. Nurse endoscopists provide a most useful resource extension to a busy endoscopy unit, especially since they work full time within the unit, both as endoscopy nurse and nurse endoscopist. They can manage most aspects of endoscopy by training, and hence will be able to compensate for fluctuating demands in the endoscopy unit. Physician time can be allocated for more demanding patients and tasks. The experience gained from this programme, together with experience shared by Scottish colleagues from Glasgow and Edinburgh, constitutes the basis for the first Swedish academic course in Nurse Endoscopy. This course will start at Ersta Sköndal University College and Ersta Hospital in November 2006, and is intended to train nurses to perform both gastroscopy and colonoscopy. Training in flexible sigmoidoscopy only is not an option. We expect the first Nurse Endoscopist from this programme to run a self-sufficient practice in the autumn of 2008.

Ref.

1. Joint Advisory Group on Gastrointestinal Endoscopy (JAG)
2. Drew P Hughes MAP Hodson R Monson JRT Wedgewood KR Kaur Suthie GS (1998) A prospective UK evaluation on the first training programme for nurse endoscopist. GUT 43:5, 711-714.

Should endoscopy nurses be trained in ethical theory?

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The object of this paper is to discuss the potential impact of training endoscopy nurses in ethical theory on various practical outcomes.

Nurses' training understandably concentrates on scientific and clinical matters. Most courses involve some ethical content, often linked with legal issues, but this is rarely extensive or intensive. Theories touched upon frequently include principle-based approaches (such as Kantianism), utilitarianism, virtue ethics and the ethics of care¹.

The standards of practice required of nurses in gastroenterology and endoscopy include standards of ethical behaviour². It is widely assumed, however, that clinical ethics require little theoretical expertise. The ethical issues arising out of endoscopy practice may be raised in training, but the different answers produced by different theoretical approaches are rarely considered in depth.

But all professional practice has a theoretical basis, a theory-in-action, even if there is no espoused theory³. It will be suggested that a clear and explicit theoretical basis of ethics can make important practical differences for nursing practice, in that different actions would result if a different theory was used.

Some examples will be given, including truth-telling to patients; and conflicts between advocating patients' interests and following doctors' orders. These will be considered from an act-utilitarian and a virtue ethics standpoint, and the different practical outcomes illustrated.

Endoscopy nurses, therefore, ought to receive more training in ethical theory. It will be suggested that, by enabling nurses to make more consistent and effective ethical decisions, such training:

- would protect patients' autonomy better
- would protect patients' dignity better
- would protect patients' safety better
- would protect nurses better

Learning outcomes

At the end of this presentation participants will:

- be aware of the practical effects of different ethical theories on some everyday aspects of endoscopy practice; and
- have some strategies for developing their expertise on issues at the interface between ethical theory and nursing practice.

Ref:

1 See Beauchamp T & J Childress Principles of Biomedical Ethics (4th ed. OUP 1994) Chap. 2

2 E.g. "The gastroenterology nurse is accountable to patients to safeguard these rights while providing appropriate nursing care." Society of Gastroenterology Nurses and Associates, Inc. Standards of Clinical Nursing Practice: Performance and Standards of Care for the Gastroenterology and/or Endoscopy Setting. Gastroenterology Nursing. 24(4):197-201, July/August 2001.

3 Schön D. The Reflective Practitioner: How Professionals Think in Action (Basic Books 1983)

An evaluation of the "cut and push" method of percutaneous endoscopic gastrostomy (peg) removal

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Intro: "Cut and push", as a simple and cheaper alternative to endoscopic PEG removal, was first reported in 1991 (Korula et al) and later in 2000 (Pearce et al) for tubes of less than 15 fg).

Aim: Our prospective study sought to establish whether 15 fg tubes can be safely removed by "cut and push".

Method: Patients requiring removal of Freka 15 fg PEG tubes were identified by Dietetic and Head and Neck Services and the Endoscopy unit. Exclusion criteria: known gastrointestinal (GI) motility disorders, GI structuring, immobility or inability to give informed consent.

Patients were nil by mouth (or PEG) for 6 hours prior to removal. The fixation plate was released and the PEG tube rotated and advanced into the stomach lumen (to exclude buried bumper syndrome), the catheter cut close to the stoma and the remnant pushed into the gastric lumen with a 14 fg nasogastric tube. Patients were kept nil by mouth for 2 hours, on clear fluids for the remainder of the day and asked to look for the remnant in the stool.

Patients were contacted at day 7 and abdominal X ray arranged (same day) for those who had not seen the remnant. If the remnant was seen on plain X ray, the patient was contacted on day 14 and a second X ray ordered if the patient had still not seen the remnant.

Results: 42 patients were recruited over 29 months: 38 Head and Neck and four others (stroke, head injury, cystic fibrosis and lung cancer).

Day remnant passed	Patients numbers
+1	5
+2	13
+3	4
X ray day 7	18
X ray day 8 (bank holiday)	1
X ray day 14	1

40 patients passed the remnant by day 7, all by day 14 and no adverse events occurred.

Conclusion: "Cut and push" is a safe and inexpensive method of removing 15 fg PEG tubes. Patients can have their PEG removed sooner by a less invasive procedure. It does not have to be carried out by a doctor, with further benefit to the health economy - within our Trust the majority of PEGs are now removed by a nurse or dietician using the "cut and push" method.

Ref:

Pearce CB, Goggin PM, Collett J, Smith L & Duncan HD (2000). The "cut and push" method of percutaneous endoscopic gastrostomy removal. *Clinical Nutrition* **19(2)**: 133-135

Korula J & Harma C. (1991). A simple and inexpensive method of removal or replacement of gastrostomy tubes. *Journal of the American Medical Association*; **265**: 1426 – 1428

Expected Learning Outcomes:

"Cut and push" is a safe method of removing Freka 15 fg PEG tubes in ambulant patients.

Cut and push" has significant cost savings over endoscopic PEG removal, particularly if carried out by a nurse or dietician.

Incidence of Clostridium difficile in a Hospital Digestive Disease Service.

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Introduction:

C. difficile is a spore-forming, grampositive anaerobic bacillus that releases two toxins: toxin A (enterotoxin), responsible for most diarrhea associated to antibiotics; and toxin B (cytotoxin). The two appear to act synergically. The organism had been isolated from diverse natural habitats including soils, hay and sand, as well as from dog, cat, reptile and human feces. Since 1977, it is known as the etiological agent of pseudomembranous colitis associated to antibiotics.

Aims:

To determine the incidence of *C. difficile* in patients with gastroenteritis, and evaluate nursing care measures.

Material and methods:

We studied all patients who presented gastroenteritis during hospitalization and in whom *C. difficile* toxin A (+) was isolated in the study period: 01/01/1999-02/28/2002 An epidemic outbreak of *C. difficile* enteritis appeared in the Service in 1999.

We determined the isolation measures necessary to avoid the transmission of *C. difficile* and the possible appearance of further nosocomial epidemic outbreaks.

Results:

- Following the implementation of these measures no further epidemic outbreaks have been noted. All the cases of nosocomial infection for *C. difficile* has been sporadic.
- During the study period , 653 microbiological exams of feces samples from 359 patients with gastroenteritis were performed; *C. difficile* toxin A (+) was isolated in 17 cases and toxin A (-) in 636.

Conclusions:

1. Implementing isolation measures to avoid contact transmission together with standard protection was effective in containing the outbreak.
2. All patients improved clinically with Metronidazole treatment.
3. Implementation of a nurses' alert program and supervision of the antibiotic prescription policy has prevented the appearance of new epidemic outbreaks.

References:

1. L. Alcalá Hernández y E. Bouza Santiago. Infecciones por bacterias anaerobias esporuladas. Capítulo 44. Pag 471. Tratado SEIMC de Enfermedades Infecciosas y Microbiología Clínica. V. Ausina Ruiz, S. Moreno Guillén. Buenos Aires; Madrid: Médica Panamericana (2005)
2. Prevention and Control of Nosocomial Infections. Fourth Edition. Richard P. Wenzel. Lippincott Williams&Wilkins.
3. Hospital Epidemiology and Infection Control. C. Glen Mayhall
4. Hospital Infections. Fourth edition. Jhon V. Bennet, Philip S. Brachman. Lippincott – Raven

Two Things:

Isolation measures to prevent nosocomial infection.

A Comparison Of Patient Experience Of Colonoscopy And Flexible Sigmoidoscopy: A Qualitative Study Using A Semi Structured Interview.

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Abstract

The purpose of this study is to explore the issues patients have in undergoing lower gastrointestinal endoscopy procedures. A qualitative approach was used, using a semi-structured interview to gain insight into the patient experience. Comparison of the patient's experience of colonoscopy and flexible sigmoidoscopy was undertaken to identify any differences and similarities between the two groups.

A convenience sample of ten patients attending the endoscopy department of a District General Hospital (DGH), were recruited into the study; six in the colonoscopy and 4 in the flexible sigmoidoscopy. Local research ethics committee approval and Trust approval has been obtained.

The findings of this qualitative research may have implications for informing the modality for colorectal cancer screening programmes, for current local practices; endoscopy service provision and future research.

Aim of research:

1. To explore and compare the patients' experience of colonoscopy and flexible sigmoidoscopy.
2. Identify any problems or concerns patients have in complying with preparation for procedures.
3. Identify any problems or concerns patients have about the procedure itself
4. Identify any problems or concerns patients have about having the procedure either with or without the use of sedation.
5. To identify any problems or concerns patients have with access to services locally.

Outcomes

1. To identify any patient education needs regarding endoscopic procedures.
2. To identify any changes needed in service provision for endoscopic procedures.
3. To inform any changes to current practices as a result of patient views on services locally.
4. Compare the patients' experience of flexible sigmoidoscopy and colonoscopy to inform the modality for colorectal cancer screening

Keywords: patient experience, endoscopy, qualitative, research, and colorectal cancer.

Results

Five themes emerged from data analysis of patient interviews: 1. Procedure experience. 2. Bowel preparation. 3. Understanding and information. 4. Choice and access to services 5. Interactions with staff - these themes are complex and interlinking.

Data analysis suggests that sedated patients who were symptomatic were more likely to remember some of their procedure. Patients with previous cancer diagnosis reported more anxiety. Patients who were having screening procedures were less anxious and had no recollection of their procedure. Anxieties came from a variety of sources and were experienced by both patient having flexible sigmoidoscopy and colonoscopy.

Oral bowel preparation caused patients concerns; the effects influenced the patient experience of both colonoscopy and flexible sigmoidoscopy.

Flexibility of appointment dates and times were of benefit and appreciated by patients. Support from staff influenced the experience of patient procedures; patient expectations of the health service were exceeded.

Conclusions

Patient experience of flexible sigmoidoscopy or colonoscopy is dependant on the patient symptoms; anxiety; sedation used; effects of bowel preparation; choice and access to services; support of staff, rather than the procedure type.

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Bone Density (Dexa) Scan In Newly Diagnosed Coeliac Patients Under The Age Of 45 Is Unnecessary In The Absence Of Additional Risk Factors Or History Of Previous Fragility Fracture.

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Introduction

The Royal College of Physicians and the Bone and Tooth Society for Great Britain (2000) recommend that all those over the age of 45 with known risk factors for osteoporosis should have a DEXA scan. The British Society of Gastroenterology (BSG, 2002) recommends that **everyone** with coeliac disease should have a DEXA scan routinely at diagnosis.

Aims and Objectives With no DEXA scanning facilities at our hospital, and outlying services experiencing mounting waiting times, as nurses we questioned whether DEXA in newly diagnosed coeliac patients under the age of 45 was necessary in the absence of risk factors or history of previous fragility fracture, and if not how this could be managed as part of nurse led follow up.

Method An audit of Coeliac patients attending our nurse follow up clinic between August and November 2005 was undertaken. All patients with coeliac disease attending the clinic during these months were included, excluded were those with known osteoporosis at time of diagnosis. Presenting symptoms and age at diagnosis were documented, in addition to the date and results of the 1st DEXA and treatment recommendations. 34 patients were included (24 female, 10 male) with a mean age at diagnosis of 52 and 53 respectively (Range 2-80 years).

Results All those with osteoporosis diagnosed at first DEXA were over the age of 40 years. All those diagnosed with osteopenia were over the age of 39 years. All, bar two, with normal Bone Mineral Density were in the younger age range (18-38).

Summary There was no evidence of osteoporosis in any coeliac patient under the age of 45. However there were three instances of osteopenia in this group. Suggesting that setting the threshold at 45 is too high.

Conclusions There is no evidence of a need to routinely scan any newly diagnosed coeliac patient under the age of 40, and with the current pressure on services and cost implications, DEXA is recommended only in those of 40 years or above, unless there is good evidence of additional risk factors or a history of previous fragility fracture.

Risk assessment is therefore vital to identify any real need for DEXA in those less than 40 years, and ALL patients should routinely receive lifestyle advice on maintaining bone health, regardless of age. This is often neglected, but risk assessment and lifestyle advice can competently be delegated to appropriately trained nurses as part of a package of continued care for patients with coeliac disease.

Learning Outcomes

1. There is no evidence of a need to routinely scan any newly diagnosed Coeliac patient under the age of 40.
2. All new Coeliac patients should undergo a risk assessment and receive lifestyle advice on maintaining bone health regardless of age and this can be undertaken by appropriately trained nurses as part of a package of continued care.

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Endoscopic treatment of benign strictures of the gastrointestinal tract – the role of an endoscopic nurse

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Background and Aims: Strictures of gastrointestinal tract (GIT) are often found in patients undergoing endoscopic examination. Strictures are either benign or malignant. Benign strictures are usually treated endoscopically using different techniques. The new possibility has brought the use of a selfexpandible plastic stent (Polyflex) for oesophageal strictures.

The aim of our study is to present our own experience with endoscopic treatment of benign gastrointestinal strictures with special attention to the role of endoscopic nurses.

Methods: We analysed all patients undergoing endoscopic treatment of benign strictures in our department throughout 3/2004-5/2006.

Results: Main results are summarised in the table.

	NUMBER OF DILATATIONS	NUMBER OF PATIENTS	COMPLICATIONS
Peptic oesophageal stenosis	45 (balloon) 7 (bougie)	15 5	0 1 (bleeding)
Achalasia	17 (balloon)	11	1 (perforation)
Pylorostenosis	12 (balloon)	7	0
Stenosis after fundoplication	3 (balloon)	2	0
Strictures in patients with Crohn's disease	16 (balloon)	14	0
Anastomotic strictures	9 (balloon)	7	00
TOTAL	102 (balloon)	61	2 (1.8%)

For dilatation of peptic strictures, we use the "through the scope" CRE balloons (Boston Scientific). A nurse fills these balloons with water using a special pistol. Long strictures are dilated with bougies (Cook). Patients with achalasia or patients with severe dysphagia following fundoplication are treated using Rigiflex balloons (Boston Scientific). An endoscopist fills these balloons with air and a nurse

must counterbalance the tension on the balloon. We have reported two complications (bleeding and oesophageal perforation). Both were successfully treated endoscopically (clipping). In one patient with resistant peptic stricture, we have placed a selfexpandible plastic Polyflex stent (Rüsch). A nurse puts together the introducing system to make possible to place a stent.

Conclusion:

Endoscopic treatment of benign oesophageal strictures is safe and effective. An endoscopic nurse has an important role in assisting in all procedures.

Abc holistic care in emergency endoscopic retrograde cholangiopancreatography (ercp)

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Background. Biliary tract diseases have an impact on both physical and psychological conditions of patients, especially for those who have chronically suffered from their related pain and complications. Exacerbation of these diseases may need urgent ERCP. This report presents a patient who was treated by ERCP in emergency condition under the concept of ABC holistic care.

Method. NKC institute is a tertiary care center serving people in southern Thailand with all kinds of endoscopic procedures for diagnosis and treatment of hepatobiliary and gastrointestinal diseases. The policy is to provide service at all time for those requiring emergency investigation and treatment. The concept of ABC holistic care is translated into emergency service of ERCP which is considered the most risky procedure performed in GI endoscopic unit. This concept includes:

1. A - Action. Prompt response is a key success factor in emergency situation. On call, the endoscopy team should include a senior nurse as a leader for holding the emergency situation. A set of equipment will be prepared on the basis of an ongoing emergency checklist.
2. B - Belief. People in southern Thailand are mixed with Buddhists and Muslim. Patients' belief has its values for relieving pain and stress. Relatives have an opportunity to pray or touch their loved one until reaching the ERCP room.
3. C - Care which incorporates the 4 Cs as follows;
 - a. Collaboration. Endoscopy nurses have a role to collaborate with an endoscopist regarding patients' condition and expected therapeutic result. Ward or emergency room nurses were asked in brief over patient's physical and psychosocial problems.
 - b. Communication. Proficient endoscopy nurse will timely notice the concern of patient and relative. Their belief and preference should be identified and responded as appropriate. Written instruction or information regarding hepatobiliary disease and ERCP procedure would help relieve relative's anxiety during waiting.
 - c. Cooperation. Sedation will facilitate ERCP procedure. Monitoring of patient's vital signs, oxygen saturation and EKG is mandatory. Endoscopy nurse is required to cooperate and work well along with an endoscopist during the procedure.
 - d. Continuum of care. Endoscopy nurse will accompany the patient until reaching the ward. Information about ERCP finding and procedure will be transferred to the ward nurse. Post-ERCP visit should be scheduled until the patient is discharged from the ward.

Case study :

A 50 year-old Buddhist married woman was set for an emergency ERCP. She was febrile, lethargic and sepsis with hyperbilirubinemia and coagulopathy. Patient's husband accompanied her to the endoscopy room. Exchange of information between senior nurse and her husband was done to relieve his insecurity and stress. During waiting, instruction sheet was given to him to provide information about ERCP and hepatic biliary disease. Extraction of common bile duct stones was successfully performed under sedation with meperidine and diazepam. Patient's husband was able to touch patient during transferring her back to the ward. This is the time for endoscopy nurse to talk and discuss with her husband regarding to the treatment given and

discharge plan. Her husband agreed with nurse for using meditation as a tool to relieve pain and stress. Information of her condition and treatment performed was transferred to the ward nurse especially the effect of sedation. Post-ERCP was uneventful. Patient gained in consciousness and was able to have meal on the next day. Endoscopy nurse and endoscopist were together on schedule for post-ERCP visit until the patient was discharged from the ward.

Conclusion : ABC holistic care is a key concept to the success of patient care and teamwork in emergency ERCP.

Drainage of pancreatic pseudocysts with multiple stents using a double wire technique

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Introduction: One of the problems with the endoscopic treatment of pseudocysts is placement of multiple stents. Re-entry into the pseudocyst after placement of a first stent can be particularly cumbersome. Failure to re-enter the pseudocyst may lead to suboptimal treatment (1).

Aim: To develop a technique in which re-entry into the pseudocyst is not necessary by simultaneous placement of multiple guidewires.

Procedure: We have developed two techniques to place multiple guidewires. The first technique uses the 10Fr cystotome. After the pseudocyst has been accessed with the tip, the needle is removed. The first wire is then placed through the sheath of the needle. After the 10Fr outer sheath of the cystotome has been advanced into the cyst, the inner catheter is removed and a second wire can be placed. Now the outer sheath is also removed and two wires are in place inside the pseudocyst and the first stent can be placed.

The second technique uses the guiding catheter of a Fusion Oasis 10 system, to perform an intracystic exchange (I.C.E.). For this technique the Fusion catheter is loaded over the first centimetres of the wire and exits the port 2.5 cm from the distal end. The Fusion catheter is advanced into the pseudocyst. Subsequently the wire is pulled back under radiological guidance until it leaves the Fusion catheter (I.C.E.). Now the stylet of the Fusion catheter is removed and replaced by a second wire, which is also advanced into the cyst. Once the second wire has also entered the cyst, the catheter can be removed by pulling it out of the endoscope. Two wires are now appearing side-by-side from the cystogastrostomy. It is now possible to place two stents or to repeat the procedure to place more wires.

Results: Using the 10 Fr cystotome and the guiding catheter of a Fusion Oasis 10 system in combination with an intra-cystic exchange is an easy technique for placing multiple stents, because access is guaranteed by the double wire technique.

Conclusion: A therapeutic E.R.C.P. and in particular a pseudocyst drainage is a rather technical procedure. For the patient's welfare it is important that the procedure will be done efficiently and in a period as short as possible. Therefore it is essential that nurses are familiar with the different materials and techniques (2). In our hospital we succeeded in this by organising 6 days of intensive training on the job for nurses and fellows as a team (per annum) (3).

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-

Effectiveness of the programme of ano-rectal biofeedback in the treatment of anal incontinence in our environment

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Antecedents: Anal incontinence due to failure of the anus-rectal continent structures is very prevalent in the elderly, causing significant alteration to the quality of life. The programmes of anus-rectal physiotherapy with biofeedback constitute an effective treatment, but requires a high degree of involvement from nursing staff to ensure its success.

Objective: To evaluate the effectiveness of biofeedback programmes in incontinence patients of our environment, and to evaluate possible predictive factors of response.

Methods: Patients with anal incontinence were referred to our Unit from Nov.2002 to Nov.2005. The unit's nurse carried out: a patient advice session covering hygiene and diet, manometric evaluation of the ano-rectal function and a customized program of ano-rectal physiotherapy exercises .

Results: 59 patients (46 women and 13 men) completed the programme, average age 64 ± 12 years old. 86% had feces incontinence, 5% gas incontinence, 5% clothes staining only and 3.4% urgent need to defecate but without leakage. 67% of women had given birth to two children, most of them without complications. Three patients presented previous ano-rectal surgery. The average duration of the treatment was 5.7 ± 1.5 sessions per patient. There was a complete recovery of continence and quality of life in 71% of cases, and incomplete or zero response in 29%. Response to treatment was not influenced by the age, sex, type of incontinence or the existence of previous anal surgery ($p > 0.05$).

Conclusion: Ano-rectal biofeedback monitored by nursing staff is highly effective for the recovery of continence and quality of life for all patients with anal incontinence. The patient-nurse relationship is probably essential for these good results.

The necessity for special care nursing for patients in hepatitis c virus treatment

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Educating patients in hepatitis VHC treatment is fundamental for good treatment response, and consequently for better patient outcome.

Objective

- To form a nursing team specialised in the care of hepatitis patients.
- The unification of working methods.
- The unification of information

Materials and methods:

- Focus discussion group made up of nurses from different healthcare environments in Catalonia and the Balearic Islands.
- To define patients with Hepatitis C virus (VHC) acute, chronic and cirrhosis compensate, to whom this education is addressed, in outpatient departments or hospitalised patients.
- Data collection from different participating institutions: registers, information and working methods.

Results:

Creation of a nursing team specialising in the treatment of hepatitis (GEAPH) patients.

- Four sessions, each of approximately three hours duration
- Identifying common problems.
- Creating three working groups : information, registers, patient guide

- Reaching a consensus and consolidating the above mentioned aspects.

Conclusion:

- **Checking that the same criteria have been applied, regarding patient education, in all participating centres.**
- Necessity of creating a common data base
- Production of a patients' guide for those in treatment for hepatitis VHC

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Two things delegates could learn from the presentation:

The importance of patient education.

The importance of specialised nursing in the care of hepatitis patients.

Quality of life and chronic liver disease questionnaire in cirrhotic turkish patients

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Background and Aim

Chronic liver disease has negative impact on quality of life and chronic liver disease questionnaire (CLDQ) has been used to detect the impact of disease on quality of life of the patients with chronic liver disease. We aimed to translate and validate of CLDQ in Turkish patients with chronic liver disease.

Methods

The CLDQ was formally translated from the original version to Turkish language. Variables were were demography, physical findings, laboratory tests and prognostic scores such as Child Pugh classification and MELD scores. All patients were asked to complete the translated versions of CLDQ. One-way Anova or non-parametric tests were used and p-value <0.05 was considered statistically significant. Spearman's rank correlation was used to assess convergent validity.

Results

A total of 86 cirrhotic patients were recruited into the study. Forty-nine (57%) of them were male and mean age was 53.67±14.5 years. The number of cirrhotic patients classified as Child A, B and C were 19 (22%), 28 (33%) and 39(45%) respectively. The mean MELD score and Child score were found as 16.3±6 (range, 6 to 35) and 8.8±2 (range, 5 to 13). The CLDQ was found to have discriminant validity and significant correlation was found between domains of the CLDQ and disease severity. The highest scores of CLDQ domains were found in Child A patients and scores were lower in Child B and C patients and higher MELD scores (p<0.05).

Conclusion

Chronic liver disease questionnaire is appropriate in Turkish patients to detect the impact of disease on quality of life. Quality of life is more impaired in advanced stage of CLD, especially, in Child B and C patients and higher MELD scores.

Endoscopic examinations in gastroenterology: why suffer?

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Background: Endoscopic examinations are invasive procedures, causing pain and discomfort. In order to lessen patient suffering and to win their cooperation, medications are given to lightly sedate the patient and lessen the pain (e.g. Midazolam and Pethidine). At times, these medications are not sufficient and require higher than customary dosages. Some patients who undergo the examination describe it as a traumatic experience – which leads to a refusal to undergo the test again in the future, if required. In addition, there are certain circumstances under which the attending physician is obliged to stop the procedure due to patient anxiety and lack of cooperation.

Today, there are drugs available that allow the patient to be more heavily sedated during the examination, such that the patient cannot feel pain, he fully cooperates and the time of the examination is thus shortened. The drugs used for deep sedation and pain relief are: Ketamine and Propofol. These drugs have a short half-life and therefore the recovery period is also shorter. These drugs must be administered by an anesthesiologist thus increasing the cost of the examination. On the one hand the use of deep sedation increases the cost of the examination but is necessary; on the other it is of great importance to the patients. This fact necessitates our examining the various treatments given to reduce patient fear and pain; and identify the groups of patients who need heavy sedation in order to perform endoscopic examinations.

Purpose: To describe and compare various pain treatment modalities in different groups of patients who underwent endoscopic examinations.

Methods: The research was designed as a comparative descriptive study. The sample included two groups of patients that underwent endoscopic examinations (colonoscopy and /or gastroscopy) in the Gastroenterology Unit of the Hadassah Medical Center - Ein Kerem. Each group included 82 patients. In the first group pain treatment included the use of Midazolam and Pethidine and in the second the pain was treated with Propofol and Ketamine, administered by the Anesthesiology Service.

The evaluation tool included two questionnaires. The first checked various aspects of the procedure including: patient behavior and hemodynamic and respiratory stability of the patient. This questionnaire was completed by the nurses and physicians present during the procedure. The second questionnaire documented various indicators such as level of pain during the procedure; the patient's memories of the procedure; and his willingness to repeat the procedure in the future using the same pain treatment method. This questionnaire was completed by the patient.

Results: Primary results of the study indicate that the patient group which underwent heavy sedation reported no pain, and no patient anxiety or resistance was noted during the procedure. Some of the patients in this group had undergone the examination in the past, under light sedation but the examination was stopped due to intolerable pain or the patient considered the procedure too traumatic an experience.

The other group underwent endoscopic examination with light sedation. The majority of the group reported an absence of pain during the procedure, a percentage suffered mildly and a smaller percentage reported high levels of pain. It should be noted, that in some of the patients

Nursing consultation as an important factor for patient satisfaction in screening endoscopy

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Introduction: Due to time pressure patients often are not able to properly discuss individual wishes and concerns. As a result they may feel misinformed, which may increase the anxiety level prior and during the procedure. Nursing consultation is an additional, more intensive, informative talk carried out by specialized nurses. By increasing the patient's information level through nursing consultation patient's anxiety may be relieved and quality management should be improved, assuming e.g. a higher detection level of individual risk factors.

Aim: The aim of this study was to assess the patients' overall satisfaction and anxiety levels when receiving additional nursing consultation.

Methods: 20 inpatients and 20 ambulant patients scheduled for screening colonoscopy received a nursing consultation a week before the procedure. During the consultation general medical information like medication, anamneses, and risk factors were discussed as well as individual wishes and concerns e. g. regarding sedation, or the procedure. 14 days after the procedure the patients were interviewed by phone and were asked to answer a standard questionnaire assessing patient satisfaction, anxiety level and the patient's information level. The interview was done by the same nurse who did the consultation.

Results:

Table 1: Patients' feeling concerning the procedure after receiving nursing consultation

	ambulant patients	inpatients	overall
very satisfied	85 %	75 %	80 %
satisfied	10 %	15 %	12,5 %
less satisfied	5 %	10 %	7,5 %

Table 2: Patients' feeling concerning nursing consultation

	ambulant patients	inpatients	overall
very satisfied	100 %	80 %	90 %
satisfied	-	20 %	10 %
less satisfied	-	-	-

All patients judged completely positive about the nursing consultation, they felt better informed about the procedure and taken seriously in their individuality. All patients voiced significantly less anxiety prior and during the colonoscopy.

Conclusions: The results show significantly increased overall patient satisfaction in patients having a nursing consultation before undergoing screening colonoscopy. This effect is mainly based on a higher patient information level, which also leads to a decreased anxiety prior and during the procedure. Through this reduced anxiety level possible complications might be avoided, for e.g. less sedation might be needed or the procedure itself might be less traumatic. Additionally, more patients might agree to undergo a screening colonoscopy if they are better informed.

Learning outcomes:

1. Nursing consultation leads to a better patient information and therefore to less anxiety prior and during endoscopy.
2. Through a more thorough explorative talk individual risk factors are easier detected and can be individually responded to.

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The typical patient experience of ogd and colonoscopy

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Introduction:

As endoscopy nurses we have a worldwide goal: to provide high-quality care maintaining dignity, to provide a safe environment conducive to restoring and maintaining health, and to be a resource for the physicians for treatment, diagnosis and management of their patient with gastrointestinal disorders. The management of our endoscopy unit is influenced by the individual care given to our in- and outdoor patients, innovations and new techniques in the practice of therapeutic endoscopy as well as our high production level. In our hospital, most diagnostic procedures are performed without sedation, allowing patients to return to their homes as soon as possible. It's exciting to hear how patients experience these overwhelming examinations, from the moment they make an appointment, the information they get pre-procedure, the procedure and the follow up care.

Objectives:

At the conclusion of this presentation, the participant will be able to:

- Recognize the importance of good patient information

- Discuss the (dis-)advantages of performing a diagnostic GI-procedure with and without sedation
- Describe the effects our high production level has on the management of our endoscopy unit

Method:

300 questionnaires were distributed in 2005 and evaluated. The inquiry was composed from the moment the patients heard from the doctor that they had to have the examination till the follow-up care. They also could describe how they experienced the procedure and made a choice about sedation or not, if they had to have the examination again in the future.

In this period we were situated on two locations, and had to merger within a year. To identify possible differences, the same amount of questionnaires were distributed on both locations.

Conclusion:

Most patients preferred diagnostic procedures like an EGD or sigmoidoscopy without sedation, even when they had moderate complaints. But, good patient information is essential and inevitable. Colonoscopies however, were often preferred with sedation.

In my opinion, when sedation is given it should be at the level of conscious sedation. Differences in this inquiry depend on the individual patient and the gastro-enterologist performing the procedure.

The outcome of our procedures can be reviewed and discussed with our patients. It gives them more insights of possible abnormalities or illness.

Even with our high production level, we are able to provide high-quality care. We are well organized and the overall satisfaction of our patients is very good.

Finally, the discussion after this presentation may focus on possible differences, hopefully resulting in a worldwide higher standard in delivering care in a job we love the most: GI Nursing!

Acceptance and satisfaction of screening-colonoscopy: a triple centre evaluation in germany

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Introduction and aims: In Germany in October 2002 the screening-colonoscopy was introduced into the national programme for colorectal cancer prevention for asymptomatic subjects older than 55 years. The colonoscopy is an established low risk examination for symptomatic patients, but there is not enough literature about acceptance and satisfaction in asymptomatic patients (1, 2, 3). The study was designed to determine whether there are differences in men or women who participate in the screening-colonoscopy, how the patients were informed about the new prevention-strategy with the screening-colonoscopy and to analyze the acceptance of different bowel preparation in outpatients of 3 practices for gastroenterology in Germany.

Methods: 300 consecutive patients (3-5/2006 - 100 in each centre) were prospectively given a questionnaire and a prepaid envelope after the screening colonoscopy, with the request to complete the questionnaire at home and to send it back to the evaluating practice (1). Data was extracted from the questionnaire.

Results: Out of 272 questionnaires (91 %) a total of 263 questionnaires were included, because 9 were invaluable because of mistakes. Of these, 48 % were male and 52 % were female. We found no significant differences in the 3 centres, so the items were evaluated all together. The general practitioner did the main part of the work in informing patients about the screening-colonoscopy (m=79%; f=57%). Discussing about prevention strategies was more frequently relevant in gynaecologists (46 %) than in urologists (10 %). Patients informed themselves in advertising and media in 44 % (m= 13 %; f=31 %). In the private surrounding of patients the colonoscopy is an open theme in 30 % (multiple answers were possible). The bowel cleansing was done with Golytely RSS (Endofalk®) in 2 centres and with Phosphosoda (Fleet®) in 1 centre. 83 % (m=90%; f=75%) were satisfied with the bowel cleansing procedure. 50 % of male and 30 % of female had no fear because of the examination. 44 % of men and 53 % of women were worrying about the result of the colonoscopy . Women (26%) had more fear about pain concerning the colonoscopy compared to men

(14%). Patients felt well informed about the colonoscopy by the gastroenterologist (95 %). They plan to talk free and easy about their colonoscopy with family members (83%) as well as with friends (88%) or at work (45 % of employed patients). Patients who undergo screening-colonoscopy participate in other cancer screening programmes in nearly 90 %.

Conclusion: According to this evaluation the screening-colonoscopy is a well accepted method of cancer prevention in the German population in an outpatient setting in private practices of gastroenterology. In the society a bowel examination is not a taboo topic anymore. The standard bowel cleansing procedures are well tolerated. However the screening programme will only be successful in a long run, when general practitioners and specialized doctors are convinced of the effectiveness and importance of the screening-colonoscopy, and when they are willing to motivate their patients to choose this chance of cancer prevention.

Learning outcomes: Motivation of patients for the screening-colonoscopy. Acceptance of bowel cleansing regimes.

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Compliance scoring system in nursing evaluation of patients with hepatorenal Syndrome. do we have tools to assess prognosis?

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Key words: Hepatorenal syndrome, compliance, Child-Pugh scoring system

Hepatorenal syndrome (HRS) is an end-stage complication of cirrhosis with severe portal hypertension, characterized by always-irreversible functional renal failure in absence of underlying intrinsic renal disease. The aim of our study was to explore correlations between compliance with therapeutic measures, Child-Pugh scores and degree of hepatic encephalopathy. On the other hand, we tried to establish some alerting signs able to predict deterioration of the patient's clinical state.

Patients and methods. We selected 18 patients in which HRS was diagnosed by the following criteria: severe hepatic insufficiency with severe portal hypertension, absence of renal disease or fluid depletion, seric creatinine > 1.5 mg/dl, proteinuria < 500 mg/dl, lack of response at diuretic cessation, oliguria, serical Na under 40 mEq/l and urinary Na under 10 mEq/l. All patients were staged using Child-Pugh classification, which accounts for bilirubin, seric albumin, ascites, prothrombin activity index, and hepatic encephalopathy. In our study, two patients were staged class A, 7 class B and 9 were staged class C. Considering the severity of hepatic encephalopathy, four patients were included in stage I, 5 in stage II, 6 in stage III and 3 in stage IV. We imagined a nursing-specific parameter that we called *compliance*, which was designed to assess the patient's capacity to participate actively to the therapeutic program. In all, compliance was defined as the possibility to establish a good psycho-affective relational link with the nurse; ability to accept various therapeutic measures; adaptability to accept repeated and prolonged hospitalisation and capacity to understand the efforts of the nursing staff. We assigned four points for excellent compliance, three for a good one, two for an almost satisfactory one and one point for poor compliance. Finally, we tried to estimate whether some easy-to use parameters used in the nursing surveillance, as rapid weight growth with more than 0.5/day, fall of diuresis with more than 200 ml/day and aggravation of encephalopathy with more than one degree in one day could predict unfavourable prognosis.

Results and discussions. All data was electronically collected and submitted to statistical validation using professional statistical software. At the end of the study we found that compliance was in average satisfactory (2.167 ± 0.023). There is a good statistical correlation between lower degrees of hepatic

encephalopathy and good and excellent compliance ($p < 0.0001$). Child-Pugh scores did not have significant interference with compliance ($p = 0.1543$) but unfavourable progression of disease can be well predicted by low compliance scores ($p = 0.0332$). Finally, fall in diuresis and rapid weight increase had a good predictive value for unfavourable prognosis ($p = 0.0035$, $\chi^2 = 12.262$) while rapid encephalopathy aggravation did not correlate with fatal evolution in patients with HRS.

Conclusion. The compliance scoring system can be a valuable tool in the nursing process of patients with HRS. We found good scores in patients with low-grade hepatic encephalopathy, but there is no correlation between compliance and Child-Pugh's classification. On the other hand, low compliance scores can predict unfavourable prognosis in HRS, as well as fall in diuresis and rapid weight growth.

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Level of information to patients with crohn's disease and ulcerative colitis before treatment with infliximab

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To increase compliance and quality of life¹ further to create less anxiety² in IBD patients we intended to supply the oral and written standard information (SI) at the Patient Educational Centre-Infusion Centre (PEC-IC), Day hospital Unit relating infliximab(INF) treatment. Added to the SI patient information was a take home video(CD-Rom).

Method: Development of a video CD-Rom with the staff and a patient. The script was developed by the nurse staff, a Crohn's disease (CD) patient, and a consultant. A professional film crew made the film. Experience from the patients in the Danish Crohn Colitis Database, 1998-2005 created the basis of information level. The nurses and doctors do nationally prospectively or retrospectively registration of the indication and response to INF, concomitant immunomodulation therapy, infusion time, adjuvant therapy and side effects during and after last infusion, occurrence of pregnancy, cancer and death. Furthermore we illustrated the nurses' preparation of an INF infusion. To illustrate the biological effect of anti-TNF inside the patient we developed a computer animation of INF. The project was accepted by the local ethical committee.

Results: Preparation of the script was in progress during 3 meetings and final minor corrections done at the shooting. The movie of how to prepare the infusion and the patient information and infusion movie at the site was processed during 24 hours working. The animation movie was done at a professional computer laboratory not situated at Herlev hospital.

Hereafter film editing was done primarily by professionals in collaboration with the staff the subsequent 2 weeks. The total cost of the video was 40.000 Euros provided after application for an unrestricted grant from Foundation of Schering-Plough, Denmark.

The concept is now being validated via our 110 patients which were treated from 1999-2006 at Herlev. 10 consecutive patients at the Day hospital Unit were validated after SI and INF infusion. 10 patients were validated after SI, CD-ROM and INF infusion.

Conclusions: Film cut of content and the process creating patient information film is presented. HADS¹, Hospital Anxiety & Depression Scale, S-IBDQ²(Short-Inflammatory Bowel disease Questionnaire) and a Questionnaire of patient's satisfaction are being analysed comparing conventional SI versus SI plus video information.

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Evaluating the quality of the endoscopy service using a patient questionnaire

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Introduction

The introduction of a patient focused partial booking service and implementation of new documentation in 2004 to improve patient's preparation for their procedure led to a need for a patient quality study to be undertaken to evaluate the documentation and service. The previous endoscopy satisfaction audit had been undertaken in 2000

Objective

To review the quality of the service using the Gastrointestinal Endoscopy Satisfaction Questionnaire (GESQ)

To obtain the patients own personal view and experience of having an endoscopic procedure

Method

The project team felt all upper and lower GI procedures should be included in the study, which would be strictly confidential with no patient identification.

The size of the study was to include 100 patients over a two week period, allowing all the endoscopists lists to be covered in February 2006. The type of questionnaire used was the GESQ in a tick the box format of 21 questions.

The questionnaire was given to the patients on the day of their procedure with a covering letter asking them to complete the form 24 hours after their procedure and return in the stamped address envelope to the unit. All patients were asked if they were happy to take part in the questionnaire.

A daily record was kept of the total letters sent out per list.

Results

The project team were very pleased with the return and compliance with the study, of 84 questionnaires out of 100. An example of some of the results looking at information, pain and discomfort.

61% of the patients found the information sent to them before the procedure very easy to understand
60% found the information very useful and answered their questions about the procedure. 75% felt they had the opportunity to ask questions before their appointment. 54% found the explanation easy to understand

37% of the patients experienced mild pain during the procedure

38% of the patients no discomfort after the procedure

62% overall patient satisfaction with the procedure

Conclusion

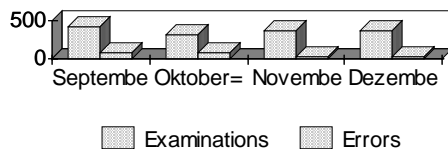
The quality audit has highlighted that patients are happy with the information given to them before their appointment when they are able to ask questions and book their appointment. Patient information appears to be the key to patient satisfaction. The patients were very satisfied with their endoscopy procedure and would have a future procedure if required. The project team highlight the need to undertake a further study in six months, using the same document, as part of the ongoing review the Endoscopy Service

Reference: Gastrointestinal Endoscopy Satisfaction Questionnaire (GESQ) University of Wales Swansea copy right CHIRAL

Booking of and preparation for endoscopic examinations – how well were our standards observed?

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The specific objective of this study was to improve effectiveness and quality of endoscopic work, mainly for nurses and assistants, by avoiding loss of time and checkbacks. Therefore a check with 1499 examinations was done on crucial issues of our standards for preparation, online booking, patient's informed consent, test results, specific focus, i.v. cannular and patient's labels. Feedback of erroneous or incomplete preparation of these issues was given to the wards having required endoscopic examinations or operations. A reduction from 20% to 7% erroneous preparations was reached within four months.



Differences between requiring wards appeared and can be used for further instruction. The reduction was small, but noticeable. Count and feedback of the crucial issues were easy, the check did not strive for statistical significance, but it gave hints for different sources of errors anyhow, and will be used as a pretest whose methods will have to be refined. In comparison to difficulty and cost even a small reduction of idle work is to be regarded as a success that makes replication of this method worthwhile for other endoscopic departments. It motivated us to continue check and feedback for a second survey starting from February 2006.

Influencing outcomes - has a structured approach to percutaneous endoscopic gastrostomy (peg) placement made a difference?

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Introduction. Health Professionals need to ensure that clinical processes deliver to patients what they should be delivering. (NHS Modernisation Agency). It was decided to assess the effectiveness of a 'PEG pathway' introduced throughout the Leeds Teaching Hospital Trust in 2002.

Aim To establish whether the introduction of the pathway had made any significant impact on the number of referrals received, the number of PEGs placed and 30 day post placement mortality.

Pathway Structure

- Guidelines for PEG placement devised and disseminated throughout the Trust
- Procedure specific request card
- Formal assessment of suitability of patient by Gastroenterology SpR
- MRSA prophylaxis

Methodology A comparison was made between figures obtained from a 1999 -2001 retrospective audit and a 2005 -2005 retrospective audit.

Results

Year	Number of Requests	Number of PEGs placed	30 Day mortality
2000	193	104	13.6%
2005	118	65	6.1%

Conclusion Whilst PEG placement is thought of as a relatively safe, reliable procedure (Gauderer et al 1980), the safety of the procedure can be improved by a coherent approach to the process.

Gastroenterology unit in general hospital : improving the service.

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Background : The Gastroenterology Unit at the Hadassah Medical Center - Ein Kerem serves a wide population of ambulatory and hospitalized patients. The Unit is active five mornings a week and is available for emergency cases seven days a week. Monthly, approximately 700 patients are treated with a wide range of interventions that require precise advance preparation in order to be successful.

Until about a year ago, the Gastroenterology Unit was characterized by overcrowding and less than pleasant physical conditions, overwork and lack of structured methods for treating patients prior to their arrival for an intervention. The year 2004 saw the beginning of preparedness for, and building of procedures to improve the service and the guidance given to patients. Many changes were instituted, related to work methods, service quality and treatments. These changes were derived from the desire to make the Unit more efficient and to provide better service and treatment to its patients.

The changes included: (1) Empowering the nurses to be responsible for the sub-divisions within the Unit. (2) Defining specific job responsibilities for each nurse, at each station, throughout the work day. (3) The creation of a structured educational guidance program which includes: written materials that are used both in the hospital and in the community. (4) Structured discussions take place, according to a known schedule, on subjects that are related to situations and conflicts affecting the Unit's ability to provide quality service. (5) The crystallizing of the Unit's staff as a learning group, working together to solve problems in real time and having the patient's good and welfare as its focus. (6) Significant improvement in the Unit's physical conditions.

Methods : Two satisfaction surveys were done among the patients before and after each of the changes. The first survey included 96 patients and the second included 104 patients.

Results : The results of the surveys indicated a certain degree of improvement in each of the measures that were checked, with some showing significant improvement.

During the Conference, we will present the process which led to improvement in the quality of service provided for the patients' welfare.

The evaluation of the turkish endoscopy nurses and technicians' practices

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Introduction:Gastrointestinal endoscopy practice is dependent on endoscopist, endoscopy nurse and technicians. Patient's comfort and quality of endoscopy are mainly determined by the endoscopy nurse and technician. The aim of the study was to evaluate the education level of the endoscopy nurses and technicians.

Methods and Measurements: An education course concerning the definition of endoscopy, maintenance of endoscopy instruments, and disinfection were performed by Turkish Gastrointestinal Endoscopy Nurse Association and Fujinon. After the course, a questionnaire with 27 questions was given to the 201 endoscopy nurses or technicians in three cities of Turkey from private, goverment, and University Hospitals. Twenty (10%) of the participants were male and none of the participants had a special education course about endoscopy. The mean age was 30.7±7.7 (19-55). Fourty seven of the participants (%23.4) had their enscopy education from the endoscopy companies and the 154 (%76.6) had their education from their colleagues. Ninty-seven (48%) of participants were graduated from nursing high school, 76 (37.8%) were graduates from 2 year nursing school after high school, 23 (11.4%) were graduates from 4 year nursing school after high school, 5 (%2.5) had post-graduate nursing education. The mean working period as an endoscopy nurse or technician of the participants was 3.6±4 (1-27) years.

Results:One hundred-thirty (64.7%) of the participants were using pulse oxymeter during the endoscopy session. Onehundred-five (52.2%) of the participants were using both midazolam and

dolantin; 78 (38.8%) were using midazolam; 8 (4%) were using propofol; 7 (3.5) were using none of the premedication; and 3 (1.5%) were using other premedications for the sedation and/or analgesia. Injection of the premedication was performed by gastroenterologists in 30 (14.9%) of the questionnaires, by nurses in 142 (70.6%), by anesthesiologists in 23 (11.4%), by anesthesia technicians in 6 (3%). One hundred seventythree of the participants did not know the antidotes of the employed sedative drug. One hundred-nintyseven (98%) of the participants acknowledge the patients before the endoscopy. One hundred-fortysix (72.6%) of the participants have the informed consent of the patients before the procedure. Eightythree (41.3%) of the participants had cardiopulmonary resuscitation education. One hundred-thirtyseven (68.2%) of the participants were using disinfectant with gluteraldehyde; 28 (13.9%) without gluteraldehyde; and 36 (17.9%) other disinfectants. One hundred-twentyeight of the participants followed a guideline of disinfection. Ninety (44.8%) of the participants were performing the microbiologic surveillance in every three months.

Conclusion: Although a special education program is not employed in Turkey for endoscopy nurses and technicians their endoscopy practices are at an acceptable level.

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Cleaning advances in flexible endoscopy

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Background:

Endoscopy related infections must be prevented. There exists a wide spectrum of automated or manual cleaning and disinfection methods As per the RKI guidelines, each instrument must processed manually before being taken up for machine cleaning to thereby reach a sufficient microbiological reduction The important factor in the manual processing is the brush cleaning In this phase, the instruments should be separately cleaned before disinfection.

Aim:

To demonstrate, in a study, that the contamination of the instruments and germ reduction after brush cleaning.

Methods:

The endoscope canals were tested for microbiological by means of the rinsing though the instrument prior to the endoscopic investigation. After the procedure, the devices was tested again, before the manual cleaning took place After that sucking and rinsing with cleaning solution and the brush cleaning was done and then instruments were tested again for microbiological. They were brought subsequently for the final machine cleaning and disinfection

Results:

Through these tests, we could clearly demonstrate microbiological contamination before and after the endoscopic investigation. There was a significant reduction of bacteria after the manual cleaning.

Conclusion:

To reach an essential germ reduction the manual brush cleaning is indispensable. Only a clean instrument can be further successfully disinfected

Evaluation of the cleaning and disinfecting of endoscopic equipment in a general hospital

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Background

The use of endoscopic equipment in diagnostic procedures and treatments has dramatically increased in recent years and so too the spread of infections to both patients and staff via this equipment. Hospital acquired nosocomial infections are one of the most serious problems facing hospitals. The rate of acquired infections in the Western World is estimated at between 5-10 percent of all hospitalizations.

The cleaning and disinfecting of equipment is an important aspect of preventing nosocomial infections. In our Hospital, cleaning and disinfecting techniques are based on Israel Ministry of Health and US - CDC procedures with an emphasis on using "user friendly" methods and materials, while keeping costs in mind.

In cooperation with infection prevention nurses, we drew a number of samples from endoscopic equipment which showed bacterial growth. Our findings are primarily as a result of the lack of appropriate work conditions and overcrowding which hampered our ability to optimally clean and disinfect the equipment.

With the passing of time and the Unit's move to its new location in the Medical Center, we intensified our efforts to better protect our patients and staff from nosocomial infections. There was a need to: plan and organize cleaning and disinfecting protocols according to accepted standards; train the staff; define areas of responsibility and authority; verify the staff's knowledge and perform random tests on equipment.

Purpose

1. Assimilation of knowledge by the staff
2. Implementation of proper cleaning and disinfecting procedures
3. Performance of periodical sampling of equipment as part of ongoing, methodical quality control

Methods

1. Testing the staff's knowledge via a structured questionnaire
2. Observing the manner in which cleaning and disinfecting takes place
3. Repeated random bacterial sampling from different pieces of equipment

Results

1. Most of the staff was knowledgeable in the subject
2. Most of the staff knew how to clean equipment
3. With the exception of one colonoscope, the various pieces of endoscopic equipment (colonoscope, duodenoscope, gastroscope) which were randomly sampled were found to be clean. This one piece of equipment was found to be infected following multiple samplings, even after proper cleaning and disinfecting. It was returned to the manufacturer to be checked.

Conclusions and Recommendations

In order to prevent the spread of germs to patients and staff via endoscopic equipment there is a need to train the staff and take periodic random samplings on an ongoing basis.

At the Conference we will present our work plan as well as the results of the random samplings.

Nursing supporting the endoscopic management of elderly and advanced aged patients with extrahepatic biliary tree stones

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The aim of our study was to underscore the nursing staff experience in a General Surgery Department running an Endoscopic Unit, concerning the post ERCP complications management of elderly and advanced aged patients with choledocholithiasis.

Methods: Between 1996 and 2005, 695 consecutive patients with choledocholithiasis underwent ERCP in our Endoscopic Unit. Among them there were 383 elderly and advanced aged patients with a median age of 79 years (range 75-101) offered: Endoscopic Sphincterotomy, bile duct stones clearance, placement of bile duct prostheses or naso-biliary tube.

Risk factors that were recorded in our study were the age in 42 advanced aged patients (range 89-101 years), cardiopulmonary and/or neurological disorders in 105 and 44 patients respectively, diabetes mellitus in 44 patients, as well as the presence of chronic renal failure in 14 patients. A concrete protocol was used for patient observation concerning the postERCP complications within 24 hours after their transfer to the surgical ward. Emphasis was given in the recognition of these complications individually, with recognition of clinical picture, via estimation of their haemodynamics, attendance of temperature chart, serum glucose measurements, and determination of fluids balance.

Results: The management of the complications and of any other problem that came to shift nurses' notice was conservative according to the being on duty doctor's recommendations. The complications that were recorded concerned in: upper abdominal pain accompanied by obstinate abdominal distension in 81, cholangitis (acute cholangitis) in 9, pancreatitis in 6, acute cholecystitis in 8, haemorrhage in 4 and oliguria in 12 patients. There were no major complications or deaths that would be owed in insufficient support or attendance from the nursing staff.

Conclusions: The nursing staff is called to attend and to evaluate patients with multiple co-morbidities undergoing ERCP. The knowledge of the procedure, as well as of the related complications, and the recognition of risk factors in combination with their early confrontation, ensures the better outcome for the patient.

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Invited Presentations

Breaking Bad news to patients and significant others

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Announcing good news is easy for anyone. Concerning medical information and diagnosis, in France is the doctors' role. But in all circumstances nurses and other paramedical staff will have to support the patient and his significant others family in when difficult news, like cancer, is announced to them by the medical team. Conveying bad is much more challenging because doctors and paramedical staff have a difficult mission to care for patients whatever the outcome. This situation happens often in Endoscopy and GI units where the hectic schedules and rapid patient turn-over make it difficult to find the right conditions to communicate effectively with patients in this specific context with heavy psychological implications. In turn the patients or their representatives will have to break the news to significant others.

Observation of staff and patient behavior in different situations of difficult diagnosis announced is the material analyzed in this presentation to suggest adequate communication between staff and patients and psychological support for all concerned. Communication techniques will be presented to help nurses during this challenging task.

Examples of suggestions to patients after they have learnt bad news concerning their health:

- Break the news at your own pace..
 - Choose language that suits you.
 - Enlist help from others.
 - Be prepared for people's curiosity
 - Allow yourself not to answer questions and change topics
 - Break the news as calmly as possible to children..
-

Assessment of Quality of Life in Gastroenterology

Christiane Neumann, Birmingham, UK

Quality of Life (QoL) means different things to different people. Aristotle gave it much thought in his Nicomachean Ethics and eventually settled on the notion of eudaimonia, a Greek term often translated as Happiness. In the broadest sense, QOL encompasses not only the physical and mental health of a person or group, but also the impact of culture, environment, economic, and other financial factors. For a nation, QoL might be measured with the "Gross National Product" (GNP), i.e. the wealth and income of a nation. In a population it might mean the means or resources necessary to satisfy ones needs, wants and desires, enabling personal development and self actualisation. QoL can be measured in many domains such as:

- Personal Growth - the development of skills that enhance effectiveness to deal with challenging situations in life.
- Health - your general level of health and fitness for your age.
- Fitness - your general level of fitness.
- Career - your current job and its present and future prospects for satisfaction and reward.
- Wealth - the extent to which your income provides the standard of living you wish,
- Environment - the quality of your physical surroundings at home and work.
- Special Relationship - your relationship with your life partner or soulmate.
- Self Image - The conception that one has of oneself, including an assessment of qualities and personal worth.
- Giving Back - voluntary gifts of service, ideas or money to a worthwhile cause.
- Spiritual Growth - your belief in and/or connection to, a higher being or self.

There are numerous validated QoL measurement tools with a variety of domains, depending on what is intended to be measured.

Only part of QoL is a consequence of physical well being. Therefore QoL measures have been refined to focus on **Health-Related Quality Of Life (HRQOL)**. Understanding HRQOL is today particularly important in health care, where monetary measures do not readily apply. Decisions on what research or treatments to invest the most in are closely related to their effect of a patient's quality of life. Over the years patients and their self help organizations have demanded a greater regard to their subjective experience of their disease and its treatment.

HRQOL questionnaires measure the functional effect of an illness and treatment on a patient as perceived by the patient. The patients' perception is the key to understanding how patients function in daily life with their condition. There are four broad domains that are considered part of a health-related quality-of-life questionnaire: 1) physical and occupational function, 2) psychological state, 3) social interaction, and 4) somatic sensation.

Again there are many generic HRQOL questionnaires, the best known one, and probably the most translated one, is the SF-36. However, generic HRQOL questionnaires are limited in their ability to identify condition specific aspects of different diseases. Therefore in recent years disease-specific instruments have been designed for patients with specific diseases – **in Gastroenterology** the generic GI SYMPTOM RATING SCALE (GSRs), more specifically -for IBS (IBSQOL), IBD (IBDQ), GORD (HBQoL, GORD-HRQoL), etc. (for a more detailed list see web reference below)

These QoL Disease Specific Measures differ from the **Disease Activity Indices** (e.g. CDAI) available for some GI diseases. QoL measures establish how the patient is feeling and how the condition affects a patient's life, while the Disease Activity Indices primarily focus on gastrointestinal and systemic symptoms, physical findings, height, weight, growth velocity, and general well-being, as well as laboratory parameters of inflammation. In some scoring systems radiologic and endoscopic findings are also included. In the development of these Disease Activity Indices, the gold standard for scoring has been the Physician's Global Assessment of how the patient is doing with the input from patients being minimal.

Although QOL measures have been an advance in that the patient can have an input in the assessment of his/her condition, it has led to development of **QALYs** and their use in rationing health care. Quality-Adjusted Life Years, or QALYs, are a measure of the benefit of a medical intervention. QALYs are controversial as the measurement is used to calculate the allocation of healthcare resources based upon a ratio of cost per QALY. As a result some people will not receive treatment as it is calculated that the benefit to their quality of life is not warranted by the cost.

The application of HRQOL therefore can be a blessing in clinical practice as it takes the patient's limitations and responses to a condition and its treatment into account, or a curse if it is used to ration health care.

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Nurse led Follow up in G.I Disease

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Whatever the political context of service improvement and delivery the aim of nursing according to Orem (1995) is related to:

'The patient's need and ability to undertake self care, to sustain health, recover from disease and injury or to cope with their effects'

Given that a major part of the increasing workload in gastroenterology relates to those with chronic disease (BSG, 2006) appropriately trained nurses are well placed to ensure that patients with chronic gastrointestinal disease are followed up in a timely and effective manner. The outcomes can be seen in slowing down disease progression, fewer complications, greater patient independence and satisfaction.

However given Orem's (1995) definition of nursing, nurse-led follow up is not simply about the disease but about being able to recognise and harness the patient's ability and capability to choose health over illness, these are skills that nurses need to develop and foster.

Any nurse-led follow up service must be carefully planned to be both effective and importantly sustainable. In a climate where status quo is not an option, the pace of change can create resistance unless the risks and benefits of the service are clearly identified.

The aim of this presentation is to explore why nurses should follow up G.I patients, who nurses should follow up, the principles of a nurse-driven service and how to ensure that an effective service is set up and sustained.

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Nurse Endoscopy – What training is necessary?

Di Campbell, Torbay, UK

Learning Outcomes

After this session attendees should be able to:

1. Appreciate the need for structured training for Nurse Endoscopists
2. Describe the key components of a robust training programme for Nurse Endoscopists

Nurse endoscopy was introduced in the UK in the early 1990s and is now a common part of advanced nursing practice. Clinical effectiveness studies have shown nurse endoscopists to be as safe, competent and well accepted by patients as their medical counterparts. In addition they contribute significantly to service delivery and the reduction of waiting lists generated by the increasing demand for endoscopy. Other European countries are increasingly acknowledging the potential benefits of nurse endoscopists and are introducing the role.

However, there are known risks to endoscopy, primarily the hazards of sedation, and the risk of bleeding or perforation. The standard of competence for all endoscopists, regardless of their professional background needs to be equal and all need to be able to provide evidence to support their knowledge and skill should the need arise.

Nurses who expand their role are legally accountable for their practice and must be confident that they are able to perform their role to the appropriate legal standard of care. Employers are also responsible for the actions of their staff and, once an expanded role has been agreed with an accurate job description approved, will usually accept responsibility for compensating an injured patient should negligence be proved. However any nurse considering role expansion to include endoscopy should ensure that local arrangements for insurance cover are in place to comply with national practices.

The European Network of Nursing Organisations (ENNO) and the Permanent Council of Nurses in the EC (PCN) now known as the European Federation of Nurse Associations (EFN) has developed a European Framework for Post-Basic Nurse Education with quality criteria such as length and academic level of courses, balance of theory and practice, qualification of teaching staff and organisation of courses with the aim of harmonisation of specialist education. Nurses wishing to become endoscopists need to examine their education and training to ensure that they can comply with this framework.

The practical skill of performing endoscopy is a very important element in development of every endoscopist and in the UK recommendations have been made concerning skills training for endoscopists of all disciplines. The Joint Advisory Group (JAG) recommendations include statements on facilities, endoscopic experience, supervision, assessment and appraisal of trainees in addition to approving the content and delivery of a range of courses. During the past few years these courses have been increasingly attended by Nurse Endoscopists.

When considering the development of nurse endoscopy it is essential to be sure that this will be in the best interests of the patients for whom we provide the service and that we are capable of producing a safe, competent and effective practitioner.

References: JAG 2004 (<http://www.thejag.org.uk>)

Recommendations for a European Framework for Specialist Nursing Education (<http://www.pcnweb.org>)

Diseases Of The Small Bowel – Manifestation And Investigations

Dr Brian Cooper, Gastroenterology Unit, City Hospital, Birmingham, UK

Small bowel diseases are considerably less common than diseases of the oesophagus, stomach or colon. Nevertheless diseases such as coeliac disease and Crohn's disease are important causes of ill health. The important function of the small bowel is to absorb nutrients and so the absorptive area of the small bowel lumen is greatly increased by the presence of villi.

Small bowel diseases present in three different ways:

1. Malabsorption as a result of abnormal small bowel mucosal function
2. Diarrhoea and abdominal pain without malabsorption.
3. Mechanical obstruction of the small bowel.

Small bowel disease may present acutely or insidiously. Malabsorption may be discovered incidentally by the presence of abnormal blood tests in the absence of any symptoms.

The small bowel causes of malabsorption are loss of mucosal absorptive area (eg mucosal damage caused by coeliac disease or Crohn's disease), obstruction to the lymphatic drainage of the small bowel (eg as a result of cancer), infection (eg bacterial overgrowth of the small intestine, giardiasis), endocrine disorders (eg diabetes,

thyrotoxicosis), specific biochemical defects (eg primary lactase deficiency), immunological disorders (eg common variable immune deficiency, AIDS) and drugs (eg tetracycline, methotrexate, colchicines). The commonest small bowel cause of malabsorption is primary lactase deficiency in which a single nutrient (lactose) is malabsorbed. Generalised malabsorption is characterized by the presence of excessive fat in the stool (steatorrhoea) and the commonest causes are coeliac disease, Crohn's disease and short bowel syndrome. The commonest symptoms of malabsorption are diarrhoea, abdominal pain, abdominal bloating with flatulence, weight loss and excessive tiredness. Other symptoms include mouth ulcers, sore tongue, bone pain, skin rashes, easy bruising, and neurological symptoms. The signs of malabsorption may be none, or short stature, anaemia, skin rashes, finger clubbing, mouth ulcers, abdominal distension and tenderness, peripheral oedema, peripheral neuropathy and bone tenderness. The commonest causes of small bowel diarrhoea without malabsorption are acute infections, food poisoning, food intolerance, food allergy, Crohn's disease, irritable bowel syndrome, side effects of drugs and alcohol, diabetes, thyrotoxicosis, gastrointestinal surgery and intestinal tumours. Small bowel diseases that can cause obstruction are Crohn's disease, malignancy, and surgical disorders such as hernia, intussusception, adhesions and post surgical strictures.

Investigation of suspected small bowel disease:

1. Initial work up: full blood count; serum urea, electrolytes, liver function tests, inflammatory markers, blood sugar, TSH; coeliac antibodies; stool microscopy and culture; plain abdominal film. Sigmoidoscopy and biopsy may be necessary to exclude colitis as the cause of diarrhoea.
2. Anatomical assessment
 - a) Endoscopy: upper GI endoscopy with small bowel biopsy, ileoscopy (with the colonoscope) with biopsy, enteroscopy, capsule endoscopy.
 - b) Imaging: small bowel meal/enema, CT scan, white cell scan, angiography
3. Functional assessment: serum iron, B12, folate, calcium, vitamins D and K, and immunoglobulins; faecal fat excretion; absorption tests for carbohydrate, B12 and bile salts; tests for bacterial overgrowth of the small bowel; tests of small bowel permeability.

In patients with malabsorption, it is helpful to know whether the site of the malabsorption is in the upper small bowel or in the ileum. Folate is absorbed in the upper small bowel, so a low serum folate suggests upper small bowel disease, which can be demonstrated by imaging and by endoscopic small bowel biopsy. Vitamin B12 and bile acids are absorbed in the terminal ileum, therefore B12 deficiency or bile salt malabsorption indicates ileal disease, which can be confirmed by imaging and by endoscopy and biopsy.

Is It Good Or Bad For You - The Alternative Diet Talk?

Prof Alastair Forbes , University College London

There are some gastrointestinal diseases in which diet is closely linked to pathogenesis and other in which "abnormal" diet is clearly identified as causal agent

Diverticulosis/appendicitis and gall stones belong in this category as well – obviously – as alcohol-related problems

There are also links between GI cancers and diet

- Oesophageal cancer and diet

Fastest increasing malignancy in the West – link with Barrett's and reflux and with Western diet

- Gastric cancer and diet

Still v frequent malignancy in the East – H.pylori and genetic element – high risk in Japan but falling rapidly with adoption of Western habits and diet

- Pancreatic cancer and diet

Associated with coffee – and linked to k-ras tumour-associated oncogene. Mutations more common in coffee drinkers (82.0% v 55.6%) mean of only 2 cups/day

But coffee protects against breast cancer in women with BRCA mutations on lifetime basis with same amount of coffee, and also appears to protect against Type 2 diabetes

- Biliary cancer and diet

Uncertain magnitude of association but also rising rapidly in most countries

- Hepatoma and diet

Main dietary risk is from poorly stored peanuts contaminated with aflatoxin

➤ Small bowel tumours and diet

Rare and no definite associations found but failing to keep to a gluten free diet certainly puts coeliac patients at high risk of intestinal tumours (lymphoma and carcinoma)

➤ Colorectal carcinoma and diet

Experimental human work shows clear risk from peanut lectin. Even 100 g of peanuts each day for 5 days increases rectal cell turnover (by 40%) and probable cancer risk increase as a result

However peanut lectin from regular consumption of peanuts, peanut butter and true nuts reduces risk of type 2 diabetes by over 25%

Edible mushroom lectin however is a different lectin which inhibits colon cancer cell lines and cell proliferation

➤ Acute diarrhoeal illness in children

Effective interventions based on folk remedies include

Stem bromelain from pineapple stem – effective against infectious diarrhoea, and is an effective anthelmintic in rodents. Has also been shown to have an effect against UC in case reports

Banana pectin - effective in acute diarrhoeal illness in children (250g green banana/kg feed) - and reduces fluid loss in chronic diarrhoea

Occlusions – still much to learn – don't dismiss "old wives' tales"

MRSA in Endoscopy – What is really necessary?

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MRSA have been reported in increasing case numbers since the early 1960s. Cross resistance to different antibiotics gives reason to report them as not only methicillin-resistant, but **multi-resistant Staphylococcus aureus**. In terms of infectivity and resistance to disinfectants and antiseptics MRSA do not differ from MSSA (**methicillin sensitive Staph. aureus**). This fact offers the chance to limit transmission of MRSA by the same basic hygiene measures that are employed to limit the transmission of other bacterial pathogens. Although there are several reports on community acquired MRSA in the literature, the main source of MRSA still are healthcare settings. The endoscopy department should be informed by the submitting department or physician about MRSA carrier status of a patient. To avoid infection of MRSA colonized patients due to endoscopic procedures, such patients should undergo thorough decontamination of colonized sites before endoscopy. To avoid spread of MRSA in endoscopy departments, routine hygiene measures should be enforced. Adequate handling of endoscopes after use and state of the art reprocessing exclude the risk of transmission via instruments to patients and the environment. Adequate hand hygiene (including hand disinfection and glove use) and appropriate barrier clothing and equipment (depending on type of procedure) should be used to minimize the risk of staff colonization and environmental spread. Since Staphylococci have a high tenacity on dry surfaces under environmental conditions, hard surface disinfection should support the other hygiene measures. This should at least include all patient and staff contact surfaces. Other surfaces may be included depending on the extensiveness of the carrier status of a patient, the procedures undertaken and the general hygiene regime, to limit the transmission of MRSA via the environment. In conclusion information policies and routine hygiene measures should be enforced to avoid the spread of MRSA via endoscopy departments. To limit the infection risk for patients with positive MRSA carrier status, they should be decontaminated before endoscopy, whenever possible.

New ESGE-ESGENA-Guideline on validation of reprocessing cycles according to prEN ISO 15883

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Validation is an important tool of quality assurance in hygiene and infection control. So far the clinical service provider has to rely on the correct functioning of automated washer disinfectors (WD). Routine maintenance and microbiological surveillance are the current tools for regular quality control. The new ESGE-ESGENA Guideline is based on the standard prEN ISO 15883 which describes requirements of design and function of

WD. The ESGE-ESGENA-Guideline addresses the necessity of validating the whole reprocessing cycle of flexible endoscopes and their accessories.

The aims of this guideline are:

- To support individual endoscopy departments and clinical service providers to establish local standards and protocols for validation processes for WDs
- To support national societies and official bodies to develop national recommendations for the validation of reprocessing flexible endoscope processes

Quality assurance systems of WD differentiate between three parts:

1) The **type test** is the responsibility of the manufacturer and checks that the WD complies with prEN ISO 15883.

2) **Validation** is the responsibility of the clinical service provider and has to be performed before the WD is used in daily routine. It proves that the whole reprocessing process gives reproducible results and consist of three different parts:

a) The Installation qualification (IQ) is the process of obtaining and documenting evidence that the WD has been supplied and installed in accordance with its specifications.

b) The Operational Qualification (OQ) is the process of obtaining and documenting evidence that the installed WD operates within pre-determined limits. Different parameters are checked (e.g. leak test, the flow control function, temperature)

c) The Performance Qualification (PQ) is focussing on the in-use-testing condition of the WD. Endoscopes used in clinical practice should be reprocessed following the day-to-day standardised reprocessing protocol. Microbiological tests should be performed to test the PQ.

3) **Routine tests** are the responsibility of the clinical service provider and ensure that the required performance standard is delivered consistently at all times. Routine tests cover the check of technical parameters on the WD and microbiological tests on endoscopes used in daily routine. For performing microbiological tests on endoscopes it is recommended to follow the "ESGE-ESGENA-Guideline on Microbiological Surveillance Testing in Endoscopy".

The guideline encloses examples of different check lists.

Frequency

- A complete validation is necessary before routine use.
- A re-validation is necessary after each major repair and/or change of the reprocessing cycle. Regular maintenance of WD is part of quality management
- Routine tests are recommended on a regular basis according to national requirements. It is the responsibility of the clinical service provider to decide about interval between microbiological tests. As a point of reference, the ESGE/ESGENA guideline committee recommends a routine testing of 3 months at least.

Results

If any routine test result is out of specification (technical parameters or contamination), it is the responsibility of the clinical service provider to take the suspected device out of service (e.g. WD, endoscopes), until corrective actions have been taken and satisfactory results has been achieved.

References:

1. Pr EN ISO 15883
2. ESGE-Guideline for Process Validation and Routine Tests of Reprocessing Endoscopes in Washer Disinfectors according to Pr EN ISO 15883 Part 1, 4 And 5. submitted for publication in ENDOSCOPY 2006
3. ESGE-ESGENA-Guideline ESGE-ESGENA-Guideline for Reprocessing Quality Assurance "Microbiological Surveillance Testing in Endoscopy", submitted for publication n ENDOSCOPY 2006

The Importance of Optimal Hand Hygiene

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Objective: It's easy and simple, yet vital to our health and the importance that is underestimated in the day to day working life. The hand hygiene of the (endoscopic) nurse is one of the most important factors in the fight against hospital infections. The facts are that 65% of hospital infections are directly connected to insufficient hand hygiene. This is the most neglected regulation that could prevent hospital infections. Every year thousands of patients die due to hospitals infections that in turn cost millions of euros and thousand of

extra hospital beds. For example: in Great Britain hospital infections cost 5000 deaths a year, in Belgium 3000 deaths and in Holland up to 1000 deaths. Optimal hand hygiene is essential, but what is lesser known is the preference for the use of hand alcohol that has an enormous germ reduction effect. Patients with a reduced immune system will benefit greatly from this.

Method: I have recently carried out a test among my colleagues to see how hygienic we were. On blood agar plates I took fingerprints from five colleagues at four different intervals on one day: before starting work at eight o'clock in the morning, after the morning break, after the lunch break and at the end of the working day. The agar plates were then left for 48 hours in incubation to allow germ growth.

Results: The results were obvious and alarming. Arriving at work in the morning fresh and clean from their morning shower my colleagues had the most germs on their hands. It also emerged that the amount of alcohol used was not nearly enough to create the desired effect. After a few months I repeated the agar test and again hands that were not disinfected before performing a task had a high amount of bacteria.

Conclusions: First of all, it is important to disinfect our hands with hand alcohol on arriving at the place of work in the morning. (Hand alcohol in the staffroom!). It is necessary to use a minimum of 3 ml alcohol for a period of 30 seconds, and to rub this into the hand following the correct hand method to create that desired effect. Above all I want everyone to be aware of the importance of hand hygiene in the hospital situation and that we can contribute in the fight against hospital infections.

References:

1. www.medinews.be "Operatie schone handen"
2. www.refaja.nl "Het voorkomen van ziekenhuisinfecties"
3. www.WIP.nl "Werkgroep infectiepreventie"

Complication during ERCP – prevention & management

Theo Pordon, Amsterdam, NL

"There is no kind of medical specialism that depends so much on the quality and skills of the assistant than endoscopy"

(prof. Jacques Deviere, Erasme Hospital Brussels)

Most of us know that this statement is true.

We have our own responsibility in handling equipment, like guide-wires, needle-knives, injection needles and so on.

What complications can occur during ERCP?

How can we prevent them?

Our first concern of course is the patient.

Second best are our technical skills.

In the presentation we will discuss:

- assessment of the ERCP patient
 - preparation of the patient
 - preparation of the ERCP room
 - papilla bleeding
 - major bleeding
 - impacted stone
 - breaking of the dormia basket
 - dangers of electro-surgery
 - perforation of duodenum
 - perforation in liver
 - migrated stents
 - stones or stents blocking the working channel or suction-knob
-

Migration of Nurses Internationally – Implications and Ethical Concerns

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Migration of healthcare staff is increasing as is migration in general. The International Council of Nurses has made the issue to one of its main areas of activity recently. In 2005 the international Centre on Nurse Migration was established to monitor the development of migration and its impact on health systems and individuals worldwide.

Migration always existed. Patterns of migration in the 21st century are more complex and people move on more quickly. There are more women among immigrants today. The transfer of money by emigrants to their home countries exceeds the amount of money given in support by governments worldwide to developing countries.

Every individual nurse has the right to improve her life and make a better living. If she finds a work place where her competencies are more appreciated in every way she has the right to move on. However, there is the risk that emigrating nurses (and other health professionals) may cause deteriorating health services in the country they are leaving. Most countries of the developed world face a shortage of health care personnel. Is it acceptable to solve our problems by damaging the poor part of the world? We have to find a balance globally between the need of rich countries, the desire of individuals for better living and the need of the people in poor countries for health care provision.

WHO expressed its concern by stating,

“The loss of human resources through migration of professional health staff to developed countries usually results in a loss of capacity of health systems in developing countries to deliver health care equitably. Migration

of health workers also undermines the ability of countries to meet global, regional and national commitments, such as the health-related United Nations Millennium Development Goals, and even their own development. Data on the extent and the impact of such migration are patchy and often anecdotal and fail to shed light on the causes, such as high unemployment rates, poor working conditions and low salaries.” WHO, 2004

ICN has developed ethical guidelines for the recruitment of nurses. These guidelines have been adopted by health ministers of the Commonwealth and many nursing groups. <http://www.icn.ch/psrecruit01.htm> Migrants are vulnerable. It is the responsibility of us all to protect our colleagues wherever they come from. At the same time we need to protect the public by safeguarding the quality of health care.

How to support Colleagues in developing Countries

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History

In 1991, the Dutch Society of Gastroenterology organized a congress called “the Holland Digestive Disease Week”. The board of the Holland Digestive Disease Week decided to spend a part of the money left over at the end of this congress to help young gastroenterologists from Eastern Europe with their education. A special fund was set up, the East Europe Fund, subsidize improvements in the level of education. Gastroenterologists from Eastern Europe and later also from South Africa and the Middle East came to the Netherlands for a two weeks course on gastroenterology.

In 1992 the first courses were organized by Prof. Nelis in the Sophia Hospital in Zwolle and Prof. Mulder in the Rijnstate Hospital in Arnhem. Since 1996 about 10 nurses have been invited to visit the endoscopy unit of the Rijnstate Hospital in Arnhem. Since 1995 more than 150 endoscopes have been sent to developing countries, mainly fiber

endoscopes but also video endoscopes and endoscopy accessories. Ever since then I have been involved in supporting gastroenterologists and colleagues in developing countries.

How can we support colleagues in developing countries?

- Invite foreign nurses to attend your national congress. It is important to communicate and to share experiences with each other.
- Invite them to workshops with hands-on training and live demonstrations.

- Support them with teaching material like books, papers, standards and European guidelines.
- Support gastroenterologists and endoscopy nurses by collecting good working endoscopes and endoscopy equipment.

Aims

The aims of our support are:

- to improve the level of endoscopy treatment and care in developing countries
- to advance the implementation of new techniques and treatments in the underprivileged countries
- to advance the education of endoscopy nurses and doctors in developing countries

Legal Aspects

If you send endoscopy materials, the legal aspects in your country and the receiving country have to be taken into account.

Ethical Aspects

Never forget that all equipment, sent to colleagues in developing countries, must be safe for the patient. All equipment should be ready for use and should fulfil all safety requirements.

Conclusion

Supporting gastroenterologists and endoscopy nurses in developing countries is worthwhile. By sending endoscopes and accessories, the gastroenterologists will be able to treat more patients. This will enable them to earn more money and to invest in better endoscopy equipment and safer procedures. By teaching and showing different ways of working, organizing workshops and sending teaching material, the treatment and care in endoscopy will be improved.

Expanded Roles for nurses – the UK experience Erweiterte Aufgaben für Pflegepersonal – die Englische Erfahrung

Christiane Neumann, Birmingham, UK

Seit Anfang der neunziger Jahre gibt es für Schwestern in Großbritannien die Möglichkeiten, sich beruflich weiterzubilden, und ehemals ärztliche Aufgaben zu übernehmen.

Dies hat sich im folgenden Rahmen und unter den folgenden Voraussetzungen entwickelt:

NATIONALE VORRAUSSETZUNGEN waren die Kooperation und Einwilligung der

- Medizinischen "Royal Colleges"
- Nationalen Pflegeverbände (wie z.B. DBfK, DPV, ÖKV)
- Nationalen Registratur / Lizenz (z.B. Kammer)

Außerdem wurden ein gesetzlicher Rahmen und national anerkannte Ausbildungskurse an Universitäten entwickelt.

Kliniken erfüllen die folgende **LOKALE VORRAUSSETZUNGEN**:

- Es gibt nicht genug Ärzte
- Einwilligung vom Klinischen Direktor/in
- Einwilligung von der Pflegedienstleitung
- Die Klinikverwaltung übernimmt die Versicherung

Nicht jeder Schwester steht diese persönliche Weiterentwicklung zur Verfügung.

Es müssen auch **PERSÖNLICHE VORRAUSSETZUNGEN** erfüllt werden wie z.B.:

- Universitätsabschluss (Batchelor)
- Klinische Erfahrung im Fachbereich und Fachweiterbildung
- Die Bereitschaft, die volle Eigenverantwortung für die Tätigkeit zu übernehmen

Die AUSBILDUNG wird dann auf die speziellen Aufgaben zugeschnitten:

- Masters Degree in "Advanced Practice" (2 Jahre) - alle
- Universitätskurs in "Nurse Prescribing", wenn Rezepte verschrieben werden,

- Universitätskurse für die speziellen klinischen Eingriffe, wie z.B. "Nurse Endoscopist", Chirurgische Eingriffe, und für relevante klinische Fachbereiche, usw.

Ausserdem muss nachgewiesen werden, dass stattfinden:

- Regelmäßige Fort- und Weiterbildung
- Regelmäßige Überprüfung der Kompetenz
- Audit = Überprüfung der klinischen "Outcomes"

Zusammenfassung

Studien haben gezeigt, dass entsprechend ausgebildete Schwestern / Pfleger, die gleichen Kompetenzen & Wissen wie ein vergleichbarer Arzt in dem bestimmten Bereich haben, dass Patienten oft Schwestern bevorzugen, und dass durch die vermehrte Patientenschulung, Patienten mit chronischen Erkrankungen weniger oft einen Rückfall haben.

Kosten für die Patientenversorgung sind im allgemeinen nicht weniger, da höhere Gehälter gezahlt und weniger Patienten pro Stunde gesehen werden, da das Pflegepersonal zusätzlich Patientenschulung macht. Für praktische Eingriffe, die vom Pflegepersonal übernommen werden, bedeuten oft das "Deskilling" von Jungärzten.

Am Ende ist es eine ethische & politische Entscheidung- was und an wen delegiert wird - wenn nicht genug Ärzte vorhanden sind, um die Patientenversorgung zu garantieren.

NACHTRAG:

Durch die geldlichen Probleme im Gesundheitssystem sind im letzten Jahr viele Stellen in den Kliniken gestrichen worden. Die Dienste der "Clinical Nurse Specialists", Nurse Practitioners, usw. wurden als besonders teuer bewertet (im Vergleich zu anderem Pflegepersonal), und wird deshalb zur Zeit dramatisch gekürzt, während zur gleichen Zeit Ärzte aus den neuen EU Ländern angestellt werden.

Weiterführende Literatur:

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Guidelines for the training, appraisal and assessment of trainees in GI endoscopy - JAG 2004

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Electronic Documentation as an Instrument of Quality Assurance.

Jo. Corrigan, Leeds General Infirmary, Leeds., U.K

Quality assurance is a process which requires an individual or organisation to achieve and maintain minimum standards of care. These standards are governed and set by a various professional and legal bodies, throughout every healthcare setting.

Examples of these governing bodies relating specifically to endoscopy in the United Kingdom are: The HTM/20/30 guidelines for decontamination, the Department of Health,(Dept Health 2001) policies for Consent for treatment or procedures and the more recent introduction of the National Endoscopy Team. The National Endoscopy Team have developed a patient centred framework for measuring quality within endoscopy services; this is The Global Rating Scale, (NHS 2005)

Documentation of any aspect of patient care is an integral part of their journey within the hospital setting. This documentation should be completed accurately and efficiently and meet the legal requirements of the practitioner registering body (i.e. Nursing/Midwifery Council). It can be achieved by either written format or electronically.

There are a variety of software packages available for recording endoscopic activities and procedures and the assessment of the quality of this, however a large number of these only allow electronic recording of the endoscopic procedure and do not incorporate the nursing element of patient's endoscopic journey.

The need for electronic documentation which incorporates every aspect of the patients journey and, allows recording of the nursing intervention was identified by the quality assurance group at the Leeds General Infirmary and has been an ongoing development within the Leeds General Infirmary (U.K.) since 2001 in conjunction with Fujinon. As a result we now have a robust quality assurance programme (ADAM) which allows both medical and nursing documentation to be recorded electronically, and updated and modified on a

regular basis by the users following regular audits. This has been rolled out to the other three endoscopy units within the Trust and is an ongoing process which forms part of our continuous quality assurance programme.

Refs:

Department of Health (2001) Guide to consent for treatment
 National Endoscopy Team (2005) Endoscopy Global Rating Scale
 N.H.S. Estates (1997) HTM20/30 Health Technical Memorandum 2030

Scores in Nursing Documentation

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The risk of patients undergoing endoscopic procedures varies greatly, depending on the patient's history, her/his actual general state of health, the extent and related risks of the endoscopic procedures and treatments. Documentation in endoscopy should make the individual risks of patients transparent and should document medical and nursing actions.

Scores are used in medicine and nursing to assess the individual health status and risks of a patient. The patient's data become comparable and can be evaluated. Scores are focused on diseases, organs or physical functions. Scores can be used to assess the patient's risk before undergoing an endoscopic procedure.

The ASA classification (1) is one of the oldest and widely used scores. It is purely focused on physical functions of the cardio-pulmonary tract. The Danish Hvidovre-Score combines procedure-related and patient-related risk factors (2). This risk score was developed to calculate the level of monitoring, number and qualification of staff. The Endoscopy-Dependence-Risk Score (3) was developed to increase the risk awareness in endoscopy and to gain comparable data.

The Endoscopy-Risk-Score (4) developed by German endoscopy nurses combines the Hvidovre score and the EDRS score:

Procedure related Risk	Upper GIT Sigmoidoscopy.	ERCP, Colonoscopy, Broncho	Therapeutic procedures	
Patient related Risks				
Vital signs	Stabile vital signs, Spontaneous breathing	Compensated cond (pulse, blood pres difficulties in breathing	In stabile vital signs Shock symptoms Artificial respiration	
Mobilisation	Complete independenc	Help in personnel hyg transfer and positioning	immobile, total depende transfer by staff	
Communication	Patient is orientated	Patient is disorientated Premeditation	Patient is disorientated	
Total points:				

Up to now nursing data in endoscopy have not been evaluated in a structured way. Therefore an endoscopy relevant score can be an instrument to:

- increase the risk awareness of endoscopy staff
- assess the individual risk of patients before undergoing endoscopic procedures
- calculate staff recourses
- decide on proper prophylactic measures
- plan nursing actions before, during and after the procedure
- compare the clientele of different endoscopy departments

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 3. Ritter J. Spitzempersonal gleich Spitzenqualität ? Krankenhaus Umschau. 1 / 1999, 32-35
 4. Beilenhoff U. et al Pflegedokumentation in der Endoskopie. Endopraxis 1-4, 2005
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Education of new staff = Einarbeitung neuer Mitarbeiter

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Die Einarbeitung eines neuen Mitarbeiters ist in der Endoskopie von großer Bedeutung. Es geht darum, dass der Mitarbeiter in einem bestimmten Zeitraum lernt, selbständig und eigenverantwortlich zu arbeiten. Das ganze Team ist dafür verantwortlich.

Idealerweise wird ein Mentor als Bezugsperson für die gesamte Einarbeitung bestimmt.

Das speziell für die Abteilung erarbeitete Einarbeitungskonzept trägt zu einer umfassenden, zielgerichteten und systematischen Einarbeitung bei. Sie fördert die Motivation und die Qualifikation des neuen Mitarbeiters und hilft dem Mitarbeiter bei der Integration ins Team und der Identifikation mit der Abteilung.