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16th ESGENA Conference

hosted by the
**Dutch Society of Endoscopy and GE Nurses and Assistants
(V&VN Maag Darm Lever)**

In Conjunction with the 20th UEGW
20-22 October 2012

1. Word of Welcome

Dear colleagues,

On behalf of ESGENA and the Dutch Society of Endoscopy and GE Nurses and Assistants (V&VN Maag Darm Lever) it is our great pleasure to welcome you to the 16th ESGENA Conference, which will be held during the 20th UEG Week on Saturday 20-22 October 2012, in Amsterdam, the Netherlands.

The ESGENA conference is not only an opportunity to meet colleagues from throughout Europe, but also from North and South America, Africa, Asia and Australia. The exchange with nurses from all over the world combined with the opportunity to attend the medical programme of the UEG Week provides that the ESGENA conference will be an exceptional educational event.

In 2001, the 5th ESGENA conference was held in Amsterdam. We are thrilled to once again organise a meeting with the Dutch society of endoscopy and GE nurses, who have continued to be very active colleagues within ESGENA.

The three day conference will include state-of-the-art lectures, free papers & posters, lunch sessions, several workshops with hands-on training and live transmissions. Interesting topics in Gastroenterology and Endoscopy will ensure a truly global context. It is our aim to provide a full and varied programme. This format will encourage networking and communication between the delegates – between both individual nurses and national groups.

We wish you an interesting conference and a good time in Amsterdam.

Michael Ortmann
President of ESGENA

Petra Bol
President of V&VN MDL

2. Announcement of ESGENA and V&VN MDL

Nurses exposed to advertising from drug industry

Dear colleagues,

We have to inform you that in the Netherlands nurses who are not qualified to prescribe medication, should not receive any advertising material from the pharmaceutical industry.

Legal background

The Dutch regulations are based on the EU Directive 2001/83/EU which states in article 88:

1. Member States shall prohibit the advertising to the general public of medicinal products which:
 - a. are prescription only medicines, in accordance with Title VI;
 - b. contain substances defined as psychotropic or narcotic by international convention, such as the United Nations Conventions of 1961 and 1971.

The Dutch Medicines Act states in article 82 that nurse practitioners are qualified to prescribe medication. However 'ordinary' nurses are not qualified to prescribe medicines, so they are considered part of the 'general public' (see above). This means that the majority of our nurse delegates at the conference are not permitted to be exposed to advertising from the drug industry.

How do we manage this at the ESGENA conference and the UEG Week?

- The name badges of UEG Week and ESGENA conference have different colours, therefore can easily be identified by the industry as nurses.
- UEG Week and ESGENA have conference bags in different colours with different content. The ESGENA conference bags will include only advertising material from manufacturers of endoscopy related equipment and chemicals.
- ESGENA participants will receive a separate programme book without adverts from the pharmaceutical industry
- Nurses can easily be identified by their name badge and their conference bags
- Nurses are allowed to enter the exhibition which opens on Monday morning, October 22, 2012.
- Nurses can receive information from manufacturers offering
 - products relevant to Endoscopy and/or
 - information relevant for patient care in Gastroenterology (e.g. information about patient groups or diseases).
- Nurses will be able to receive hospitality (e.g. to drink a cup of coffee) at the booths in the exhibition area.
- Representatives of pharmaceutical industry should not actively approach nurses with advertising material and should be aware of the person's qualification before offering any specific product information.
- Nurses who are qualified to prescribe can receive any information from the pharmaceutical industry

We have checked with the Dutch bodies that these arrangements fulfill the requirements of the regulations. We are confident that these arrangements will not restrict your educational opportunities as it only affects the contact with a few companies in the exhibition.

We wish you an interesting conference and a good time in Amsterdam

Best regards

Michael Ortmann, President of ESGENA

Petra Bol, President of V&VN MDL

Ulrike Beilenhoff, ESGENA Scientific Secretary

3. General Information

3.1. Contact Addresses

ESGENA Scientific Secretariat

Ulrike Beilenhoff
Ulm, Germany
Phone: +49 (0) 731 950 3945
E-mail: UK-Beilenhoff@t-online.de

ESGENA Technical Secretariat

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85077 Manching, Germany
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Fax: +49 (0) 8459/323942
E-mail: info@esgena.org

Society website: www.esgena.org

ESGENA Governing Board

- | | | |
|------------------|-----------------|----------------------------|
| • President | Michael Ortmann | Basle, Switzerland |
| • Vice President | Jayne Tillett, | Bristol, UK |
| • Secretary | Herta Pomper | Vienna, Austria |
| • Treasurer | Marjon de Pater | Amsterdam, The Netherlands |
| • Councillors : | Jadranka Brljak | Zagreb, Croatia |
| | Mette Olesen | Copenhagen, Denmark |
| | Stanka Popovic | Ljubljana, Slovenia |

Society Website : www.esgena.org

V&VN MDL Governing Board

- | | | |
|------------------------|-------------------|-----------------------------|
| • President | Petra Bol | Amersfoort, The Netherlands |
| • Vice president | Thea Korpershoek | Dordrecht, The Netherlands |
| • Secretary | Wanda Kuin | Alkmaar, The Netherlands |
| • Treasurer | Wendeline Bruijn | Bilthoven, The Netherlands |
| • Councillors | Angelie de Heer | Tilburg, The Netherlands |
| | Monique Knops | Heerlen, The Netherlands |
| | Anja Nijmeijer | Enschede, The Netherlands |
| • Board members elect: | Jacqueline Caelen | Heerlen, The Netherlands |
| | Jeanine Elzerman | Apeldoorn, The Netherlands |

Society Website: www.mdl.venvn.nl

3.2. Useful Conference Information

Attendance Certificates	Attendance Certificates will be given to delegates who hand in a completed evaluation form at end of the sessions on Sunday afternoon at the ESGENA information desk in the Topaz Lounge (directly at the ESGENA lecture halls) or on Monday morning at the UEG Week registration desks. Evaluation forms are on the last page of this Abstract Book (see yellow page).
Cloakroom	A cloakroom can be used free of charge from Saturday, October 20 through Wednesday, October 24 at the entrance of the conference. Participants can also store their luggage here.
Coffee & Lunch	Coffee and Lunches will be served for all ESGENA registered participants from Saturday to Monday in the catering areas.
Conference Language	The official language of the ESGENA Conference is English.
Congress Registration Desk	The congress counter will be located in the Europe Foyer of the Amsterdam RAI Exhibition & Convention Centre. Opening hours: Friday, Oct 19, 2012, 14:00 - 18:00 Saturday, Oct 20, 2012, 07:30 - 18:00 Sunday, Oct 21, 2012, 07:30 - 18:00 Monday, Oct 22, 2012, 07:30 - 18:00 Tuesday, Oct 23, 2012, 07:30 - 18:00 Wednesday, Oct 24, 2012, 07:00 - 16:00
ESGENA Annual General Meeting	ESGENA Annual General Meeting will be held on Saturday, October 20, 2012 from 17.15-18.30 hours in Room G 106 (Access for ESGENA members only)
ESGENA Hands-on-Training	Hands-on-Training on bio simulators will be offered on Saturday and Sunday in the ESGE Learning Area (Onyx Lounge). See Workshops 5,10-13 in the ESGENA detailed programme. Please note that there are only a limited number of tickets available in order to ensure small training groups at each station. Tickets for nurses will be available at the entrance of the ESGE Learning Area- on a first-come-first-served basis.
ESGENA Lunch Sessions	3 parallel Lunch Sessions on Sunday, October 21, 2012 will combine state-of-the-art-lectures and hands-on-training.
ESGENA Payments	Membership payments (up to Euro 50) will be accepted in cash (Euro) at the ESGENA membership desk on Saturday afternoon and Sunday only.
ESGENA Poster Sessions	ESGENA posters will be displayed in the Topaz Lounge. Posters should be mounted on the assigned board on Saturday 14.00 hours and removed before Sunday 18.00 hours. ESGENA will have two poster sessions on Sunday, October 21, 2012: <ul style="list-style-type: none"> • From 13.00-14.00 hours • From 16.00-17.00 hours Poster authors will receive material to fix the posters at the ESGENA membership desk.
ESGENA Welcome Reception	Attendance at the Welcome Reception is included in the ESGENA registration. See page: 11 Ticket: Access only with badges of ESGENA Conference.
Exhibition	The UEG Week will be accompanied by a major technical exhibition. Opening Hours <ul style="list-style-type: none"> • Monday October 22, 2012 09.00 – 17.00 h • Tuesday October 23, 2012 09.00 – 17.00 h • Wednesday October 24, 2012 09.00 – 14.00 h

Internet Centre and Wireless Lan	<p>The Internet Centre is located in Hall 3 of Amsterdam RAI. Opening hours are between</p> <ul style="list-style-type: none"> • 09:00 to 17:00 (Mon-Tue, Oct 22 – 23) and 09:00 to 14:00 (Wed, Oct 24). <p>As a courtesy to all participants several Internet terminals and wireless LAN areas allow easy access to the Internet.</p> <ul style="list-style-type: none"> • Please select the WiFi network UEGW2012 and enter the password: uegw2012. • By opening a browser, you get to the UEG Week landing page. • Then click “click here for internet access”.
Membership Desks of <ul style="list-style-type: none"> • ESGENA • V&VN MDL • SIGNEA 	<p>The membership desks will be situated in the Topaz Lounge</p> <ul style="list-style-type: none"> • On Saturday, October 20, 2012 from 12.00-17.00 hours • On Sunday October 21,2012 from 08:30-15:30 hours
Programme Changes	<p>The organizers cannot assume liability for any changes to the programme, due to external or unforeseen circumstances.</p>
Public Transport Pass	<p>Upon arrival at the congress venue, ESGENA delegates receive a 3-day public transportation ticket with their congress material. The pass entitles the holder to travel on all public transport facilities within the Amsterdam city boundaries during the entire period of the ESGENA congress.</p>
Speakers Centre	<ul style="list-style-type: none"> • Please come to the Speakers Centre the day before or at least three hours prior to your lecture. • Highly experienced technicians will capture your PowerPoint presentation and store it on the central congress server. • At the Speakers Centre you can check and rehearse your PowerPoint presentation. <p>Opening hours:</p> <ul style="list-style-type: none"> • Friday October 19,2012 14.00 h – 18.00 h • Saturday October 20, 2012 07.30 h – 18.00 h • Sunday October 21, 2012 07.30 h – 18.00 h • Monday October 22, 2012 07.00 h – 18.00 h • Tuesday October 23, 2012 07.00 h – 18.00 h • Wednesday October 24, 2012 07.00 h – 14.00 h <p>In the lecture room</p> <ul style="list-style-type: none"> • Your PowerPoint presentation will be made available in your lecture room via a computer network. There will be no possibility to connect your personal notebook in the lecture room. • The computer presenting your presentation will be operated by a technician. From the lectern you will be able to remote control your PowerPoint presentation. A laser-pointer will be available. • Neither overhead projector nor slide projector will be available in the lecture rooms; double projection will not be provided. No changes in your presentation can be made in the lecture room
UEG Week Post Graduate Course	<p>Nurses are welcome to attend the UEG Week post graduate course on Saturday to Sunday at no extra charge.</p>
UEG Week Core Programme	<p>Nurses are welcome to attend the medical lectures of the UEG Week core programme at no extra charge. Nurses who want to attend the UEG Week on Tuesday and Wednesday, October 23-24, 2012, have to contact the conference registration desk on Tuesday and Wednesday to get a new badge (free of charge).</p>

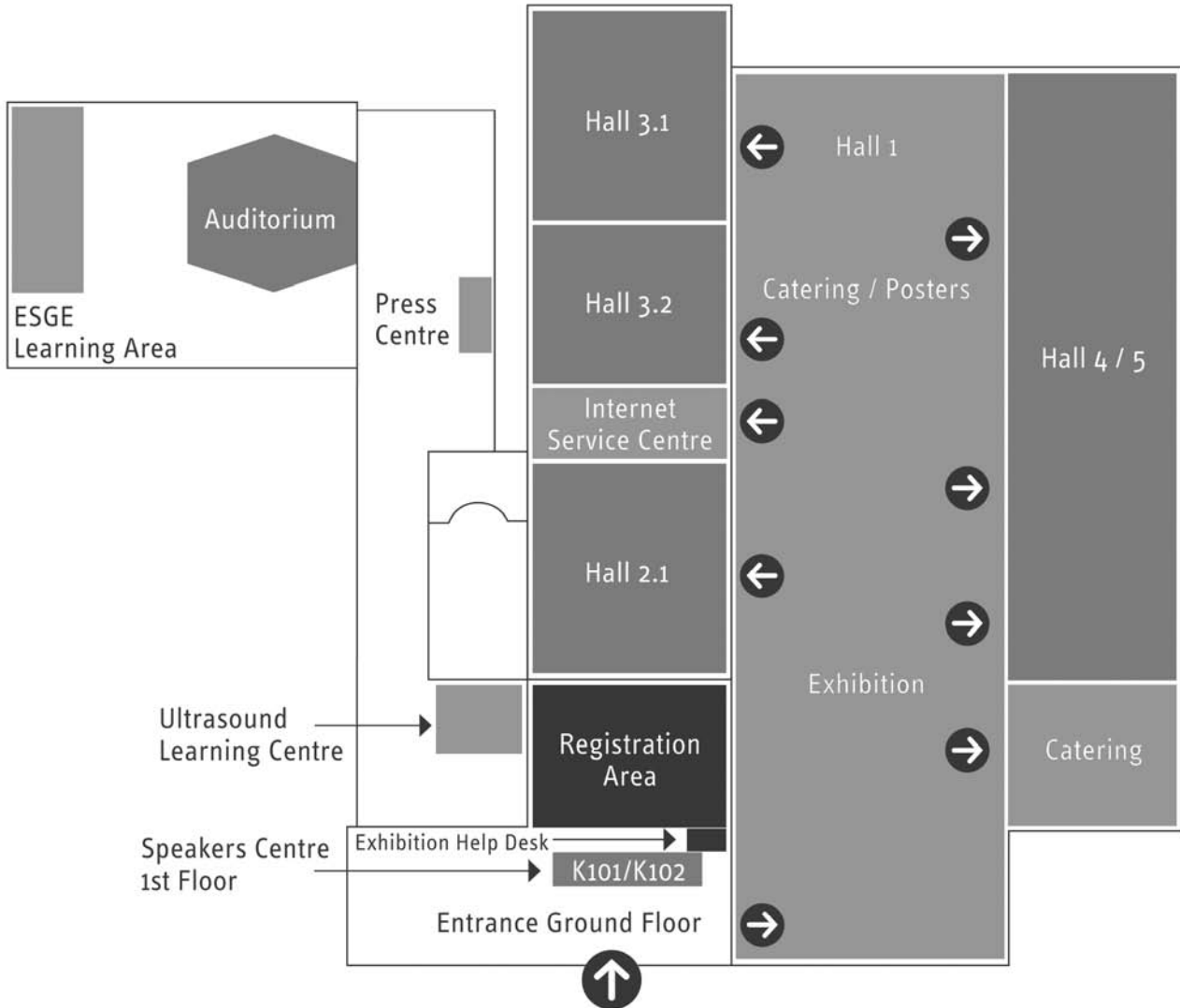
<p>20th Anniversary of the UEG Week</p>	<p>UEG Week is celebrating its 20th Anniversary this year in Amsterdam and to mark the occasion there will be a wide range of special events taking place.</p> <p>Rock the Week Party This private party, open only to UEG Week delegates, is being held on the ship OCEANDIVA ORIGINAL. When you arrive for the evening you will follow the red carpet towards the fully illuminated ship. Once on board you will be greeted with spectacular views, multiple bars serving both alcoholic and non-alcoholic drinks, and a dance floor with a live DJ. Have no fear if you are not the best dancer! The ship features a large balcony overlooking the central dance floor which has comfortable tables to sit at and watch the party from above. UEG Rock the Week – the highlight event of UEG Week 2012. Meet friends, chat with colleagues, or simply dance the night away! Secure your space and register (first come, first serve!)</p> <ul style="list-style-type: none"> • Date: Sunday, October 21, 2012 • Time: 20:00 • Location: Ship OCEANDIVA ORIGINAL • Cost: EUR 20 per person (incl. drinks) • Tickets available at the conference registration desks - on a first-come-first-served basis <p>UEG Film Presentation: A History of United European Gastroenterology</p> <p>Congratulatory Birthday Speech Delivered</p> <p>Anniversary Coffee Break</p> <p>Showcase of UEG History</p> <p>Anniversary Lottery Wheel at the UEG Booth</p> <p>Special Anniversary Symposia</p>
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3.3. Useful Information about Amsterdam

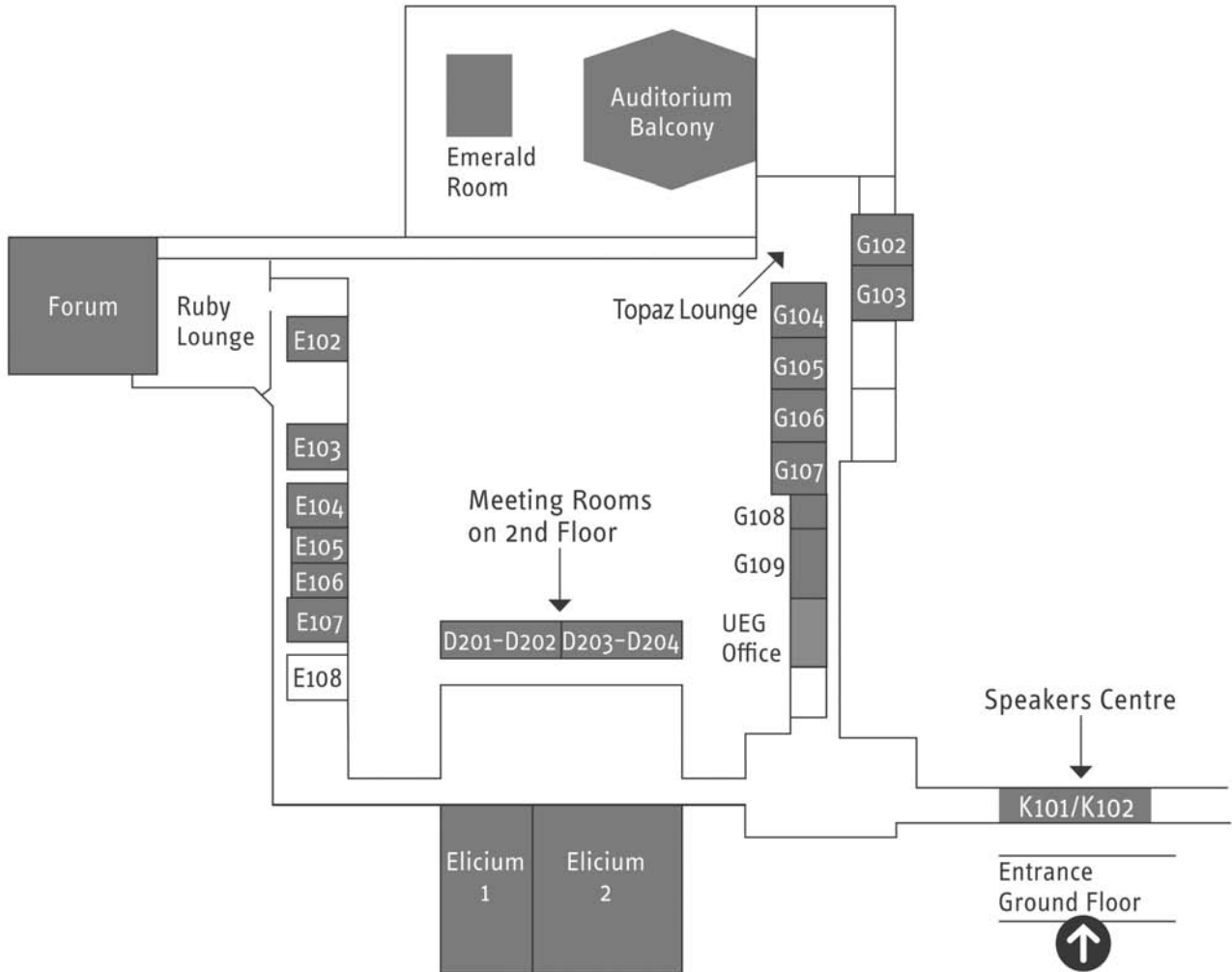
Bank and ATM	<p>Banks are open weekdays only, between 9:00 and 16:00.</p> <p>Bank cards using the Cirrus and Maestro systems can be used at any of the ATM machines in Amsterdam. If you need cash on your arrival in Amsterdam there are loads of ATM machines in Schiphol airport and at Central Station. Most shops and restaurants in Amsterdam accept credit cards, but not all. It is therefore recommended to either ask before you order or ensure you have a sufficient amount in cash to cover the bill. Most shops and restaurants do not accept EUR 200 - EUR 500 notes.</p>
Climate	<p>Amsterdam's climate is mild. In October, the average temperature is 12°C during the day. Fluctuation between day and night temperatures are about 7°C. Rain is possible.</p>
Currency	<p>Payments will be accepted in EURO (EUR). At most banks as well as at exchange bureaus in the city currency can be exchanged. Credit cards are widely accepted.</p>
Electricity	<p>The voltage in The Netherlands is 230 Volts, 50 Hertz. Sockets meet European regulations and use the two-round pin system.</p>
Public Transportation and Metro	<p>Amsterdam boasts an impressive public transport network including metros, buses, trams, ferries and trains to help you get around the capital. All delegates will receive a public transportation pass (PT Smart Card) of the public transport company (GVB).</p> <p>This entitles to unlimited travel in Amsterdam – day and night – by tram, bus and metro, for three days. Trams are common in Amsterdam, with routes heading out from the centre in all directions. Trams are ideal for short journeys around the city centre, as well as for traveling to other districts. Amsterdam's metro runs underneath the centre, from Central Station to the outer districts.</p> <p>Amsterdam operates a full bus network, which will take you anywhere you have to go. Behind Central Station, ferries hustle their way across the River IJ, transporting passengers to various locations in the north of Amsterdam. Some specialist ferries also travel along the river to other districts of the city.</p>
Sightseeing in Amsterdam	<p>During the UEG Week 2012, the officially appointed local partner RAI Special Events will offer various guided tours in and around Amsterdam for participants and their accompanying persons. All tours are accompanied by an English-speaking guide.</p> <p>Please note that all tours will start and end at the congress venue Amsterdam RAI Exhibition & Convention Centre.</p> <p>A special registration desk for sightseeing is located in the registration area</p>
Taxi	<p>Taxis can be called, hailed on the street or found at one of more than 50 official taxi ranks located around the city. The ranks, identifiable by blue boards, can be found near to tourist spots such as the Dam, Leidesplein and Rembrandtplein. Space in the city centre is limited; taxis cannot stop anywhere they like. To keep traffic flowing in the city at peak efficiency, stopping is not allowed at various places.</p>
Telephone	<p>Country code: +31. Outgoing international code: 00.</p>
Time Zone	<p>The time zone in The Netherlands is Greenwich Mean Time (GMT) +1 hour in winter and +2 hours in summer.</p>

3.4. Floor Plans of RAI

Ground Floor



First Floor



3.5. Official Conference Opening & Welcome Reception

ESGENA Welcome Reception

**The Dutch Society of Endoscopy and GE Nurses and Assistants
(V&VN Maag Darm Lever)**

invites the ESGENA conference participants

to the

Official Welcome Reception & Opening of the ESGENA Conference

**On Saturday, October 20, 2012
From 19.00 - 21.00 hours**

**at the “De rode hoed”
Keizersgracht 102
1015 CV Amsterdam**

You are invited to a most enjoyable, informal evening with the opportunity to meet colleagues and friends from all over Europe and overseas.

Attendance at the Welcome Reception is included in the registration
Ticket: Access only with badges of the ESGENA Conference

3.6. ESGENA Free Paper & Poster Prize

Best Free Paper Prize is sponsored by

PENTAX

Accepted Abstracts receive Free Registration at the ESGENA Conference

PRIZES to be won:

Best Free Paper – Oral Presentation wins

Free Registration and 2 nights' Free Accommodation
at the next ESGENA Conference, in October 2013 in Berlin, Germany

Best Free Paper – Poster Presentation wins

a Digital Camera from PENTAX

The best Free Paper and best Poster will be announced at the ESGENA Plenary
Session on Monday, 22 October 2012

For details how to submit an abstract
for the next ESGENA conference 2013 in Berlin
please find the Call for Abstract included in this Book and
on the ESGENA Website www.ESGENA.org

4. ESGENA – Programme Overview

SATURDAY, 20 October 2012					
Hall 4/5	Room G 104	Room G 105	Room G 106	Room G 107	ESGE Learning Area In the Onyx Lounge
11.00-13.00 UEGW – PG Training Programme ESGE Live Endoscopy	13.30-15.00 Workshop 1 EN ISO 15883- 4: Legal responsibilities of the clinical service provider organised by Olympus Europa Holding GmbH	13.30-15.00 Workshop 2 GI Function tests – “The good, the bad and the ugly” organised by ESGENA	13.30-15.00 Workshop 3 Liver cirrhosis organised by V&VN MDL	13.30-15.00 Workshop 4 Extra intestinal manifestations in IBD: what nurses need to know organised by V&VN MDL	13.30-15.00 Workshop 5 Hands-on Training on Bio Simulators: Upper GI Bleeding ERCP Colonoscopy
Coffee Break 15:00 - 15:30					
14.00-16.30 UEGW – PG Training Programme ESGE Live Endoscopy	15.30-17.00 Workshop 6 Hemostasis Techniques: Clip, Band, Burn or Inject? organised by Boston Scientific	15.30-17.00 Workshop 7 GI Bleeding: Diagnosis and Endoscopic Management organised by US Endoscopy	15.30-17.00 Workshop 8 How to create scientifically sound abstracts and posters for conferences organised by ESGENA	15.30-17.00 Workshop 9 Nutrition – PEG tubes organised by V&VN MDL	15.30-17.00 Workshop 10 Hands-on Training on Bio Simulators Upper GI Bleeding ERCP Colonoscopy
			17.15-18.30 ESGENA General Assembly (members only)		
	19.00-21.00 ESGENA- V&VN Maag Darm Lever Welcome Reception				

**SUNDAY
21 October 2012**

Room G 104/105	Room G 106/107	Room G 109	Topaz Lounge	ESGE Learning Area In the Onyx Lounge
08.30-10.00 Session 1 Free Paper Session	08.30-10.00 Session 2 Emergency Management	-----	-----	-----
10:00 – 10.30 Coffee	10:00 – 10.30 Coffee	-----	-----	-----
10.30-12.00 Session 3 Free Paper Session	10.30-12.00 Session 4 Bronchoscopy	-----	-----	10.00-12.00 Workshop 11 Hands-on Training on Bio Simulators Upper GI Bleeding ERCP Colonoscopy
12.00-13.00 Lunch	12.00-13.00 Lunch	-----	-----	-----
13.00-14.30 Lunch Session 1 New Techniques & Developments	13.00-14.30 Lunch Session 2: Bronchoscopy	13.00-14.30 Lunch Session 3: Hygiene	13.00-14.00 Poster Round I	12.30-14.30 Workshop 12 Hands-on Training on Bio Simulators Upper GI Bleeding ERCP Colonoscopy
14.30-16.00 Session 5 Quality Assurance	14.30-16.00 Session 6 Hot Topics in Endoscopy	-----	-----	15.00-17.00 Workshop 13 Hands-on Training on Bio Simulators Upper GI Bleeding ERCP Colonoscopy
16.00-17.00 Coffee	-----	-----	16.00-17.00 Poster Round II	-----
17.00-18.30 Session 7 GE Disease	17.00-18.30 Session 8 Education	-----	-----	-----

MONDAY
22 October 2012

Hall 2.1

8:30-10:30

New techniques and developments in Endoscopy
Presentation by Major Sponsors

Scientific Lectures

Best Free Paper and Best Poster Award

Invitation to next conferences

10:30 – 11:00

Coffee

Visit of Exhibition
ESGE Learning Area
UEG Week Sessions

12:30-14:00

Lunch

Visit of Exhibition
ESGE Learning Area
UEG Week Sessions

15.30-16.00

Coffee

Visit of Exhibition
ESGE Learning Area
UEG Week Sessions

5. ESGENA - Detailed Programme

5.1 ESGENA-Workshops on 20 October 2012

Workshop 1: EN ISO 15883- 4: Legal responsibilities of the clinical service provider

This workshop is organised by **Olympus Europa Holding GmbH**

13.30-15.00 Room G 104
Chairs: Holger Biering, Grevenbroich, Germany
Reinhard Blum, Hamburg, Germany

Background

EN ISO 15883-4 is the first norm in the area of medical endoscopy, which specifies responsibilities of companies specialised in development and production of endoscope washer-disinfectors (EWD) and hospital service providers (HSP). The norm is expected to facilitate the decision process of HSP in their purchasing workflow for EWD. Furthermore, it shall improve reliability and safety of the reprocessing workflow in endoscopy. The HSP will be on the safe side as long as the EWD according is operated according to its specifications and the manufacturers' instructions of use.

However, what happens in case the HSP decides to deviate from EWD manufacturers' instructions? Which legal consequences can be expected? How do liabilities change? Often HSP may have the impression to be left alone in this difficult decision...

Aim of this workshop

This workshop will give:

- an overview about current regulations as set forth in EN ISO 15883-4
- discuss potential legal consequences the HSP may face in case of deviations from the EN ISO 15883-4 norms
- Insights from practice how to adjust the theoretical EN ISO 15883-4 requirements to daily work life and problem settings.

It is the target of the workshop to specify open issues and questions in order to forward them to the EWD manufacturer.

Presentations

Specify responsibilities according to the EN ISO 15883-4. How was this copied into national norms and guidelines (Case: The Netherlands)

Arjan van Drongelen, Bilthoven, The Netherlands

Legal consequences in case of setups which differ from the EWD manufacturer specifications and type testing results

Cord Willhöft, Munich, Germany

Practical View: Questions and answers (i.e. use of EWD with process chemistry which was not used during type testing)

Claus Kuhlmann, Münster, Germany

Discussions

Workshop 2: GI Function tests - “The good, the bad and the ugly”

This workshop is organised by **ESGENA**

13.30-15.00 Room G 105

Chairs: Ulrike Beilenhoff, Ulm, Germany
Christiane Neumann, Birmingham, UK

Aims & Content

Function tests are essential diagnostic tools in Gastroenterology. In some countries nurses perform these tests. In other countries it is the exclusive task of doctors.

The workshop aims will discuss the following issues

- Tasks and responsibilities of nurse involved in GI Function tests
- Legal and ethical considerations
- Education & Training requirements
- Difficulties and resources in establishing a national training system
- Limitations in practice and difficulties in daily routine
- Job satisfaction and financial rewards
- etc.

This is an open question-and-answer based workshop where the audience will be encouraged to participate, to exchange experiences, and for those who are interested in the topic to ask questions (orally or in writing).

Workshop 3: Liver cirrhosis

This workshop is organised by **V&VN MDL** and sponsored by **Gilead Sciences Netherlands B.V**

13.30-15.00 Room G 106

Chairs: Anja Nijmeijer, Enschede, The Netherlands
Thea Korpershoek, Dordrecht, The Netherlands

Aims & Content

13.30 – 14.00 Liver cirrhosis and the effect of alcohol and drugs
S.B. Willemse, Amsterdam, the Netherlands

Liver cirrhosis is a chronic, diffuse, degenerative disease of the liver tissue. Healthy tissue is replaced by fibrous tissue while the remaining liver cells multiply and form nodules islands. This fibrous scar tissue causes a reduction of blood flow through the liver. The result is an impaired liver function. The effects of both alcohol and drugs are discussed.

14.00 – 14.30 Portal hypertension and oesophageal haemorrhoids, how to treat
J.N.L. Schouten, Rotterdam, The Netherlands

Impaired liver function can lead to portal hypertension and oesophageal varices. Co-incidentally, an increased risk of bleeding is seen due to the decreased production of clotting substances. The treatment of portal hypertension and oesophageal haemorrhoids is discussed.

14.30 – 15.00 Liver cirrhosis and malnutrition
C.A.H. van der Meijden, Amsterdam, The Netherlands.

Liver cirrhosis decreases the production, syntheses and degradation of carbohydrates, proteins and lipids. The storage of vitamins and minerals is disturbed and the production of bile will decrease, which will lead to malabsorption and maldigestion. This results in a range of complaints and complications like malnutrition. A good nutritional status can decrease complications, mortality, morbidity and relief complaints. Therefore, full assessment of the nutritional status of the liver cirrhosis patient is justified. The nurse practitioner in the outpatient's clinic can play an important role in this assessment. Biochemical, clinical and anthropometric assessment can supply objective data, which can lead to optimizing nutrition management strategies in time.

Workshop 4: Extra intestinal manifestations in IBD: What nurses need to know

This workshop is organised by **V&VN MDL**

13.30-15.00 Room G 107

Chairs: Angelie de Heer, Tilburg, The Netherlands
Maria de Jong, Amsterdam, The Netherlands

Aims & Content

13.30-14.00 Hepatobiliary disease in IBD
Cyriel Y. Ponsioen, Amsterdam, The Netherlands

Patients with inflammatory bowel disease (IBD) often exhibit disturbed liver biochemistry. Unrelated chronic liver disease or medication may be the underlying cause. However, primary sclerosing cholangitis (PSC) is a main concern in the differential diagnosis. Prevalence of IBD in PSC patients ranges from 67% to 73%. Conversely, approximately 5% of IBD patients exhibit PSC. It has been reported that PSC patients exhibit a distinct IBD phenotype characterized by colitis, rectal sparing and backwash ileitis. In this lecture, the diagnosis, differential and management of PSC in IBD patients will be discussed.

14.00-14.30 Extra intestinal manifestations: How to manage?
A.A. van Bodegraven, Amsterdam, The Netherlands

Extra intestinal manifestations may hamper quality of life in IBD-patients, already suffering from intestinal complaints. This session aims to initiate an interactive discussion concerning the many manifestations of IBD outside the gut and its implications for patient and treatment.

14.30–15.00 IBD and Smoking: A Hot Item
F van der Heide, Enschede and Groningen, The Netherlands

The two most common inflammatory bowel diseases are Crohn's disease (CD) and ulcerative colitis (UC). They are characterized by relapsing inflammation of the gastrointestinal tract. A remarkable difference between CD and UC is the opposite effect of smoking. Smoking seems detrimental for CD, but beneficial for UC. In this presentation the effects of active and passive smoking on the development and disease course of both CD and UC are discussed. In addition, some aspects of smoking cessation are highlighted.

Workshop 5: Hands-on Training on Bio Simulators

This workshop is organised by **ESGENA**

13.30-15.00 ESGE Learning Area in the Onyx Lounge

Chairs: Michael Ortmann & Eric Pflimlin, Basle, Switzerland

Aims & Content

Hands-on training on bio simulators (pig models) under the supervision of highly experienced tutors: Participants will have the opportunity to perform endoscopic techniques on the following topics:

- OGD with Injection techniques, Ligation, Clipping, APC
- Colonoscopy with Polypectomy, EMR and APC
- ERCP with stone extraction and stenting

As participation will be limited, registration will be treated on a first-come-first-served basis. Tickets will be available onsite only – at the entrance of the ESGE Learning Area.

Workshop 6: Hemostasis Techniques: Clip, Band, Burn or Inject?

This workshop is organised by **Boston Scientific Europe**

15.30-17.00 Room G 104

Chairs: Dennis M. Jensen, Los Angeles, USA.
Michèle Donnelly, Boston Scientific

Aims & Content

This programme is designed to increase nurses' knowledge of hemostasis pathologies and procedures and the clinical application and benefits of the different types of hemostasis treatments.

- Presentation on clinical best practice in Hemostasis (Pathologies, Procedures, Techniques ,etc.)
- Hands-on training on each hemostasis treatment (Clipping, Ligation, Electrocoagulation therapy, and Injection therapy)
- Conclusion

Oral presentations (40 minutes) followed by hands-on practice (50 minutes) on 6 hemostasis stations

Workshop 7: GI Bleeding: Diagnosis and Endoscopic Management

This workshop is organised by **US Endoscopy**

15.30-17.00 Room G 105

Chairs: Maria Cirocco, Toronto, Canada
Simone Schwardt, US Endoscopy

Aims & Content

The role of the nurse during a GI bleed is critical. These emergency situations require that all staff is prepared and properly trained to diagnose and manage the bleeding. Join us to discuss tools and techniques that you and your colleagues can use to improve patient outcomes and efficiency.

This workshop is intended to:

- Define gastrointestinal bleeding
 - Identify major causes of upper and lower gastrointestinal bleeding
 - Review endoscopic treatments for gastrointestinal bleeding
 - Describe the nursing role in caring for patients with gastrointestinal bleeding
-

Workshop 8: How to create scientifically sound abstracts and posters for conferences

This workshop is organised by **ESGENA**

15.30-17.00 Room G 106

Chairs: Ulrike Beilenhoff, Ulm, Germany
Christiane Neumann, Birmingham, UK

Aims & Content

The professional duty of each nurse includes sharing good evidence based practice. This can be done by teaching staff in one's own department, publication in journals or conference presentations. However, the way scientific presentations are prepared is not normally taught during nurse training.

The workshop aims to introduce nurses to follow scientific principles when

- Choosing a topic
- Preparing and evaluating an abstract for a conference
- Producing a poster which is both scientific and visually attractive
- Presenting a poster at a meeting to the poster round judges

Workshop 9: Nutrition – PEG tubes

This workshop is organised by V&VN MDL and sponsored by **Cobra Medical/Kimberly Clark**

15.30-17.00 Room G 107

Chairs: Wanda Kuin, Alkmaar, The Netherlands
Wendeline Bruyn, Bilthoven, The Netherlands

Aims & Content

15.30 – 15.55 PEG care in the Netherlands
S. Breg, Amsterdam, The Netherlands

There is a lot of difference in follow-up care for patients with a percutaneous endoscopic gastrostomy tube in Dutch hospitals. In this session the follow-up care for patients with a PEG-tube in the VU medical centre will be described. An inventory was done about the follow-up care in academic and top clinic hospitals and it learned that actions were rather more practice based than evidence based.

15.55-16.20 PEG tube related complications
K. Boeykens, Sint Niklaas, Belgium

A journey through frequently occurring complications in PEG patients, ways to prevent them and possible solutions. In this session the participants will see a lot of examples out of every day practice and it will be possible to discuss strategies between colleagues from different countries.

16.20 – 16.45 Percutaneous Endoscopic Jejunostomy
B. Witteman, Ede, The Netherlands

In this session there will be a demonstration of endoscopic placement of jejunostomy tubes. Is the placement of a PEJ just as easy as a PEG? Are there specific complications that we have to take into account?

16.45-17.00 PEG vs G-tube placement on the GE department
L. van Audenhove, Kimberly-Clark, Belgium

The Kimberly-Clark* MIC*, MIC-KEY* line of Introducer Kits contain Percutaneous Radiologic Gastrostomy (PRG) tools designed to assist Interventional Radiologists with safe and efficient primary placement of balloon-retained feeding tubes. The all-in-one kit delivers unique and reliable PRG devices - such as our Saf-T-Pexy* with T-fasteners and proprietary serial dilator - that allow for minimally invasive placement of our G, J, and TJ tubes in patients who require long-term nutritional support.

Workshop 10: Hands-on Training on Bio Simulators

This workshop is organised by **ESGENA**

15.30-17.00 ESGE Learning Area in the Onyx Lounge

Chairs: Michael Ortmann & Eric Pflimlin, Basle, Switzerland

Aims & Content

Hands-on training on bio simulators (pig models) under the supervision of highly experienced tutors: Participants will have the opportunity to perform endoscopic techniques on the following topics:

- OGD with Injection techniques, Ligation, Clipping, APC
- Colonoscopy with Polypectomy, EMR and APC
- ERCP with stone extraction and stenting

As participation will be limited, registration will be treated on a first-come-first-served basis. Tickets will be available onsite only – at the entrance of the ESGE Learning Area.

17.15-18.30

ESGENA General Assembly
(members only)

in Room G 106

5.2. ESGENA-Scientific Programme on 21 October 2012

SESSION 1: Free Paper Session I

08.30-10.00 Room G 104/105

Chairs Anita Jorgensen, Skien, Norway
Herta Pomper, Vienna, Austria
Gunilla Strand, Stockholm, Sweden

08.30-08.40 Welcome
Petra Bol, Utrecht, The Netherlands (President of V&VN MDL)

08.40-09.00 Quality improvement of outpatient services for patients at NKC Institute of Gastroenterology and Hepatology L-1
Siriporn Ratanalert RN*, Wanpen Pinyopasakul PhD**, Sopa Boonviriyaya RN*, Varaporn Senapitakkul RN*, Sulee Saengnil RN*, Ruankwan Pongprayoon RN*; * NKC Institute of Gastroenterology and Hepatology, Songklanagarind Hospital, **Faculty of Nursing, Mahidol University Thailand

09.00-09.20 Developments in endoscopy nursing in New Zealand – A vital component of a whole service quality improvement program L-2
Jennifer Masters, National Endoscopy Service Improvement Lead, Capital and Coast District Health Board & Ministry of Health, Wellington, New Zealand

09.20-09.40 Establishing nurse endoscopist training in Australia L-3
Dianne Jones, Elizabeth Shepherd, Logan Hospital, Queensland, Australia

09.40-10.00 Percutaneous endoscopic gastrostomy nurse first assist: the New Zealand experience L-4
Jacqueline Watkins, University of Auckland, Counties Manukau District Health Board, Auckland, New Zealand

SESSION 2: Emergency Management in Endoscopy

08.30-10.00 Room G 106/107

Chairs: Christine Petersen, Amsterdam, The Netherlands
Enriqueta Hernandez-Soto, Barcelona, Spain

08.30-08.40 Welcome
Michael Ortmann, Basle, Switzerland (ESGENA President)

08.40-09.05 Management of GI Bleeding – A structured training programme L-5
Eric Pflimlin, Basle, Switzerland

09.05-09.30 Out of hours - Absolute indications for emergency endoscopy...or: when to call GI at 3 a.m. L-6
Ingo Mecklenburg, Basle, Switzerland

09.30-09.55 Foreign body and bolus removal L-7
Sylvia Lahey, Arnhem, The Netherlands

09.55-10.00 Discussion

Workshop 11: Hands-on Training on Bio Simulators

10:00-12:00 ESGE Learning Area in the Onyx Lounge

Chairs: Eric Pflimlin & Björn Fehrke, Basle, Switzerland

Hands-on training on bio simulators (pig models) under the supervision of highly experienced tutors. Participants will have the opportunity to perform endoscopic techniques on the following topics:

- Upper GI Bleeding
- ERCP
- Colonoscopy

As participation will be limited, registration will be treated on a first-come-first-served basis. Ticket will be available onsite only – at the entrance of the ESGE Learning Area.

SESSION 3: Free Paper Session II

10.30-12.00 Room G 104/105

Chairs: Anita Jorgensen, Skien, Norway
Herta Pomper, Vienna, Austria
Gunilla Strand, Stockholm, Sweden

- 10.30-10.48 A beneficial experience of an information day for patients with familia adenomatous polyposis and their relatives L-8
Orania Sennevall¹; Kaisa Fritzell^{1,2}; Jan Björk^{1,3}. ¹The Swedish Polyposis Registry, Department of Gastroenterology and Hepatology, Karolinska University Hospital, Stockholm; ²Department of Neurobiology, Care Sciences and Society, Division of Nursing, Karolinska Institutet, Stockholm; ³Department of Medicine, Karolinska Institutet, Stockholm, Sweden
- 10.48-11.06 Results of a regional, nurse led Inflammatory Bowel Disease (IBD) telephone helpline audit L-9
Patterson Deborah, Houston Yasmine, Rawle Maxine, Rook Lisa for Yorkshire/Humber IBD Nurse Network, UK
- 11.06-11.24 Nurse-driven contact phone for patients with cancer in GI-tract or HPB area L-10
Reidun Gustavsen, Anne Rita Melvold, Solveig Zerener and Turid Heiberg, Division of Cancer Medicine, Surgery and Transplantation, Oslo University Hospital, Oslo, Norway
- 11.24-11.42 Dutch nurses consultation visits for the treatment of patients with faecal incontinence or constipation L-11
Jolanda Koeleman RN, Cristel E. Conradie-Kousbroek RN, Joke Groot Ph, Arjan Visscher MD, Richelle J.F. Felt-Bersma MD, PhD, VU Medical center, Amsterdam, The Netherlands
- 11.42-12.00 The effect of aroma oil inhalation on nausea, vomiting, abdominal discomfort and compliance in preparation for colonoscopy L-12
Lee, E. J., Asan Medical Center, Seoul, Korea
-

SESSION 4: New and established Techniques in Bronchoscopy

10.30-12.00 Room G 106/107

Chairs: Michael Ortmann, Basle, Switzerland
Marja Rolink, Emmen, The Netherlands

10.30-11.00 Electro Navigation Bronchoscopy" L-13
Peter Grendelmaier, Basle, Switzerland

11.00-11.30 Thoracoscopy L-14
Ales Rozman, Golnik, Slovenia

11.30-12.00 Management of hemoptysis L-15
Linda Penninx, Amsterdam, The Netherlands

Workshop 12: Hands-on Training on Bio Simulators

12.30-14.30 ESGE Learning Area in the Onyx Lounge

Chairs: Eric Pflimlin & Björn Fehrke, Basle, Switzerland

Hands-on training on bio simulators (pig models) under the supervision of highly experienced tutors. Participants will have the opportunity to perform endoscopic techniques on the following topics:

- Upper GI Bleeding
- ERCP
- Colonoscopy

As participation will be limited, registration will be treated on a first-come-first-served basis. Tickets will be available onsite only – at the entrance of the ESGE Learning Area.

Lunch Session 1: New Techniques & Developments

This lunch session is organised by **ESGENA**

13.00-14.30 Room G 104/105

Chairs: Suzanne Swartz, The Netherlands
Ulrike Beilenhoff, Ulm, Germany

EndoClot- New therapeutic solutions for gastrointestinal Endoscopy
(MIRO-TECH Europe)
Sasha Klein & Mark Tschersich Düsseldorf, Germany

Biofilm, don't let it get to that point in the first palce (Karl Storz GmbH / mtp medical
technical promotion gmbh)
Thomas Makowski, Tuttlingen, Germany
Wilfried Beckmann, Neuhausen, Germany

Olympus ERCP V-system and EXERA III (Olympus Netherlands)
Bronek Bienias, Zoeterwoude, The Netherlands

Lunch Session 2: Bronchoscopy

This lunch session is organised by **Olympus Europa Holding GmbH**

13.00-14.30 Room G 106/107

Chairs: Michael Ortmann, Eric Pflimlin, Peter Grendelmeier, Basle, Switzerland;
Tutors: Ivana Kulfa, Zagreb, Croatia; Ales Rozman, Golnik, Slovenia; Anja Schuster, Hamburg, Germany

Hands-on training on:

- Practice diagnostic bronchoscopy on anatomical models
- Transbronchial needle aspiration, biopsy and BAL: handling and tissue preparation
- Foreign body removal - get the feeling
- Work safely with electrosurgery using different devices
- Other diagnostic and therapeutic applications

Lunch Session 3: Hygiene

This lunch session is organised by **ESGENA**

13.00-14.30 Room G 109

Chairs: Sylvia Lahey, Arnhem, The Netherlands
Enriqueta Hernandez-Soto, Barcelona, Spain

Message from the bottle (Minntech / Opus Medical)
Shane Grivich, UK

Centralized Endoscopy Reprocessing (Steelco Spa)
Christopher Sillet, Italy

How regulations changed endoscope reprocessing (Wassenburg Medical Devices B.V.)
Ronald Wassenburg, Dodewaard, The Netherlands

Posterround I

13.00-14.00 Poster area in front of Topaz Lounge

Chairs:

Jayne Tillett, Bristol, UK
Stanka Popovic, Ljubljana, Slovenia
Hanne Olsen, Copenhagen, Denmark

1. Reusable Sphincterotome : Cleaning validation and monitoring of reuse P-1
Lúcia H L Tomiato (1), Mirtes Leichesenring(2); (1) Gastrocentro-Estatual University Campinas, Campinas, Brazil; (2) Clinics Hospital- Estatal University Campinas, Brazil
2. An orientation program for new nurses admitted in an endoscopy unit P-2
Isabel, Pampulha; Nuno, Pereira; Piteira, Rita. Portuguese Institute of Oncology of Lisbon, Portugal
3. A multi centre study to review how informed consent is implemented into the patients pathway P-3
Jadranaka Brljak (1), Lena Marković (1), G.Jakupčević (2), Jayne Tillett (3), (1) Intervential Gastroenterology, KBC- Zagreb-Rebro,Croatia., (2) KBC- Split, Croatia, (3) Emersons Green NHS Treatment Centre, Bristol ,UK
4. Preparing patients for gastrointestinal endoscopy: the impact of counseling in reducing anxiety P-4
Mattiola R, Chiarioni L, Coppolino M, Lamanna L, Locoro S, Violino I, Puddu D. Digestive Endoscopy, Ospedale Maria Vittoria, Torino, Italy
5. Quasi-experimental study: Comparison of two different nursing interventions in gastroscopy without sedation. P-5
Rosa María García-Sierra, Iolanda Caballero, Raquel Mena, M^aJosé Calero, M^aJosé Esquivá, Nuria Lasheras, Isabel Mayer. Consorci Sanitari de Terrassa, Spain
6. Fluoroscopic guided Percutaneous Endoscopic Gastrostomy Insertion P-6
Krisztina Tari RN (1), Péter Lukovich MD (1), Ibolyka Dudás MD (2), György Herczeg MDS (3), Michael Mamah MD (1), László Harsányi MD (1), 1st Department of Surgery (1), Department of Diagnostic Radiology and Oncotherapy (2), Faculty of Medicine (3), Semmelweis University, Budapest, Hungary
7. Ethical issues surrounding the removal of a Percutaneous Endoscopic Gastrostomy tube P-7
Marie-Claire Pellegrini BSc(hons) Nursing Studies; MA Bioethics (state registered nurse at Mater Dei Hospital, Malta), Faculty of Theology, Bioethics at the University of Malta
8. Hands-on training of application of over the scope clip improves the skills of endoscopic nurses P-8
Jana Folttíný, Ivana Kozáková, Ludmila Bártová, Markéta Hůlová, Pavla Hnátová, Zuzana Černá, Šárka Maříková, Hana Bulířová, Jan Martínek. University Military Hospital, Prague, Czech. Rep.
9. Complications in Interventional Endoscopic Ultrasound (IEUS): The role of the endoscopy nurse P-9
Giulia Provenzano, Mario Traina, Ilaria Tarantino, Luca Barresi, Gabriele Curcio, Gaetano Fazio, Italy

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| 10. | RCT to test the evaluation quality of the PillCam Colon capsule endoscopy by doctors and nurses compared to the expert's evaluation with the involvement of the professional identity of nurses
<u>Ute Pfeifer</u> , Evangelisches Krankenhaus Düsseldorf, Department of Gastroenterology, Düsseldorf, Germany | P-10 |
| 11. | Nutritional status in patients undergoing endoscopic, transmural drainage and necrosectomy for walled-off pancreatic necrosis
<u>Maria Bonde</u> RN, Srđan Novovic MD, Erik Feldager MD, Palle Nordblad Schmidt MD. Department of Gastroenterology, Hvidovre Hospital, Copenhagen, Denmark | P-11 |

SESSION 5: Quality Assurance

14.30-16.00 Room G 104/105

Chairs: Mette Olesen, Copenhagen, Denmark
Jacqueline Caelen, Heerlen, The Netherlands

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|-------------|--|------|
| 14.30-14.50 | Nurses responsibilities with patient preparation before endoscopy
Marianna Kooijman, Haarlem , The Netherlands | L-16 |
| 14.50-15.10 | Team Time Out – A benefit for Endoscopy
Marjon de Pater, Amsterdam, The Netherlands | L-17 |
| 15.10-15.30 | Critical incidence reporting system (CIRS) in Endoscopy / GE
Björn Rembacken, Leeds, UK | L-18 |
| 15.30-16.00 | Coordinator of national colo rectal cancer screening programme – An advanced nurses role
Anita Jorgensen, Skien, Norway | L-19 |

SESSION 6: Hot Topics in Endoscopy

14.30-16.00 Room G 106/107

Chairs: Pilar Perez Rojo, Pamplona, Spain
Suzanne Swartz, Amstelveen, The Netherlands

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| 14.30-15.00 | MultiDrug-Resistant Organisms (MDROs) – 'What do the Dutch do differently?
Annet Troelstra, Utrecht, The Netherlands | L-20 |
| 15.00-15.30 | Children in Endoscopy – A challenge for endoscopists and nurses
Raul Furlano, Basle, Switzerland | L-21 |
| 15.30-16.00 | Non-surgical treatment for type 2 diabetes and obesity
Jürgen Hochberger, Hildesheim, Germany | L-22 |

Workshop 13: Hands-on Training on Bio Simulators

15.00-17.00 ESGE Learning Area in the Onyx Lounge

Chairs: Eric Pflimlin & Björn Fehrke, Basle, Switzerland

Hands-on training on bio simulators (pig models) under the supervision of highly experienced tutors. Participants will have the opportunity to perform endoscopic techniques on the following topics:

- Upper GI Bleeding
- ERCP
- Colonoscopy

As participation will be limited, registration will be treated on a first-come-first-served basis. Ticket will be available onsite only – at the entrance of the ESGE Learning Area.

Posterround II

16.00-17.00 Poster area in front of Topaz Lounge

Chairs: Jayne Tillett, Bristol, UK
Stanka Popovic, Ljubljana, Slovenia
Hanne Olsen, Copenhagen, Denmark

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| 12. | Does a low residue diet improve bowel preparation?
<u>Deirdre Clune</u> , CNM 1, MWRH Ennis, Co. Clare, Ireland | P-12 |
| 13. | Preliminary data on safety, efficacy and tolerability of picoprep based bowel preparation for colonoscopy in IBD patients
<u>Matteo Martinato</u> , Iris Frankovic, Roberta Caccaro, Mirella Scacchi, Roberta Cesaro, F. Marzari, Federica Colombara, Doriana Compagno, Suzanne Judet, Giacomo Carlo Sturniolo, Renata D'Incà. Azienda Ospedaliera - Università di Padova, Padova, Italy | P-13 |
| 14. | Assessment of bowel preparation for colonoscopy: comparison between different tools and different healthcare professionals
<u>Matteo Martinato</u> , Iris Frankovic, Roberta Caccaro, Mirella Scacchi, <u>Roberta Cesaro</u> , F. Marzari, Federica Colombara, Doriana Compagno, Suzanne Judet, Giacomo Carlo Sturniolo, Renata D'Incà. Azienda Ospedaliera - Università di Padova, Padova, Italy | P-14 |
| 15. | Moviprep®Taken at Split Dose Intervals is More Effective Than Single Dose Preparation For to A Morning Colonoscopy: A Literature Review
<u>Jennifer Hewson</u> , University Hospital Limerick, Ireland | P-15 |
| 16. | Assessment of the quality of the unit colonoscopies endoscopies area hospital hospital of Vigo Spain
<u>Mar Rionda</u> , Ana Alonso, Pilar Iglesias, Angela Antunez, Isabel Perez, Immaculate Pardo, David Rodriguez, Esperanza Feteira, Meixoeiro Hospital, Vigo, Spain | P-16 |
| 17. | The right hand for the right press: abdominal press during colonoscopy, experience of a colorectal cancer screening team
<u>Samuele Gallo</u> ¹ , Cristina Magro ¹ , Silvano Sorti ¹ , Violetta Kopczynska ¹ , Corrado Lucchini ¹ , Orfeo Canova ¹ , Silvia Cocchio ² , Vincenzo Baldo ² , Diego Caroli ³ , Erik Rosa- Rizzotto ¹ , Franca De Lazzari ¹ , 1Dpt of Medicine, Gastroenterology Unit, St Antonio Hospital, Padua, ITA, 2Dpt of Molecular Medicine, Laboratory of Public Health and Population Studies, University of Padua, Padua, ITA, 3Dpt of Medicine, Chioggia Hospital, Venice, Italy | P-17 |

18. Illness perception in patients with hereditary colorectal cancer
Kaisa Fritzell, PhD1,2; Lars E Eriksson, PhD2; Jan Björk, PhD1,3; Lena Wettergren, PhD2. 1The Swedish Polyposis Registry, Department of Gastroenterology and Hepatology, Karolinska University Hospital,; 2Department of Neurobiology, Care Sciences and Society, Division of Nursing, Karolinska Institutet,; 3Department of Medicine, Karolinska Institutet, Stockholm, Sweden P-18
19. Sharing nursing experience in Hepatology
Rikke Lænsø Baltzer, RN; Department of Hepatology and Gastroenterology V, Aarhus University Hospital, Denmark P-19
20. Nursing and alcoholic Hepatitis.
Olesen L, Andersen AL, Baltzer R, Staldgaard D & Ladegaard L., Department of Hepatology and Gastroenterology V, Aarhus University Hospital, Aarhus, Denmark P-20
21. Reasons for telephone consultations of patients on treatment for chronic hepatitis C
Maria López-Parra, Laura Moreno-Salas, Angelina Dosal-Galguera, Mercè Vergara, Mertixell Casas, Mireia Miquel, Blai Dalmau, Montserrat Gil, Eva Martinez, Jordi Sánchez, Núria Rudi-Sola, Gema Silva-Riadigos, Isabel Parra, Hospital de Sabadell, Corporació Sanitària Parc Taulí. Sabadell, Spain P-21
22. Assessment of workload and manning levels in endoscopy units
Cinzia Rivara ASL TO4, Davide Cordioli ULSS 22 Veneto, Giorgia Zamboni Policlinico G.B. Rossi AOUI Verona, Daniela Carretto ASL AT Ospedale Cardinal Massaia, Daniela Rigoni ASO San Giovanni Battista Torino, Margherita Caldana Regione Veneto, Italy P-22
23. Hemochromatosis: nursing care in therapeutic blood letting versus blood donation.
Soldevilla de la Esperanza, María del Pilar; Granados-Martín, Mónica; Díaz-Rodríguez, Dania-Rocío; Villanueva-Jiménez, Hospital de Fuenlabrada. Madrid, Spain. P-23

SESSION 7: GE Disease

17.00-18.30 Room G 104/105

Chairs: Marjon de Pater, Amsterdam, The Netherlands
 Irene Dunkley, Huntington, UK

- 17.00-17.20 Hypnotherapy in the management of IBS-patients
 Erna Broers, Amstelveen, The Netherlands L-23
- 17.20-17.40 Nurses role in the care of Celiac patients
 Jadranka Brljak & Marina Premužić, Zagreb, Croatia L-24
- 17.40-18.00 Function tests in Gastroenterology – What they diagnose and how they used in the clinical management of patients
 Jac Oors, Amsterdam, The Netherlands L-25
- 18.00-18.20 Colo rectal cancer Screening in the The Netherlands
 Michiel van Haastert, Groningen, The Netherlands L-26
- 18.20-18.30 Discussion
-

SESSION 8: Education

17.00-18.30 Room G 106/107

Chairs: Jadranka Brljak, Zagreb, Croatia
Christiane Neumann, Birmingham, UK

17.00-17.20	UEG e-learning opportunities in Gastroenterology Lars Aabakken, Norway	L-27
17.20-17.40	Do competencies substitute recognised qualifications? Christiane Neumann, Birmingham, UK	L-28
17.40-18.00	Workshops as an effective training tool - ESGE-ESGENA Handbook on Workshop organisation Ulrike Beilenhoff, Ulm, Germany	L-29
18.20-18.20	Difficult ERCP – what should the nurses know? Michael Ortmann, Basle, Switzerland	L-30
18.20-18.30	Discussion	

5.3 ESGENA-Scientific Programme on 22 October 2012

SESSION 9: New Techniques and Developments in Endoscopy

08.30-10.30 Hall 2.1

Chair Michael Ortmann, Basle, Switzerland
Petra Bol, Utrecht, The Netherlands

Presentation of Major Sponsors

08.30-08.45 Advancing the Art of Endoscopy - EVIS EXERA III
(Olympus Europa Holding GmbH)
John Cobain, Hamburg, Germany

08.45-09.00 Stricture Management: Stress Free Solutions (Cook Medical)
Adrian R. W. Hatfield, London, UK

09.00-09.15 Comparison of GI Clips for Hemostasis of non-variceal GI Bleeding
(Boston Scientific)
Dennis M. Jensen, Los Angeles, USA

09.15-09.30 Up to date on EUS guided technique (PENTAX Europe GmbH)
Gwen Kreitzmann, Tel Aviv, Israel

09.30-09.35 Invitation to the next SIGNEA Conference 2013 in Shanghai
Diane Jones, Queensland, Australia (SIGNEA President)

Scientific presentations

09.35-09.55 PerOral Endoscopic Myotomy (POEM) L-31
Nils Andersen & Thomas Rösch, Hamburg, Germany

09.55-10.15 The development of endoscopy / GE nursing – career options L-32
Diane Campbell, Torbay, UK

10.15-10.25 **Best Free Paper and Best Poster Award (sponsored by PENTAX)**
Michael Ortmann, Basle, Switzerland
Petra Bol, Utrecht, The Netherlands

10.25-10.30 **Invitation to the next ESGENA Conference 2013 in Berlin**
Ulrike Beilenhoff, Ulm, Germany
Sigrun Kauertz, Dortmund, Germany

5.4. UEG Week Postgraduate Teaching Programme

The UEG Week Postgraduate Teaching Programme is the preeminent Continuing Medical Education opportunity in Europe for Medical and Surgical Gastroenterologists. It caters for both established practitioners and trainees.

The congress offers a full two-day Postgraduate Programme on Saturday and Sunday incorporating gastroenterology, hepatology, endoscopy, surgery, imaging and other diagnostic modalities. Participants need to purchase a "passport" to move around the various options that will be running in parallel to allow them to "pick'n mix" according to their needs and interests. Full registration for the congress is not required. ESGENA delegates have full access to the UEG Week Postgraduate Teaching Programme.

Saturday, October 20, 2012

	Hall 4/5	Elicium 2	Auditorium	Elicium 1
09.00 h – 10.30 h	Management of GI and liver emergencies			
11.00 h – 13.00 h	Live endoscopy	Case-based update on management of viral hepatitis	Nutrition in IBD and other GI disorders	Fistulizing Crohn's disease
14.00 h – 16.30 h	Live endoscopy	Hepatocellular carcinoma	Characterising and managing IBD today	Management of pancreatic and biliary cancer

Sunday, October 21, 2012

	Hall 4/5	Elicium 2	Auditorium
08.30 h - 10.30 h	ERCP update	Alcohol and liver disease	Modern medical and surgical management of difficult GORD
11.00 h – 13.00 h	Colonoscopy challenges	What is new and what is controversial about NAFLD?	Assessment and treatment of motility disorders: Medical and surgical issues
14.00 h – 16.00 h	The multidisciplinary approach to morbid obesity		

Tuesday, October 23, 2012

	Hall 4/5
08.30 h - 10.30 h	Live endoscopy
11.00 h – 12.30 h	Live endoscopy

5.5. ESGE Live Endoscopy



On Saturday, October 20, during the Postgraduate Teaching Programme and on Tuesday, October 23, live demonstration sessions will be broadcast from the Academic Medical Center (AMC).

With Professor Paul Fockens and Jacques Bergman as Course Directors, international experts will perform and comment live procedures. The live video demonstrations are moderated on-site by a team of speakers, and accompanied by short talks relating to the procedures shown.

Saturday, October 20, 2012

11.00 – 13.00 **Hall 4/5**
Chair: Paul Fockens, Netherlands; Horst Neuhaus, Germany

14.00 – 16:30 **Hall 4/5**
Chair: Jacques Bergman, Netherlands, Guido Costamagna, Italy

Tuesday, October 23, 2012

8:30 – 10.30 **Hall 4/5**
Chair: Lars Aabakken, Norway; Todd Baron, USA

11.00- 12.30 **Hall 4/5**
Chair: Pierre Deprez, Belgium; Rob Hawes, USA

5.6. ESGE Learning Area

At the ONYX Lounge



Hands-on Training Centre

On Saturday and Sunday, with access to state of the art endoscopic equipment and accessories, participants will have the opportunity to perform techniques under personal doctor and nurse tutoring. In cooperation with ESGENA, the aim of this activity is to increase the awareness of diagnostic and therapeutic techniques and to offer delegates the possibility of practicing their skills.

Registration: Registration starts at the ESGE desk within the Learning Area on Saturday at 10.00 am. Participation will be on a first-come-first-served basis. To maintain a high standard of teaching each workstation is limited to a maximum number of participants.

From Monday to Wednesday, the Hands-on Training Centre is open on a walk-in basis. Haemostatic techniques, advanced GI endoscopy, radiofrequency ablation techniques on Barrett's oesophagus and laparoscopic as well as endoscopic simulator training can be practiced on biologic models.

All delegates are invited to visit the Learning Area at any time and participate in the open hands-on sessions with doctor tutoring. Please also refer to the on-site schedule in the Learning Area for more details.

ESGE DVD Learning Centre

The DVD Learning Centre offers all delegates the opportunity to view the latest teaching material on video screens with headphone sound transmission. Case studies from the ESGE DVD Encyclopaedia are complemented by select video submissions from ASGE. This offering is ideal for individual study and special interest.

ESGE Lecture Theatre

In the ESGE Lecture Theatre highly qualified and uprising young endoscopists have been invited to present their views and experience with current endoscopic procedures and techniques. Their counterparts in discussion are well-known, more senior specialists. The number of participants is limited to 70 in order to ensure a small-forum atmosphere where active participation is possible.

Sunday, Oct 21, 2012

10.00 – 10.30	P. Familiari, Italy I. Aabakken, Norway	SEMS in the bile duct: when and how?
12.30 – 13.00	G. Terheggen, Germany P. Deprez, Belgium	Barrett's esophagus: should we treat before or after dysplasia?
13.30 – 14.00	C. Hassan, Egypt R. Bisschops, Belgium	Intestinal metaplasia and dysplasia in the stomach: can we replace biopsies?
14.30 – 15.00	J.-C. Saurin, France A. van Gossum, Belgium	Small bowel polyps: how to manage?

Monday, Oct 22, 2012

10.00 – 10:30	A. Bredenoord, Netherlands H. Inoue, Japan	POEM in achalasia treatment: what is the current role?
11.30 – 12.00	J. van Hooft, Netherlands J. Deviere, Belgium	Colonic stenting: how is it done?
12.30 – 14.00		ESGE General Assembly
14.30 – 15.00	J. East, UK J. Regula, Poland	In situ diagnosis of colonic polyps: can we be sure? Can we really discard them?
15.30 – 16.00	M. Manno, Italy H. Yamamoto, Japan	Enteroscopy: SBE, DBE or spiral?

Tuesday, Oct 23, 2012

10.00 – 10.30	M. Häfner, Austria P. Siersema, Netherlands	Benign esophageal strictures: inject, dilate, stent?
11.00 – 11.30	T. Matsuda, Japan T. Ponchon, France	Management of colorectal adenomas: how far should the endoscopist go?
12.30 - 13.00	C. Rolanda, Portugal S. van der Merve, South Africa	Endoscopic closure of perforations: what do we have? What do we use?
13.30 - 14.00	I. Hritz, Hungary E. Kuipers, Netherlands	Endoscopy and bleeding peptic ulcer: what are the standards? What is new?
15.00 – 15.30	I. Mostafa, Egypt M. Bruno, Netherlands	Gastric variceal bleeding: How do I stop it?

Wednesday, OCT 24, 2012

10.00 – 10.30	L. Lopes, Portugal P. Fockens, Netherlands	Difficult biliary canulation: how to manage it?
11.00 – 11.30	J. Iglesias-Garcia, Spain M. Giovannini, Italy	EUS guided biliary drainage: ready for prime time?
12.00 – 12.30	O. Pech, Germany H. Neuhaus, Germany	Complications after gastric ESD: can we predict them? How to treat?

6. Abstracts

6.1. Oral Presentations On 21-22 Oct. 2012

Session 1: Free Paper Session I

L-1

Quality improvement of outpatient services for patients at NKC Institute of Gastroenterology and Hepatology

Siriporn Ratanalert RN*, WanpenPinyopasakul PhD**, Sopa Boonviriyaya RN*, Varaporn Senapitakkul RN*, Sulee Saengnil RN*, Ruankwan Pongprayoon RN*, *NKC Institute of Gastroenterology and Hepatology, Songklanagarind Hospital, Thailand.

**Faculty of Nursing, Mahidol University Thailand.

Introduction: The outpatient endoscopy unit at NKC institute, Thailand aims to provide excellent treatment and care for patients. Lean management program has been introduced to reduce total turnaround time for outpatient service.

Aim: The purpose of the study was to examine the average total turnaround time for endoscopic investigation and treatment, and to develop strategies to reduce waiting time for these patients.

Method: This study was conducted at the NKC institute from October 2011 to February 2012. The samples comprised 472 persons attending outpatient services. Data collection began by examining routine care and an average total turnaround time of patients prior to implementing lean management strategies¹. A lean management program was then initiated. Strategies in this program included establishing communications between a nurse manager and four physicians to gain cooperation with regard to service and time management. Supporting staff were also introduced with lean concepts² and given opportunity to visit other outpatient units to gain experiences of outpatient work flow management. On completion, total turnaround time was recorded post implementing lean management for each physician. Data were analyzed by using frequency and percentage to reveal the overall average total turnaround time and also the average total turnaround time for each physician.

Results: Results showed that before introducing lean management, the average total turnaround time of patients undergoing all ambulatory endoscopy procedures (n = 30) was 143 minutes with efficiency at 23.08 %. For post- lean management, the average total turnaround time of these patients (n = 472) was 49.2 minutes. The average total turnaround time slightly varied in each physician, ranging from 51.16, 43.3, 46.5, and 56.0 minutes, respectively. The time reduction measured among these physicians yielded efficiency at 26.07 % to 35.85 %, with the overall efficiency post lean management at 30.28 %.

Summary: This study demonstrated that the use of lean management in the endoscopy care process could reduce total turnaround time for patients at outpatient services.

Conclusion: Lean management could be integrated into routine care as part of the quality improvement strategies so as to reduce total turnaround time for outpatients attending the endoscopy unit.

Learning Outcomes

Quality improvement initiative using a lean concept may maximize efficiency of outpatient care service in endoscopy unit.

References

1. Mazzocato P, Savage C, Brommels M, et al. Lean thinking in healthcare: a realist review of the literature. *Qual Saf Health Care*. 2010; 19(5):376-82.
2. Supachutikul, A. New HA standards: Concept and overview. Paper presentation in 9th HA National Forum, March 11-14, 2008 at Impact Arena, Thailand. 2008.

L-2

Developments in endoscopy nursing in New Zealand – A vital component of a whole service quality improvement program

Jennifer Masters National Endoscopy Service Improvement Lead. Capital and Coast District Health Board & Ministry of Health, Wellington: New Zealand.

Background: In 2010 the New Zealand (NZ) Ministry of Health (MoH) created the role of National Endoscopy Service Improvement Lead (NESIL). This sector based, MoH funded nursing position is to investigate, develop and centrally drive a quality improvement programme (QIP) in endoscopy services in NZ. This work is being conducted in conjunction with the National Clinical Lead GI Endoscopy (NCL), a medical appointment. NESIL is a unique role within nursing, endoscopy and the wider health services in NZ. After visiting every endoscopy unit nationwide these two leads produced a baseline "DHB Endoscopy Services Summary Report" in July 2011. The report highlighted the wide variation in the way endoscopy services are structured and delivered. In particular the report recognised the quality of endoscopy nursing varied greatly across the country including poor recognition of endoscopy nursing as a specialty, few refined endoscopy-based competencies for endoscopy and ad hoc development of senior nursing roles (MoH, 2011).

Aim: The aim is to have every unit in NZ providing a high-quality, patient-focused service after the report suggested a planned approach to improving the quality of endoscopy services in NZ. As well as addressing issues at a Unit level, the plan included optimising the performance of individual staff, both medical and nursing, and refining training and assessment.

Method: A development trial of a validated quality assurance system known as the Global Rating Scale (GRS) was recommended. The UK GRS standards were adapted to meet the NZ environment by an expert NZ working group. A twelve month development trial of the NZ GRS began in four trial sites in August 2011. The sites underwent an initial baseline self-assessment against the GRS standards and completed a six month assessment in April 2011.

These results were up loaded onto the NZ GRS website by each site and followed by a visit from the two national leads to discuss and plan further quality improvement. On-going support has been given to each

site to assist with service improvement throughout the trial. One of the domains of the GRS (Workforce) looks primarily at the nursing staff and is the focus of this presentation.

Results: At the six month census there have been improvements in four of the five measures in the Workforce domain: 'Skill mix', 'Orientation and Training', 'Staff are cared for' and 'staff are listened to'. The only measure that has remained unchanged is 'Assessment and Appraisal'. This can be attributed to the lack of agreed national competencies specific to endoscopy nursing in NZ. Other results of the QIP include identifying nurse leaders around NZ, developing communication and sharing of knowledge between hospitals and between public and private and raising the profile of endoscopy nursing within hospitals and nationally.

Nursing Council of New Zealand (2009) describe competence as the combination of knowledge and skills, attitudes, values and abilities that underpin the performance of a nurse. With this understanding the NESIL successfully negotiated with the MoH Health Workforce NZ to fund the development of an endoscopy nursing knowledge and skill framework (EKSF) for NZ. This work was led by an experienced nurse with significant engagement from the wider public and private endoscopy nursing workforce.

Conclusions: The trial continues until August 2012 where the sites will complete another GRS assessment. The EKSF will be incorporated into the quality improvement work being undertaken by the NESIL and implemented nationally alongside the wider QIP (including GRS) program in 2013 - 2014.

Learning Outcomes:

1. Understand the drivers, processes and pathway for collaboratively developing the EKSF in NZ
2. Understand of how nursing fits into and is vital to a wider patient focused QIP.

References:

- Ministry of Health. (2011). DHB endoscopy services summary report. Ministry of Health. Wellington: New Zealand
- Nursing Council of New Zealand. (2009). Competencies for Registered Nurses. Nursing Council New Zealand

L-3

Establishing Nurse Endoscopist Training in Australia

Dianne Jones, Elizabeth Shepherd. Logan Hospital, Queensland, Australia.

Introduction: The expansion of nursing roles to encompass performance of endoscopy procedures has occurred in several countries over the past 2 decades. Impetus for that role expansion has largely been due to workforce shortages or the availability of medical endoscopists. The role is well established in the United Kingdom and is supported by a well-defined training program in that country. Australian healthcare is undergoing workforce reform in an endeavour to meet the health care needs of the ageing population whilst in a period of workforce shortage. The introduction of an advanced nursing role to assist with the workload of endoscopic procedures is proposed within the reform agenda and is being funded as a pilot program with a view to national implementation.

Aims and Objectives: The Logan Hospital developed a proposal to submit for funding to develop the training program. That bid was accepted. The overarching theme of the training program being developed is that any program for training of nurse endoscopists will be successful in production of competent and safe endoscopists and will also prepare the nurse for the independent practice role of a nurse practitioner.

Method: Funding from the federal government is being provided to develop a structured training program. The Logan Hospital proposal incorporates initial training at the Queensland Health Skills Development Centre as a preparatory stage for endoscopists. The enhancement of learning to the competence level that has been obtained from this simulation training will be separately researched. Initial training will be measured by validated metrics and ongoing procedure skills acquisition recorded on Direct Observation of Procedure Skills (DOPS) documentation. Theoretical components include validated modules from tertiary education centres. An online e-portfolio and log book will be used to record all procedures performed by the trainee and will allow evaluation of training progress by the Project Lead / Trainers. Evaluation will be ongoing and includes measurement of Key Performance indicators (KPI's), Patient surveys and trainer feedback.

Implementation: The training program as developed will be suitable for application across disciplines. For universities offering nurse practitioner programs, it is hoped that this course will constitute the requirements of the NP internship.

Conclusion: Expansion of nursing roles in gastroenterology is a strategy to address the current long waiting lists for endoscopic procedures. It is expected that this advanced nursing practice role will be assimilated into our public healthcare system and become a valuable member of the team.

L-4

Percutaneous Endoscopic Gastrostomy nurse first assist: The New Zealand experience

Jacqueline Watkins, University of Auckland, Counties Manukau District Health Board. Auckland, New Zealand.

Introduction: Percutaneous endoscopic gastrostomy (PEG) is a common technique for enteral feeding. Normal practice comprises two roles: endoscopic and surgical. Nurses have taken on the expanded surgical role of PEG first assist as safely as doctors (Gerred, Watkins, Bank, & Haque, 1998; Patrick, Kirby, McMillion, DeLegge, & Boyle, 1996; Sturgess, O'Toole, McPhillips, Brown, & Lombard, 1996). National guidelines and an education package for PEG nurse first assist were developed (New Zealand Nurses Organisation, 2004).

Aim: The aims of this Master of Nursing research study were to investigate the prevalence of nurse first assist in Percutaneous Endoscopic Gastrostomy (PEG) placement in New Zealand hospitals and the attitudes and current practice of medical and nursing staff involved in this procedure.

Methodology: National ethics approval was obtained and the study was divided into two parts. (1) An audit of practice related to insertion of PEG was sent to charge nurse managers of units listed in the New Zealand

Gastroenterology Nurses database. (2)A postal questionnaire to measure the attitudes, education and experience of doctors and nurses undertaking PEG placement was distributed by charge nurses identified in the audit.

Results: The audit of New Zealand endoscopy units (response rate 68%) revealed that PEG placement is almost exclusively carried out in public hospital as expected in a predominantly publically funded health system. PEG nurse first assist is reported in 52% of units and is more than twice as common in gastroenterology and endoscopy units as in theatre suites. The majority of PEGs (60%) are placed in a small number (26%, n=5) of large hospitals however a large number of small hospitals (42%, n=8) undertake a less than ten procedures a year. This may have implications for education and competency. The questionnaire (response rate 42%) demonstrated a lack of clarity regarding the definition of PEG nurse first assist with 48% of nurses never inserting the trocar for PEG placement. Nurses have a greater involvement in post procedure patient care, especially patient education. Health professionals in the study believed that formal education was important however practice demonstrated that informal 'on the job' preparation was prevalent. Attitudes of both doctors and nurses are positive with regard to the safety of PEG nurse first assist as well patient acceptance, planning of lists and enhancement of patient care.

Recommendations: (1) Develop a training program for PEG nurse first assist which consolidates theoretical knowledge with practical skills simulation training. (2) Establish a PEG first assist support group in order to disseminate knowledge and provide peer support particularly for small rural hospitals.

References:

- Gerred, S., Watkins, J., Bank, R., & Haque, M. (1998). *Nurse-assisted Insertion of Percutaneous Endoscopic Gastrostomy Tubes: The Middlemore Experience*. Paper presented at the New Zealand Gastroenterology annual scientific meeting, Palmerston North, New Zealand.
- New Zealand Nurses Organisation. (2004). Self-Directed Learning Package: Registered Nurse First Assist for the placement of percutaneous endoscopic gastrostomy tubes (PEG) in endoscopy suites in New Zealand Retrieved 8 August, 2007, from <http://www.nzno.org.nz/LinkClick.aspx?fileticket=NaxPe3EhtC4%3d&tabid=358>
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- Sturgess, R. P., O'Toole, P. A., McPhillips, J., Brown, J., & Lombard, M. G. (1996). Percutaneous endoscopic gastrostomy: evaluation of insertion by an endoscopy nurse practitioner. *European Journal of Gastroenterology & Hepatology*, 8(7), 631-634.

Session 2: Emergency Management in Endoscopy

L-5

Management of GI Bleeding – a structured training programme

Eric Pflimlin, Basle, Switzerland
Abstract not submitted

L-6

“Out of hours - Absolute indications for emergency endoscopy ...or: when to call GI at 3 a.m.”

Ingo Mecklenburg, Basle, Switzerland

Most of us are frequently engaged on-call for the emergency service of the endoscopy unit. The 24 hour accessibility of an experienced endoscopy team is a pivotal function of any large scale hospital and is vitally important for the rapid and effective treatment of gastrointestinal bleeding. However, many “emergency examinations” reveal a subsided or non-active bleeding source and only minorities of patients require an immediate endoscopic therapy. In many cases, endoscopy could safely be postponed and performed electively or as an out-patient. Therefore, the night-time gastroenterological assessment on-call to discriminate life-threatening diseases (like variceal bleeding or active ulcer bleeding) from more benign conditions (e.g. bleeding from gastrointestinal reflux or Mallory-Weiss tears) is challenging.

Various scoring systems have been described for the initial evaluation of gastroenterological patients. Several prognostic markers can be applied for a risk-stratification of emergency patients and can be of valuable help, not only for beginners or less experienced colleagues.

The talk will highlight the most common scores and strategies for the initial assessment of gastroenterological patients in the emergency room. This approach may provide assistance for an appropriate timing of endoscopy (immediate vs. scheduled endoscopy) and for a reasonable triage of patients (ICU vs. IMC monitoring). A responsible risk-stratification should improve patient care without enforcement of dispensable invasive procedures or inadequate waste of personal resources.

L-7

GI Foreign Body & Food Bolus Overview & Retrieval Management

Sylvia Lahey, Rijnstate Hospital, Arnhem, the Netherlands

Introduction: Endoscopy is useful in the clearance of retrieval of foreign bodies and food bolus impactions, which is accomplished by different endoscopic accessories that are passed through the endoscope. About **80 to 90%** of foreign bodies will pass on their own and will not require any medical intervention, while about **10 to 20%** of foreign bodies will require a doctor, to evaluate the situation with an endoscope and remove the foreign body using a grasper or with a net. Less than **1%** of cases will require surgical intervention.

Foreign body and food bolus impaction

In the pediatric population, children younger than 5 years are most commonly affected. Balloons, balls, and small parts are the most commonly aspirated items. Food, particularly hot dogs, sausages and peanuts are frequently aspirated by children. Other objects include buttons, pen or bottle caps, rubber or plastic materials, marbles and disk batteries.

Unintentional foreign bodies in the adult population are most frequently occur in patients with diminished mental capacity, for instants like demented people or people who are under the influence of alcohol, they often present themselves to the Emergency Room. Many of intentional foreign body ingestion occur in patients suffering from some type of psychiatric disorder. Food Bolus Impactions can occur in both children and adults. They may occur as the result of under chewing food or perhaps not chewing the food at all, this is frequently seen in toothless adults. It is most frequently seen and associated with those patients that have some degree of underlying esophageal pathology; whether the condition is known by the patient or not. People with narcotic packets are often referred to body packers or 'mules' and is seen in regions with high drugs traffic. They often present to the Emergency Room. Many or most foreign bodies are radiopaque, that means that they will show up on an X-ray. Wood, plastic and glass, fish and chicken bones can not be seen on X-ray. Proximal esophageal impaction, whether by a true foreign body or a food bolus, universally brings about symptoms like drooling, dysphagia, odynophagia, respiratory symptoms like stridor.

Risk Management: There are many risks and complications associated with esophageal foreign body and food bolus cases. Aspiration, the inability to handle oral secretions, infection, bleeding, erosion at the site of lodging, tracheoesophageal, bronchoesophageal, aortaesophageal fistula formation and perforation have also been reported. All of these potentially serious complications can occur, if endoscopic intervention is delayed. Gastric and Duodenal risks and complications can include caustic injury, bleeding, gastric outlet obstruction, perforation and infection.

The choice of sedation or general anesthesia with endotracheal intubation, is important for patient safety and should be considered in the management of a patient with a foreign body or food bolus based on the type of item being retrieved, patient age and patient condition

Methods: Before you start a procedure you need to have all the devices available. It is important that you are familiar with the equipment. Stay updated on the latest techniques and accessories. Keep abreast of technology reports. There are several foreign body retrievals like retrieval nets, overtubes, retrieval baskets, polypectomy snares, different forceps and a foreign body protector hood. If the patient's airway is not protected by an endotracheal tube then the risk of aspiration is a concern, if the foreign body or food bolus is every lost during extubation. While intubation or the use of an overtube can prevent this occurrence, it presents potential for injury or perforation of the esophagus.

Conclusion:

- Endoscopic retrieval is a tricky business that requires decision making and technical skill
- Foreign Body and Food Bolus removal requires risk management
- Protection of the patient's airway is *critical*
- Be prepared for "anything"
- Equip your facility with all the retrieval devices you may need

References:

Guidelines for management of ingested foreign bodies, Gastrointestinal Endoscopy. Volume 55, no.7 2002. Endoscopic retrieval devices, Brenna C. Bounds

Session 3: Free Paper Session II

L-8

A beneficial experience of an information day for patients with familial adenomatous polyposis and their relatives

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Introduction: The Swedish Polyposis Registry is a national competence center for patients with polyposis syndromes such as familial adenomatous polyposis (FAP). FAP is a rare hereditary condition with high risk of gastrointestinal cancer (1). In Sweden approximately 350 persons are currently living with the syndrome, a prevalence of 35 per million (2). The national guidelines include recommendations of removal of the colon (ileorectal anastomosis, IRA), or the colon and rectum (ileal pouch anal anastomosis, IPAA, or ileostomy) at age 18–20, followed by a lifelong endoscopic screening program (1). The outpatient clinic affiliated to the Swedish Polyposis Registry provides care for approximately 25% of all FAP-patients in Sweden. The primary catchment area is Greater Stockholm, with a population of approximately two million, whereas health care for most of the remaining FAP patients in Sweden is provided by hospitals in the patients' county council. Although FAP is a rare and complex disease that involves extensive surveillance guidelines to prevent cancer, care for patients in Sweden varies and is not always provided by specialized health care providers.

Objectives: Our registry staff identified a great need for more information about FAP from the large number of e-mails and phone calls reaching us from patients throughout the country asking for advice. In order to provide information about FAP to patients and families who do not attend our clinic, in addition to those that do, as well as give people an opportunity to share experiences with others who are dealing with similar struggles an Information Day was planned.

Results: The first Information Day for patients with FAP and their relatives was held at Karolinska University Hospital in 2008, since then two more Information Days have been held. In average 80 persons from all over the country attended each information day. Based on the opinion of the participants the program has been modified over time. Examples of lectures that have been given are: FAP overview, anatomy, surgical options, genetics and genetic testing, research, pre-implantation genetic diagnosis, and how to communicate difficult issues with children. In addition to lectures the information days have included workshops such as: people share experiences, presentation of the Swedish Polyposis Registry, endoscopy – an opportunity for patients and relatives to test their skills on dummies.

Conclusion: The completed evaluation sheets proved the value of the days; the talks received high marks and comments included: "although I consider myself fully informed about FAP, I learn something new about the

disease every information day”; “it is so valuable for me to meet other persons with similar concerns”.

Summary: The success of the days far exceeded our expectations and the goal is to make it an annual event. However, although participants come from all over Sweden to attend the information day, it would be beneficial for persons living far from Stockholm if the Information day could be held in other parts of the country as well.

References

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2. Björk J, Åkerbrant H, Iselius L, Alm T, Hultcrantz R. Epidemiology of familial adenomatous polyposis in Sweden: changes over time and differences in phenotype between males and females. Scand J Gastroenterol.1999;34(12):1230-5

L-9

Results of a regional, nurse led inflammatory bowel disease (IBD) telephone helpline audit

Patterson Deborah, Houston Yasmine, Rawle Maxine, Rook Lisa for Yorkshire/Humber IBD Nurse Network, UK

Introduction: Nurse led Telephone Helplines provide rapid access to specialist advice in line with United Kingdom (UK) IBD Service Standards (C2) (IBD Standards Group 2009). Patients consider them central to an IBD service (Carter et al 2004). The authors report on an audit of Helplines in 9 hospitals across the Yorkshire/Humber region.

Aims/Objectives: To quantify Helpline activity: who calls and why, time spent on related activity along with associated cost benefits and financial consequences of not having this service.

Method: Each site captured data for Telephone Helpline activity on a proforma during February 2012, data then entered onto central spreadsheet for analysis.

Results

1187 helpline calls recorded (72-289 per site).

See table 1-3

- Busiest day : Monday
- 60% calls lasted <5 minutes, 38% 5-15 minutes, remainder >30 minutes.
- 79% calls needed <15 minutes follow up activity, 2% >30 minutes to complete.
- If no Helpline, 41% callers would see General Practitioner (GP).

Summary: Slightly more callers were female, had Crohn’s disease (Table 1) and were aged 26-35 but Helplines used by both sexes and all conditions/ages. 66% of calls were related to disease management and medication (Table 2). Main intervention (Table 3) was disease and medication advice +/- treatment change, arrangement of tests and results’ discussion. Majority (78%) were dealt with independently by IBD Nurse Specialist without medical involvement. 198 calls were administrative, not requiring clinical input, with potential to filter out. UK tariff for ‘non face to face’ consultations = £23.00. Across 9 sites, between 25 -75% of calls were chargeable, earning £1012 - £1932 for this period. 3 Trusts not charging may have lost up to £28,000 per year.

Conclusions: IBD Nurse Helplines are a well-used resource, generating income and achieving cost

savings by preventing out patient /GP appointments and ensuring rapid access to expert advice & treatment. Helpline activity represents a significant proportion of IBD nursing time and needs timetabling accordingly with educational support to ensure a high quality service. Those not charging might reconsider as monies earned could be ploughed back into patient care.

References

1. IBD Standards Group (2009) Quality Care Service Standards for healthcare of people who have IBD <http://www.ibdstandards.org.uk/>
2. Carter et al (2004) Guidelines for the management of IBD in adults, Gut 2004;53

Learning Points

- (1) IBD Nurse Helplines can be both cost saving and income generating
- (2) Non medical prescribing qualification desirable as many calls require medication advice/treatment change

Table 1: Caller : Diagnosis/Gender

	M	F
Crohns	257	355
Ulcerative Colitis	218	243
Indeterminate Colitis	25	45
Microscopic Colitis	1	14
Unknown diagnosis	14	15

Table 2: Calls : Reason

	%
Disease management	44
Medication	22
Administration	16
Results	10
Other	8

Table 3 Action Taken

	%
Disease management/advice	18
Medication information	15
Administration	15
Urgent Appointment	8
Repeat Prescription	8
Results discussed	7
New/Change of treatment	7
Book tests	6
Refer to other Professional	6
Admit	2
Other	8

L-10

Evaluation of a Nurse-led contact-phone service for patients with cancer in the GI-tract or the HPB area

Reidun Gustavsen, Anne Rita Melvold, Solveig Zerener and Turid Heiberg. Division of Cancer Medicine, Surgery and Transplantation, Oslo University Hospital, Oslo, Norway.

Introduction: Patients with cancer need help to cope well with physical, mental and social challenges caused by the disease. Many challenges arise between appointments at the referral centre. These challenges often call for specialized competence. Patients had previously the opportunity to return to the clinic without a new referral. This opportunity was removed and replaced by a contact phone which was managed by nurses.

Objective: To describe and summarize 4 months of the contact-phone service, with respect to the number of patients with cancer in the GI-tract or HPB area, individual use/gender differences, number of calls, duration and reported benefit.

Method: A card with an open invitation to use a nurse-led contact phone for questions was given to all patients with cancer in the GI-tract or HPB area who had an appointment at the tertiary gastro referral centre. To evaluate this specialized service, the use of the contact phone was registered over a period of 4 months (January-April 2009). The number of patients, gender, age, individual and total call times, and the nature of the inquiry were registered. We also recorded when the phone call led to an appointment with the nurse and we recorded spontaneous feed-back from patients

Results: 87 patients (females/males 41/46, mean (SD) age 63.0 (13.6) years) each made 1-16 calls, giving a total of 263 calls. The total time spent on each patient varied from 5 to 510 minutes (mean (SD) 70.3 (84.0) including follow-up calls and follow-up appointments. In total 92.75 hours were spent on this activity during the 4 months. Males called more frequently than females, but females' calls lasted longer. 31 of the patients made 1-6 appointments with the nurse, giving a total of 46 consultations, of which 39 were carried out at the outpatient clinic and 7 visits were made to hospitalized patients upon request, each lasting from 10 to 40 minutes. In total 21.08 hours were used to these appointments in the department during the four months. The calls addressed a broad variety of issues. Among these were: information on treatment and preparation for surgery, postoperative symptoms, nutritional advice or how to cope with altered bowel movements, pain, anxiety in general and also in relation to planned specific procedures, and help to contact primary care, hospital or palliative care. Patients expressed gratefulness when given this opportunity, and they referred to the nurse-led contact phone as a notable improvement in health care and a feasible and easy-access option. Cost-effectiveness has been shown with similar interventions. (1)

Conclusion: Contact phone for specialized support and advice is an easy-access and dedicated service to help patients with problems between appointments at this tertiary gastro referral centre. (2)

Summary: Patients who require help to cope well between consultations at the referral centre need

support from nurses with specialized competence. This service was highly relevant and appreciated by the patients.

Learning outcomes:

- The structure of the use of the nurse-led contact phone
- The types of challenges that patients face between consultations.

References

1. Sack C, Phan VA, Grafton R, et al (2012) A chronic care model significantly decreases costs and healthcare utilisation in patients with inflammatory bowel disease. *J Crohns Colitis* 6: 302-310
2. Strom M, Marklund B, Hildingh C (2009) Callers' perceptions of receiving advice via a medical care help line. *Scand J Caring Sci* 23: 682-690

L-11

Dutch nurses consultation visits for the treatment of patients with faecal incontinence or constipation

J.Koeleman RN, Cristel E. Conradie-Kousbroek RN, Joke Groot Ph, Arjan Visscher MD, Richelle J.F. Felt-Bersma MD, PhD. VU Medical center, Amsterdam, The Netherlands

Introduction: Faecal incontinence is defined as the involuntary passage of faeces through the anal canal (1). A prevalence of 2-7% of this condition is seen in the general population (2). At the Vu Medical Center in Amsterdam special consultation visits are held for patients with faecal incontinence or constipation who mostly have ongoing complaints, and still need specific attention or guidance. These consultations are lead by a nurse and a physiotherapist who specializes in pelvic floor muscle strengthening.

Aim/ objective: Our aim with these nurse-led consultations was to reduce the physical, emotional and social problems that faecal incontinence and constipation cause. We aimed to instruct patients on healthy bowel habits and to aid in medicinally changing the consistency of the stool.

Method: All patients were first assessed by a gastroenterologist. The patients were asked to complete and maintain a defecation journal. During the consultation visit the use of laxatives were adjusted and adapted for individual needs. Patients were educated on the use of fibre and nutrition, the correct posture for defecation and defecation habits in general. Exercises to strengthen and relax the pelvic floor muscles in order to improve incontinence and constipation were promoted.

Results/ findings: Between November 2010 and April 2012 seventy-eight patients were assessed. Twenty-six patients agreed to participate and they all completed a pre- and post intervention questionnaire. 65% of all patients felt an improvement after the intervention, 35% felt no improvement and 0% had worsening of their problem. Follow-up data revealed that non-compliance and anxiety were the main reasons for therapy failure.

Conclusions: Improvement of the overall quality of life can be achieved by special nurse-led consultancies. Almost two-third of our cohort experienced improvement after the intervention.

Learning outcomes: Complaints were improved by giving extra attention, physical therapy and the use of

fibres/laxatives. For this group of patients nurse-led consultancies are beneficial.

References:

1. Johanson JF, Lafferty J. Epidemiology of faecal incontinence: the silent affliction. *Am J Gastroenterology* 1996; 91:33-6
2. Haylen BT, de Ridder D, Freeman RM et al. (IUGA)/International Continence Society (ICS) joint report for the terminology for female pelvic floor dysfunction. 2009; 21:5-26

L-12

The effect of aroma oil inhalation on nausea, vomiting, abdominal discomfort and compliance in preparation for colonoscopy

LEE, E. J. Asan Medical Center, Seoul, Korea

Introduction: The purpose of this study was to examine the effects of Aroma oil Inhalation on Nausea, Vomiting, Abdominal discomfort and Patient Compliance during preparation using PEG solution(4L) for Colonoscopy.

Aims & Methods: The research design was a nonequivalent control group post test design. The data were collected from June 2011 to August 2011. The subjects of this study were 152 people who had undergone colonoscopy in a medical center located in Seoul. They had symptoms of nausea, vomiting, abdominal discomfort during preparation using large volume polyethylene Glycol Electrolyte solution (4L) for Colonoscopy. 152 subjects were divided into Aroma oil Inhalation group (77) and control group(75). Aroma therapy was applied to inhalation of an aroma necklace using 1drop of peppermint and 4drops of lavender during drinking PEG solution (4L). However, the control group did not receive any intervention during study periods.

The research tools used INV(Index of Nausea, Vomiting) for Nausea, vomiting and VAS(Visual Analogue Scale) for abdominal discomfort. The compliance was calculated with total time of drinking PEG solution. The data were analyzed with SPSS WIN18.0 program using frequency, percentage, x2-test and t-test.

Results & Summary: The Nausea of the experimental group and control group showed significant difference. There were significant differences between 2 groups in Nausea; incidence of nausea ($t=2.497, p=.014$), duration of nausea($t=4.299, p=.000$), discomfort due to nausea($t=4.808, p=.000$). The experimental group and control group showed no significant differences in vomiting; incidence of vomiting ($t=-0.537, p=.592$), amount of vomiting($t=1.070, p=.286$), discomfort due to vomiting ($t=.648, p=.518$). The experimental group and control group showed no significant differences in abdominal discomfort; abdominal distension ($t=1.289, p=.199$), abdominal pain ($t=1.621, p=.107$). The experimental group and control group showed no significant difference in patient compliance ($t=1.801, p=.074$).

Conclusion: The findings of this study showed aroma oil inhalation were effective for nausea during preparation using large volume PEG solution for Colonoscopy.

Preference in preparation method for next colonoscopy was 81.8% among aroma oil Inhalation group. So aroma oil inhalation can be used in nursing intervention and practice.

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Session 4: New and established techniques in Bronchoscopy

L-13

Electromagnetic navigation bronchoscopy

Peter Grendelmeier, Basle, Switzerland

Solitary pulmonary nodules (SPN) are common and mostly incidental findings on CT scans. The number of SPN will further increase, as CT versus chest x-ray screening for lung cancer showed a 20 % reduction in lung cancer mortality in the CT arm.

The diagnostic yield of **transbronchial lung biopsy** (TBB) under fluoroscopic guidance was shown to be 14 – 63 % for malignancy. Of note, the yield is highly dependent on lesion size (yield of < 34 % for lesions of < 2 cm in diameter) and the number of biopsies taken. CT guided **transthoracic needle aspiration** (TTNA) has a sensitivity for malignancy of up to 90 %. However the rate of minor pneumothorax is about 25 %. Major pneumothorax requiring insertion of a chest tube occurs in 5 % of cases.

Endobronchial ultrasound radial probe (EBUS-RP) has a diagnostic yield of 69 to 77 %.

Further improvements in yield might be achieved by enabling the bronchoscopist to steer the bronchoscope through the bronchial tree to the target lesion by using a navigational system.

The two currently available techniques include virtual bronchoscopy and **electromagnetic navigation bronchoscopy** (ENB).

The overall **diagnostic yield** of ENB ranges between 59 and 77 %. In a randomised controlled trial by Eberhardt et al. 120 patients were randomised to undergo bronchoscopy with ENB alone, EBUS-RP or combined ENB and EBUS-RP. The reported diagnostic yields were 59, 69 and 88 %, respectively. In the combination group, ENB allowed navigating to the lesion and EBUS-RP was used to confirm the position within the target.

Several **factors might influence the success rate**: the presence of a bronchus leading directly to a SPN (the so called 'bronchus sign') has a positive impact on diagnostic yield. In addition the size of the lesion and the localisation of the lesion seem to affect the yield. Yield might be lower in lower lobes lesions, possibly due to respiratory motion of the lungs in proximity of the diaphragms. No statistically significant difference could be demonstrated in terms of mode of sedation (conscious sedation versus general anaesthesia).

As far as **safety** is concerned, the most commonly observed complication was pneumothorax in less than 10 % of cases.

The procedure itself starts with the accurate preparation of the mapping of the pathway to the target lesion using a CT scan and planning software. The patient is then placed on a so-called location board generating the

magnetic field. After a surveillance bronchoscopy the **extended working channel (EWC)** and **locatable guide (LG)** are inserted together through the working channel of the bronchoscope. The position of the tip of the LG within the magnetic field is registered and displayed on a screen in up to six different views including sagittal, axial and coronal CT scans as well as virtual bronchoscopy. The tip of the LG can thereby be aimed in different directions.

Once the LG's tip is in close proximity to the target lesion, the LG is removed with the EWC being left in place. Biopsy tools can then be inserted through the EWC.

The use of ENB, especially when combined with EBUS-RP, markedly increased diagnostic yield as compared to conventional transbronchial biopsies under fluoroscopic control. However costs of ENB remain a major drawback.

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L-14

Thoracoscopy

Aleš Rozman, Golnik, Slovenia

Thoracoscopy is an endoscopic method, where we insert the instrument in the pleural cavity through a short incision in the chest wall. By that, we can inspect the contents of the pleural cavity, collect biopsy samples, evacuate pleural effusion and perform pleurodesis where indicated.

Main indications for thoracoscopy are:

- Diagnostics of pleural effusion,
- Staging of lung cancer,
- Treatment of septated pleural effusion,
- Pleurodesis.

Absolute contraindication for thoracoscopy is the lack of pleural space due to adhesions / fibrosis. Relative contraindications are:

- Disorders of blood coagulation (including anticoagulant therapy),
- Uncontrolled hypoxemia,
- Poor performance status of the patient,
- Uncontrolled cough,
- Severe cardiac disease.

Traditionally we perform thoracoscopy by rigid instrument. In recent years new, semi-rigid instrument was introduced on the market. New instrument resembles flexible bronchoscope; the tip is flexible and commands on the handle are similar as on the bronchoscope. The working channel is narrower and dedicated flexible forceps lacks mechanical power what makes sampling procedure more difficult. However, it appears so far, that diagnostic yield of semi-rigid thoracoscopy is not inferior to rigid thoracoscopy.

The procedure is performed under local anesthesia and moderate intravenous sedation. Patients are placed in the lateral decubitus position with continuous monitoring of blood pressure, pulse rate, and hemoglobin saturation. Supplemental oxygen is given.

Chest ultrasound is advised before thoracoscopy to evaluate conditions in the chest cavity and for selection of the entry point. Pneumothorax is introduced under C-arc fluoroscopic control and the thoracoscope is usually inserted in the mid-axillary line at the level of the fifth to seventh intercostal space.

All pleural fluid should be removed after insertion of the thoracoscope and the pleural space is thoroughly inspected, biopsies are taken, and talc pleurodesis performed where indicated. A chest tube is placed at the end of the procedure and a chest radiograph should be obtained afterwards.

Possible complications are:

- Bleeding,
- Infection,
- Persistent air leak,
- Transient fever,
- Subcutaneous emphysema.

Thoracoscopy is safe, well-tolerated and useful procedure in experienced hands. It replaces more invasive procedures, such as thoracotomy and thus reduces risks and discomfort for patients.

L-15

Management of Hemoptysis

Linda Penninx, Amsterdam, The Netherlands

Bronchoscopic techniques play an increasingly important role in the diagnosis and treatment of many respiratory conditions. The development of targeted treatments for patients with lung cancer has increased the demand for adequate tissue samples. In addition, new interventional techniques are being added to the repertoire of the interventional pulmonologist. These developments increase the risk of complications. Although complications are rare, the consequences can be severe. Therefore, bronchoscopists and bronchoscopy nurses need to be prepared and able to respond adequately when such complications occur. The most common complication is bleeding, with the risk of oxygen desaturation or asphyxia.

In order to adequately respond to complications of bronchoscopy the following conditions should be met. First, the patient should be informed about the possibility of complications before consenting to the procedure. Second, all the equipment necessary to treat complications (such as cold saline, epinephrine, ambu bag, tubes, crash car, bronchial blockers) should be available in the bronchoscopy suite. The doctors and nurses have to be familiar with the equipment and skilled. Before starting the bronchoscopic procedure the team should talk the procedure through so the nurses can gather the necessary equipment. The assistant or RT has to participate in a proactive way. When starting the procedure it is useful to do a "time out" so the bronchoscopist can repeat the goal of the procedure so all team members are informed. Once the procedure starts adequate communication between the doctor and nurses is the most important factor in patient safety. All team members should feel free to communicate about

the events taking place and to suggest possible solutions.

Because complications are rare it is best to practise in a simulation setting. Get the whole team together for a practise session so that everyone knows where they can find the materials (cold saline, adrenaline, intubationsets etc) and knows how to use them. These sessions will make the entire team more confident and able to act calmly and adequately in the event of a complication. It is important to repeat this practice regularly, so the whole team becomes familiar with this way of working.

Session 5: Quality Assurance

L-16

Nurses responsibilities with patient preparation before endoscopy

Marianna Kooijman, Haarlem, The Netherlands

This presentation will give endoscopic nurses an opportunity to learn about the purpose of pre-assessment interview. By taking these interviews the endoscopic nurse can give information about the endoscopic procedure and possible complications. You can get specific differentiation of symptoms and patient history. Explanation of the sedation course and you can achieve adequate bowel preparation. The major disadvantage for the patient is an extra hospital visit. We have a survey conducted among 100 patients to get an answer to this. The results of the survey from 2010 and 2012 showed no significant differences, 96% in 2010 and 97% in 2012 agree with the extra visit. We are therefore convinced that by conducting these interviews we take this responsibility.

- Who? Endoscopic nurses
- What? Pre-assessment interview developed
- When? Started in 2008 and continues to the present
- Where? Kennemer Gasthuis in Haarlem, The Netherlands
- How With the help of a gastroenterologist questionnaire created and strategy discussed. Always one gastroenterologist available for advice/consultation.

Reference;

R.W.M. van der Hulst, MD Phd. Department of Gastroenterology. Kennemer Gasthuis Haarlem, The Netherlands

L-17

Time out a benefit for Endoscopy

Marjon de Pater RN, Academic Medical Center, Department of Gastroenterology & Endoscopy, Amsterdam, The Netherlands

Background: System failures, human errors and problems with medical devices and medication can all lead to potentially preventable clinical incidents in a health care facility. A clinical incident is defined as: 'an event or circumstance resulting from health care which could have, or did lead to unintended harm to a person,

loss or damage, and/or a complaint'. Reducing risks will increase the safety of the patient.

Aim: The aim is to prevent the following key principles; wrong patient, wrong procedure and wrong site incidents. It is important to establish an active involvement and effective communications between the patient and all member of the Endoscopy unit to ensure that the correct procedure is performed on the correct patient.

Methods: It is a prerequisite to perform a good time-out to have data of the patient before the procedure, because the time-out is the final safety check. We have started two years ago with the time-out procedure at our department of Endoscopy. The checklist is multidisciplinary, every staff member (doctors, nurses, supporting staff) are all responsible for completion the checklist. It is important to use a standard checklist, and to tune who is taken the time-out and what's the role of the patient, who is involved, what is the best moment for the time-out. How much time do you needed.

Conclusion: A 'culture of safety' is required in the organisation, to reduce risks. With the introduction of the time-out procedure has introduced a simple security system. This simple appealing concept has its origin from the aviation and international knowledge exchange helped the procedure to get accepted.

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L-18

Critical incidence reporting (CIRS) in Endoscopy

Björn Rembacken, Consultant Gastroenterologist and Specialist Endoscopist at Leeds

Background: Attention and analysis of "Critical events" were first developed during the second World War when the RFA started to analyse problems. It was mainly industries such as engineering which first started to pay attention to "accidents" and malfunctions. In 1990, a British Psychologist proposed the "Swiss cheese model" of accident causation whereby "systems" put in place to prevent adverse events sometime line up allowing an accident to happen. As most of the time, the accident is stopped by one of the layers, the objective is to detect such near misses (latent failures) and act on their underlying cause.

Most accidents can be traced to one of 4 levels:

- 1) Poor Supervision, Training or Leadership (i.e. "pilot errors")
- 2) Preconditions of unsafe practise (for example HALT: Hungry, Angry, Late, Tired)
- 3) Organisational influences (large number of patients to assess, drugs with similar packaging being stored next to each other)
- 4) The accident itself (may detract attention away from other pressing issues)

The Aviation Industry is probably the most frequently proposed example of “Critical Events” analysis. The Aviation Industry has also been in the forefront of developing systems to reduce errors. One such training system is that of “Crew Resource Management” (CRM) whereby the whole Team is involved in mitigating against errors. CRM has its origin in Cockpit voice recordings from air disasters where the other members of the crew officers can be heard trying to bring important information to the captain’s attention in an indirect and ineffective way. It was noted that by the time the captain understands what is being said, it may be too late to avert the disaster.

Examples in the Endoscopy unit: Adverse events are common in the endoscopy units and range from the wrong patient being called into the procedure room to cardio-respiratory arrests. In a hierarchical health care system, lines of communications are sometimes not open between supervisors and subordinates and between teams. CRM aims to foster a climate or culture where the freedom to respectfully question authority is encouraged.

Error reporting can be carried out on several different levels. Perhaps the most effective is a simple registry of adverse events covering anything which had the potential to lead or did lead to an undesirable outcome. Regular review of these by the team members (endoscopists, nursing staff, managerial) should aim to determine the “level of error” and the underlying system cause. On the basis of this a more complete investigation may be launched or the problem could simply be highlighted to teams together with a recommended “fix”. However, the issue must be tracked over time to make sure that the working practices are being adhered to.

Endoscopy Reporting Systems have the potential of being able to carry out ongoing analyses of multiple indirect measurements of “quality” such as doses used, lesion detection rates, and complete examination rates. There is a link between the experience of the endoscopist and the time to reach the caecum, as well as with polyp detection rate and with outcomes following polypectomy.

Screening for Cancer provides an opportunity to assess the Endoscopy Service on a National Level. Unfortunately few countries have taken this opportunity. Furthermore, the few countries who have attempted to introduce National monitoring have done so on a voluntary basis. Voluntary participation of screening centres in the QA process is not satisfactory. In the voluntary Norwegian Gastronet project, initially 73 endoscopists at 14 hospitals agreed to enter information on all their colonoscopies. At the initial analysis, complete datasets were available from only six institutions and in these only 87% of examinations appeared to have been fully captured. In the follow-up phase of the study, the participation dwindled further and eventually only eight institutions entered any level of data. Furthermore, the authors concluded that it was the least experienced endoscopists who submitted the least data, particularly when the examinations were incomplete.

Recommendation: All Endoscopy Units should have a simple registry of adverse events. Endoscopy units should also invest in an electronic reporting system to allow ongoing analysis of performance. Ideally, data from the electronic reporting system is complemented by data from the Hospital Administration system to capture events which happen outside of the endoscopy unit. Finally, all countries offering organised screening

for cancer should have a mandatory system in place to monitor the activities and performance of the programme.

L-19

Coordinator of national colo rectal cancer screening programme- an advanced nurses role

Anita Jørgensen, Skien, Norway

Colorectal cancer (CRC) is a leading cause of cancer death in Europe. Each year approximately 435.000 people are diagnosed with CRC (Ferlay, Parkin & Steliarova-Foucher 2010), about half of these patient die of the disease making CRC the second leading cause of cancer death in Europe.

1. The aim of population screening is to discover latent disease in order to reduce mortality and possibly incidence of CRC without adversely affecting the health status of those who participate in screening. Early diagnosis allows complete surgical resection and cure. Most cases (60-90%) of CRC’s develop from adenomatous polyps.

Bowel cancer screening program in Norway is a pilot study. 140.000 individuals at age 50-74 years are to be invited for screening with iFOBT or flexible sigmoidoscopy (1:1 randomisation) in two screening centres, in the south east of Norway. iFOBT is to be repeated biennially (i.e. each round must be completed within 2 years) and an offer of once-only flexible sigmoidoscopy is aiming to be completed within 4 years. Invitees in the two groups will be matched for age and sex at invitation. www.tarmkreftscreening.no

2. The pilot project is designed as a randomized study and will function as a platform for Comparative Effectiveness Research(CER)

The aim of CER is to provide knowledge, to assist consumers, clinicians, purchasers, and policy makers to make informed decisions to improve health care at both the individual and population levels.

3. Cancer screening programmes with proven effect on cancer mortality may be considered a health service for many with objective benefit only for a few. It is therefore important to monitor, understand and intervene with any unwanted effects of screening on the population level. Such effects may be culturally dependent and results from one programme or one country may not be applicable to another setting in another society.

In addition to the primary endpoint 10-year CRC mortality, there are three major psychological issues to be addressed:

- Does screening have undesirable effect on lifestyle and lifestyle-related disease? If so, how can these be reduced
- What are the psychological reaction to screening (participation, re-call for investigation of positive tests, false positive-and false negative results) and how can undesirable effects be reduced.
- How are different screening modalities perceived in the target population and how can the most effective screening modality be made into the one that is most perceived.

Session 6: Hot Topics in Endoscopy

L-20

MultiDrug-Resistant Organisms (MDROs) – 'What do the Dutch do differently?

Annet Troelstra, Utrecht, The Netherlands
Abstract not submitted

L-21

Children in Endoscopy – a challenge for endoscopists and nurses

Raoul I. Furlano, Basle, Switzerland

Flexible endoscopy in children was first reported in the 1970's. Experience with diagnostic and therapeutic gastrointestinal endoscopy grew rapidly accompanied by the development of pediatric gastroenterology as a subspecialty of Pediatrics.

The diagnostic and therapeutic dimensions of modern endoscopy require a dynamic collaboration between gastroenterologist, endoscopy nurse and assistant, surgeon, pathologist, and radiologist.

My talk will cover basic knowledge of pediatric gastrointestinal endoscopy such as patient and parent preparation, dietary restrictions, correct indications, sedation and monitoring, procedure competence and training. Finally I will present a few cases and end my talk with possible future developments of pediatric gastrointestinal endoscopy and pediatric gastroenterology in general.

Indications for Esophagogastroduodenoscopy in Children:

- Dysphagia / Odynophagia
- Unexplained vomiting
- Unexplained abdominal or chest pain
- Intestinal malabsorption
- Chronic infectious or chronic inflammatory disease
- Upper gastrointestinal hemorrhage
- Chemical or mechanical injury
- removal of foreign body
- Placement of enteral feeding tubes
- Polyposis disorder
- Cancer surveillance

Indications for Colonoscopy in Children

- Lower gastrointestinal hemorrhage
- Acute or chronic colitis
- Chronic diarrhea
- Suspected disease of the terminal ileum
- Suspected polyposis disorder
- Cancer surveillance
- Dilation of stricture
- Decompression of obstructed colon
- Removal of foreign body

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L-22

Non-surgical treatment for type 2 diabetes and obesity

Jürgen Hochberger, Hildesheim, Germany
Abstract not submitted

Session 7: GE Disease

L-23

Hypnotherapy in the management of IBS patients

Erna Boers, Amstelveen, The Netherlands

IBS, a common, chronic gastrointestinal disorder, affects 10-15% of the population of western countries. Symptom improvement with the generally used treatments varies widely and is often unsatisfactory. Factors predicting treatment improvement are generally unknown, although research into brain-gut interactions with support of modern technologies like brain imaging has made it possible to uncover certain mechanisms of IBS. My presentation of today is based on the dissertation I have written on the subject. It is woven around the following question: "Why favour a Hypno-/Psychotherapeutic approach in the treatment of IBS?" I looked for recent research on IBS, containing research into brain-gut interactions, and found literature about the most recent approaches in medical care as well as psychological treatments. When comparing these studies, I have found a significant result in favour of hypno-/psychotherapeutic approaches.

L-24

The nurses role in the care of Celiac patients

Jadranka Brijak, Marina Premužić, Daria Vranešić-Bender, University Hospital Zagreb-Rebro, Croatia

Aims: To conduct education resulting in understanding the cause of the problem and the ways of solving it, including members of the family into educational activities to avoid contamination while preparing food. To show the importance of taking biopsy samples, saving and filing them.

Summary: The symptoms of celiac disease were first recorded by the Greek physician Aretaeus in the second century BC, who we owe the name of the disease to (coeliac (Amer celiac) -relating to or in the region of the abdominal cavity / via Latin from Greek KOILIAKOS, from KOILIA cavity, from KOILOS hollow / intestine problems. Celiac patients are not resistant to gluten, the protein component of wheat, rye, barley and oats. When these patients consume the food which contains gluten, their immune system reacts in the way that results in damaging small intestine, that is - a number of reactions take place in which antibodies class IgA and IgG appear and inflammatory processes in small intestine develop.

The result of these inflammatory processes is the destruction of intestine mucous membrane cells and

intestine villi necessary for the absorption and use of nutrients. Therefore, in case the disease is not treated malabsorption and malnutrition take place regardless of the amount of the consumed food. The disease can clinically manifest itself at any age. The elements we use in making diagnosis are a combination of clinical picture, pathohistological analysis of the intestine mucous membrane, serology, the positive response to gluten-free diet and, in dubious cases, genetic testing. The only reliable lab test to diagnose celiac disease is biopsy of small intestine with pathohistological analysis. The only cure for celiac disease is a strict gluten-free diet. The main features for planning the nurses' care of celiac patients concern collecting data such as the evaluation of independence degree, collecting data concerning nutritive status, the inability of preparing food independently and the inability to consume food in a socially acceptable way. One of the leading goals particularly important to the patients is being informed on the quality of food and the way it is prepared. Therefore, after the diagnostic procedure is finished and being educated on the disease while hospitalized, the patients and the members of their families are advised to join the Association for Celiac Disease in order to get support and help in overcoming the principles of gluten-free diet.

The prognoses of the disease is excellent on condition the life-long gluten-free diet is conducted. The patients with active disease have increased mortality concerning the possible complications, particularly malignant intestine disease. However, this risk disappears after 3-5 years of gluten-free diet.

Lerning outcomes.

- to motivate the patient to follow the diet
- to connect celiac patients to associations
- to educate the families

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L-25

Function tests in Gastroenterology-What they diagnose and how they used in the clinical management of patients

Jac Oors, Amsterdam, The Netherlands

Gastrointestinal motility in the past decades was the most rapidly growing subspecialty within gastroenterology. With the growing knowledge and understanding of how a dysfunction of the gastrointestinal muscle and nerves can cause disease there was a 'revolution' in the approach to the diagnosis and treatment of gastrointestinal motility disorders.

Available tests are performed widely spread in The Netherlands, by nurses, technicians and gastroenterologists. Not clear is the quantity and quality that is presented.

This presentation overviews the present available tests in the ultimate equipped motility lab related to diagnose and/or treatment, as there are: PNLT, EMG, anorectal electro sensibility, barostat, breath tests, EndoFlip,

manometry (anorectal, colonic, antroduodenal, Oddi and esophageal) and ambulatory studies such as pH-, impedance metry and manometry.

L-26

Screening for colo-rectal cancer in the Netherlands

Michiel van Haastert, Groningen, The Netherlands

In September 2013 the Nationwide Colo-Rectal Cancer Screening Program will start in the Netherlands. In 2009 the National Health Council advised the Minister of Public Health to start a screening Program on Colo-Rectal Cancer in the Netherlands. The National Institute for Public Health and the Environment (RIVM) performed an intensive Study on the Attainability with special Interest in Capacity and Quality. In 2011 a positive Advice was given by the RIVM.

The primary Test will be the iFOBT. Every other year Dutch Inhabitants, between the Age of 55 and 75 will receive a Test by Mail. The predicted return of the Test will be 60 %.

We predict a positive Test of 6 % and 85 % of these Screenees will have a Colonoscopy. About 40-45 % will have an Advanced Adenoma and nearly 5 % will have a Carcinoma. The Figures, as described above, are extracted from International Programs in the United Kingdom as well as local screening Area's in the Netherlands in Amsterdam and Rotterdam.

In the Netherlands 12.117 new Cases of Colo-Rectal Cancer are found every Year (2008) but the Numbers are increasing. Of these new Cases 4.800 people will die because of this Disease. In the Screening Program the estimated decrease of Deathnumbers will be 1.462 people. The Netherlands has 16.669.112 Inhabitants, 4.400.000 of them are between the age of 55 and 75.

According to the Organisation of other Screening Programs the Netherlands will be split up in 5 Regions with their own Organisation but controlled by the RIVM. There are about 100 Units where Endoscopies can be performed and via a Process of Auditing a Centre can enter the Program as a Screenings Organisation. 350 Gastro-Enterologists, working in University- and General Hospitals and in Private Clinics, can participate in the Program. Because the Program will be introduced in 5 Years, stepwise, there will be estimated increase of Colonoscopies of 68.000 a year 5 years after the Introduction of the Program. This will be a great challenge. We are still discussing the Roll of the Nurse-Endoscopist (NE) in the Program. Will they participate in the Program with a positive Yield of about 45 % or should the NE participate in the regular Programs for follow up with a much lower Incidence of Abnormalities?

A great Effort has been made to up-date all the Protocols concerning Colonoscopy, Treatment of Adenomas and Carcinoma as well as Protocols for Quality and Safety.

Session 8: Education

L-27

UEG e-learning opportunities in Gastroenterology

Lars Aabakken, Oslo, Norway

Teaching and teaching material increasingly rely on electronic media. This, together with the facilities of internet and improving internet connections opens the opportunity for web-based e-learning in all areas, including gastroenterology.

The United European Gastroenterology Federation recently decided to invest substantial time, money and effort into creating a platform for e-learning on a European level. This project, previously known as OLGa, is now the UEG –Education initiative, with a web-based portal as the core element.

On this platform, educational material is collected, indexed, and presented with top-level technology assuring superb functionality for the user. The material is partially text based (e.g. UEG posters), partially recorded presentations and partially video material per se, e.g. endoscopy cases. In addition, formal e-learning courses have been developed, 2 at present time, but more in the pipeline. At present, most of the material is collected during the UEGW, but the concept is to use this platform as a joint learning platform also for the sister societies. ESGE has been the first society to come aboard, and already a range of ESGE material is available on the website.

In this presentation, core functionality of the website will be presented, along with some examples of relevance for ESGENA.

L-28

Do competencies substitute recognised qualifications?

Christiane Neumann, Birmingham, UK

Traditionally, the route to clinical practice was easily identified. With increasing health care demands additional training has been required to meet those demands. This has meant that to reach the required levels of competency staff had to train first in general training, followed by specialist training, and for nurses, often training for extended roles such as nurse endoscopist or nurse practitioner. However, health care providers have realised that this takes many years resulting in potentially expensive staff and therefore increasingly ways are being explored not only to shorten the time of training but also to keep staffing costs low. Rather than taking staff through the whole spectrum of training, in some countries staff are trained for specific purposes and to reach competency in a very narrow section of health care. For example, in the UK a pilot project trained people without any health care qualification to become endoscopists. In other instances unqualified staff are specifically trained to carry out a very narrow spectrum of tasks in which they become competent. National laws have restricted some clinical practice to suitably registered personnel such as in Germany only doctors are allowed to make a

diagnosis and in the UK medicines can only be given/dispensed by registered staff. As these developments are relatively new not enough time has passed to evaluate the safety of staff with narrow and limited training, especially with regard to patient safety when things go wrong.

Competency is the ability of an individual to do a job properly and is a combination of **knowledge, skills and suitable behaviour**. What has not yet been clearly demonstrated is if a narrow area of competency is enough to deal with serious emergencies occurring during the execution of the delegated tasks.

Training personnel for limited and specific tasks may increase at a time of increasing demand, shortages of nursing and medical staff, and limited financial resources. This response to the pressure of demand for clinical services and suitably trained staff should not be at the cost of patient safety. Any such developments need to be carefully monitored and evaluated before becoming widespread.

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- <https://tools.skillsforhealth.org.uk/> - Competence Search: Endoscopy or for specific competency (END01-END21)
- [http://www.skillsforhealth.org.uk/component/docman/doc_iew/1761-skills-for-health-assistant-practitioners-expert-paper.html](http://www.skillsforhealth.org.uk/component/docman/doc_view/1761-skills-for-health-assistant-practitioners-expert-paper.html)

L-29

Workshops as an effective training tool - ESGE-ESGENA Handbook of Workshop organisation

Ulrike Beilenhoff, Ulm, Germany

Over the last 30 years, endoscopy has become an essential tool in the diagnosis and therapy for digestive diseases. Technical developments and complex procedures require regular continuous education. In addition to lectures, seminars and conferences, workshops are very popular for continuous training in endoscopy as they combine specialized knowledge and practical training.

Definition: A workshop is a training SESSION event, which may last from several minutes to several days in length. It emphasizes problem-solving, practical demonstration, hands-on training and requires hands on involvement of the participants. Workshops in Endoscopy are helpful tools for teaching new staff or updating staff in new equipment and techniques. However, workshops are often organized in an unstructured way.

The ESGE-ESGENA-Handbook: In response to requests from several European countries, the ESGENA Education Working Group (EEWG) and the ESGE Education committee developed a handbook for organising different kinds of workshops.

The aims of the handbook are

- To provide a framework for planning, delivering and evaluating different kind of workshops for teaching digestive endoscopy
- to support national nursing societies, educational institutes and individual departments within Europe in optimising structured practical training for nurses and physicians working in Gastroenterology and Endoscopy.

Content of handbook

General Aspects: The organization of any teaching event has uniform organizational steps covering

planning, preparation, delivery, assessment and evaluation of the event. Each step needs to be planned and performed in chronological order. Essential points are the outlining of aims and expected learning outcomes for a defined target group, detailed planning and a structured teaching plan. The assessment of participants and the evaluation of the event are essential tools of quality assurance and the basis for improvements.

Three different groups of workshops were identified:

1. Skills Workshops are mainly focused on technical aspects of endoscopic procedures. They also cover aspects of patient care relevant to the respective technique, health and safety issues for patient and staff as well as hygiene aspects. Equipment skills workshops are often used as first level training.

2. Dummy Workshops include any kind of dummies for practical training:

Simple home-made dummies can be a mixture of meat, vegetables, fruits, sweets, tubes boxes and parcels.

Commercial dummies are offered as

- **Biological dummies** combining plastic dolls with organic material and organs
- **Artificial dummies** combining plastic dolls with artificial material to simulate organs
- **Computerised systems** simulating complex body functions in order to train whole endoscopic procedures rather than single techniques.

Dummy training enables the training of technical skills under realistic simulations. Single Procedures or scenarios can be simulated.

3. Live demonstration (LD) is defined as any teaching event which involves patients. The "observer" is a person not directly involved in the procedure or patient care. LD includes events such as

- Teaching a new member of staff or a visiting nurse/doctor in the procedure room,
- Clinical teaching demonstration of new equipment by an industry representative with additional staff attending
- Demonstrations in the clinical room,
- Endoscopic procedures transmitted into a local seminar room during a course or workshop
- LD transmitted into a big lecture hall during a conference, for example ESGE Workshops.

Patient rights and safety are crucial considerations when organising LD. LD in one's own department are easier to organise, as local infrastructure, staff and equipment can be used. Bigger events require a complex organisation; increased costs. Risks and benefits for the patient should also be taken into account.

Conclusion: The Handbook gives an overview of the organisation of different types of workshops. Detailed tables, forms and templates provide helpful information and tools for organising smaller as well as larger teaching events in form of workshops.

Further information: www.esgena.org and www.esge.org

L-30

The difficult ERCP: Some important points for the assistants

Michael Ortmann, Basle, Switzerland

Background: In addition that during the ERCP, the medical and technical progress leads to ever more sophisticated for the physician and nurse assistants. The higher risk examinations requiring the use of a vast variety of equipment and personal support.

Aims & Method: The aim of is to address questions on the difficult ERCP:

Some important points for the assistants patient:

Learning objectives:

- 1) What factors make ERCP difficult?
- 2) What training and experience are needed to a competent ERCP endoscopist and assistants?
- 3) Strategies for successful cannulation in situations of anatomic difficulty?

What makes an ERCP cannulation "difficult"?

- A) Inexperience / exceeding one's abilities
 - B) Agitated patient
 - C) Difficult or unusual anatomy
- At least 180-200 procedures to gain basic diagnostic and therapeutic experience

Strategies to make ERCP go more smoothly:

- 1) A detailed review of the procedure ahead of time, including review of all relevant prior imaging.
- 2) Detailed informed consent (allows you to think through possible outcomes of the procedure).
- 3) Discuss the case with your assistant(s) so that they will know what to expect
- 4) Make sure that the equipment you expect to use is easily available
- 5) Reevaluation of clinical need
- 6) Second ERCP in 1-2 weeks
- 7) Different endoscopist and assistant(s)

The Method and important steps are to make sure of realistic strategies and an action plan with alternative procedure.

Session 9: New Techniques and Developments in Endoscopy

L-31

Achalasia & POEM – Endoscopy meets surgery

Nils Andersen & Thomas Rösch, Hamburg, Germany

Background: Recently, peroral endoscopic myotomy (POEM) has been introduced as a new minimal invasive treatment for achalasia. Up to date ca. 150-200 POEM procedures have been performed in the Western world, while in Japan and especially China, this figure may approach 1000, but is sometimes hampered by unclear patient selection, fast performance and high complication rate as reported from China. The procedure is challenging for both the examiner and assistants and should be performed in specialized centers only.

Patient selection: As far as we know, all types of symptomatic achalasia can be treated with the POEM procedure. Prior endoscopic treatments with balloon dilatation or botulinumtoxin injection are no contraindications. Only the submucosal tunneling can be challenging due to inflammatory fibrosis.

Methods: Required pre-procedure diagnostics include endoscopy, manometry, and barium swallow, as well as pre-anesthesia tests; POEM has to be performed under

general anesthesia. After disinfection of the pharynx and esophagus the procedure starts with an incision of about 2 cm of the mucosa 3-4 cm above the presumed myotomy length. The creation of the submucosal tunnel and the myotomy of the circular muscle fibres are the parts, where endoscopy really meets surgery. At the end of the procedure the mucosal entry site is closed by clips.

Postinterventional high dosage PPI, antibiotics and fasting for 24 h followed by soft diet for 2 weeks are advised. On the 2nd and 3rd postinterventional days the patient undergoes control EGD and contrast swallow before discharge.

Results And Conclusions: Short- term clinical results are excellent up to now but require larger case numbers and long-term follow-up. Given the fast recovery POEM appears to be an excellent option to treat symptomatic achalasia.

Key words: Achalasia, POEM, Endoscopic Myotomy

L-32

The development of Endoscopy/GE nursing – a lifetime experience

The word Endoscopy is of Greek derivation, Endo meaning within and skopein meaning to view or observe. Records show that attempts were already being made to use this technique as far back as the time of Hippocrates. However, due to candle light being the only form of illumination results were poor and little progress was made until the discovery of the carbon filament electric light bulb in 1879. This led to the development of rigid, tube like instruments which were the prototypes of many instruments still in use today. Enthusiasts developed and pioneered improvements and by the start of my own nursing career in 1961 semi flexible instruments relying on a system of lenses and prisms to transmit images were in common use in GI investigation. However, due to the GI tract being long and tortuous examinations remained limited in extent and usefulness.

The invention of fiberoptics able to transmit both light and images through flexible cables in 1957 truly revolutionised endoscopy, giving, for the first time, access to much of the GI tract. By the late 1960s fully flexible endoscopes were introduced into general use for diagnostic purposes. Enthusiastic endoscopists were quick to develop therapeutic techniques and by the late 1970s these were becoming established.

The world was and remains rich in clever, innovative surgeons' physicians and radiologists all of whom contributed to the growth of new procedures. The need for nursing support for patients undergoing ever more complex examinations and treatments gradually became apparent but, due to the diverse backgrounds of medical leaders in the field, education training qualifications and job descriptions of these nurses varied widely, not only from country to country but from hospital to hospital, clinic to clinic and office to office too.

The role of nurses working in endoscopy and gastroenterology has undergone many changes since the start of my own career in the specialty in 1978. Technological advances, a greater understanding of infection control and health and safety issues, professional requirements and guidelines, and growth in demand for services are contributors to the need for

properly prepared, highly skilled nurses to be employed in the specialty. The contribution of ESGENA in addition to that of National Societies has been considerable.

This presentation will focus on the development of nursing roles within the field of gastroenterology and GI endoscopy since the introduction of flexible fiberoptic endoscopes. It will highlight the requirement for patient needs to remain the focus of all concerned in providing these services.

Diane Campbell FRCN

6.2. Poster Presentations On 21 October 2012

P-1

Reusable Sphincterotome: Cleaning Validation and Monitoring of Reuse

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Introduction: Cleaning hospital instruments is a fundamental process if the instruments are to be reused. It must be done thoroughly because if there is any organic material the instruments cannot be reused. What makes it difficult to clean is its complex design. When the electrical current goes through the sphincterotome it heats up which then causes the organic materials to stick to it. When examined through a Steroscopy there is organic material suck on the area of the cut. Objective: Validate an effective method for cleaning reusable sphincterotome and monitoring reuse.

Method: We chose to analyze the cleaning of 2 Olympus sphincterotome modelKD6G12Q1. We began by looking through steroscopy 2 sphincterotome wires that had never been used to use as a reference for what would be considered clean. We then used a steroscopy to examine the wires throughout the cleaning process. Our procedures were followed. During in ERCP we injected sterile water in the double channel and kept it humid to avoid the organic material from sticking to the wire. It was cleaned in a enzyme solution detergent. It was then cleaned by ultrasonic machine for 30 minutes. We examined it with a Steroscopy and found the presence of organic matter. A new cleaning process was then added the cutting edge and it immersed in 2% hydrogen peroxide for 20 minutes, but we still found the presence of organic matter. We repeated the cleaning process in ultrasonic machine for 30 minutes, but still found traces of the organic matter. We used a synthetic abrasive cleaning sponge on the cutting edges of the sphincterotome. This time when we looked at the stereoscopy and there was no longer any organic matter. Then we did a follow up test was to detect of blood residue, the result were negative. We also monitored the reuse of 8 sphincterotomes and how they were cleaned. It was then wrapped in surgical grade paper and sterilized in autoclave.

Results: In order to be affective the cleaning should be done with wire sponges. Through our monitoring we

noted that the average number of times the 8 sphincterotomes were used was 20 times. Summary: The established and practiced cleaning procedures were effective when they included using a wire sponge to clean the cutting wire. **Conclusion:** The cleaning process for sphincterotome has been proven effective when given a critical abrasive sponge cleaning with mean number of 20 reuses.

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2- AAMI TIR12:2010

Learning outcomes: This study proves that abrasive sponges can be used to insure that the cutting wire and the area where electrical currents pass through are properly and efficiently cleaned. We believe it is imperative to use abrasive sponges to clean instruments that use electrical currents that heat up.

P-2

An orientation programme for new nurses admitted in an endoscopy unit

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Endoscopy Units are very specific nursing care services. In Portugal still doesn't exist a nurse specialty for endoscopy nurses that exist in some European countries. Therefore, an orientation programme was created with 28 weeks duration for new admitted nurses in an Endoscopy Unit, which includes two phases. The first phase (14 weeks) includes basic endoscopy exams and procedures – Colonoscopy, Sigmoidoscopy, Upper Gastrointestinal Endoscopy, Endoscopic Ultrasonography, Percutaneous Endoscopic Gastrostomy, Liver Biopsy and Paracentesis. The second phase (14 weeks) includes more complex endoscopy exams and procedures – Endoscopic Retrograde Cholangiopancreatography (ERCP), Esophageal/Colonic Dilation with or without stents insertion, and Double Balloon Enteroscopy. In the end of the orientation programme an evaluation of the new admitted nurse is made by the preceptor nurse and also the newcomers fill a satisfaction questionnaire to evaluate the orientation programme and the respective preceptor. Also during the programme all the exams and procedures are recorded on a specific sheet. In the end of the programme the nurses have to be able to: provide holistic care, individualized to each patient before, during and after completion of diagnostic and therapeutic procedures; ensure proper maintenance of endoscopic equipment and its accessories; to control and prevent infection, including with respect to reprocessing of endoscopic equipment and accessories; make appropriate nursing records; undertake health education for patients and their families; working in multidisciplinary team, promoting health and safety work and demonstrate capacity for organization and management (ESGENA, 2004, 2008). Objectives: With this study we intend to assess the satisfaction of the new admitted nurses in an Endoscopy Unit under an orientation programme between 09/2008 and 02/2012. Methodology: We conducted a descriptive and retrospective study with a quantitative approach using a satisfaction questionnaire

that was created with a likert scale (1 to 5 – nothing to very much) that included 9 questions and was applied to the new admitted nurses in an Endoscopy Unit that were orientated under the established programme. Results: The total sample was 9 new admitted nurses, with an average age of 27.1 years. Four of the new nurses (44.4 % of the sample) never worked before and five of the nurses (55.6 % of the sample) have worked before in other departments with an average working time of 6.2 years. The average rate of the nine questions of the questionnaire were: considers the orientation programme essential – 4.55; considers the programme appropriate – 4.33; the programme facilitates the integration – 4.33; considers the programme very rigid – 2.11; considers the programme extensive – 2.22; considers the programme evaluation appropriate – 3.66; orientation time appropriate – 3.77; degree of overall satisfaction with the orientation programme – 4.00; efficiency and suitability of the preceptor nurse – 4.44. Summary and Conclusions: Based in the results obtained, we can infer that there is a high degree of satisfaction with the orientation programme. The programme was considered essential, appropriate, facilitator of the integration, flexible, not extensive and with an appropriate evaluation and time of orientation.

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- European Society of Gastroenterology and Endoscopy Nurses and Associates (ESGENA, 2008). ESGENA Core Curriculum for Endoscopy Nursing. Retrieved from http://www.esgena.org/downloads/pdfs/general/esgena_core_curriculum.pdf

Learning outcomes for audience: A systematic orientation programme with two phases for new admitted nurses in an Endoscopy Unit, and the characteristics and assessment of the satisfaction of the established orientation programme.

P-3

A multi centre study to review how informed consent is implemented into the patients pathway

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Introduction: Providing informed consent to patients can be defined as the ability to make the decision based on sufficient knowledge and information to be able to agree or disagree to have the procedure. Providing informed consent requires written and verbal information throughout the patient pathway The multicentre study was put together to look at the different practice.

Aim: To discuss through a multicentre study, how informed consent is implemented by nursing staff.

Method: An explanation of the study was given to the staff and asked if they were happy to take part. The questionnaire was a tick box and some explanation, all questionnaires were anonymous. A questionnaire was designed with open and closed questions for all grades of the endoscopy team involved with patient care to complete. A series of 15 questions were designed to cover all areas of informed consent. To explore the theory to practice, protocols and training needs. A total of 17 questionnaires were completed. Each nurse was asked to take the questionnaire and complete using their current knowledge of informed consent.

Results: There was a high return rate of the questionnaires and the answers provided a good knowledge of theory to practice and understanding of informed consent.

- What is your understanding of informed consent? An understanding - written and verbal information about the procedure, has legal issues, signing of the consent after given a full explanation of the risks and benefits of the procedure.
- Who should be involved with the consent process? Patient, Physician, Nurse, Relative, the Doctor who performs the procedure - all the medical team.
- Who should interpret for the patient? A Nurse, close relative, an interpreter, the Physician.
- When does consent begin? Outpatients Department, before surgery, throughout the patient pathway.
- How do you evaluate your service? From the patient, questionnaires, post operative telephone call, thank you cards.

Conclusion: The aim of this study was to look at how informed consent was implemented into the patient pathway and the nurses understanding how informed consent is achieved. The study was very well received by the nursing teams and a high level of knowledge about informed consent. The information showed the nursing teams were aiming to achieve best practice through informed consent. The managers of each department were very pleased with the underpinning knowledge of the nursing teams. The common area of concern from the nurses was the communication and information provided between different hospitals and departments. Informed consent is a process to ensure the patient has an understanding of the procedure the risks and complications. To provide sufficient information about the procedure, and a chance to ask questions. The nurses are valuable members of the team involved with informed consent.

Learning outcomes. Sharing of knowledge and reflection of practice through a multi centre study.

References

- Guidelines for Informed Consent for Endoscopy Procedures Clinical Services and Standards Committee British Society of Gastroenterology
- Patients Right Act
- Act on Protection of Persons with Mental Illness

P-4

Preparing patients for gastrointestinal endoscopy: the impact of counseling in-reducing anxiety

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Introduction: OMS has defined Counseling as an effective approaching method to establish a real dual interaction between patients and nurses in both prevention and care areas. In an endoscopy unit communication skills are requested in each of the following steps:

- Booking
- Admission
- Endoscopy procedure
- Discharge

More and more nurses are requested to increase the quantity of performances instead of quality: very often this pressure to produce numbers seems to be incompatible with an effective nurse-patient relationship.

Because of this hectic pace patients can feel themselves as "crushed", identified only as a part of the human body or a disease to recover from. Another obstacle is the frequent inadequacy of the working areas where counseling should be held.

Objectives: In Endoscopy Services nurses' relational skills have a considerable influence on the performance. Patients undergoing gastrointestinal endoscopy procedures feel worried, anxious or even frightened. Anxiety and fear are difficult to manage without an effective ability to relate with the patient.

Method: We have taken into consideration a sample of 400 randomly selected patients undergoing gastrointestinal endoscopy procedures which were divided in two groups (exclusion criteria: age under 20 or over 70, evident communication or comprehension deficiency). Group A received standard care (usual information and coaching by a nurse during the procedure); group B received an individual pre-procedure counseling conversation with the aim to provide very extensive information, to answer patients doubts and to reduce anxiety. In order to grant a standardized approach we decided that only one nurse was designed to give pre-procedure counseling. A feedback form was filled by every patient after the procedure.

Results: As a result patients in group B declared they underwent the endoscopy procedure with less anxiety (14% GB vs 46% GA), more satisfaction about the information given before the procedure (97% GB vs 65% GA) and about nursing care during the examination (90% GB vs 70% GA).

Conclusions: In our experience a pre-procedure counseling conversation can reduce anxiety and increase patients satisfaction.

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P-5

Quasi-experimental study: Comparison of two different nursing interventions in gastroscopy without sedation

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Introduction: Nursing role in a gastroscopy begins when the patient arrives to the endoscopy unit, providing him or her information about the process and helping to reduce the pre-procedure state of anxiety. There is a disparity among nurses of the endoscopy team, about the better nursing action in a gastroscopy. Some of them think that the contribution of information is enough to reduce anxiety, to improve tolerance and satisfaction of the test; the rest think that, besides the provision of information, a behavioral training and positive reinforcement during the test is required.

Hypothesis & Objectives: The intervention based on information, training and reinforcement (experimental group) is more effective than the one based in only information, with reference to reduction of anxiety and improvement of tolerance and patient satisfaction. The objectives of the study are, on one hand, measuring the differences between the two nursing actions in the state of anxiety, and on the other hand, evaluating also the differences in tolerance and satisfaction.

Method: Inclusion: outpatient adults to whom the gastroscopy without any sedation is performed. They previously must sign an informed consent. N: 109 people, between 18 and 85 years old, divided into an experimental group (n = 51) and a control group (n = 58). Participants complete the STAI test on arrival and when the intervention is finished. Psychophysical parameters of anxiety before and after the gastroscopy are measured. Tolerance is assessed by the nurse. The patient fills out a satisfaction questionnaire. Data are entered in an Excel database and they are analyzed with SPSS version 17, with repeated measures analysis of variance (ANOVA)

Results: The STAI score decreased more in the experimental group than in the control group (p = 0.035). Tolerance is better in the experimental group than in the control group (p = 0.008). Satisfaction is the same in both groups (p = 0.5). The difference in systolic blood pressure values, diastolic and heart rate is the same in both groups (p = 0.085, p = 0.690, p = 0.984)

Conclusions: Data support the hypothesis only partially. Anxiety improves more in the experimental group than in the control group when it is assessed with STAI. However, if it is evaluated with psychophysical parameters, there are no differences between the two groups. Tolerance value in the experimental group is better than in the control group. Satisfaction is similar in both groups.

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Learning outcomes for Audience: Experimental investigations to obtain scientific evidences of appropriate clinical practice are possible in nursing. It is

possible to improve the tolerance of gastroscopy and reduce anxiety due to the procedure, with a nursing intervention focused on cognitive and behavioral of the person.

P-6

Fluoroscopic guided Percutaneous Endoscopic Gastrostomy Insertion

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Introduction: Percutaneous Endoscopic Gastrostomy (PEG) is a widely accepted method used to provide a means of long term feeding for patients incapable of oral intake in conditions like CVA (Cerebrovascular Accident/Stroke). The minimal invasive technique has a lot of advantages for every patients and it plays significant roles for elderly patients. The most common endoscopic 'pull through' technique in certain cases cannot be carried out safely.

Materials and method: We performed Fluoroscopic Guided PEG tube insertion for four patients in the 1st Department of Surgery, Semmelweis University between 2010 and 2012. Our patient sample included a 78 years old male with a past history of Billroth-II resection who had a dysphagia secondary to a CVA, a 64 years old male with diaphragmatic paralysis (complication of anesthesia). The paraoesophageal hiatus hernia and upside down stomach caused oral feed inability for a 90 and 87 years old male patients.

In these cases the localization of the stomach could not be safely determined accurately therefore the PEG was inserted with radiologic assistance. The upside down stomach was repositioned into the abdomen with the aid of a gastroscope then the PEG was fixed to the abdominal wall. The procedures lasted an average of 32 minutes. The patients were discharged in 1-3 days following of learning the usage of the PEG from the endoscopic assistant. She also checked if the patient had the competent knowledge.

Results: The PEG insertions of these patients were successful in all cases. The 78 years old post Billroth-II gastrectomy patient has now commenced oral feeding. The 90 years old patient with an upside down stomach commenced oral feeding however he died in the following 3 months in urosepsis. The 87 and 64 years old patients still continue PEG feeding since their swallowing improved minimally.

Conclusion / Learning outcomes: Sometimes PEG cannot be inserted safely. In such cases it can be inserted by the means of combined endoscopic and radiologic intervention. Since the PEG insertion applied for patients with the need of special treatment (e.g. upside down stomach) and the complex knowledge of combined endoscopic and radiologic intervention is required nurses have to be more prepared and updated and also have to have skill to work in team to avoid and to reduce also the complications.

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P-7

Ethical Issues surrounding the removal of a Percutaneous Endoscopic Gastroscopy tube

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Introduction: There are times when life-sustaining treatments can be legitimately withheld or withdrawn. The bioethical challenge lies in maintaining human dignity in a world where technological methods are constantly improving, one of these methods is through tube feeding. Yet when is aggressive treatment too aggressive? Is one who believes in intrinsic human value committed to indefinitely preserving human life in disregard of other factors? Can the concept of ordinary and extraordinary treatment, although predominantly Catholic ideas, apply when it comes to feeding tubes?

Aims: To investigate when it is ethically possible to remove a Percutaneous Endoscopic Gastrostomy tube and to highlight cases such as that of Eluana Englaro in order to take a morally sound decision.

Method: Due to the nature of the subject, research was carried out through meticulous literature review.

Findings: Feeding tubes may be removed from patients in two situations. Either when in a persistent cognitively impaired state, when the patient may not have the capacity to get up and get food for themselves, open their mouths and swallow it but their digestive system works well and they are not dying and therefore the tube is sustaining their lives. The removal of the tube in these cases results in dehydration and a slow, painful death.

The other situation involves not forcing food and water upon patients who have stopped eating and drinking as part of the natural dying process. This typically occurs, for example, at the end stages of cancer when patients often refuse nourishment because the disease has distorted their senses of hunger and thirst. In these situations, being deprived of unwanted food and water when the body is already shutting down does not cause a painful death (1) Eluana Englaro (November 25, 1970 – February 9, 2009) was an Italian woman who entered a persistent vegetative state. Shortly after Englaro had started artificial nutrition and hydration, her father requested to have her feeding tube removed and to allow her to die "naturally" (2).

Summary: There are instances when a feeding tube may be removed, however these must be carefully reviewed in order to comply with the four ethical principles, especially that of non-maleficence.

Conclusions: Unless the body is rejecting the nutrition administered, it is difficult to assume that a feeding tube is extraordinary treatment.

Learning outcomes: 1) The ethical implications combined with gastroenterology is not such a popularly explored subject, however ethical issues do exist. 2) Nursing is a caring profession, and we need to understand the ethical issues involved with our practices.

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P-8

Hands-on training of application of over the scope clip improves the skills of endoscopic nurses

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Introduction: Over the scope clip (OTSC) is a new tool used for closing of iatrogenic perforations, sealing fistulas and for hemostasis. Since the OTSC is not as frequently used in clinical practice, hands-on training of both, endoscopists and endoscopic nurses, might be of benefit.

Aim: The aim of this study was to establish whether hands-on training can improve the skills of setting up and application of OTSC clips. We also report the clinical outcome of three patients where we used the OTSC clip.

Methods: We performed an experimental study where 10 endoscopists and 16 nurses participated in one day hands-on training on ex-vivo animal model. The skills had been evaluated by independent assessors using a scale of 1-5 (1= excellent; 5 = for insufficient) as well as based on the actual success of the procedure.

Results:

A. Ten endoscopists improved their skills to prepare and apply the clip (given the score of 4.5 before and 2.5 after, $p < 0.01$). Before the training, only one clip application was successful (10%), whereas after the training, nine applications were successful (90%).

B. Sixteen nurses improved their skills to set the application system up (score of 4.0 before and 1.5 after, $p < 0.01$). The mean time necessary to prepare the OTSC system was 11 ± 5 minutes before and 6 ± 3 minutes after the training. All endoscopists as well as nurses assessed the participation as beneficial and a majority of participants thought that a course improved their ability to use the OTSC clip in clinical practice. In our department, we have successfully used OTSC clip in 3 patients all in emergency situations. In two patients, the clip was used for closing of iatrogenic perforation (1x sigmoid colon, 1 x duodenum during ERCP). In one patient, the clip was used for hemostasis after polypectomy. All clips were released successfully.

Conclusion: OTSC clip seems to be effective in treatment of iatrogenic perforations and in hemostasis. Hands on training on ex vivo animal model significantly improve skills of both endoscopists and endoscopic nurses in application of the clip.

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Learning outcome:

OTSC clip is a new tool for closing perforations, sealing fistulas and for hemostasis. Since OTSC is being used rarely in clinical practice, the hands on training of how to prepare and apply the clip might be of benefit. In our study, we have shown that such training improves significantly the skills of both - doctors and nurses.

P-9

Complications in interventional Endoscopic Ultrasound (IEUS): The role of the endoscopy nurse

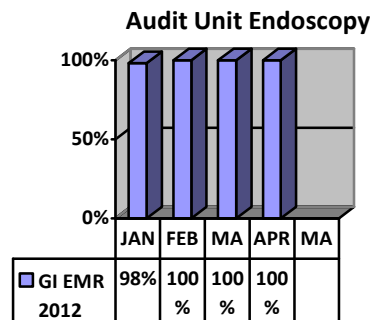
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Background and Aims: The role of endoscopic ultrasound (EUS) therapeutic procedures is continually expanding. Tissue acquisition was the first EUS-guided interventional procedure, followed by such procedures as celiac plexus neurolysis (CPN) and block (CPB), pancreatic pseudocyst drainage, abdominal and mediastinal collection/abscess drainage, and pancreatic and biliary ductal system drainage. No prospective-study data are available on the rate of complications in therapeutic EUS-guided procedures. This study describes the role of endoscopic nursing care in the detection and monitoring of complications related to interventional endoscopic ultrasound before, during, and after an EUS procedure.

Material and Methods: EUS database entries from January 2011 to October 2011 were collected for all complications (e.g., sedation reaction, fever, hemorrhage, acute pancreatitis, intestinal perforations) related to IEUS. For each patient, before the procedure, a nurse checked that the patient data entered into the electronic medical record (EMR) included diagnosis, indication for procedure, comorbidity, drug intake history, whether the patient was NPO, laboratory results, allergies, type of sedation, type of patient education, method of discussion, and eventual on-call blood and antibiotic. Before the procedure a "time out" was done by the nurse, and signed by the endoscopist, anesthesiologist, and nurse. The "time out" folder included patient name, date of birth, scheduled procedure, and whether informed consent had been signed by the patient. Immediate and early complications (e.g., bleeding, abdominal pain, chills) were monitored by a nurse-led, process-driven protocol, based on collection of vital signs, anesthesia data, sedation notes, laboratory results, antibiotic administration, and on the nurse assessment until discharge. Upon discharge, written instructions were provided, with emphasis placed on observation of complications. Follow-up appointments usually continued one week later and, thereafter, based on the clinical situation. Complications were classified as early or late onset, and as mild, moderate, severe, or fatal, on the basis of time to resolution.

Results: A total of 315 interventional EUS were performed over 10 months: 293 EUS-guided biopsies, 14 celiac plexus neurolyses, 7 pseudocyst/abscess drainages, and 1 biliary drainage. For all procedures a nurse's chart was compiled, and "time out" completed. The overall complication rate was 3.5% (11/315). Complications were 2 cases of diarrhea (post-CPN), 1 epigastric pain (post-FNA), 2 intra-cystic hemorrhages and 1 gastric bleeding (post-FNA), 4 fevers (post-FNA,

and 1 post-pseudocyst drainage. All events occurred within 10 days of the procedure, and all but one (moderate) were mild.



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Conclusions: These complex procedures required a fully trained GI nurse, who is responsible for the safety of the patient (often elderly and frail) before, during, and after the procedure. The same nurse is responsible for ensuring that all necessary equipment is available and correctly disinfected, and assists the endoscopist during the procedure.

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P-10

RCT to test the evaluation quality of the PillCam Colon capsule endoscopy by doctors and nurses compared to the expert's evaluation with the involvement of the professional identity of nurses

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Background and aim: There is a current debate on the reorganization of clinical tasks and responsibilities due to the challenge of modern clinics to work cost efficient. The aim of this study was to find out if special trained and experienced nurses can evaluate PillCam Colon capsule endoscopy films as accurately as physicians do. A further interest was to detect possible changes in the professional identity of nurses.

Method: In a nationwide randomized controlled multicentre single blinded trial 9 nurses and 9 physicians interpreted the same 30 PillCam Colon capsule endoscopy films to investigate the agreement in detection of polyps. The results were compared with the diagnosis of 14 international approved experts. The results of the experts were used as reference. Considering the results of the pretest 270 films were needed to detect an adequate diagnostic difference between the two groups. Possible changes in the professional identity of nurses and responsibilities were detected through qualitative group discussions using structural questionnaire.

Results: The sensitivity for detecting polyps of the caregivers in comparison to the expert group was 80.3% and a specificity of 43.7%. Sensitivity and specificity of the diagnosis of polyps >10mm for caregivers were compared to the reference group, 72.4% and 72.6%, respectively. 73.5% voted in the polyp diagnosis consistent with the predicted reference values (OR caregivers: 1.54; doctors OR: 1.89). In determining the size > 10 mm were 93.8% (OR caregivers: 6.4; OR doctors, 9.7). The number of years worked, the analysis time and the number of performed or assisted colonoscopies had no impact on the probability of the reference value of the experts. There is no economic value in the pre-evaluation of colon capsule endoscopy seen by trained caregivers. 90% of the nurses considered a predetection as learnable. The majority (59.3%) did not have any fears to overlook relevant findings. Most of the nurses (72%) have the confidence that a pre-analysis of capsule endoscopy films would have a positive impact on their professional identity.

Conclusion: Considering the comparable sensitivity in polyp-detection a pre-analysis of capsule endoscopy films can be delegated to well trained nurses. The specificity in detecting relevant polyps can be increased through special training and experience. Since the detection of polyps first of all requires a good visual perception and experience, a pre-analysis through well trained nurses seems to be possible. Two Third of the nurses have no concerns to take the responsibility of a pre-detection and more than 70% believe that this new field of activity would have a positive impact on the professional identity.

Learning outcomes:

The conference participants should be aware of

1. the advanced role of nurses in gastroenterology endoscopy

2. pre-analysis through well trained nurses seems to be possible

3. this new field of activity could have a positive impact on the professional identity

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-

P-11

Nutritional status in patients undergoing endoscopic, transmural drainage and necrosectomy for walled-off pancreatic necrosis

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Introduction: During last decade, nutrition in severe acute pancreatitis (SAP) has received a lot of attention. A number of studies have shown that early and active nutrition in patients with SAP improves morbidity and mortality. However, data on frequency of active nutrition and influence on BMI are sparse.

Aim: To investigate the frequency of active nutrition in patients with necrotizing pancreatitis and to investigate whether use of active nutrition has an influence on BMI.

Methods: In November 2006, endoscopic, transmural drainage and necrosectomy (ETDN) for walled-off necrotizing pancreatitis was introduced in our tertiary referral center. During a 5-year period (Nov 2006 – Nov 2011), we retrospectively collected data on all patients who underwent ETDN.

Results: Eighty-one patients were treated with ETDN (mean age 51, 52 men). Fifty-four (67%) received active nutrition. Type of nutrition is shown in Table 1.

In 74 (91%) patients, BMI was registered at both admission and discharge. In active nutrition group, 82% of the patients experienced reduction of BMI during admission.

Table 1. Type of active nutrition

	N (%)
Parenteral + naso-gastric tube + naso-jejunal tube	11 (20,4)
Parenteral + naso-gastric tube	10 (18,5)
Parenteral + naso-jejunal tube	5 (9,3)
Parenteral nutrition only	24 (44,4)
Naso-gastric tube only	3 (5,6)
Naso-jejunal tube only	1 (1,9)
Total	54 (100,0)

Conclusion: We documented a decrease in BMI in majority of our patients despite active nutrition.

Summary: This retrospective study shows that patients with necrotizing pancreatitis are at great risk of losing weight even when receiving active nutrition during the course of disease.

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Learning outcomes: It is important to register data on nutritional status in patients with necrotizing pancreatitis. Despite focus on nutrition, a majority of patients with necrotizing pancreatitis experience reduction in their BMI during the course of the disease

P-12

Does a low residue diet improve bowel preparation?

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Introduction: The importance of improving bowel preparation for colonoscopy is evident from the frequency of poor bowel preparation seen in clinical practice and its resultant negative effects (Dongen, 2012); missed lesions, prolonged procedure time, increased patient discomfort, and the need for repeat procedures (Wu et al, 2011). Our unit performed a literature review on the effectiveness of a low residue diet prior to including this information with our pre procedure patient education pamphlets.

Aim/Objective: To examine the role of a low residue diet in bowel preparation for colonoscopy.

Method: Critical evaluation of studies found through search engines: Embase, Medline; Pub Med; CINAHL; Cochrane reviews. The terms used were 'low residue diet', 'colonoscopy' and 'bowel preparation'.

Results: There are limited number of studies on the effect of dietary restrictions and quality of bowel preparation. Traditionally, patients undergo long periods without food as part of their bowel preparation regime; however this can make compliance difficult for patients and also created added anxiety and discomfort (Wu et al, 2011). One randomized controlled trial aiming to determine whether liberalization of a patient's diet enhances tolerance to bowel preparation regimens found that those following a fibre-free diet on the day prior to their procedure were better able to tolerate the bowel preparation and had better bowel cleansing than patients having to follow a clear liquid diet (Soweid et al., 2010). Wu et al (2011) performed a study on 789 patients who required elective colonoscopies. The patients were provided with written instructions advising them to adhere to a low residue diet for 2 days prior to the procedure. On the day of the procedure they were asked to record their food intake during the preceding 2 days. The authors acknowledge that a limitation to the study was that they asked patients to record type of food and not the amount and as the information was asked retrospectively it was prone to recall bias (Wu et al 2011). The study observed that there is a clinically significant relationship between restriction of dietary residue and the quality of bowel preparation. In an older study Delegge & Kaplan (2005) patients who had a prepackaged low-residue diet had a better bowel preparation than those on a clear liquid diet but it is not clear what contribution the diet had on the preparation as different bowel cleaning preparations were used in the study. Spada et al. (2011) carried out a study to evaluate the effect of a new regimen of bowel preparation for colon capsule endoscopy (CCE) and stated that the impact of a 5-day fibre free diet prior to CCE is unclear. Eliakim et al. (2009) who followed a similar regimen for their study without including a fibre free diet and results of overall colon cleanliness was the same. Park et al (2009) performed a randomized trial to evaluate the efficacy and tolerability of bowel prep protocols based on low residue diet and traditional liquid diet. Results showed that both diets showed similar cleaning efficacy but the low residue diet was more tolerable for the patients.

Summary: Although the institution of a low residue diet preceding a colonoscopy makes intuitive sense there is limited evidence (Wu et al, 2011). Following a low residue diet may be a good adjunct to recommend to patients but is not likely to be sufficient enough to enhance the quality of bowel preparation alone (Dongen, 2011).

Conclusion: There is a need for further research. However, all articles stressed the importance of both patients and nursing staff understanding the importance regarding the different aspects of bowel preparation and institutions should find the means and resources to improve in this area.

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P-13

Preliminary data on safety, efficacy and tolerability of picoprep based bowel preparation for colonoscopy in IBD patients

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Introduction: IBD patients are required to perform several colonoscopies for disease management and cancer surveillance during their lifespan. In the era of sedation the major concern on patients' side is still bowel preparation tolerability and on physicians' side its safety and efficacy. Nurses, being widely involved in informing and educating patients on examination preparation, are often required to mediate between these two positions, but evidence based data on these variables in IBD patients are lacking.

Aims & Methods: Aim of the study is to assess safety, efficacy and tolerability of sodium picosulfate based formulation for colonoscopy preparation (Picoprep) in IBD patients. Consecutive patients in clinical remission (assessed by Harvey Bradshaw Index or Modified

Truelove & Witt Severity Index according to disease sub-type) scheduled for colonoscopy were instructed on bowel preparation with sodium picosulfate formulation. After informed consent, blood and stool samples were collected three times (before, the day of colonoscopy and 30 days after) to assess electrolytes, acid-base status, renal function and gut inflammation (faecal lactoferrin). Efficacy was assessed using the Ottawa Bowel Preparation Scale (OBPS) scoring 0 (perfect cleansing) to 14 (no cleansing). Symptoms were recorded on a diary during bowel preparation and after examination (-3 to +30 days). Wilcoxon signed rank test was used to assess variations on laboratory results between the selected time points in the same patient. Frequencies of reported symptoms and adverse events were used to analyze tolerability. Mean and standard deviation were used for bowel preparation assessment.

Results: 15 patients were enrolled in the study. No statistically significant differences in faecal lactoferrin levels, acid-base status, serum Na, K, and Ca levels were observed before, during and after bowel preparation. A decrease in blood urea nitrogen and an increase in serum creatinine, Mg and Cl levels, but all laboratory results remained inside normal values and returned to previous values 30 days after colonoscopy. Mean score of OBPS was 6.28 (SD 3.02). Regarding tolerability, no severe adverse events were reported. Few mild to moderate adverse events were observed: mild abdominal pain (10/15), nausea (3/15), vomiting (1/15), headache (1/15) and dizziness (1/15).

Conclusion: Despite limitations due to the small number of patients, preliminary data on safety, efficacy and tolerability of Picoprep prescribed to IBD patients seems to confirm that this bowel cleansing formulation is safe, effective and well tolerated.

References:

- LC Hookey, S Vanner. A review of current issues underlying colon cleansing before colonoscopy. *Can J Gastroenterol* 2007;21(2):105-111.
- J. Belsey, O. Epstein & D. Heresbach. Systematic review: oral bowel preparation for colonoscopy. *Aliment Pharmacol Ther* 2007; 25: 373-384

Learning Outcomes: Delegates could learn a relatively new (and probably more acceptable) way of bowel cleansing for IBD patients, its safeness, effectiveness and tolerability.

P-14

Assessment of bowel preparation for colonoscopy: comparison between different tools and different healthcare professionals

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Introduction: Optimal bowel preparation is essential for an appropriate endoscopic examination of the colon. Different schemes and formulations have been developed in order to identify safe and efficient preparations, however the low acceptability in terms of taste and/or volume plays a significant role in bowel cleansing completion. Few complex and time consuming tools have been proposed to evaluate bowel cleansing and all of them required the endoscopist's assessment. In order to simplify further research on

bowel preparation efficacy, it could be useful to identify new tools equally valid and reliable but more user friendly. It may be also interesting to explore the ability of endoscopy nurses to assess gut cleansing as compared to endoscopists.

Aims & Methods: The aims of the study are to assess the concordance of the Ottawa Bowel Preparation Scale (OBPS) with a visual analogic scale (VAS) in measuring bowel cleansing and to measure the agreement on the assessment of bowel cleansing performed by nurses and physicians. Quality of bowel preparation was evaluated independently by the physician and by the endoscopy nurse using the OBPS and VAS. Agreement between healthcare professionals and concordance between tools were assessed by the Pearson correlation coefficient (r).

Results: 85 consecutive colonoscopies were analyzed. Concordance between OBPS and VAS was satisfying both in nurses' hands and in physicians' hands: $r=0.843$ and $r=0.848$ respectively, $p<0.01$ in both cases. Agreement between nurses and physicians was $r=0.571$, $p<0.01$, using OBPS and $r=0.584$, $p<0.01$, using VAS.

Conclusion: VAS assessment of bowel cleansing is significantly correlated with OBPS, a more complex and time consuming tool. It seems plausible that a VAS could be employed in the assessment of bowel preparation in future research and clinical activities. A reliable evaluation of bowel cleansing could be also performed by endoscopy nurses.

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Learning Outcomes: Delegates could learn that ability of nurses to assess gut cleansing is comparable to endoscopists. They could also learn that a VAS can be employed in the assessment of bowel preparation in future research and clinical activities being less complex and less time consuming than other tools.

P-15

Moviprep® taken at split dose intervals is more effective than single dose preparation for to a morning colonoscopy: A literature review

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Introduction: Moviprep® taken at split dose (AM/PM) intervals gives superior bowel cleansing than Moviprep® taken as single dose only (Matro et al, 2010). However, for some patients the early morning regime may not be tolerated (Lichtenstein, 2009)

Aim: To perform a literature review for articles accessing adequacy, tolerability and compliance of AM/PM bowel preparation (prep) for early colonoscopy appointment.

Method: A literature review of CINAHL (Cumulative Index to Nursing and Allied Health Literature) was conducted for full text articles using phrases 'bowel cleansing' (138) 'colonoscopy prep' (6) and 'advances in colonoscopy preparation' (23). 6 articles were specific to split dose bowel prep. Data on patient tolerability,

compliance and adequacy for AM/PM bowel prep was analyzed and reviewed.

Findings: Linking the final dose of AM/PM bowel prep to 4-6 hours pre colonoscopy, increases adequacy of prep (Matro et al, 2010). Dietary restrictions on the day prior to colonoscopy ranged from low residue diet for breakfast and clear fluids versus thick liquid diet for lunch followed by fluids only and bowel prep was recorded as adequate (very good and good) in 72.5-95% of patients. Patient compliance ranged from 85-96%. Although patients are required to get up at 4am and recorded some sleep disturbance (25%) it is not statistically different to other preps. However, there is a statistical difference in patient's pain /discomfort $p0.035$ as split dose experience less discomfort but the incidence of nausea/vomiting and distension is insignificant. One study, Park et al (2010) found that 93% of respondents would be willing to repeat the same bowel prep again.

Summary: Split dose bowel prep achieves adequate bowel cleansing and is tolerated well by patients who are required to take AM dose early on the morning of their colonoscopy.

Conclusion: Split dose prep has been demonstrated to be adequate for bowel cleansing and tolerable for patients. Statistically significant reduction in pain/discomfort is recorded. However, no study discusses rural centers and travel time from home to hospital and this may have an impact on patient's tolerability to split dose morning prep.

Learning Outcomes: split dose bowel prep has been demonstrated to be an effective alternative to single dose bowel prep and patients experience a statistical significant reduction in pain/discomfort.

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P-16

Assessment of the quality of colonoscopies in an area hospital endoscopy unit hospital in Vigo Spain

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Introduction: The quality of endoscopic tests, specifically for colonoscopy is determined, among others, by the degree of cleaning of the colon, which will determine the difficulty, speed and success of a complete test. For this reason, we ask what is the quality of colonoscopies performed in our unit and what

factors could be modified for improvement in quality and performance.

Goal: Assess the level of quality of colonoscopies performed in the unit based on the following variables: patient tolerance to the preparation and exploration, cleanliness of the colon, cecal intubation rate and complication rate in exploration.

Materials and methodology: Cross descriptive study done between the months of July to December 2011, by questionnaire to all patients who came to the unit to undergo a complete colonoscopy. The questionnaire consists of two parts, the first completed by the patient and the second by the nursing staff. The obtained data were analyzed using Excel database.

Results: During the study period 868 colonoscopies took place, distributing questionnaires to all patients. Valued 723 (83,29% of the total) due to errors in the completion. The profile of the patient were men aged 56. In terms of tolerance to the preparation it is valued according to the following items: abdominal bloating, nausea / vomiting, abdominal pain and thirst. The results were placed in the top three, between 75% - 80% in the answer "nothing". Highlight the item "thirst" in which the results are in the answer "nothing" in a 57.68% and "a little" 31.40% of cases. Tolerance to the exploration, the 89.49% of cases are grouped into the answers with 47,58% "good" and "excellent" with 41,91%. The degree of cleanliness of the colon was bad by 2.49%, to regulate a 45,92% and good a 44.95%. The cecal intubation rate was 93.78% and the complication rate in the exploration of 0.41%.

Conclusions: The results in tolerance to the preparation were homogeneous in all items, except the thirst, and this is the trouble that most patients presented. For exploring tolerance, almost 90% of cases are grouped into "good" and "excellent", which conveys an assessment of consensus on the positive results. We think it is important to highlight that, although to the degree of cleanliness of the colon was "regular" almost in half of the cases, the rate of cecal intubations is close to all of colonoscopies carried out and there is a minimum percentage of complications during exploration.

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The learning outcomes

- Highlight the "thirst" symptom to explain the preparation to the patient.
- Importance of a good preparation to improve the degree of cleanliness of the colon and cecal intubations rate.

P-17

The right hand for the right press: abdominal press during colonoscopy, experience of a colorectal cancer screening team

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Introduction: Percentage of cecal intubation and also the time required to reach the cecum are important criteria used to assess the adequacy of a colorectal cancer screening team. Experienced endoscopists won't reach high percentages of cecal intubation without the work of an experienced nurse team. How to press abdomen during a colonoscopy is a fundamental practice to reduce the duration time of colonoscopy, increase percentage of cecal intubation and reduce patients discomfort^{1,2}.

Aims & Methods: find the best sequential abdominal compression procedure according to patients anthropometrical features to obtain maximum percentage of cecal intubation and in an adequate time.

Methods: 100 (46 F and 54 M) consecutive patients gone for screening colonoscopy were enrolled in the study, mean age 60,7 yr (range 49- 69). Clinic and anthropometric data were collected. All nurses in our service were instructed to perform the abdominal compression sequence (APS) necessary to accomplish the endoscopy: 1)first 15-20 cm, squeeze with left hand in right iliac fossa exerting pressure from outside to the contralateral side. 2)From 25 to 50 cm, keeping the position n. 1, with the right hand to make a compression from the epigastrium downwards. 3)From 50 cm up to the splenic flexure, slightly compressing the right upper quadrant and epigastrium with the outer edge of the left hand while his right hand makes a compression from the outside inward in left hypochondrium. 4)At the transverse, if the patient is placed supine, compress the epigastrium with the left hand, while with his right hand to compress the upper left hand to direct the instrument toward the hepatic flexure.5)At the hepatic flexure, exert compression right upper quadrant with the right hand.

Results: cecal intubation rate was 99%. Average cecal intubation time (CIT) was 4 min and 49 sec (range 1 min 30 sec - 13 min). In 86 patients the APS has been successful, producing a lower CIT (4 min 4 sec vs. 7 min 16 sec, p<0,0001). BMI, abdominal circumference, sex, age, weight, past abdominal surgery don't influence our APS (p=ns). At the multivariate analysis CIT is correlated with Sex (F 5min 4sec vs. M 4min, p<0,05), APS (p<0,001) and Age(p<0,05).

Conclusion: our abdominal press sequence is associated with optimal cecal intubation, requires shorter time and it is not influenced by physical features of the patients. Trained nurses in this procedure will contribute to achieve the highest colonoscopy success rate, minimizing the patient discomfort .

References:

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P-18

Illness perception in patients with hereditary colorectal cancer

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Introduction: Familial adenomatous polyposis (FAP) is a genetic predisposition to developing colorectal cancer. Although rare (1% of all colorectal cancer cases), FAP is one of the most clearly defined of the inherited colon cancer syndromes. To prevent colorectal cancer most patients require removal of the colon in young age followed by lifelong endoscopic surveillance [1]. Non-adherence to endoscopic surveillance in FAP-affected patients has been reported to be quite high, ranging from 26% [2] to 46% [3]. Illness perceptions are considered to be important for patients' actions to a health threat (e.g., adherence or non-adherence to treatment) [4] and have also been shown to be related to general distress and cancer worry in patients with hereditary cancer [5].

Objectives: To examine how patients with FAP perceive their illness and to investigate socio-demographic, clinical (including number of abdominal symptoms) and physical and mental health predictors of illness perception.

Method: Two hundred nine of 276 eligible persons with FAP participated (response rate 76%). The Revised Illness Perception Questionnaire (IPQ-R) was used to evaluate patients' illness perception. Short form 36 (SF-36) was used to measure the patients perception of physical and mental health. To determine predictors of illness perception seven hierarchical linear regression analyses were computed.

Results: Patients with FAP considered the condition as chronic and difficult to control. Negative consequences on life and emotional distress caused by FAP were reported to a limited extent. Nevertheless, lower levels of physical and mental health had a statistically significant impact on illness perception as did number of abdominal symptoms. Patients responded to statements suggesting good understanding of the illness.

Conclusion: Overall, surgically treated patients with FAP have a coherent understanding of the illness and to some extent comprehend its negative consequences and emotional impact on life. However, an increased number of self-reported abdominal symptoms together with lower levels of physical and mental health were found to be important predictors of negative illness perceptions. Based on the present results, it is strongly recommended that surgically treated patients with FAP are followed-up by professional caregivers who assess self-reported abdominal symptoms as well as physical and mental health.

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P-19

Sharing nursing experience in Hepatology

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Introduction: In Denmark advanced hepatology is centralized at the Clinic of Hepatology at Rigshospitalet in Copenhagen and Department of Hepatology and Gastroenterology in Aarhus. Therefore specialist knowledge is concentrated at these two departments. The doctors of these departments have traditionally shared knowledge and experience to promote qualified and evidence-based treatments. A similar structured cooperation between the nurses of the two departments has never been established leading to limited development of existing knowledge and best practice nursing patients with liver diseases. A group of nurses from Aarhus set out to develop a clinical guideline regarding the specialized nursing care for patients with liver cirrhosis. During the developing process it became evident that cooperation between nurses from the two departments could improve the future work insuring regimentation and optimization of the nursing standard to liver patients in Denmark.

Aims: The establishment of a cooperation and knowledge sharing culture between the nurses from the two departments, that can be beneficial to both patients and staff.

Methods: To launch the cooperation, an exchange of nurses between the departments was arranged. Comparison of documentation tools and nursing guidelines from the two departments were exchanged and compared. Furthermore interviews concerning nursing procedures, work organization and tradition determinant cultures in the departments were done.

Results: An annual conference, dealing with hepatology nursing on a specialist level is established. Nurse-led studies and projects from both departments is presented and discussed at this conference. Furthermore the ongoing exchange of nursing staff between Aarhus and Copenhagen contribute to a more versatile knowledge of hepatic nursing and has increased awareness of development potentials.

Conclusion: A knowledge sharing culture and structured cooperation and between nurses from highly specialized departments is advantageous to staff and patients alike, insuring regimentation and high nursing standard as well as evidence-based nursing.

Learning outcomes: I hope our experience can inspire to engage in similar cooperation between specialized

wards. We found that the exchange of nurses is an effective way to learn and add to existing knowledge. It breaks down barriers of distance and different cultures in the wards, and made the set up of a peer group simple.

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P-20

Nursing and alcoholic hepatitis.

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Introduction: Patients with alcoholic hepatitis are known to suffer from malnutrition. We also know that these patients have a high mortality rate. Early nutrition intervention is essential to insure an adequate consumption of energy and protein. Studies show increased mortality for patients with alcoholic hepatitis and a negative nitrogen balance compared to those with a positive balance. Furthermore enteral nutrition shows better long term survival than corticosteroid treatment, which means that nutrition does matter. Nursing these patients we face the challenge of making the patients eat, because of loathing of food, nausea and vomiting. How do we face this challenge?

Aim: To investigate the nutrition treatment and nursing of patients with alcoholic hepatitis, in order to identify areas to be optimised.

Method: Retrospective study of 20 patients diagnosed with alcoholic hepatitis in hepatic-gastroenterological unit. The data sources were medical – and nursing journals. We searched for: weight, nutrition status at admission, daily food registration, loathing of food, nausea and vomiting (both prior to and during hospitalization), nutrition interventions (NI) (tube feeding or parenteral nutrition) and medication.

Findings: The journal audit showed that nutrition was the key issue in nursing and treating patients with alcoholic hepatitis. 13 patients already had problems with loathing of food, nausea and vomiting on the day of admission. For 11 patients, these problems continued during the whole hospitalization. Only five of them were treated with nauseareducing medicine. Nine patients experienced difficulties taking their prescribed medicine orally. All patients had a daily food registration from the first day. Six patients waited between Two – six days before starting NI. Five patients did not receive NI. Four patients died and three of these had delayed or none NI.

Summary: Most of the patients hospitalized with alcoholic hepatitis suffer from loathing of food, nausea and vomiting. These problems continued for most of the patients during hospitalization. More than half of the patients waited more than two days before any NI were made.

Conclusions: Nutrition is essential for these patients and a key issue of nursing and treatment. Still we are not consistent in the way we approach these patients. We tend to hesitate when it comes to NI and we are not

consistent in reducing nausea. We need a standard nursing guideline for these patients.

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Learning outcomes:

If we can make nurses aware of the problem and motivate them to face the challenge, we can reduce mortality.

After highlighting the issue, every nurse will go home and reflect upon how patients with alcoholic hepatitis are treated in their department.

P-21

Reasons for telephone consultations of patients on treatment for chronic hepatitis C.

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Background: Treatment of hepatitis C consists of a combination of peginterferon and ribavirin for 24 to 48 weeks depending on viral genotype and treatment response. Adherence is a key factor to improve cure rates. Health education and easier access to the multidisciplinary team improve adherence.

Objective: To identify the main reasons for telephone consultation of these patients.

Method: A prospective, observational, two-year study. Primary variable: reason for consultation; secondary variables: demographic data, treatment week, query resolution.

Results: A total of 176 patients with a mean age of 48 years, 67.6% males, were enrolled in the study. There were 264 telephone consultations performed by 109 patients (53% women). The main reasons for telephone consultation included side effects (40.2%) and questions about doubts (28%). Actions performed included provision of information (58.3%), visit appointment or advancement (22%), discussion with physician in charge (11.4%).

Conclusions: Most telephone consultations concerned side effects of treatment. Consultations were mainly made by women. The capacity of nurses to solve many of the consultations shows their significant role in the multidisciplinary team.

Keywords: hepatitis C, medication adherence, nursing assessment, nursing care.

Learning Outcomes

This study has allowed us to detect areas to improve patient education. Extended side effects treatment should be provided.

Provision of a telephone number facilitates contact of patients and/or families with the multidisciplinary team.

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P-22

Assessment of workload and manning levels in endoscopy units

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Introduction: The definition of the needs and requirements for manning is among the various duties of a Nursing Department. In Italy there aren't national norms indicating a method for assessing the workload and the manning level for professional nurses and support personnel in different clinical specialties. However some national laws and other publications may act as helpful references for this purpose.

Aim: A group of Nurse Coordinators of Italian Gastroenterology and Endoscopy Units proposed to:

- estimate the need of nursing care in an Endoscopy Unit
- estimate the manning level based on the health care needs and the type of endoscopy procedures

Method: The group worked to develop a paper with the following content:

- surveying of the competences of professional nurses and support personnel in Endoscopy
- description of the prevailing processes which mainly weigh upon the activity of health workers in Endoscopy
- assessment of the staff needed in different Endoscopy and Gastroenterology Rooms according to the type of procedure and healthcare activity

Results: Using the method described above, the following scheme was sketched out:

Typology of room - procedure/health care activity	N. of professional nurses
Gastroscope Room (diagnostic-operative procedures)	1,5
Colonoscopy Room (diagnostic-operative procedures)	2
Sigmoidoscopy Room	1
Physiopathology Room	1
Room for UBT	1
Gastroenterology Ambulatory	1
Recovery Room	1
On call availability	1 + 1 nurse ER/OP theatre

Besides professional nurses, support personnel like the so called socio-sanitary operators (one every second room) or administrative staff (one dedicated to the Endoscopy Unit) can be considered. (In Italy "OSS" (socio-sanitary operators) are unlicensed healthcare workers that can support professional healthcare workers)

Conclusions and learning outcomes: This work describes a methodology which may be helpful for the quantification of nursing and support personnel in Endoscopy Units. In particular we underline how the methodology adopted can facilitate:

- a. creation of conditions for the assessment and improvement of professional performances;
- b. clear identification of healthcare processes relevant for nurses and of managerial processes that are of competence of the Endoscopy Unit Coordinator;
- c. implementation of productivity in terms of efficiency.

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Hemochromatosis: Nursing care in therapeutic blood letting versus blood donation

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Introduction: Hemochromatosis type 1 is a genetic problem caused by a genetic mutation (known as HFE gene C282Y) which is characterized by an accelerated rate of intestinal iron absorption from childhood. There are progressive iron depositions that begin to be expressed in maturity, including hepatic cirrhosis, hepatic fibrosis, cancer, diabetes, cardiomyopathy, arthritis, hypogonadism and impotency.

Treatment is based on phlebotomies (therapeutic blood letting) until levels of serum ferritin are lower than 50 g/l. There are no screening tests. Weekly and then quarterly phlebotomies contribute to lowering the amount of iron in the body.

In Spain, prevalence is 1/1000*. The patient with hemochromatosis with no symptoms is considered a blood donor if they fulfill the "Basic Criteria for Blood Donors Selection" published by the Ministry of Health in Spain.

Aims:

- to detail nursing care administered during therapeutic blood letting versus blood donation;
- to describe the protocols of therapeutic blood letting versus blood donation; protocol
- to capitalise on the possibility of safety using blood products of excellent quality donated by patients with hemochromatosis.

Methods: First of all, the nurse evaluates the patient/donor through physical examination, blood tests and a questionnaire. When all of these are suitable, the phlebotomy will be carried out.

The blood is drawn from a large arm vein such as basilic or cephalic vein which is touchable, strong and with no scars. A tourniquet is wrapped around the upper arm and the skin over the blood vessel is disinfected with chlorhexidine. The blood is collected into a 4 bag blood container that also contains anti-coagulant and a connector for blood samples. A mechanical tray agitates the bag to mix the blood and weighs it during the whole procedure.

Patient should be reclined during donation and may drink refreshments. This allows a continuous evaluation and to provide recommendations and nursing care post-phlebotomy.

After about 450 ml of blood is taken, the needle is removed. A gauze covers the place to press firmly.

Nursing recommendations after the procedure are: to drink liquids (1-1.5 litres) within 2-3 hours, to not lift weights with the arm, to avoid warm places, to wait 30-60 minutes before driving, and keep the gauze on for 2-3 hours.

Results and conclusions:

The blood from patients who suffer from hemochromatosis is proved to be suitable for blood donation because of its higher quality than that of regular donors.

Proper nurse information and advice contributes to make this procedure more profitable.

Campaigns of blood donation should be carried out by nurses in Gastroenterology Units.

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Learning outcomes

Hemochromatosis type 1 does not contradict blood donation. This is valuable because of its rich in iron and reticulocytes.

The politics of promotion blood donation should be concerned with the inclusion of groups of this kind because there are studies that demonstrate they are safe and useful.

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10. Announcement for next ESGENA Conference



17th ESGENA Conference

12-14 October 2013

Hosted by the



In Conjunction with the
21st United European Gastroenterology Week
At the "Internationales Congress Centrum Berlin" (ICC), Germany

Conference Website 2013: www.ueg.eu/week/

Call for Abstracts for the 17th ESGENA Conference 2013

ESGENA invites nurses from Europe and from all over the world to present their experience, studies and projects at the 17th ESGENA Conference in October 2013 in Berlin, Germany. Participants wishing to submit abstracts can do so only in electronic format by sending a MS Word document with their abstract by email to:

Ulrike Beilenhoff, ESGENA Scientific Secretariat, Email: [UK-Beilenhoff\[at\]t-online.de](mailto:UK-Beilenhoff[at]t-online.de)

Deadline for submitting abstracts: May 31, 2013

The authors will receive an official confirmation within 3-5 days after submitting their abstract. If authors do not get an official confirmation within 5 days, please send the abstract again to Ulrike Beilenhoff and a copy to the ESGENA technical secretariat: info@esgena.org.

General Information on Abstract Submission

Participants are invited to submit original scientific abstracts for oral or poster presentation. Authors have to conform to the following guidelines for abstract submission.

Those not conforming to the guidelines will not be considered for reviewing.

- Abstracts must be submitted in English and must be presented in English.
- Abstracts will be reviewed by a panel of experts and may be selected for oral or poster presentations, or may be rejected.
- Notification of acceptance (for oral or poster presentation) or rejection by the Scientific Programme Committee will be emailed to the presenting author by June 30, 2013
- Detailed information, guidelines and recommendations for oral or poster presentation, as well as day, time and room will be sent in due time to duly registered presenting authors.
- The time allotted for each oral presentation will be 10 minutes, followed by 5 minutes of question time.
- During the poster round, authors of posters should also be prepared to answer questions in English.
- The presenting author of an accepted free paper or poster will receive a free registration to the ESGENA Conference.
- Accepted abstracts will be published in the ESGENA Abstract Book and on the ESGENA website.

Preparation of Abstract

The abstract should be typed as follows:

- Use font that is easy to read such as Arial, Times Roman, Helvetica or Courier fonts.
- The abstract must not be more than 500 words long or must not fill more than one A4 page, using type in 12-point font.
- A brief title, which clearly states the nature of the investigation.
- Abbreviations should, if possible, be avoided in the title, but may be used in the text if they are defined on the first usage.
- The authors' names (full first name, surname) and the institution (hospital, university, organisation, city and country and email) where the research was carried out, with the name of the presenting author underlined.
- Use single line spacing.
- Include tables if necessary.
- The abstract should be as informative as possible.

- The abstract should have a logical, scientific structure (introduction, mains & objectives, method, results, conclusion, summary, references, learning outcomes for audience) (see further information below “Scientific Abstract Template”)
- Statements such as „results will be discussed “ or „data /information will be presented “ cannot be accepted.
- Please ensure that your abstracts do not contain any spelling, grammar or scientific errors, as it will be reproduced exactly as submitted.
- The abstract should have a nursing relevant content and should add to existing knowledge.
- The abstract should have a minimum of 2 relevant references.
- The abstract should state 2 things the delegates could learn from your presentation.

Possible Reasons for Rejection:

- Not complying with conference-specific format requirements – Abstract Template - see below
- The authors’ inability to communicate effectively in written English.
- Poor Grammar, spelling, sentence structure, or incorrect abbreviations,
- Inconsistency between Title, Aims, Results, Conclusion, etc
- Poor Science / Methodology*
- Vagueness – not giving enough information
- Too specific, failing to succinctly summarise findings and/or too long. (limit to 200 – 300 words or one A4 page)
- Incomplete results (e.g. no results or stating “results will be presented”)
- Descriptive work without analysis
- Abstract without any New Information
- Abstract advocating unacceptable or dangerous practice
- Already presented at previous ESGENA conferences
- Predominantly Medical Abstract not stating relevance to Nursing Practice

* Different Types of Research (Methodology):

Please, choose the Methodology you want to use

Systematic Review	Literature Review focused on a research question. Identifies, appraises, selects and synthesises all high quality research evidence relevant to the research question (e.g. bowel prep)
Meta-Analysis	Combines data from several already published studies (statistical method of combining data evidence) ➤ Focused on contrasting and combining results from different studies with same or similar research methodology (patient selection, inclusions / exclusions, etc)
Cohort Study (Prediction)	A (prospective) study in which a particular outcome, (e.g. death from a colon cancer), is compared in groups of people who are alike in most ways, but differ by a certain characteristic (e.g. diet). ➤ It is an analysis of risk factors ➤ A COHORT is a group of people who share a common characteristic or experience within a defined period
Qualitative Research Studies (Exploration)	Qualitative research aims to gather : ➤ an in-depth understanding of human behaviour and ➤ the reasons that control such behaviour.
Service or Program Evaluation	Appropriateness, need and efficiency of a health care service. ➤ May include patient satisfaction study of new or changed service ➤ May include evaluation of an educational initiative
Audit	Examination of a programme, functions, operation or the management systems and procedures – and how practices compare to e.g. guidelines, e.g. ➤ Conformity audit (e.g. with ISO,) ➤ Clinical audit ➤ Hygiene audit ➤ Etc
Case Report	Detailed report of a single (unusual) event (Anecdotal evidence) e.g.: ➤ Clinical: the symptoms, signs, diagnosis, treatment, and follow-up of an individual patient. ➤ Managerial ➤ Educational
Randomized controlled Trial (Intervention)	– usually requires Ethics Approval if patients are included and medical products are used = CTIMP (European Clinical Trials Regulation)

How to prepare a well-written abstract

Use Abstract Template (see Word file)

Please complete **ALL Sections** of the **Abstract Template** and delete the *Explanatory Notes Column* before submission

Scientific Abstract Template (limit: 500 words or one A4 page) - Please complete ALL Sections	Explanatory Notes When completed, and before submission – delete this column
Title	10 – 12 words that capture the relevance and essence of the research
Introduction / Background	<ul style="list-style-type: none"> ➤ What has been investigated ➤ Why is the research important ➤ Context of the study - has something similar already been done and how the presented work differs
Aims / Objectives	<ul style="list-style-type: none"> ➤ The purpose of the RESEARCH / project– <i>not of the abstract!</i> ➤ Providing a brief synopsis ➤ Hypothesis, question or concept underpinning the research.
(Research) Methods * Please indicate which methodology you have used and delete non-applicable methods: <ul style="list-style-type: none"> ➤ Randomized Controlled Trial (Intervention) ➤ Meta-Analysis ➤ Systematic Review ➤ Cohort Study (Prediction) ➤ Qualitative Research Studies (Exploration) ➤ Service / Program Evaluation ➤ Audit ➤ Case Report ➤ Other: <i>state which</i> 	<ul style="list-style-type: none"> ➤ Should describe HOW the AIMS of the research were achieved. ➤ What the research/project involved - for example: <ul style="list-style-type: none"> * Short description of the study design * Underpinning theoretical or conceptual frameworks, * Sampling technique(s) used, e.g. qualitative or quantitative, * Retrospective or prospective * Method of data collection: e.g. review, surveys, focus groups, patient cohorts etc. * Sample size, criteria for selection and exclusion, * Randomised or non-randomised. * Type / method(s) of data analysis (tests) * Statistical or interpretative analysis software programs used (GENERIC name of the software) * If applicable: state if <i>Ethics Approval</i> was obtained.
Findings / Results	What the research discovered <ul style="list-style-type: none"> ➤ Synopsis of the findings of the study, using key data to demonstrate the outcomes. ➤ Avoid simply citing data, particularly in quantitative studies. ➤ State statistical significance (quantitative studies) ➤ Synthesis of the data and how it answers your research question. NEVER submit an abstract without results,
Summary and Discussion	<ul style="list-style-type: none"> ➤ Provide a short explanation of HOW the findings relate to the <i>AIMS</i>, ➤ present EVIDENCE of the findings from your <i>METHODS</i> (to support the implications of your study = conclusions) ➤ Critically define any weaknesses / strengths identified in your data

Conclusion	What the research implies ➤ IMPLICATIONS of the findings and ➤ how they ADD to the existing knowledge
Learning Outcomes + Relevance to Nursing Practice	Relevance to Nursing and how the findings can be used/applied in Clinical Practice
References	What publications were reviewed ➤ before study started (Background) ➤ in the Critical Analysis of the findings/results and conclusions
Declaration: This research has previously been presented at an ESGENA Conference <input type="checkbox"/> YES <input type="checkbox"/> NO	

Writing a **high-quality abstract** is essential if it is to be selected for presentation at an international conference.