Message from the Chair

Dear colleagues

Although belated I would like to wish you all a Very Happy New Year and success and happiness in all your endeavors.

The past year has been another very busy but also successful one for ESGENA.

Our annual conference in conjunction with the UEGW was a success with over 400 nurses attending, despite a disappointingly low turnout from Spain as they had their own annual conference within the same month. This highlights the continued disadvantage nurses have compared to doctors when trying to get conference sponsorship and study leave. I would like to take this opportunity of sincerely thanking all my colleagues in ESGENA for the immense support during the preparation of the conference. In particular I would like to thank the Spanish nurses’ committee who despite limitations in English worked extremely efficiently, and promptly responded to any queries. Above all I would like to thank Pilar Perez Rojo and Laura Sicilia for their help and co-operation, which can’t have been easy, as they also had to prepare their national congress. All the stress of organizing the meeting was forgotten during a very joyful and entertaining Welcome Reception organized by the Spanish nurses on Saturday night.

Our other education activities have also been successful. The Education Working Group has continued the work on the Core Curriculum and we have now finalized the Modules and their content. This year we will concentrate on the way we want to assess and evaluate the various competencies. Our co-operation with ESGE has continued during 2003 with both the Guideline Committee, which produced 2 publications (Guidelines for Live Demonstration, Technical Note on Cleaning & Disinfection), and with the Education Committee in form of a very successful...
Live Demonstration Workshop in Athens where ESGENA was represented by Pilar Perez Rojo, Sylvia Lahey and Christine Petersen. Again, the good co-operation with the local nurses’ group and in particular Vassiliki Katsilaki was a key element in the success of the meeting. You will find a more detailed report about this workshop in the Newsletter.

Membership of ESGENA has increased over the last year and for the first time our total membership exceeds 6000. Also for the first time a non-endoscopy GI nursing society has joined – the Spanish Society of Hepatology nurses.

On a broader level we have increased our co-operation with the Standing Committee of Nurses in the EU and with other European specialist nurses’ societies. We will report on this in the next newsletter.

All these activities were only possible through the continued support from the Industry. Their financial backing provides the main income of the society. I would like to thank all our sponsors, both major sponsor of the society as well as the conference sponsors for their unflagging support.

Last but not least I would like to thank Ulrike Beilenhoff. I am greatly indebted to Ulrike for her continued help to me personally and her hard work for ESGENA, despite her pregnancy last year, and in October - birth of her baby son. Although this joyful occasion prevented her from attending our conference in Madrid, it did not prevent her from contributing significantly in the preparation, nor was she forgotten as many of the delegates wanted to hear about her good news.

My first year as president has been a most enjoyable one and it goes without saying that I have developed a great affinity with my colleagues in ESGENA and particularly with all the members of the Board who I wish to thank for their help. It has been rewarding to share work with so many of you, and the society would not be the same without all your contribution. Together we look forward to a fruitful year 2004.

Christiane Neumann, President

We would like to express our gratitude to our major sponsors who have continuously supported ESGENA financially. This has facilitated the society different activities, including the European conference:

Thank very much for your support!!!

- BOSTON SCIENTIFIC INT.
- FUJINON (EUROPE) GmbH
- OLYMPUS OPTICAL (Co.) EUROPE
- PENTAX
- WILSON COOK MEDICAL INC.

ESGENA – Governing Board

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<th>ADDRESS</th>
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<th>FAX</th>
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<tr>
<td>PRESIDENT</td>
<td>Christiane S. Neumann</td>
<td>c/o Clinical Investigation Unit</td>
<td>+44 121 5075581</td>
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<tr>
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<tr>
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<td>0031 26 3786737</td>
<td><a href="mailto:sylvia.lahey@planet.nl">sylvia.lahey@planet.nl</a></td>
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<tr>
<td>TREASURER</td>
<td>Ulrike Beilenhoff</td>
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<td></td>
<td><a href="mailto:UK-Beilenhoff@t-online.de">UK-Beilenhoff@t-online.de</a></td>
</tr>
<tr>
<td>COUNCILLOR</td>
<td>Hélène Desirat</td>
<td>I.F.S.I. du CH de Rambouillet</td>
<td></td>
<td></td>
<td><a href="mailto:H.Desirat@ch-Rambouillet.fr">H.Desirat@ch-Rambouillet.fr</a></td>
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<td>+386 1 231 6096</td>
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<td>University Hospital Vienna Internal Medicine IV, Endoscopy</td>
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Letter from the Editor

In the past the ESGENA Newsletter included general information as well as information specific for members. It was a communication instrument as well as an advertising instrument of ESGENA. The ESGENA governing board decided to increase the advertising activities on one hand and to increase the communication with its members on the other hand. Therefore membership information are published now on special membership pages as an additional supplement which are sent to ESGENA members ONLY, while the newsletter can be used for advertising issues also. This management can also be a stimulus to get new members.

We would like to thank all authors for submitting articles. Their contribution made this issue of the ESGENA Newsletter possible.

Ulrike Beilenhoff

The 7th ESGENA Conference: A warm Spanish Welcome!

The first days of last November were very enriching for the participants of the 7th ESGENA conference organised in conjunction with the 11th United European Gastroenterology week in the cosmopolitan and historic city of Madrid. 355 attendees from the nursing profession representing over 35 countries world-wide found a varied scientific programme of lectures beginning on Saturday November 1st with 8 workshops held in Spanish or English.

Table: ESGENA Participants in Madrid

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<th>Countries and participants per country</th>
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<td>Australia 6</td>
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<td>Japan 1</td>
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Once again this international venue enabled nurses from Gastroenterology and Endoscopy to share experiences around the different topics presented such as: Extended nursing roles in endoscopy; quality assurance in endoscopy; hygiene in endoscopy; aspects of nutrition care. The smaller size of the workshop attendance capacity made discussion, questions and exchange of ideas very enriching for speakers and audiences. Between lectures on Monday 3rd November, attendees were impressed by the quality of the scientific posters and had the opportunity to browse around the numerous stands of the ever popular trade exhibition.

A very impressive welcome reception was held at the famous Feria of Madrid with a delicious and colourful buffet of Spanish food and wine. During their stay participants had the opportunity to sample some of the delights the colourful and bouncing capital of Spain had to offer especially in the evenings.

The energy, smile and high professional level of the nurses of the Spanish Society of Endoscopy Nurses and Associates(AEED) made this meeting a very successful one leaving us with additional scientific and cultural knowledge.

Helene Desirat
ESGENA Councillor
30th Annual Congress,, Society of Gastroenterology Nurses and Associates and the Certifying Board of Gastroenterology Nurses and Associates in Atlanta, Georgia, USA.

Atlanta: the city in the south of the USA, capital of the state of Georgia, former venue of the 1996 summer Olympic games and birthplace of Martin Luther King, Jr. This city is now the main home office of many large international companies, such as Coca Cola and American Airlines, and boasts the second largest airport in the USA. Today’s Atlanta is a continually changing and upcoming city. In the spring of 2003, Atlanta was the host city and site of the 30th Annual Congress of the SGNA and the CBGNA. The Congress was held from May 16 to May 21, and this year’s motto was, “The Three Ts: "Traditions - Trends – Tomorrow.”

The American Society of Gastroenterology Nurses and Associates (SGNA) includes 7000 members and 62 regional teams which provide very motivated, constructive and specialized services. At the Congress, the regional sections took advantage of the opportunity to present their region and their current work in a separate poster session that was met with avid interest.

The Congress venue, the enormous Hyatt Regency Hotel with 1500 beds, is located directly downtown, and offered outstanding possibilities for meetings. Some 1570 participants used the opportunity to exchange information, to make interactive contacts, to expand their knowledge, and to catch up with friends and colleagues. Because this was the largest purely American Congress, the number of non-Americans (Canadians, Australians, one Dutch and one Swiss) was somewhat small, but this was not a problem. On the contrary, this only encouraged the „foreign” participants to take a common yet broader look “past the rim of the endoscopy plate.” A stronger participation by European colleagues in the future would certainly make sense as even Europeans can contribute to the continued development of our profession!

The goals of this SGNA Congress were to:

- Present information about current and newly developed diagnostic and treatment techniques in gastroenterology and their application in the "art and science" of nursing care;
- Provide a forum for "networking" and exchanging ideas among the participants present, with the objective of further improving the practice of nursing and patient care, and
- Continued education in a wide range of clinical and speciality offerings at all levels, from beginners up to experts.

Accordingly, the SGNA had organised a challenging and broadly-based Congress program where the events focused on topics ranging from general interest issues, such as would be appropriate for beginners or for advanced staff, up to speciality-programs in paediatrics endoscopy, management, nursing research, out-patient services and much more.

In many lectures and discussions, the central importance of nursing care in endoscopy was worked out and fine-tuned. This means an occupation that is not just limited to assisting at the examination table, but something much more comprehensive! In many presentations under the key-word of "wholeness,” the focus was consciously placed on the patient.

New this year was the opportunity to choose additional speciality events where chosen topics could be followed from Friday to Sunday. During the practice-oriented meetings, more information was delivered on topics such as advanced EUS, pneumology and how to provide the best services in the field of endoscopy.

The plenary sessions began on Sunday with an introductory overview talk by Barbara Blakeney on the topic of "Nursing: Building for the Future Through Partnership and Collaboration.” Dr. C. Robert Dahl presented a lecture on the topic, "The Varied Presentation of Celiac Disease: How to Evaluate and Treat.” The main presentations in the following days included „Foreign Matters” by Dr. Daniel Meline; „The Changing Face of AIDS,” by Cathy Robinson and a panel discussion led by Dr. Gordon Eckerling on the topic of „Therapy in the Community Setting: Treatment for Gastropareisis.” The final presentation was again an overview talk by Dr. Joyce

All of the e-Sig Sessions provided continuing education information on a specific topic that was followed by an interactive event. The competing meetings were filled from A to Z with traditional pathophysiology and future trends and challenges for practical nursing care.

The industry was likewise present in large form with their exhibitions that ran from Sunday to Tuesday, and also during the on-going programs, parallel industry-specific lectures were also held.

In addition to a diverse Congress program, one could meet colleagues and friends in a relaxed atmosphere and exchange ideas during the evening events that spanned the gamut from the "Welcome Reception" to the "Gala Awards Banquet." This importance of this type of dialogue and networking should not be underestimated.

Summarising the Congress:

Endoscopy personnel in America and Europe should, no - must, collaborate more closely together and continuously exchange experiences. Common personnel-specific aspects that stand out in importance include subjects such as additional certification, job description, field of activity, advanced and continued education, teams, and uniform standards. An international, recognised classification for nursing personnel in the field of endoscopy must be further established!

Additionally, patient-specific aspects, such as health promotion and health education together with nursing care research and ethics in endoscopy, must be increasingly considered and discussed. These exchanges should traverse borders in both Europe and in the US.

"The patient stands at the center of our daily versatile and challenging work. Caring for the entire patient is one aspect that must be improved even further!"

Basle, July 9, 2003,

Michael Ortmann

Qualification:
RN, Endoscopy specialist education

Responsibilities / tasks:
Advanced and Continued Endoscopy Education at the University Hospital Basle
Advanced and Continued German Education within the Swiss Society SVEP/ASPE

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ESGENA Activities in 2003

ESGENA membership – update

The ESGENA members total 6100 from 31 different countries:
- 27 Endoscopy nurses’ societies in 24 countries
- 94 individual members in 27 countries
- 8 passive members in 5 countries
- 1 honorary member and
- 12 affiliated members from 9 companies

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Subtotal: 5983 94

Passive members:
Australia (2) Canada (1) Sudan (1)
USA (3) Zambia (1)
Affiliated Members:
12 members of 9 different companies:
Boston Scientific, CBC,
Endotronic Finland, Fujinon (Europe) GmbH,
Olympus Optical (Europe), Pauldrach & Mackay,
Pentax GmbH, Schülke & Mayr,
Steris Corporation

ESGENA welcomes its new members.

New ESGENA Web Page

Since December 2003 the ESGENA website www.esgena.org has been redesigned with updated information and some new columns.

ESGE-ESGENA-Guidelines

The "ESGE-ESGENA-Guideline for Live Demonstration Courses" was published in Endoscopy 2003; 35 (9); 781-784.

The "ESGE-ESGENA Technical Report on Cleaning and Disinfection" was published in Endoscopy 2003; 35 (10); 869-877. This report gives information about advantages and disadvantages of Glutaraldehyde and its various alternatives used on the European market.

ESGE-Workshops and Symposia

ESGENA delegates participated in the ESGE-ESGENA-workshop on advanced endoscopy, which was held on 28-30th November 2003 in Athens, Greece. A report about this workshop will be published in the next issue of the ESGENA newsletter.

In June 2002 three ESGENA delegates were invited by ESGE to participate in the 1st Symposium on Ethics in Gastroenterology and Digestive Endoscopy in Greece. Several recommendations were developed, covering the following ethical issues concerning: teaching and learning Endoscopy, ethical and legal issues, implementation of new techniques, informed consent in GI Endoscopy, Endoscopy based research, PEG and placement of nutritional support. These recommendations have now been published in Endoscopy 2003; 35 (9); 760-781.

In June 2003 ESGE and the UEGF organised a Colorectal Cancer Public Interface Workshop. During the workshop different groups worked on the following aspects of CRC: Screening methods/economy, Implementing screening, Public awareness/lobbying, Screening ethics. It is planned to publish statements, which were developed for each subject in Endoscopy.

Ulrike Beilenhoff, Sylvia Lahey

How ESGENA chooses Abstracts and awards the Prizes

Many times we are asked how ESGENA makes the decision which abstracts are accepted for Oral Presentation and which are selected for Poster Presentation, as well as how we make the decision who wins the prizes.

Abstract Selection

Abstracts received are anonymised (names and addresses removed) and sent out to a minimum of 4 reviewers from 4 different European countries with criteria for reviewing. These criteria are

- Educational Value: e.g. has the abstract the potential to improve practice / services for patients, knowledge, etc.
- Originality: e.g. does the abstract have new information, new approach to old problems, etc. - Something not already known and is the content generalisable, i.e. useful to other peoples practice
- Presentation: e.g. is the abstract organised in a logical fashion: with aims / objectives, method, results, summary & conclusion.
- Context Quality: The abstract needs to contain information which is in line with acceptable levels of practice, i.e. can contain neither wrong information nor advocate potentially dangerous practice (ethical = do no harm)
- Comprehension Quality: e.g. correct & easy to understand English, terminology / abbreviations explained, etc.

At the stage abstract can only be evaluated by submitted content - not by final presentation at the conference. As we only have room for 12 oral presentations the reviewers have to rank the abstracts considered for oral presentation and 12 with the highest mark get selected. Abstracts which do not fulfil submission criteria (as laid out in the "Call for Abstracts") and have no nursing relevant content get rejected. All other abstracts tend to get accepted for poster presentation.

Selection of Best Presentation / Poster during Conference

During the conference three judges are appointed for each session (three for each of the oral sessions and three for the poster session) and each judge has a marking sheet for every author's presentation. The scoring sheet has additional criteria to ones mentioned above and also includes marks for:

- Visual Presentation: e.g. layout, easy to read type face, etc.
• **Oral Presentation:** e.g. clear, structured presentation in reasonable English and within the
time allocated (10 minutes), etc.
• **Responses to Questions:** e.g. at the end of the
presentation or during the Poster Round, etc.

To be fair to speakers whose first language is not
English, lower marks are awarded for verbal skills then
for the sections pertinent to the scientific content. Authors of Posters who are not present during the
Poster Round on Sunday cannot be awarded any marks
for "Responses to Questions".

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The Presentation with the highest marks wins the prize.
Our current "Best Oral Presentation" Prize is Free Registration to the following year's ESGENA
Conference and 2-nights accommodation arranged by
ESGENA. The "Best Poster" Prize is a Pentax Camera.
The Prizes are kindly sponsored by PENTAX.

I hope this help you when submitting an abstract for
this year's conference. Good Luck and I am looking
forward to receiving your abstract.

Christiane Neumann
ESGENA President

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### Abstracts of 7th ESGENA Meeting, November 2003 in Madrid, Spain

**Best Free Paper 2003**
- **Category: Oral Presentation**
- **presented on 2 November 2003 in Madrid**

**Important Changes Leading to Significant Improvements in Bowel Preparation for Colonoscopy Procedures**

Jenny Lau Braddock, Abdul Mohamed, Jayne Tillett, Paul Sparks.Endoscopy Unit, University Hospital of Wales, Cardiff. Wales.UK

**Introduction:** The indications for colonoscopy are varied but an optimum diagnostic procedure can only
be achieved if the patient has had good preparation of the bowel. Clear vision of the bowel is essential. Good bowel preparation improves the success of the procedure, reducing trauma and stress to the patient. It will also reduce the waiting list for repeat procedures due to poor bowel preparation. The original bowel preparation used was two sachets of citramag, which did not produce a clean bowel.

**Objective:** The objective of the study was to improve the effectiveness in bowel cleansing by introducing
another form of bowel preparation, senna, to work with the current preparation of citramag.

**Method:** A working group was set up to look at making significant changes to the current bowel preparation. The team included the manufacturers, the pharmacist, Research Registrar, and two nurses. A literature review was undertaken to establish if this method of bowel preparation had been used previously. The ethical issues were addressed of

Introducing a change in bowel preparation and if there
would be any side effects for the patients. The pharmacist researched the data on the quantity and
preparation of the senna and compatibility with the citramag. The granules would have to be bought in bulk
and made up by pharmacy to the correct dosage in
small pots. A patient information and instruction leaflet
was designed on how to take the regime. The two
sachets of citramag, the pot of senna granules and the
instruction leaflet were all prepacked in individual
packs for each patient. A Pilot study (no 1) was
undertaken of 50 patients taking the senna in the
morning prior to taking the citramag. A record was kept of how the endoscopists reported the bowel
preparation – poor, satisfactory, good.

**Results:** The data found that 64% of the bowel preparation was poor / satisfactory. The group reviewed the data and, seeking advice from the pharmacist, changed the regime for the patients to take the senna the night before starting bowel preparation. The information leaflet and instructions were changed. A 2nd pilot study of 50 patients, randomly selected using this preparation was reviewed. A record was kept of how the Endoscopists reported the bowel preparation – poor, satisfactory, good. The data found 60% of the bowel preparation was good.

**Conclusion:** We have found by changing the regime for bowel preparation, significant improvements have been achieved to bowel cleansing. The Endoscopists have commented on the improvement in overall bowel preparation. This study has been cost effective whereby the patients do not have repeat procedures due to poor bowel preparation, thus reducing the trauma and stress to the patient. Good bowel preparation can be achieved by a good regime and clear concise instructions for the patients. Clear vision of the bowel is essential for diagnostic / therapeutic colonoscopy.
A Program of Education for Patients with Inflammatory Bowel Disease and their Family members.

Peter Sehstedt, Olle Broström, Birgitta Häkansson, Annelie Lindberg, Inger Löfberg, Per Karlén, Robert Stig

Introduction: Inflammatory Bowel Diseases (IBD) are a spectrum of disorders that are lifelong, often complicated and young people are often affected. Many patients are being operated on during the course of their disease. The need for reliable information to the patients and their relatives is substantial. Newspapers and other media very often provide inaccurate and contradictory information. This brings confusion and uncertainty to our patients.

Aim: Our aim with this program was to provide our patients and their relatives with relevant information and knowledge about their disease. At the start of the project we hoped that this information would help the patients cope with their disease. One aim was also to give the patients knowledge, helping them in their discussions with their own physician. We also hoped that the patients would need less time and less effort at regular outpatient visits.

Method: Our method was to give a group of patients and their family members a series of lectures. Every course comprised of four two hour’s lectures with one week apart. Lectures were given by the entire team responsible for the care of IBD-patients at our unit including a medical gastroenterologist, a colorectal surgeon, a stoma therapist, a social counsellor, a dietician and a dental hygienist. The curriculum of the course covered all aspects of disease including ethiopathogenesis, symptoms, medical and surgical treatment, psychosocial aspects, stomatherapy, future aspects including research.

Results: After the course the patients and their relatives were given a structured evaluation sheet. Their response has helped us develop and change the program. The overwhelming majority of the patients and their family members have been very positive about the education. It has been hard to prove that the education program has eased the burden at the policlinic. The long-term benefit for the patients in terms of decreased requirement for medical care is difficult to predict and remains to be shown.

Conclusion: There is a great need for reliable information and knowledge for the patients with IBD. We have provided an educational program in an effort to increase the knowledge of the patients. So far we believe that our patients have found this information useful but long term benefit remains to be shown. In the poster we provide details about the educational program and our experience in doing this work.

Oral Hygiene pre Percutaneous Gastrostomy Tube Placement

Julie Hogan, Christine Denahay ,University Hospital Aintree, Lower Lane, Fazakerley, Liverpool L9 7AL
email julie.hogan@aht.nwest.nhs.uk

Background: A significant percentage of PEG patients could be categorised as an “at risk” group for fungal colonisation and opportunistic infections. Oropharyngeal candidiasis (OPC) is a common, opportunistic fungal infection, the most prevalent site of colonization is the oral cavity. Staphylococcus Aureus (SA), a common gram positive bacteria, is a potential pathogen for opportunistic infections. Cancer metastasis at the PEG stoma originating from oropharyngeal and oesophageal tumours is being increasingly reported (Brown, MC 2000). Seeding of OPC or SA to PEG sites does not appear to have been investigated. Colonization of PEG tubes with candida has been documented (Gottlieb et al, 1993 & 1994; Marcuard et al 1993).

Aims: To assess the potential importance of oral hygiene prior to PEG placement

Method: An audit of 100 patients who returned to the unit with a PEG “problem” showed that 40% had site infections. A review of these 40 patients was undertaken.

Results: Microbiology from the PEG site swabs of these 40 patients reported 20 (50%) SA and 6 (15%) candida albicans in the organisms isolated.

Conclusions: PEG patients are potentially at risk from opportunistic infections that colonise the oral cavity. Further research is needed with larger groups of patients.

Discussion: Pre procedural antibiotic cover is given to PEG patients. If OPC is present should prophylactic antifungal cover be given? We have amended our pre procedural PEG protocol to include examination of the oral cavity for signs of candida infection by the assessing PEG nurse. Anti fungal therapy will be commenced where appropriate. In addition all PEG patients have a mouth wash with an oromucosal solution the evening prior to and the morning of their PEG placement. Chlorhexidine Gluconate 0.2% has been the solution of choice because of its antifungal and antibacterial action. It is effective for gram +ve and gram –ve organisms and in addition has a residual effect that prevents microbial regrowth. We will review
Candida, Dentures & Upper Endoscopy

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Background: Candida is present in the oral cavity of almost half the population and everyone who wears dentures will have candida (Pillinger, 2002). Factors that contribute to oral disease are dehydration, carcinoma, renal failure, and oxygen therapy (Peate, 1993), side effect of steroids, antibiotics, and immunodeficiency (Pillinger, 2002). The elderly are recognised as a potentially immunosupressed group and old age is listed as a factor favourable to fungal colonization (Zwalinska-Weilso, 2001). Anecdotally the dentures of patients attending for endoscopic procedures are frequently noted by endoscopy staff to be inadequately cleaned. Dentures increase candida colonisation and should be cleaned to remove food debris after each meal. They must be removed for soaking in a proprietary cleaner for 6hrs of each 24 hour period (Butz-Jorgensen et al, 1975; Firrola, 2001). This practice reduces the build up of fungi on the gums’ surface and on the dentures. If a break in the mucous membrane is sustained, e.g. from the plastic mouth guard or endoscope, this can act as a gateway for candida. The potential exists for this mucutaneous non-life threatening illness to progress to an invasive illness that may effect any organ.

Aims:
1) To raise awareness among endoscopy nurses of the potential risks to their patients from candida
2) To assess present knowledge of denture care

Methods: Current denture-care practice on wards was assessed by distributing a questionnaire to a convenience sample of RGNs and HCAs. An audit of the cleanliness of dentures from 20 consecutive in-patients attending for upper endoscopic procedures was undertaken.

Results: Dentures of 8 (40%) in-patients attending for endoscopy were classed “dirty”. From 158 ward nurses (97 RGNs and 61 HCAs) surveyed 46% only soaked patients’ dentures over night; 76% cleaned patients dentures once a day; 7% post prandially; as few as 25% routinely remove patients dentures prior to administration of oropharyngeal anti-fungal medication.

Conclusions: General education of nurses re denture care is needed.

Discussion: Should endoscopy nurses look for clinical features of candidiasis, e.g. white plaques or cheilitis, and seek advice re postponement of procedure till anti-fungal therapy has been commenced?

Physical Stress and Patient Satisfaction related to Endoscopic Ultrasonography

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Background: We perform approximately 550 endoscopic ultrasonography (EUS) examinations per year. Eighty percent of the patients are evaluated in an out-patient setup and the patient’s diagnosis are malignant in 60% of the cases. All patients receive a written information prior to the examination, and the procedure information is repeated by the nurse and the surgeon who are performing the EUS. The patients are informed of the results of the examination 2 hour after the procedure. The physical stress as well as patient satisfaction related to the EUS procedure have never been prospectively evaluated.

Aims: To evaluate the patient’s perception of the physical stress of EUS and the level of satisfaction related to the information provided before and after the procedure.

Method: 300 patients were evaluated using a combined questionnaire and follow-up case sheet. The questionnaire included an evaluation of pain, anxiety, discomfort and information satisfaction. All patients were evaluated immediately after the procedure and again one week later. The nurse participating in the EUS examination were also responsible for the interviews.

Results: A total of 293 patients (97.7%) fulfilled the inclusion criteria. Average examination time was 19 minutes. Five percent of the patients needed tracheal suction, 0.3% vomited and 0.3% aspirated; however, none of these minor complications needed further treatment. One third of the patients reported of different complaints during follow-up; the most common problem being a sore throat and non-specific abdominal pain. Overall, there were no statistical significant differences between the results obtained at the interviews. Four out of five patients had no or only slight pain and more than 95% had experienced no or only slight anxiety. In contrast, more than half of the patients complained of moderate to severe discomfort. At both interviews more than 90% stated that they were satisfied with the information provided in relation to the procedure, and 94.5% would accept a second EUS without any hesitation if necessary.

Conclusions: A high level of satisfaction with the information provided before and after the EUS procedure combined with a low level of discomfort, pain and anxiety seem to explain why more than 90% of the patients were willing to have a second examination if necessary. A high level of patient...
information before and after the procedure is mandatory.

**Validation of Cutaneous Electrogastrography against Antroduodenal Manometry in Adults**

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Electrogastrography (EGG) is the cutaneous recording of gastric electrical activity. However non-invasive and easy to perform, the value of EGG for diagnosing gastrointestinal motility disorders has not been proven. It is unclear to what extent changes in the electrical rhythm of the stomach are associated with disturbances of gastrointestinal motor activity.

This is a retrospective analysis of 185 simultaneous recordings of EGG and antroduodenal manometry (ADM) in patients with suspected motility disorders.

**Methods:** We used a water-perfused 8-channel catheter system for stationary manometry. Pressure data were stored at 4Hz online using a Polygraph/Polygram (Medtronic Synectics, Stockholm, Sweden). EGG data were recorded using an EGG-Digitrapper (Medtronic Synectics, Stockholm, Sweden). Recordings were done for 3 hours in the fasting state and for 2 hours after a standardised solid meal.

We analysed the last pre-prandial hour and the first post-prandial hour of EGG after exclusion of artefacts. All recordings with at least 50% of the recording time left for analysis were included. EGG was analysed for percentage of normogastric (2-4 cycles per minute) rhythm during fasting (normal >70%); percentage of normogastric rhythm during fed motor activity (normal >70%); and power ratio of the dominant frequency (normal >1).

**Results:** Our study material consisted of 187 patients (151 females) with a median age of 46 (IQR 34-55) years. EGG was uninterpretable in 33 patients and another 26 patients with various organic disorders and post-operative states were excluded from the analysis. The remaining 126 patients of whom 34 had pseudo-obstruction or enteric dysmotility, 27 had slow transit constipation, 52 had irritable bowel syndrome, and 13 had gastroparesis, were divided according to manometry findings.

<table>
<thead>
<tr>
<th>EGG finding</th>
<th>Manometry finding</th>
<th>Normal (n=76)</th>
<th>Abn. P3 (n=33)</th>
<th>Burst activity (n=38)</th>
<th>No fed response (n=8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal EGG</td>
<td></td>
<td>62%</td>
<td>52%</td>
<td>47%</td>
<td>27%</td>
</tr>
<tr>
<td>Abnormal pre-prandial EGG</td>
<td></td>
<td>12%</td>
<td>27%</td>
<td>29%</td>
<td>75%</td>
</tr>
<tr>
<td>Abnormal post-prandial EGG</td>
<td></td>
<td>4%</td>
<td>15%</td>
<td>21%</td>
<td>38%</td>
</tr>
<tr>
<td>Abnormal power ratio</td>
<td></td>
<td>24%</td>
<td>15%</td>
<td>18%</td>
<td></td>
</tr>
</tbody>
</table>

Abn. P3=abnormal propagation or configuration of MMC phase-III; * p<0.05; ***p<0.001

**Conclusions:** EGG is a poor predictor of manometry findings except absence of motor response to food intake, in patients with gastrointestinal motility disorders. Rhythm disturbances seem to be uncommon even among patients with severe motility disorders.

### The First Two Danish Nurse Endoscopists - Experience from a Training Programme

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A new diagnostic strategy for patients over 40 years of age with symptoms suggestive of colorectal cancer comprise sigmoidoscopy and occult blood in feces (Hemocult sensa). Our department perform 1600 sigmoidoscopies yearly which places a considerable burden on limited surgeon resources. In Denmark endoscopy is not done by nurses but we found it relevant to establish a training programme considering the experiences from UK and USA.

**Objective:** Evaluate if nurse sigmoidoscopy can be performed safely and with high patientsatisfaction

**Method:** Nurse A and B had 15 years and ½ year respectively of experience as endoscopy assistants. Two consultants with several years of endoscopy experience trained the nurses. First part was theoretical; anatomy, physiology and pathology of the anal canal, colon and rectum. Second part was a walk through a sigmoidoscopy with tips and tricks using videotapes and drawings outlining landmarks and points of danger. Last part was a technical scrutiny of the video rack and trouble shooting. The practical part consisted of 4 modules. Module 1; The consultant retracted the scope according to instructions from the nurse (25 cases). Module 2; The nurse retracted the scope supervised by the consultant (25 cases). Module 3; The nurse inserted and retracted the scope supervised by the consultant (25 cases). Module 4: 2 days of computersimulated sigmoidoscopy. Finally a multiple choice test of 20 questions, each with 4-5 answers, were performed safely and with high patientsatisfaction
performed. The test was passed if eighteen of the questions were correct. After successful training the nurses started sigmoideoscopy on their own but the following were mandatory; always rectal exam and looping in the rectum, always conferring pathological findings except diverticula with consultants, all examinations videorecorded and reviewed by consultant. After approximately 150 sigmoideoscopies each, a questionnaire on patientsatisfaction was performed over a 3 months period (6th jan 03- 6th april 03) including patients examined by surgeons. Details on each nurse endoscopy; insertions depth, time used and findings was noted.

Results: In the 3 months periode 69 sigmoideoscopies were performed by the 2 nurses (A: 19, B: 50). Left colonic flexur were reached in 81% of the cases, however in the 13 cases where the flexur were not reached; 3 had incomplete emptying of the bowel, 2 had a rectal cancer or huge rectal polyp, 3 had loop formation of the sigmoid while no information were available for the remaining 5 patients. Thus technical problems were encountered in 12 % of the cases. The median time used were 25 minutes but in several cases waiting time for the supervising consultant were included. In two cases a rectal cancer and a huge rectal polyp were found. Reviewing of the video tapes did not cause any reexamination. Patients had lesser pain when nurses performed the sigmoideoscopy.

Conclusion: Nurse sigmoideoscopy can be performed safely with no complications, high completion rate and patient satisfaction.

The Role of Gastroenterology / Endoscopy Nurses in Physiology Tests

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Background: Physiology is the science of normal function. Some disorders of the gastrointestinal (GI) tract cannot be diagnosed visually (endoscopically) or morphologically (x-ray). Nurses, with increasing frequency, complete gastrointestinal physiological tests. Gastroenterology/endoscopy nurses are seen as having the knowledge base, and being conveniently placed. They are frequently asked to complete the tests in addition to their other duties. The tests range from relatively simple breath tests for the detection of microbial disorders or malabsorption, to complex motor and sensory function testing of the GI tract. Clinical physiologists; clinical scientists; respirator/cardiac technicians; and/or research registrars as well as nurses complete these tests, in the UK. Nurses, in generally, were offered no formal training to equip them for their extended role in GI physiology.

Technological advances and innovations are leading to more and more complex physiological investigations with interchange between disciplines and sectors. The multidisciplinary base for GI physiological investigation lead to the formation of a group, supported by the British Society of Gastroenterology (BSG), the Association of Gastrointestinal Physiology (AGIP).

Objectives: The main objectives of AGIP are the standardisation of education, training, continuing professional development and fitness to practice for healthcare professionals, with physiological, nursing or scientific backgrounds, who are actively involved in GI physiological investigations.

Methods: A constitution was formulated with membership of AGIP open to clinical practitioners who undertake diagnostic investigations on patients and those who have a continuing commitment to research and development of GI physiological measurements. Criteria were drawn up for entry to trainee membership, affiliated membership or the Accreditation Register of AGIP. A code of professional conduct was introduced together with a statement of the standard to be achieved. Pathways for education and training were instigated.

Outcomes: AGIP is an integral part of the Registration Council for Clinical Physiologists (RCCP) whose application for state registration has been submitted. Nurses have been advised that they may retain dual registration with the Nursing and Midwifery Council (NMC) and RCCP. The oesophageal section of the BSG has fully supported the efforts of AGIP in the accreditation of professionals involved in GI physiology. The BSG, together with AGIP are reviewing the guidelines for oesophageal manometry and 24hrpH studies. The National Occupational Standards (NOS) group have also supported the efforts of the group. The “grandparenting” scheme, that enables previous experience to be recognised, has ensured a core of experienced professionals. Standards of practice have been set with guidelines for
1. pre-procedural preparation of patients
2. performance of investigations
3. analysis and technical reporting of data measurements
4. provision of a safe working/clinical environment
5. maintenance of records
6. management of implanted devices
7. evaluation, procurement, calibration and quality control procedures for all equipment

In addition AGIP has liaised with the education providers to facilitate provision of appropriate courses including a specialist option course appropriate to RGNs, with placements in accredited training units where necessary.

GI physiological investigations have become an accepted role for a number of gastroenterology/endoscopy nurses. Appropriate

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GI physiological investigations have become an accepted role for a number of gastroenterology/endoscopy nurses. Appropriate
training courses exist. Personal and unit criteria must be met to validate practice. Should these changes in practice/education become pan-European to facilitate standardisation of international GI physiological investigations?

New endoscopic developments (one step button) can be more cost effective as well as patient friendly.

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The Netherlands are known for eminent but difficult to finance healthcare. Hospitals are sternly budgeted and the possibilities for medical development are becoming less. Top clinical research without new endoscopic developments is inconceivable. The department of Gastro-enterology of the University hospital in Rotterdam initiated a trial to investigate the cost effectiveness and patient comfort of the “one step button” gastrostomy catheter.

Through a normal endoscopic procedure the patient receives a button throughout the first placement of the gastrostomy catheter. The placement kit consists of a percutaneous measuring device, a “one step button” gastrostomy-kit and a patient care kit. During gastroscopy the right place for gastrostomy is chosen. Before placement of the catheter the abdominal wall-thickness has to be measured by a separate delivered device. Thereafter the right size gastrostomy set can be place by “pull-technique”. Several sizes and lengths are available.

This method shows the advantage of creating a normal fistal and placing a button in one procedure (no replacement). The department of Gastro-enterology treats patients with this new method and compared the differences between the consisting and new method.

Conclusion: The “one step” endoscopic procedure probably has a clear advantage for patient comfort (only one endoscopy), cost effectiveness and on replacement.

Open Access Gastroscopy - Is it the Best use of Resources?

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Objectives: To assess the effectiveness and appropriateness of the open access gastroscopy service in the context of recent guidelines and the “two-week wait”.

Background: Open access gastroscopy has been available in our trust to GP’s since 1996. The original referral criteria include restriction to patients over 45 years of age. It has been perceived that many referrals are inappropriate and do not meet our referral criteria. The British Society of Gastroenterology Guidelines for the Management of Dyspepsia (2002) suggest that gastroscopy is unnecessary in the majority of patients under 55 years of age. Currently 2 endoscopy lists per weeks are dedicated to open access endoscopy in our unit; performed by the Nurse Consultant Gastroenterologist and a Trust physician. A fast Track service (2 week cancer wait) has been up and running for 3 years and has a 10% pick up rate for malignancy.

Methods: Data was collected from the computerised Endoscopy Records System (ERS). Data for the last 3 years was analysed with respect to the pathology identified, the age of the patient and the referral criteria.

Results:

<table>
<thead>
<tr>
<th>Year</th>
<th>Total number of gastroscopies</th>
<th>Open Access Gastroscopy</th>
<th>Open access &lt;55 years of age</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996</td>
<td>2769</td>
<td>493</td>
<td></td>
</tr>
<tr>
<td>1997</td>
<td>2645</td>
<td>486</td>
<td></td>
</tr>
<tr>
<td>1998</td>
<td>2885</td>
<td>461</td>
<td></td>
</tr>
<tr>
<td>1999</td>
<td>2847</td>
<td>406</td>
<td></td>
</tr>
<tr>
<td>2000</td>
<td>3301</td>
<td>569</td>
<td>300 (52.7%)</td>
</tr>
<tr>
<td>2001</td>
<td>3277</td>
<td>459</td>
<td>233 (50.8%)</td>
</tr>
<tr>
<td>2002</td>
<td>3356</td>
<td>320</td>
<td>164 (51.3%)</td>
</tr>
</tbody>
</table>

From 2000-2002 1384 open access gastroscopies were performed, out of a total of 9934. 697 (52%) were in patients under 55 years of age. Only three cancers (0.2% of procedures) were detected via open access gastroscopy. 10 benign gastric ulcers (0.7% of procedures) and 36 duodenal ulcers (2.7% of procedures) were detected, and 22 cases of severe oesophagitis or benign strictures (1.7% of procedures).

Summary and conclusions: The majority of open access gastroscopy referrals detect no significant pathology and would not influence management. Half were undertaken in patients <55 years of age and would not meet current referral criteria. All cases of cancer detected would have met Fast Track criteria (and would have been endoscoped within 2 weeks
rather than the 8-12 weeks waiting time for open access endoscopy during the study period). A “test and treat” policy for H pylori negative patients would have been appropriate for patients under the age of 55.

We conclude that open access endoscopy is no longer appropriate in the context of the 2-week fast track service for suspected upper GI cancer. This endoscopy time could be used to reduce waiting times for other procedures. A nurse-led dyspepsia service, using evidence-based treatment algorithms, would provide a more effective and efficient way of managing the large numbers of young dyspeptic patients.

Meeting Targets within Endoscopy

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Background: University Hospital Aintree is a large teaching hospital serving a population of 330,000. The endoscopy unit accommodates four theatres. The nursing staff compliment is one unit manager, one deputy manager, ten staff nurses (5D/5E grades) and six health care assistants together with four nurse endoscopists and one gastrointestinal bleed nurse specialist. A National Endoscopy project was established in 2001 to identify good practice, ensure delivery of NHS Cancer Plan, which entailed rapid access to endoscopic services, and deliver timely patient access.

Objectives:
1. Reduce active waiting list from up to 26 weeks to under 13 weeks by March 2003
2. Increase activity to fully utilise resources
3. Reduce DNA rate from approximately 20% to less than 2% by March 2003
4. Achieve a 5% rate of cancelled sessions and late starts by March 2003
5. “Booked admission”for daycases (date discussed with patient) from 20% to 100% by March 2003
6. Co-ordinate a maximum 31 days journey, from referral to diagnosis, for cancer patients
7. Enable patients to identify areas for change
8. Achieve 5% in-patient cancellation rates
9. Reduce up to 5 day waiting time for endoscopy of in-patients with gastrointestinal bleeds

Methods: Activity was matched to demand with a more flexible approach to timetables, for example increasing the number of colonoscopies by reducing number of gastroscopies as required. “Waiting list initiative”, Saturday lists, was undertaken when required. An extended working day was introduced, two additional lists from 17.00 to 20.00 four days a week with designated lists for in-patients. A flexible job plan for nurse endoscopists was introduced to enable them to cover lists when medical staff had holidays. Late starts were monitored to identify trends and instigate effective timetable management. Booked admissions programme was introduced gradually. Confirmation clerks, who contact patients to confirm acceptance of appointment, were employed. We worked with GPs to ensure appropriate referral routes were used. On-going monitoring of rapid access list distribution, as per NHS cancer plan, was undertaken to ensure sustainability of designated lists. A number of suggestions from patients were acted upon, e.g. purchase of newly designed theatre gowns to maximise patients’ dignity. The booking system for in-patients was revised with a confirmation letter of date and time being sent to both the patient and the nurse in charge. Nurse endoscopists facilitated endoscopy awareness sessions to improve communication with ward staff. A gastrointestinal bleed nurse, who triages any in-patient from A&E or wards, has been introduced.

Outcomes: All endoscopy waiting times are below 13 weeks. There has been an increase in overall activity from 13,000 2000/2001 to 16,000 procedures 2002/2003. The DNA rate has been reduced to 7%. Cancelled sessions have been cut to 3% with late starts now 8%. Seventy five percent of day-cases are currently classed as booked admissions. The 31 days requirement from referral to diagnosis for cancer was achieved for 96% of oesophagogastric and 93% colorectal patients. In-patient cancellations were halved to 8%. One hundred percent of patients with GI bleeds were endoscoped within 24 hours of admission.

The continual audit of activity has by now become automatic and the staff has adjusted well to the extended working day even enjoying a lie-in on the late shift days.

THE COMPUTER FOR MANAGING THE ENDOSCOPY UNIT

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In the last decades high quality demands are required in hospitals and the computer can be a tool for this purpose. Several computerised systems became also for the endoscopy unit available but mostly for composing a report only. Several guidelines for the practice of endoscopy have been published recently for example about the cleaning and disinfection of GI endoscopes or the guidelines for preparation or guidance the patient undergoing an endoscopy. In the near future we have to register all these procedures.

Since several years we use ENDOBASE at our endoscopy department for reporting the endoscopic findings by the use of Standard reports, Textblocks and MST. To all reports diagnose codes (based on ICD-10)
are linked automatically. Besides these reports all patient and examination characteristics are stored in the database. With the statistics module all stored data can be queried for medical and management information. In our system we can continuously register the general patient care, such as heart rate, blood pressure, and oxygen saturation during (and preferable during the first hour after) an endoscopy. These data are continuously stored in the database coupled to the patient data and examination data.

Reprocessing information of scoops is registered and incorrect procedures are reported. Because scoops are coupled to the examination and patient it is easy to trace all patients who have been treated by an infected scoop. Time of maintenance and repairs can also be stored into the system and the system detects automatically when equipment needs to be checked. The hygienist can also store biological test results (of the cleaning and disinfection machines) into this module. So there is a perfect overview of the status of all equipment.

Managing the stock of all endoscopy materials such as forceps can be integrated in this system with automatic alerts if the article has to be supplied. Via HL7-standards information can be imported from (patient data and Scheduling data) and exported to (reports, financial coding) the Hospital Information System. It is also possible to view the patienthistory all over the hospital via a webbrowser (EndoView).

Because the total endoscopy procedure is monitored and stored in one database, it makes for the nurses very easy to search for all possible information of endoscopy. Patient information are well organised, reports can be easily viewed and reprinted, managing and calculation of the stock is computerised and quite effective.

Since the introduction of this system in our hospital we have experienced this is an efficient system that saves time for the nurses. The system itself and the time saved have lead to an improvement of the quality! Mistakes are nearly impossible anymore.

Conclusion: Managing an endoscopy unit needs more than only a report writing system. Working with a total computerised system makes it possible to register all important procedures at an endoscopic department resulting in better information. Using a computerised system guarantees the quality of endoscopy and patient care.

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**Endoscopic treatment of Barrett**: Detection and treatment of early esophageal cancer.

Jacques Bergman MD PhD, Dept of Gastroenterology, Academic Medical Center Amsterdam, The Netherlands. E-mail: j.j.bergman@amc.uva.nl

The incidence of esophageal cancer has changed dramatically the last four decades: whereas the incidence of squamous cancer has showed a slow but steady decline, the incidence of esophageal adenocarcinoma has increased over 350% making it the fastest rising cancer in the Western world. In everyday clinical practice, most cases of cancer are detected at an advanced stage as a result of lesion-related symptoms. The prognosis for the advanced cancer patient is still poor, even when major surgery with extensive lymph node dissection is carried out, in combination with the various forms adjuvant therapy. To improve the prognosis of esophageal cancer patients, the cancer needs to be detected at an early stage and treated before lymph node metastasis occur.

In this lecture, we will outline the detection and treatment of early forms of esophageal cancer. Which patients are at risk for developing these cancers? What endoscopic technique should be used to detect early lesions? What endoscopic treatment options are available?

Whereas esophageal adenocarcinoma has an identifiable precursor lesion (i.e. Barrett’s esophagus), the majority of squamous cancers do not develop from known precursor states. Risk factors for squamous cancers include: high age, alcohol and/or nicotine abuse, previously treated head-and-neck cancer, ionizing radiation, human papilloma virus infection, long standing achalasia, prior esophageal lye damage, and rare diseases such as tylosis palmaris.

Screening studies in several of these risk groups have found squamous cancer in three to fourteen percent of patients. There are, however, no currently accepted standards which of these risk groups should be screened or surveilled. With standard endoscopic techniques early squamous esophageal cancer is very difficult to detect. Lugol staining (1.5–3.0%) is a simple and very effective technique that greatly enhances the detection rate of dysplastic squamous lesion. In addition, it outlines the margins of lesions, facilitating endoscopic treatment. For detection of early lesions in Barrett’s oesophagus several endoscopic techniques have been studied. Methylene blue staining is currently the only technique that has been shown to increase the detection rate of Barrett’s dysplasia. The technique is however cumbersome and operator dependent. High-resolution endoscopes enable close inspection of the Barrett’s mucosa. Recently, a mucosal pattern classification, comparable that used in the colon, has been proposed. Combining high-resolution endoscopy with contrast staining agents (indigo carmine or crystal violet) may further enhance...
the mucosal contrast. Other optical techniques such as fluorescence endoscopy, optical coherence tomography and narrow band imaging are still investigational.

Most studies on endoscopic treatment of early esophageal cancer come from Japan and relate to squamous cancers. Several prospective uncontrolled series are available; some with a retrospective surgical control group. Data suggest that endoscopic mucosal resection equals surgery in terms of effectively removing cancerous lesions but carries less complications. For Barrett’s cancer only uncontrolled series are available. The ideal candidate for endoscopic treatment has a solitary lesion less than two to three centimetres in diameter, a type I, IIa, or IIc, (>1 cm) lesions and no signs of submucosal infiltration or local lymph node involvement on endoscopic ultrasonography. Endoscopic mucosal resection with the cap technique is the best-documented endoscopic technique for removal of these lesions. Histological examination of the resected specimen subsequently guides further management. The risk of lymph node involvement is less than 5% in mucosal lesions whereas it increases to 25-40% in lesions with submucosal infiltration. Recent studies suggest that for minimal submucosal involvement (sm1) an expectant management is also acceptable. For deeper invasion or irradical deeper resection margins, however, additional treatment is to be advised (surgery or radiotherapy for selected cases).

For patients with positive lateral resection margins, additional treatment may consist of local thermal ablation using APC, laser, or -as in Barrett’s esophagus- photodynamic therapy. After successful endoscopic treatment strict endoscopic follow-up is required to detect metachronous lesions at an early stage. This holds especially for Barrett’s lesions, where an underlying mucosal field defect may be present.

References


Process Guard and Validation of Cleaning and Disinfection Procedures Coupled to a Drying Time

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Introduction: Since 1996, there exists in the Netherlands, the Law of Quality Care Institutions. As a results of this law the Dutch standards organisation have come up with guidelines for disinfection apparatus and a Dutch working party on infection prevention has been formed to produce guidelines for the cleaning and disinfection of fiberoptic equipment.

In our hospital the Infection Commision gives guidelines for:
- cleaning and disinfection procedures
- requirements when bying new apparatus
- validation of mechanical disinfection both technical and micro-biological
- validation of storage time in the drying cupboards both technical and micro-biological
- log-books for disinfection machines, drying cupboards and endoscopes

Aim: Is the disinfection and drying procedure reliable to ensure the use of flexible endoscopes, free from micro-organisms, for at least 72 hours after these procedures?

Methods: In our unit, endoscopes are dried for two hours after cleaning and disinfection in the ETD2 machines. Twice yearly the Hospital Hygiene Department carries out micro-biological validation of the endoscopes and the drying cupboards.

Up until now there have been no pathogenic micro-organisms cultivated, so the storage time allocated is 72 hours.
Conclusion: Based on the methods and the results it is reliable to ensure the use of flexible endoscopes free from micro-organisms after the disinfection and drying procedure for at least 72 hours.

Efficacy and Safety of Glucoptrotamin , A New Disinfection Agent in GI Endoscopy

MC.Manzalini*, M. Forlani*R.Donatella*B.Orlandi*M.Bonazzi*A.Fiorini*
A.Lavezzo* ,A.Pezzoli° L. Trevisani°, and S. Gullini°
° Department of Gastroenterology and Digestive Endoscopy, S.Anna Hospital, Ferrara, Italy * nurses of Department of Gastroenterology and Digestive Endoscopy, S.Anna Hospital, Ferrara, Italy

Background: Patient infection from contaminated gastrointestinal endoscopes is an important problem reported in endoscopy units. New disinfectants are now available in order to improve the efficacy of disinfection procedures.

Aim: To test the efficacy and the safety of glucoprotamin, a new disinfectant.

Materials & Methods: endoscopes were treated, before use, with glucoprotamin (Sekusept plus®) a new agent with a high antimicrobial activity. Then, after the procedure, the endoscopes were reprocessed according to the national and european guidelines. Every three months bacterial contamination was tested by sampling: a) the distal end of the endoscope by contact-plate, and the rising fluid of biopsy channel by washing with 10 mL saline solution, and b) the inside of the channels using a brush.

Results: During six months we performed 9 controls: no contaminations (defined as a bacterial charge >20 CFU/mL) were found on the surface and/or in channels of gastroscopes, colonoscopes and duodenoscopes; a bacterial charge <3 CFU/ml was found on plates with samples taken from brushes after having been passed into biopsy channels. No Pseudomonas spp were isolated. In the same period, no significant contamination was found in the water reservoir of the washing machines. No side effects were noted on material or personnel. We compared these results to the controls obtained during the previous three months using glutaraldehyde (Cidex®): bacterial contaminations was tested in the same way previously described, no contaminations were found on the surface and/or in channels of gastroscopes, colonoscopes and duodenoscopes. The side effects observed were burning sensation in the eyes and upper airways and a disgusting smell.

Conclusions: Our preliminary results suggest that Sekusept plus® appears to be a good alternative to glutaraldehyde with at least the same level of disinfection and it has no relevant side effects for the personnel in direct contact with the product.

Reduction the Risks of Latex Anaphylaxis in the Endoscopy Unit - Results of a Literature Review

Vivienne Wigton, Lagan Valley Hospital, Lisburn, N. Ireland

Background: Latex allergy is not a trivial nuisance, symptoms can range from itchy rashes through to respiratory problems and anaphylaxis. Since 1990’s there has been an increasing awareness that such allergies pose significant hazard for health care professionals and patients alike. Within the authors own health care setting revealed a lack of knowledge on issues surrounding latex, prompting a Literature Review on the subject.

Method: A literature review was undertaken using BNI, Medline, Cinahl and Cochrane databases confining the search to the years 1995 - 2002. Using latex and anaphylaxis as key words. Although most articles referred to the preoperative setting it was felt that their findings were equally transferable to the endoscopy setting.

Results: Literature review revealed increasing sensitisation to latex in exposed populations with between 1-6.5% of the general population at risks and women making 75-85% of the latex allergic population. This increase in latex sensitive cases may be a result of increasing universal precautions (ie wearing of gloves) in the wake of the spread of HIV in the 1980’s. Inadequate history taking was noted by many (Porri Et Al 97...).

As the main culprit concentrating primarily on drug and food related allergies with increased education of health care professionals needed to identify and manage risks.

Outcome: An education package was devised within the authors endoscopy unit. This has resulted in the early identification of staff and patients at risks of latex sensitivity, increased use of latex free equipment within the Department and improved pre-assessment to patients to identify and manage risk.

(printed as received)
Short-term Nursing and Patient Care of Out-Patients in Elective Gastros copy and Survey of Patient Satisfaction

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Background: Nurses have very little time to practice actual nursing, as most examinations only last 5-20 minutes. Before examination all patients receive a letter from the hospital with information, among other things telling about the possibility of receiving sedatives before the examination. We have employed Virginia Henderson's theories.

Aim: To examine if the way of practising patient care results in a high patient satisfaction, and if sedation influences patient satisfaction.

Method: After examination a total of 100 out-patients were asked to fill out a questionnaire anonymously. We used the following questions:
1) What is your opinion about information? Before, under and after the examination?
2) What is your opinion about care? Before, under and after examination?
3) Did you receive sedatives? If yes, do you remember the examination?

Results: Out of the 100 patients 49% did not choose to get sedatives. Of these 83,7%, 89,8% and 81,6% respectively found that information before, under and after the examination was very good, and 83,7%, 100% and 90,8% respectively found that care before, under and after the examination was very good. The related figures for patients, choosing sedatives are 86,3%, 86,3% and 82,4% for information and 82,4%, 90,2% and 90,2% for care respectively. Out of the patients choosing sedatives 78,4% remember the examination, 21,6% do not remember the examination. If the results for the patients, who do not remember the examination, are neglected, the figures are 90,0%, 87,5% and 87,5% for information and 85,0%, 95,0% and 90,0% for care respectively.

Conclusions: There is no significant difference in patient satisfaction between the group of patients, not choosing sedatives compared to the group, choosing sedatives. In our way of practising care, sedation does not seem to influence patient satisfaction.

Clinical Notes and Nursing Endoluminal Gastroplication

Hena da Silva, Fabio Zorzan, Sandra Bonato, Domenico Oselladore, Rossana Rossoni, Casa di Cura Abano Terme SpA – Servizio di Diagnostica e Chirurgia Endoscopica – Piazza Colombo, 1 – 35031 Abano Terme (PD) – Italy – e-mail: hena.dasilva@tiscali.it

Gastro-esophageal reflux disease (GERD) affects nearly 4% of the population. The treatment of this pathology consists of long-term medication with drugs such as proton pump inhibitors (PPI) or antireflux surgery either in laparotomy or laparoscopy.

In 1994 Swain perfected the first flexible endoscopic suturing device and in December 2000 the endoscopic suture device (EndoCinch) in endoluminal gastric plication (ELGP), produced by Bard, was approved for use by the Health Ministry of Italy.

From January 2001 to February 2003 22 patients underwent antireflux endoluminal gastric plication in our department. All were suffering from important symptoms of GERD, and pH manometry demonstrated pathological findings and/or esophagus-gastro-duodenoscopy (EGDS) revealed the presence of (1st or 2nd degree) esophagitis.

The technique consists in placing plications at or just below the squamocolumnar junction arranged either lengthwise or circumferentially. The patient is placed under deep sedation or general anesthesia. Medical and nursing personnel were trained on mannequins with pig stomachs (Erlangen). The role of the nurse during ELGP is of extreme importance both before and during the intervention. In the pre-operative stage particular attention is given to correctly mounting the suction capsule onto the endoscope, the precise insertion of the needle loaded with the suture, and connecting the handle to the biopsy port of the endoscope which can later trigger the needle.

During surgery the nurse is responsible for loading the sutures into the needle of the suction capsule, keeping tension on the threads during the arrangement of the folds, and for connecting the Endocinch device to the suction capsule.

All patients who underwent ELGP had a complete resolution of their symptoms or a drastic reduction in the amounts of PPI necessary with a substantial increase in their quality of life. The advantages to this procedure are the fact that it is easily repeated, reversible and can be carried out as an outpatient procedure under sedation. Long-term results of the procedure compared to laparotomic/laparoscopic surgery must still be analyzed; this evaluation should also consider that this procedure is performed in an ambulatory/day surgery setting and that it can be easily repeated.
Efficacy, Safety and Tolerability of Two Oral Cleansing Solutions for Colonoscopy Preparation

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Background and study aim: New endoscopic techniques such as magnifying colonoscopy require optimal bowel preparation, but large volume cleansing solutions are poorly accepted by many patients. Previous studies on the efficacy and safety of bowel preparation solutions for colonoscopy have yielded conflicting results. This study is a randomised single-blinded trial that compares the safety, tolerability and efficacy of two popular bowel-cleansing solutions for colonoscopy: Oral Sodium Phosphate and Klean-Prep. The aim was to develop a guideline for the preparatory bowel cleaning for colonoscopy and sigmoidoscopy in our department.

Patients and Methods A total of 100 patients scheduled for elective colonoscopy, were randomised to undergo either Klean-prep® or phosphoral® pre-colonoscopy bowel cleansing. Consecutive patients 18 years or older that gave informed consent were eligible for the study. Patients with signs of obstruction, heart failure class III and IV, colostoma, and renal insufficiency were excluded. Blood was obtained at inclusion and during the procedure and the following tests were performed: hematocrit, electrolytes, urea, creatinine, serum osmolality, calcium and phosphate. Patient satisfactory and symptoms were measured using a questionnaire. The efficacy of bowel preparation was scored by the endoscopist who was blinded with regard to the type of preparation used, using a predefined rating scale.

Result: 50 patients received Phosphoral and 47 Klean-prep. Three patients discontinued the study either because of withdrawal of consent or because the colonoscopy was postponed. All patients reported to have completed the preparation as instructed.

Conclusion: A guideline is developed in our department for the pre-preparation of sigmoid and colonoscopy. As far as it concerns the cost of a nurse given an enema to the patients for sigmoidoscopy, it is a benefit that the patient can use phosphoral instead of klean-prep which is a large volume of drinking.

Integral Endoscopy Training for GE Physicians, Fellows and Nurses

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Objective: Training on the job as a team in order to share experiences between separate disciplines to improve skills and benefit from the joint practice.

Methods: Monthly we organise sessions for a maximum of 20 physicians and nurses, divided in four sub-groups (one physician, two fellows and two nurses). One course takes one day divided in four modules of one and a half hours. Module 1: ERCP skills and knowledge of equipment. Module 2: EASIE model (pigs stomach specimen with liver) to practice ERCP-skills. Module 3: EASIE model (pigs stomach specimen with bleeding focusses) to practice haemostase techniques. Module 4: Simbionix training (interactive computerised simulator for endoscopic procedures). Knowledge of endoscopic procedures, hands-on training of equipment involved

Conclusions: Questionair results (N=46): 92% (N=40) of the last two groups showed improvement in skills.

Video Capsule, A small Revolution

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Introduction: The video capsule has been presented for the first time at the annual meeting of AGA in May 2000. Conceived by Given Imaging, the video capsule is a new mode of investigation of the small intestine which allows the search for the cause of occult bleeding. The video capsule (11x26mm) includes: a radio transmission, a light source, an electronic chip (57000 images during the whole transit time) which allows to transmit the data to a portable recorder. It is evacuated in the stools.

Aim of the study: The aim of this study is to compare the diagnostic value of video capsule with push enteroscopy and the consequences on patient’s work-up.
Method: Elaboration of a procedure to compare these investigations.

Patient: The video capsule was introduced in May 2003 in our division of gastro-enterology. Recently, a study has been realized in 3 french centers (Nancy, Lyon, Paris) as follows: Patients were submitted to both video capsule and push enteroscopy within 72 hours, while physicians were blinded of the procedures. 50 patients have been examined. A double lecture was done to evaluate the reproducibility of the exam. The discomfort associated with push enteroscopy (hospitalisation, complete anaesthesia) is avoided using the capsule.

Results: Out of 50 patients, 71% presented lesions in the small intestine. The exam by video capsule yielded a better diagnostic value than push enteroscopy, 85% of the cases.

Conclusion: This technology provides new perspectives about exploration of the colon and the stomach. It’s major draw-back is the cost and the risk of capsule impaction in an unsuspected stenosis. This may necessitate surgery.

Practice of the wireless Capsule Endoscopy: Role of the Nurses

Michiels Griet (RN), Kaluza Irene (RN), D’Hoe Veerle (RN), Herregodts Katia (RN), Ceulemans Paul (RN), Dep. Gastro-enterology, Academic Hospital Free University of Brussels, e-mail: paul.ceulemans@az.vub.ac.be

Introduction: Wireless video endoscopy or video capsule endoscopy is a novel non-invasive technology designed primarily to provide diagnostic imaging of the small intestine, an anatomic site that has proved particularly difficult to visualize. Limited views of the oesophagus, stomach and caecum may also be obtained. Images acquired are of excellent resolution and have a magnification greater than that of conventional endoscopes.

Indications: The indications for video capsule have yet to be defined, but the experience with the capsule suggests that the main indications for its use will be: The detection of the origin of obscure gastrointestinal bleeding after conventional work-up has been completed and has not revealed a source. Assessment of the extent of Crohn’s disease in the small bowel. Helping to define the extent of malabsorptive conditions, such as celiac disease and detection of small bowel tumours, diagnosis of small bowel motility disorders and surveillance of polyposis syndromes of small intestine. Abdominal pain with reasonable suspicion of organic disease in small intestine. Visualization of surgical anastomoses.

Limitations and Contraindications: The main disadvantage of video capsule is that it does not permit tissue sampling or therapeutic intervention. The procedure may be contraindicated in patients with the following conditions: Patients with suspected obstruction or stenosis. An oesophageal stricture or swallowing disorder that could prevent passage of the capsule. Patients with heart pacemakers and other electromechanical implants.

Procedure: Patients are informed about the procedure before arrival at the hospital. They are asked to fast overnight. The nurse takes the parameters of the patient: weight, height and waist. After starting up the Given® diagnostic system software, the nurse has to enter all these data. An eight lead sensor device is fixed to the abdomen. A template defines the correct position. The device is connected to a solid-state recorder and power pack worn on a belt. The 11 x 26 mm video capsule is swallowed with water. Clear fluids and food can be taken two and four hours respectively after ingestion of the capsule. The belt is removed after seven to eight hours and the recorded images are downloaded to the Given workstation. Review of the video, selection of images can take a few hours.

Conclusions: Capsule endoscopy has several possible advantages compared to other means of visualizing the small bowel. It is non-invasive and permits examination of the majority of the small bowel mucosa, which is not possible with push enteroscopy. Apart from the interpretation of the images, the nurse plays an invaluable role in performing the whole procedure.

Endoscopic Procedures for the Treatment of Gastro-Eosophageal Reflux Disease

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Introduction: Gastro-esophageal reflux (GERD) is one of the most frequent problems in gastro-enterology. For the treatment of uncomplicated GERD patients have the choice between classic surgery and medical therapy. Recently, new endoscopic techniques were developed for the treatment of GERD. The first treatment was the plication procedure, designed by Swain. This technique uses a sewing machine to place sutures below the gastro-esophageal (GE) junction. Later techniques like the stretta procedure consists of creating a fibrotic ring at the GE junction with radio frequency heat. Other techniques try to create a mechanical barrier by injecting substances at the GE junction.

The objective of this paper is to clarify the role of the nurses in the plication technique.
The plication technique: The Bard EndoCinch method was the first to be approved for the treatment of GERD. In this method a capsule is assembled on the top of the endoscope. This capsule is being loaded with a needle, a pusher and thread. The endoscope is advanced to the GE junction under vision. Suction is applied which pulls a fold of tissue into the jaws of the sewing machine. The needle is than advanced through the tissue. The pusher pushes the thread through the needle. After withdrawal of the needle, suction is stopped allowing the tissue to leave the capsule. The thread is captured in the distal part of the sewing machine that is removed from the stomach. This procedure is repeated one time followed by a knot, placed with a suture anchor.

The role of the nurses: Positioning of the patient and the endoscopic equipment: the patient lies on the left side like for classic upper endoscopy. While positioning the endoscopic screen it is important to keep in mind that the gastro-enterologist must keep his endoscope straight during the procedure, which diminishes his freedom of movement. The screen must be placed at the head of the patient, preferably at the opposite side of the gastro-enterologist.

Assembling the sewing machine: the capsule is placed at the tip of the endoscope and the needle and pusher are advanced through the biopsy channel until they exit into the sewing machine. The exact positioning of pusher en needle is crucial for the success of the procedure. A powerful suction must be applied at an extra suction tube, present on the capsule of the sewing machine. The thread must be loaded before starting the procedure.

The procedure: suction must be stopped at the right moment to allow the tissue to leave the capsule before retrieving the endoscope so to prevent mucosal tears. Ones suturing has started, the thread(s) must be kept straight to prevent knots. At the end of the suturing the knots must be placed using the suture anchor.

Conclusions: The assembling of the sewing machine and the suturing are quite complex and requires trained nurses. Incorrect installation of the device and mistakes during the procedure can lead to complications such as mucosal tears, bleeding and loss of the capsule in the patient during the procedure. If a good coordination exists between the nurses and the endoscopist the procedure can be performed smoothly within 20 minutes

Flexible Endoscopic Treatment of Zenker’s Diverticulum

Sylvia Lahey, Dept. of Gastrointestinal Endoscopy, Rijnstate Hospital, Arnhem, The Netherlands.

Introduction: Zenker’s diverticulum (ZD) was first described by Ludlow in 1767 and by Zenker and von Ziemssen in 1877. Since then this kind of diverticulum has been called Zenker’s diverticulum.

Pathogenesis: Zenker’s diverticulum emerge from a defect in the muscular wall of the hypopharynx which is formed by the oblique fibres of the inferior pharyngeal constrictor muscle and the cricopharyngeal sphincter. Evagination of the sphincter is thought to result from chronic increased pressure on the weakened area, which may be due to high intra bolus pressures during swallowing and/or resistance to swallowing, due to abnormalities of the U.E.S. Through this defect the mucosal lining bulge outwards like a pouch. A bridge arises between the oesophagus and the diverticulum. The pouch enlarges gradually and descends behind the oesophagus downwards.

Clinical manifestations: Zenker’s diverticulum is usually discovered in older adults. Most patients present after the age of 50, having had symptoms ranging from weeks to years. Transient dysphagia may be noted early in the course. The opening of a large ZD is often aligned with the axis of the pharynx such that food is preferentially diverted into the diverticulum. When the pharyngeal sac becomes large enough to retain contents such as mucus, pills, sputum, and food, the patient may complain of pulmonary aspiration, gurgling in the throat, appearance of a mass in the neck, or regurgitation of food into the mouth. The ZD may become so large that its retained contents may push anteriorly and completely obstruct the oesophagus.

Treatment: The mainstay of treatment of symptomatic ZD has been surgery. However, in Europe, no surgical minimally invasive methods have been increasingly used. The rigid endoscopic approach used by the E.N.T. physician, was a major advance in the 1950s. However, surgery is not possible in many symptomatic elderly patients who are poor surgical candidates. The first reports using the flexible endoscope for treatment of ZD were not published until 1995. The same principle used in rigid endoscopic approach can be applied during flexible endoscopy. The procedure is performed under conscious sedation, in contrast to the surgical procedures in which general anaesthesia is necessary. Since in 1993 the flexible endoscopic technique was introduced in our hospital as a new management modality for this disorder, over 300 patients have been treated in this way. Virtually all patients have shown marked improvement in symptoms after one or two endoscopic treatments.
Case presentation: Through a case, the therapeutic procedure and especially the nursing care of the patient will be discussed in stepwise manner.

Conclusion: Optimal management of patients with ZD is evolving. The main advantage of the flexible endoscopic approach is that it can be performed without the need for general anaesthesia, and therefore also in patients whose general health is very poor. The technique can easily be performed in an interventional endoscopy unit. Flexible endoscopic treatment of ZD seems to be an effective and relatively safe method.

Endoscopic Evaluation of Foreign Bodies in the Upper Digestive Tract

Dana Mihnea, Otilia Florescu, Cristina Dorin, Gabriela Stamate, Gabriela Zuralei, Leca Sidela, Institutul de Gastroenterologie si Hepatologie Iasi, Romania

Purpose: The evaluation of the foreign bodies in the upper digestive tract and endoscopic treatment.

Material and Method: 27 patients with voluntary or hazardous ingestion of foreign bodies were evaluated endoscopically in the 2nd Medical Clinic from 1st of January 2001 to 1st of August 2002.

Results and discussion: Out of the 27 patients, 20 (74%) were male and 7 (26%) were female (average age 54.7 years); 12 (44.4%) were living in the town and 15 (65.6%) in rural areas. 8 foreign bodies got in the stomach (5 phytobezoars, 2 metallic wires and 1 spoon swallowed down) and 19 cases at the level of the esophagus (1 dental prosthesis, 3 cases of fish bones, 1 case of bone fragment, 2 cases of fruit core, 1 case of olive and 11 cases of cartilaginous meat fragment). In the case of the esophagus foreign bodies endoscopic extraction was produced was proposed in all the cases: in 14 cases (78.9%) the endoscopic extraction of the foreign bodies was succeeded (with the sneer or with the clawed probe), in four cases the foreign body was pushed into the stomach, and 1 case of alimentary residue was settled by fragmenting into smaller residues of which some were extracted and the last pushed into the stomach. In 9 cases pre-existing lesions of esophagus stenosis were present (8 benign-peptic or postcaustic and 1 malignant) and in 3 cases esophagus motor troubles (2 cases of esophagus diffuse Spasm and 1 case of Achalasia). In the case of gastric foreign bodies - 3 held with voluntary ingestion of metallic objects, 1 case (wire) was settled by the endoscopic extraction with overtubes and the others due to the fact that they were caught into the gastric mucous and transpylorically into the duodenal mucous were settled by surgical intervention.

Conclusions: Esophagus foreign bodies appear on pre-existing lesions of stenosis or esophageal motor trouble in almost 70% (68.4%) of cases. The endoscopic treatment of esophageal foreign bodies was successful in 100% of cases without accidents. In the case of metallic gastric foreign bodies caught in the gastric mucous and transpylorically in the duodenal mucous, the endoscopic therapy is very difficult. The role of the endoscopic nurse during the project
GI-Endoscopy Unit Disinfection: Efficacy & Efficiency using Automatic and Semiautomatic Washing Machines

Sección de Endoscopia (Dr JM Bordas). IMD. Hospital Clinic. Barcelona, Villarroel, 170 08036-Barcelona (SPAIN), Jose Luis Gómez, Maria Isabel Gómez, María Jesús Rodríguez; Montse Medina

Disinfection is mandatory in GI endoscopy. Few studies were devoted to the efficacy and efficiency in GI assisitencial practice.

The aim of the study is 1- to have a knowledge of disinfection’s time used by the different disinfection systems, 2- to know the total amount of endoscopes reprocessed using two Medivators, one Olympus ETD2+ washing machines and one Anios system with two disinfection sinks and 3- to assess the efficacy in obtaining high level disinfection

We studied prospectively the disinfection time used by each clean-disinfection procedure using the different washing machines: Anios, Medivators y Olympus EDT2+ and the amount of scopes reprocessed during six hours. The contact time for the selected disinfectant (Glutaraldehyde 0.260% phenol 0.916% phenate 0.156%) was 10 minute. The efficacy of disinfection was assessed by the culture of the channel fluent in MacConkey and Agar solid media (24 hours at 37ºC)

Results (see table below)

Conclusions
1- Anios semiautomatic system was more efficient for reprocessing scopes. However, constant activity of devoted specific personal is required;
2- Automatic washing-machines (Medivators by Olympus) do not need constant activity of specific personal during the cycle.
3- Adequate disinfection was obtained using both the analysed disinfectant time contact and the automatic and semiautomatic disinfectors used. The total number of scopes that can be reprocessed during six hours in the Hospital Clinic GI Endoscopy Unit range from 54 to 90 mainly related to Anios flexibility.

<table>
<thead>
<tr>
<th>Washing Machine</th>
<th>Mechanic cleaning</th>
<th>Scope Accomodatión</th>
<th>Cycle</th>
<th>Final dry</th>
<th>Trans- port</th>
<th>Time per scope</th>
<th>Num of Scope / tray</th>
<th>N° trays in the analyse d unit</th>
<th>N° of scopes during 6 hour session</th>
<th>Microbiologic control</th>
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<td>48.6</td>
<td>1</td>
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<td>51.6</td>
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<td>1</td>
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<td>28.6</td>
<td>1</td>
<td>1</td>
<td>12</td>
<td>Neg</td>
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</table>

(*) one or two tray & one or two scopes will can be simultaneously reprocessed in each tray.)

22
### Announcements of National and International Conferences and Workshops

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<td>Montreal, Canada</td>
<td><a href="http://www.anp2004.nl">www.anp2004.nl</a></td>
<td>World Congress Secretariat c/o Congrex Holland bv P.O. Box 302 NL-1000 AH Amsterdam, The Netherlands, Fax: 0031 20 50 40 225 e-mail: <a href="mailto:wcog2005@congrex.nl">wcog2005@congrex.nl</a> Conference language: English</td>
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<td>The Netherlands</td>
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<td>29th June - 2nd July, 2004</td>
<td>Gronigen, the Netherlands</td>
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<td>Groningen University Hospital Conference Secretary NP 2004, P.O. Box 30.001, NL-9700 RB Groningen, The Netherlands, Fax: 0031 50 361 92 98 e-mail: <a href="mailto:np2004@oplei.azg.nl">np2004@oplei.azg.nl</a> Conference language: English</td>
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## Announcements of National and International Conferences and Workshops

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<td><strong>6th Annual Colorectal Cancer Conference presented by the Cancer Research and Prevention Foundation</strong></td>
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<td>in conjunction with the XXXIV. Congress of the German Society of Endoscopy and Images (DGE-BV)</td>
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<td>18.-20 March 2004 Arabella Grand Hotel Munich</td>
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<td><a href="http://www.rcn.org.uk/events/">http://www.rcn.org.uk/events/</a></td>
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</table>
8TH MEETING OF THE
EUROPEAN SOCIETY OF GASTROENTEROLOGY AND ENDOSCOPY
NURSES AND ASSOCIATES
(ESGENA)

In association with the
Czech Society of Endoscopy Nurses and Associates
in Prague, Czech. Republic
25-27th September 2004
in conjunction with the
12th United European Gastroenterology Week (UEGW)

Words of Welcome

Dear Colleagues,

On behalf of ESGENA and the Czech Nurses Local Organising Committee, we have great pleasure inviting you to the 8th ESGENA Conference, which will be held during the 12th UEGW in September 2004 in Prague.

As in previous years we are hoping to provide a full and varied programme for you - to stimulate you into meeting and holding discussions with colleagues from all over Europe and afar. We are continuing the format of previous conferences as this has encouraged networking and communication between the delegates – between individual nurses as well as national groups.

On Saturday we are providing the opportunity to attend a choice of 8 workshops organised in 4 parallel rooms. The workshops will be more practically focused and in smaller groups - up to 50 - to encourage discussion, questions and exchange of ideas. For the local nurses we will hold some of the workshops in Czech; the others will be in English.

The conference will open officially with the ESGENA Welcome Reception on Saturday evening. In the past this has been a most enjoyable, informal evening with the opportunity to meet colleagues and friends from all over Europe and overseas and we are sure will be equally successful in Prague.

On Sunday the Scientific Programme, which includes two free paper sessions and a nurses' poster session, will offer mainly nursing oriented lectures in two parallel halls.

On Monday morning we will have 2 Plenary Session – lectures in just one hall - to bring together all the delegates, and will end with the Prize Giving of the best Free Paper and the best Poster, followed by the invitation to the next ESGENA conference. The trade exhibition will open on Monday lunchtime and there should be enough time to browse the stands if the medical scientific programme does not tempt you back into the lecture halls. Nurses are particularly invited to visit the Learning Corner, which offers a large variety of "state of art" videos.

But there should also be enough time to appreciate the beauty of the host city. Prague, known as the “Golden City” has enjoyed an unparalleled cultural renaissance. Amid Prague's cobblestone streets and gold-tipped spires-you find one of the world's best-preserved architectural cityscapes in Europe with new galleries, cafés, and clubs situated against a stunning backdrop of towering churches and centuries-old bridges and alleyways. Prague's Old Town is lined with historical and colourful architecture, and dates back to the 11th century. A visit to Prague will not disappoint.

We hope that we will be able to welcome you at the 8th ESGENA Conference in September 2004 in Prague, Czech Republic.

Christiane S. Neumann
President of ESGENA

Ms Sylva Jarošová, Dr.Štapán Suchánek
Representing the Czech Nurses Group Working in Digestive Endoscopy

26
SCIENTIFIC SECRETARIAT
"European Society of Gastroenterology and Endoscopy Nurses and Associates (ESGENA)"
Christiane S. Neumann
c/o Clinical Investigation Unit
City Hospital Birmingham, Dudley Road
Birmingham B18 7QH, England
Tel: (+44) 121 507 4095
Fax: (+44) 121 507 5581 OR 121 426 1773
e-mail: Christiane.Neumann@swbh.nhs.uk

CONGRESS ORGANISATION
UEGW 2004
c/o Guarant Ltd.
Opletalova 22
110 00 Prague 1
Czech Republic
Tel.: +420-284 001 477 (hotline)
Tel.: +420-284 001 444 (operator)
Fax: +420-284 001 448
E-mail: uegw2004@guarant.cz

SCIENTIFIC DEADLINES
30th May 2004: Deadline for submitting abstracts

ORGANISATIONAL DEADLINES
1st June 2004: Deadline for early registration

GENERAL INFORMATION
www.uegf.org/uegw2004

KEY NOTES
Saturday, 25 September 2004
• Afternoon: eight workshops in four parallel sessions (some in Czech)
• All day: ESGE Postgraduate Course with live endoscopy transmissions
• Evening: ESGENA Welcome Reception & Opening of ESGENA Conference

Sunday, 26 September 2004
• All day: ESGENA scientific programme
• Evening: Welcome Reception & Opening of UEGW Conference

Monday, 27 September 2004
• Morning: ESGENA Plenary Sessions and scientific programme
• Afternoon: trade exhibition and the learning centre

COFFEE & LUNCH
• Coffee-breaks will be served for all ESGENA registered participants from afternoon Saturday till Monday lunchtime.
• Lunches will be served for all ESGENA registered participants on Sunday and Monday.

REGISTRATION
• early registration: deadline: 1st June 2004 180 €
• late registration: deadline: 1st September 2004 200 €
• on-site registration: 240 €

The ESGENA registration includes:
• Admission to all ESGENA scientific sessions
• Admission to the UEGW Opening Plenary Session
• Admission to all UEGW satellite symposia
• Admission to the UEGW Learning Centre
• Admission to the UEGW Exhibition
• One congress bag with complete ESGENA conference materials
• Coffee-breaks and lunches from Saturday, 25 September through Monday, 27 September 2004
ESGENA Call for Abstracts

Participants wishing to submit abstracts for ESGENA Conference can do so only in electronic format by sending a
MS Word document with their abstract by e-mail to:
Christiane.Neumann@swbh.nhs.uk
Deadline for ESGENA abstract submission: 30th May 2004

General Information on ESGENA Abstract Submission

Participants are invited to submit original scientific abstracts for oral or poster presentation. Accepted abstracts will be
published in the ESGENA Abstract Book and on the ESGENA website.

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 (British spelling) and must be presented in English.
- Use font that is easy to read such as 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.
- Abstracts will be reviewed by a panel of experts and may be selected for oral or poster presentations, or may
  be rejected. The time allotted for each oral presentation will be 10 minutes, followed by 5 minutes of question
time.
- Notification of acceptance (for oral or poster presentation) or rejection by the Scientific Programme Committee
  will be e-mailed to the presenting author by 30th June 2004.
- 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 abstract should be typed as follows:

- A brief title, which clearly states the nature of the investigation, with the entire title in capital letters
- 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, organization, city and
  country, e-mail and fax number) where the research was carried out, with the name of the presenting author
  underlined
- Type in the top section of the abstract the title of the paper in capital letters
- Use single line spacing
- Do not leave blank lines between paragraphs
- Indent three spaces on the first line of each paragraph
- Include tables if necessary
- The abstract should be as informative as possible:
- State specific objective of the study
- State method used, if pertinent
- Summarise results obtained
- State conclusions reached
- 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.
CHECKLIST FOR ABSTRACTS: As many of you have asked for guidelines regarding abstract submission we thought that you might find this checklist useful to see if you have complied with the requirements. Abstracts not conforming to the guidelines will not be considered for reviewing.

<table>
<thead>
<tr>
<th>ABSTRACT SECTIONS</th>
<th>Checked</th>
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<tbody>
<tr>
<td><strong>TITLE</strong>, which clearly states the nature of the investigation,</td>
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<td><strong>AUTHORS’ names</strong> (full first name, surname)</td>
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<tr>
<td><strong>INTRODUCTION</strong> (what is already known, what needs further study)</td>
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<td><strong>METHOD used</strong></td>
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<td><strong>RESULTS / Findings</strong></td>
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<tr>
<td><strong>SUMMARY</strong> of Results/Findings</td>
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<tr>
<td><strong>CONCLUSION(S)</strong> reached (what has been learned)</td>
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<tr>
<td><strong>REFERENCES</strong></td>
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</tbody>
</table>

**FORMATTING etc**

- **Title in CAPITAL LETTERS**
- **Abbreviations should, if possible, be avoided in the title, but may be used in the text if they are defined on the first usage**
- **Presenting author underlined**
- **Single Line Spaced**
- **Abstracts must be submitted in English (British spelling) and checked for spelling errors**
- **Use 12 point Font e.g. Times Roman,**
- **500 words – max. one A4 page**
- **The abstract should have a NURSING RELEVANT CONTENT and should add to existing knowledge.**
Workshops are practical and can involve hands-on “work”

<table>
<thead>
<tr>
<th>SATURDAY 25 September 04</th>
<th>SATURDAY 25 September 04</th>
<th>SATURDAY 25 September 04</th>
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<tr>
<td><strong>HALLs</strong></td>
<td><strong>Club A</strong></td>
<td><strong>Club B</strong></td>
<td><strong>Club C</strong></td>
<td><strong>Club D</strong></td>
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<td>08:00</td>
<td>100 Seats</td>
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<tr>
<td>Registration opens</td>
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<tr>
<td><strong>WORKSHOP 1</strong></td>
<td><strong>PEG SYSTEMS AND PROBLEM SHOOTING</strong></td>
<td><strong>MANAGEMENT OF CLINICAL EMERGENCIES</strong></td>
<td><strong>HOW TO CREATE A POSTER FOR A CONFERENCE</strong></td>
<td><strong>CLEANING &amp; DISINFECTION</strong></td>
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<tr>
<td>15.30-17.00</td>
<td><strong>ASSESSMENT OF CLINICAL COMPETENCIES IN ENDOSCOPY</strong></td>
<td><strong>TRANSCULTURAL NURSING</strong></td>
<td><strong>HYGIENE &amp; INFECTION CONTROL UPDATE</strong></td>
<td><strong>PATIENT MONITORING</strong></td>
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<tr>
<td><strong>19:30 to 21:30</strong></td>
<td><strong>ESGENA Welcome Party &amp; Opening of ESGENA Conference</strong></td>
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</tbody>
</table>
## ESGENA SCIENTIFIC PROGRAMME

**SUNDAY 26 September 2004 - Monday 27 September 2004**

<table>
<thead>
<tr>
<th>SUNDAY 26 September 04</th>
<th>SUNDAY 26 September 04</th>
<th>MONDAY 27 September 04</th>
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<tr>
<td><strong>HALL IV</strong></td>
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<td>(Language: English + Czech ?)</td>
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<td>8:30-10:00</td>
<td>8:30-10:00</td>
<td>8:30-12:00</td>
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<tr>
<td><strong>SESSION 1</strong></td>
<td><strong>SESSION 2</strong></td>
<td><strong>SESSION 9</strong></td>
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<tr>
<td><strong>HOT TOPIC: THE NURSE ENDOSCOPIST</strong></td>
<td><strong>MANAGEMENT ISSUES IN GASTROENTEROLOGY</strong></td>
<td><strong>PLENARY SESSION 1</strong> NEW TECHNIQUES AND DEVELOPMENTS IN ENDOSCOPY</td>
</tr>
<tr>
<td>Coffee</td>
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<tr>
<td>10:30-12:00</td>
<td>10:30-12:00</td>
<td>10:30-12:00</td>
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<tr>
<td><strong>SESSION 3</strong></td>
<td><strong>SESSION 4</strong></td>
<td><strong>SESSION 10</strong></td>
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<tr>
<td><strong>FREE PAPER SESSION (CLINICAL)</strong></td>
<td><strong>MEETING THE NEEDS OF THE IBD PATIENTS</strong></td>
<td><strong>PLENARY SESSION 2</strong> GI NURSING IN THE 21ST CENTURY</td>
</tr>
<tr>
<td>Lunch &amp; Poster Session</td>
<td>Lunch &amp; Poster Session</td>
<td>Lunch</td>
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<td>13:30-15:00</td>
<td>13:30-15:00</td>
<td>Visit of Exhibition</td>
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<tr>
<td><strong>SESSION 5</strong></td>
<td><strong>SESSION 6</strong></td>
<td>Learning corners</td>
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<tr>
<td><strong>FREE PAPER SESSION (RESEARCH)</strong></td>
<td><strong>EDUCATION &amp; SPECIALIST TRAINING</strong></td>
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<tr>
<td>15:30-17:00</td>
<td>15:30-17:00</td>
<td>Visit of Exhibition</td>
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<tr>
<td><strong>SESSION 7</strong></td>
<td><strong>SESSION 8</strong></td>
<td>Learning corners</td>
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<tr>
<td><strong>ALCOHOL ABUSE &amp; LIVER DISEASE</strong></td>
<td><strong>ETHICS IN GASTROENTEROLOGY</strong></td>
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<td>17:15-18:15</td>
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<td>ESGENA GENERAL ASSEMBLY (MEMBERS ONLY)</td>
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<tr>
<td>UEGW - Welcome Reception</td>
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News from Industry

News from Boston Scientific:

New Technologies To Expand The Boundaries Of Therapeutic ERCP

“As Endoscopic biliary procedures become increasingly more therapeutic, so does the complexity of managing the numerous variables that affect the performance, safety, and cost of the procedure. Finding alternative techniques, modalities, and/or technology to continually improve the efficiency and final outcomes of therapeutic intervention is an important goal in procedural medicine. Now, more than ever, reaching this endpoint while controlling overall costs is paramount. In the setting of therapeutic biliary Endoscopy, enhancing guidewire control, device exchanges, limiting exposure to fluoroscopy and improving overall procedural efficiency is desirable.”

Boston Scientific has a long history of innovation in ERCP. New technologies such as Jagwire™, Kink-resistant Access and Exchange Guidewire, Ultratome™ XL Triple Lumen Sphincterotome, and now the full line of RX compatible biliary devices, continue to expand the capabilities of therapeutic Endoscopy*.

The introduction of RX devices to the Endoscopy unit brought with it a number of positive changes to conventional over the wire practice. Specifically it enables the guidewire to be locked in place once deep guidewire cannulation is achieved, it facilitates a reduction in the conventional exchange length to a simplified short exchange, it offers the Endoscopy unit the choice of using a short 260cm guidewire or a conventional 450cm wire and it facilitates the physician to take control of the wire at the biopsy channel for wire guided cannulation of the papilla or difficult strictures*.

During this past year Boston Scientific introduced two new RX Compatible devices namely the Autotome™ RX Rotatable Cannulating Sphincterotome and the Extractor™ C RX Triple Lumen Retrieval balloon. These two devices demonstrate the continual evolution of the RX Platform as both can be used as stand alone ERCP devices or part of the RX System.

The Autotome RX features an orientating tip designed to facilitate gaining access to the papilla and increase control of sphincterotomy in complex anatomical situations. The C Groove technology combines with the orientable tip to promote selective wire guided cannulation through tortuous anatomy, past difficult strictures and Hilar or pancreatic access. Once the desired duct has been cannulated the Nurse has the option of separating the guidewire from the open lumen so that the wire can be locked and secured in place to possibly minimise further technical complications. Should a device exchange be required the Autotome provides the Nurse the option of performing a simple 5cm exchange or a conventional over the wire exchange*.

The Extractor C RX retrieval balloon is designed to simplify stone extraction. The Two Sizes In One Balloon reduces the need to change catheters if an alternative diameter balloon size is required while the “Square Shoulder” balloon shape at both diameters facilitates stone retrieval. As a triple lumen device the improved injection flow rate makes injection of contrast easier for the nurses. The RX Compatible design provides the potential to maintain the guidewire position while facilitating multiple sweeps during stone retrieval. The nurse has the option to perform a simple 4cm exchange or a conventional over the wire exchange*.

Over the last thirty years “ERCP has evolved from a diagnostic procedure into a therapeutic procedure for a variety of biliary and pancreatic disorders”2. “The benefit to patients of effective, safe, therapeutic ERC P are high but the converse is also true; poor technique exposes the patient to complication and failure and, in turn, to greater risk than elective surgery”3. Boston Scientific looks forward to working with the clinical community to continue on our path of improving technology to help facilitate both Nurse and Physician practice during ERCP.

References and Sources:
1. Giuseppe Aliperti, MD, Jason Gaskill RN, Jane Miller, RN. The Midwest Therapeutic Endoscopy Center at BJC, St. Louis, MO
The new Microvasive® Rapid Exchange™ Biliary System reduces procedure and fluoroscopy time compared with conventional Over-the-Wire (OTW) biliary devices (White Paper)
2. Martin L. Freeman, MD Minneapolis, Minnesota. Adverse outcomes of ERCP – Volume 56, No. 6 (SUPPL), 2002 Gastrointestinal Endoscopy.
* Data on File at Boston Scientific Corp.

For further information, please contact:

Boston Scientific International B. V.
Microvasive Endoscopy
European Headquarters
91, Boulevard National,
F-92257 La Garenne - Colombes Cedex, France
www.bostonscientific.com
Setting the new standard in endoscope reprocessing: The Olympus ETD3

The Olympus ETD System has become the pioneering standard for the reliable reprocessing of flexible endoscopes. Now Olympus introduces the new ETD3, offering even more efficiency and safety for patients and users. With its innovative features, most importantly the new (optional) process based on peracetic acid (PAA) instead of glutaraldehyde, the ETD3 redefines the standard for endoscope reprocessing.

In cooperation with Miele and Ecolab, Olympus introduces a new standard for endoscope disinfection. With new and improved chemicals, a revolutionary flow control system and automatic endoscope identification, the ETD3 provides secure, fast and cost-efficient reprocessing of flexible endoscopes.

Peracetic acid provides strong advantages over glutaraldehyde

For a long time, doctors and nurses have been asking for a glutaraldehyde-free process for automatic endoscope reprocessing. Glutaraldehyde, still the current disinfectant of choice in most countries, is very compatible with the technical material used for endoscopes, but even small quantities of glutaraldehyde fumes in the working environment can give rise to allergic reactions. In addition, glutaraldehyde fixes proteins onto the endoscopes' surfaces if they have not been properly cleaned. Proteins cause so-called “biofilms”, an ideal breeding ground for microbes.

Now, an alternative is at hand: peracetic acid. No biofilms, no allergic reactions, are among its advantages. The ETD3 uses a process based on peracetic acid (PAA), which provides optimum protection for ETD3 users. The excellent disinfection characteristics of peracetic acid allow the ETD3 to carry out the process at a lower temperature, reducing the time needed to heat up the water and thus significantly shortening the cycle time.

Flow Control monitors correct flow of liquids through the endoscope’s channels

The new Flow Control is a reliable monitoring system which checks if there is unrestricted flow of disinfection liquids through the endoscope channels. Together with EndoID, the fully automatic endoscope identification, Flow Control provides full legal and hygienic safety for endoscope disinfection with the ETD3.

Additional features of ETD3 include automatic basket identification, a thermal process for rigid endoscopes and an improved rinse water treatment. Service cost can be reduced due to the possibility of remote maintenance. Test results from various independent hygiene institutes confirm the reliable disinfection and the hygienic safety of the ETD3.

An innovation in endoscope reprocessing:

The new ETD3

More than a successor: The ETD3 defines a new standard in endoscope reprocessing

- New PAA process
- Shorter cycles
- Process temperature at 35° Celsius
- Channel Flow Control
- Automated documentation

For further information, please contact:

Olympus Europa GmbH
Wendenstraße 14 - 18
D-20097 Hamburg
Phone: ++49 40 23773-825
Fax: ++49 40 23773-5731
www.olympus-europa.com
Step into the future of Endoscopy

Pentax Digital Video Endoscopy and New Technologies for GI Imaging

Conventional endoscopes often do not allow the diagnosis of lesions in an early stage, which can finally lead to tumours or carcinomas. Besides digital endoscopy systems, new technologies are offering solutions for the early detection of cancer.

The excellent image quality of the Pentax EPK-1000 Video Processor and the 70K/80K endoscopes is possible through innovative DSP technology (Digital Signal Processing) which contributes to digital image technology without loss of image quality.

At the heart of the new Pentax Digital Video Endoscopy System is the EPK-1000 Colour CCD Video Processor, which is equipped with an integrated Xenon light source. Through digital signal processing this unit offers outstanding image quality regarding resolution, colour reproduction and brightness control. The new Pentax 70K/80K digital endoscopes are equipped with special high-resolution colour CCD chips, producing brilliant, very sharp, full-screen images.

PENTAX is currently working on a new technology which will allow for the identification of microstructures in gastroenterological and pulmonological applications. PENTAX is cooperating with LightLab Imaging Inc., Boston, in the development of this technology for optical coherence tomography (OCT) in the field of endoscopy.

OCT combines the simple technique of ultrasonography (US) with microscopic image quality. As opposed to US, however, the images are not generated through the use of sound waves, but rather light waves. These waves are transmitted from a light source via a special probe which is introduced to the body through the endoscope’s instrument channel. As a result of the high frequencies and bandwidths of the utilised infrared light, a resolution of 10-20 µm can be obtained allowing for images which are 8 to 25 times better than those generated by means of US. Extremely high resolution enables to see even the smallest tissue changes within the mucosa and to differentiate amongst the individual layers in a highly precise fashion.

PENTAX has also entered into a joint venture with OptiScan Imaging Ltd., Melbourne, in 2002 in pursuit of its second research emphasis, named confocal endoscopy. With this technology laser light is applied directly via the endoscope and microscopically accurate real-time images of living cells can be generated in thousandfold magnification.

Bundled laser light is focused on the tissue in order to generate these images. The light beam is reflected by the outside surface of the tissue in the intestine, and is transmitted by means of confocal fibre optics which only conduct light from a specified focal plane to the processor. The light signals conducted to the processor are transformed into images. Thanks to thousandfold magnification of the tissue structures, microscopic images are obtained which allow for the recognition of structures all the way down to the size of cell nuclei. In order to better differentiate and identify tissue structures, the surface of the mucous membrane is first stained with a fluorescent contrast agent.

These new devices do not conform to the MDD and can not be put into service until it has been made to comply.

For further information regarding PENTAX and its current technologies please contact:

**PENTAX Europe GmbH**
Mrs. Daniela Janell
Senior Product Manager
Medical Division
Julius-Vosseler-Str. 104
D-22527 Hamburg, Germany
Phone:+49(0)40/561 92-262
Fax:+49(0)40/560 4213
E-mail:janell.daniela@pentax.de
Internet:www.pentax.de

Hamburg, January 2004
Group Membership
National societies, groups or federations, which represent interests of gastroenterology and/or endoscopy nurses and endoscopy associates. The fees of group membership are dependent upon the number of members in each organisation (see table).

<table>
<thead>
<tr>
<th>Number of Members</th>
<th>Fee</th>
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<tr>
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<tr>
<td>51-100</td>
<td>55 EURO</td>
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<tr>
<td>101-250</td>
<td>105 EURO</td>
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<tr>
<td>251-500</td>
<td>205 EURO</td>
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<tr>
<td>501-1000</td>
<td>405 EURO</td>
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<tr>
<td>&gt; 1000</td>
<td>755 EURO</td>
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</tbody>
</table>

Individual Membership
Persons practising, managing, teaching or researching in gastroenterology and/or endoscopy nursing. Membership fee 15 EURO. In case of bank transfer, please add 10 EURO for bank transfer fees.

Passive Membership:
Persons who used to practise, manage, teach or research in gastroenterology and/or endoscopy nursing and who have maintained an interest in this field. Membership fee 10 EURO.

Affiliated Membership:
Members from industry may join the society as affiliated members. Membership fee 55 EURO.

Membership Application:

Check Membership Level:
Cards Group Membership  Individual Membership  Passive Membership  Affiliated Membership

I would very much appreciate receiving information about ESGENA Membership including the constitution of the society, membership application forms, and information regarding payment of fees.

ADDRESS:

NAME (Person/Group)

DEPARTMENT  HOSPITAL

STREET

POSTCODE  CITY

COUNTRY

TELEPHONE  FAX

E-MAIL

Please send this reply slip to:
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