E.S.G.E.N.A.

European Society of Gastroenterology
and Endoscopy Nurses and Associates
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I recently read an article about “THE POWER OF ONE”. It talked about people like Nelson Mandela who single handedly by the power of his personality and influence changed the politics of South Africa, about Mahatma Ghandi who again by the power of his personality and influence headed up the struggle of India becoming an independent country, and about Smyth Baden-Powell who after he retired founded the Boy Scout and Girl Guide movement. You might say – what has this got to do with us as none of us would think of ourselves compatible with giants of history like these. But on reflection – neither did these people when they started out. All they saw was that there was a need for change and that in their own way they wanted to do something about it. The Norwegian nurse who during the European Conference in Oslo called together the attending endoscopy nurses and started a Group working towards a European Endoscopy Nurses’ Society - “THE POWER OF ONE”, the treasurer of ESGE who decided to support the newly formed working group financially - “THE POWER OF ONE” and all the nurse colleagues and the supporters from the industry who have been involved in their own way to make ESGENA a success – each one “THE POWER OF ONE”.

We all have gifts which can be used for the good and to influence our profession and standards of patient care, either directly or through getting involved with local, national or international professional societies. You may think that you have not got the same talents as others you meet, but remember, a body needs ALL its parts to function well, not only the head and brain, but also the eyes and mouth, all the different organs as well as its arms and legs. Without any of these parts the body would function less good or even die. The key to success of any organization is the people who recognize that they too are part of a functioning body. We do not all need to be leaders – in fact that would cause total chaos. Each of us has something unique to contribute – the leader, the ideas person, the visionary, the organizer, the fundraiser, etc, even the person who listens and supports when life gets too stressful and provides the cup of tea and sandwich to pick us up again – every one “THE POWER OF ONE”.

The snowballing effect of “THE POWER OF ONE” was demonstrated recently when ESGENA awarded the first Education Traveling Grant to Lilishore Poponea from Jordan last autumn (see report inside this Newsletter). She visited hospitals in London, hosted and facilitated by Mariann Baulf, one of the committee members of our British Endoscopy Nurses’ Group (BSG-EAG) - “THE POWER OF ONE”. Lilishore was so enthused after her visit that she went back to Jordan and founded the first Jordanian Association of Gastroenterology and Endoscopy Nurses and Associates “JAGENA”, which already has 60 nurse members - “THE POWER OF ONE”.

Lilishore’s London experience has highlighted to me the importance of sharing good clinical practice as an encouragement and inspiration to colleagues.

Christiane Neumann, President ESGENA

We would like to express our gratitude to our major sponsors who have continuously supported ESGENA financially. This has facilitated the society’s 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.

The ESGENA European Conference is probably the best way of meeting with the widest range of colleagues from around Europe and overseas. So please take this opportunity to come to Prague to share your experience and expertise, either as a delegate or as a presenter of a poster or free paper. I look forward to seeing as many of you as possible in Prague to be inspired to become “THE POWER OF ONE”.

Christianne Neumann, President ESGENA
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Implementation of the ESGENA Job Profile

The European Job Profile is a general statement about the nursing philosophy in endoscopy, qualification and competencies as well as knowledge and responsibilities of endoscopy nurses. It was developed by the “ESGENA Education Working Group (EEWG).” The job profile has the following aims:

• promotion of the profession
• advancement of endoscopy nursing
• tool in professional and political discussion
• basis for the European core curriculum

After ratification in the EEWG, it was distributed to all member countries with the request to support the dissemination within the ESGENA member countries. During the last EEWG-Meeting, information was collected about the acceptance and use of the European job profile in the ESGENA member countries (see table).

The majority of societies translated the job profile into their local language and distributed the translated version to their membership.

French, German and Spanish translations are also available on the following national websites:

- German: www.degea.de and www.ivepa.at
- French: http://perso.wanadoo.fr/endoscopie.gife
- Spanish: www.prouns.com

In the majority of countries the dissemination of the job profile was supported by oral presentations at national conferences and meetings. Some countries announced the job profile in their national journal or newsletter. The British society is using the ESGENA job profile as an orientation in the development of a national job profile.

Following the feedback from national representatives, the European Job Profile has been very useful in political and professional discussions on the national level. It has also been used in various national education courses for endoscopy nurses. In countries with no national profile, the European job profile has been a stimulus to encourage the development of a national job profile.

The English version of the ESGENA European Job Profile is available on the ESGENA web site: www.esgena.org

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Ulrike Beilenhoff
ESGENA Treasurer
Ferdinand-Sauerbruch-Weg 16
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For the complete table, please refer to the source document.
My name is Lilishor Poponea. Since March 1995 I have been working as a GI Endoscopy nurse specialist in the GI Endoscopy department in the Amman Surgical Hospital in Amman, Jordan. Since passing a training programme at the University Hospital in Krakow, Poland, in December 2002, I have also been working as a motility nurse specialist.

I was selected for the Education Fellowship by ESGENA and spent 4 weeks at the St. Mark’s Hospital in London, UK, from 25th October 2003 to 25th November 2003. My aim was to gain more knowledge and experience in therapeutic endoscopies, especially ERCP, in motility studies and in infection control.

Upon my arrival in London, I received a schedule focused on the different clinical areas I was interested in. I had the status of an observer and had the chance to see the following procedures:

- in the Endoscopy department: diagnostic and therapeutic EGDs and colonoscopies, PEG
- in the Physiology department: Esophageal manometry analysis, Ano-rectal function testing, Biofeedback
- in the Radiology department: ERCP, transit studies, Proctogram, Barium follow through, Barium enema, Ano-rectal US
- In the Stoma care department I could observe the work of the IBD and Stoma care nurse specialists.

I learned new procedures by observing, assisting and reading about:

- wireless capsule, Biofeedback, Transit study
- Proctogram, Ano-rectal US
- The role of IBD specialist nurses
- The role of Stoma care specialist nurses

I spent a few days in the hospital library where I read different GI atlases and books focused on endoscopy and gastroenterology.

The staff of the Endoscopy department of the St. Mark’s Hospital were well trained, experienced and updated. They displayed good team work and co-operation. They were very kind, friendly and helpful. The high level of quality in reprocessing of endoscopes and accessories was obtained by establishing high level standards of infection control and by using automated washer / disinfectors.

Comparing my endoscopy unit with that at St. Mark’s, I find there were many similarities and a few differences in the preparation of endoscopes and accessories and in performing procedures. The main differences were that the endoscopy department of St. Mark’s had the latest generation of endoscopy equipment (e.g. endoscopes, processors, monitors built in counters, 3D images, automated washer/disinfectors, new accessories). All this requires funding and depends on hospital accreditation and economic facts.

My visit to St. Mark’s Hospital in London was wonderful. It was a great exchange of experience for me.

I would like to thank the ESGENA board for giving me the scholarship with which I observed, I learned and I obtained a great exchange of experience in endoscopy.

After spending time with the staff of St. Mark’s Hospital and observing their work, I can see the following benefits for me, our patients and our department:

- the patients benefit from improved assistance
- I am able to share my new experience and knowledge with my colleagues
- I updated my knowledge and skills
- I am encouraged to try to establish European standards and level of care in our department

I hope, in the very near future, with the help of the Jordanian Nurses Association and GI Doctors Association, to found a national organisation for GI nurses with the aim of improving our education, co-operation and communication between GI nurses in Jordan and with other countries.

“A well trained and experienced nurse is the ideal person to assist in the organisation of an endoscopy service.”

Lilishor Poponea, SN
GI/Endoscopy Nurse Specialist and Motility Nurse Specialist
Amman Surgical Hospital
PO Box 815337, HKJ-11180 Amman Jordan
ESGE-ESGENA Workshop on Advanced Endoscopy in Athens

27-29 November 2003

The ESGE-ESGENA Workshop was held on 27-29th November 2003 in Athens, Greece. The Workshop combined state-of-the-art lectures and live demonstrations. European experts shared their experience with the participants, during live demonstrations of advanced endoscopic therapeutic procedures. A special lecture programme was designed for the endoscopy nurses/assistants.

Wednesday 26-11-2003
In the late afternoon, Pilar Pérez-Rojo, from Spain, Christine Petersen and myself, Sylvia Lahey, both from the Netherlands, arrived in Athens. Vassiliki Katsilaki, the European contact person of the Greek Endoscopy Society, HANELL, showed us around the old city of Athens.

Thursday 27-12-2003
The next day we had some time to visit the Acropolis from where one has a great view over the city. In the afternoon we had a meeting at the Evangelismos Hospital with the organizers, doctors, local nurses and representatives from Olympus and Cook. The workshop schedule for the next day was discussed, including the medical history of selected patients and equipment which should be used during the endoscopy procedures. After this meeting we visited the endoscopy unit where Ms. Eleni Vienna showed us around. The local nurses were familiar with live demonstrations in their hospital. After the opening ceremony, Prof. Ladas gave a presentation on “Ethics in Gastroenterology.

Friday 28-12-2003 and Saturday 28-12-2003
The lecture hall for the participating doctors and nurses was located at the War Museum. Live demonstrations were transmitted from the Evangelismos Hospital (5 minutes from the War Museum). The Exhibition was located next to the lecture rooms in the entrance hall. The program was scheduled from 9.00 - 17.30, and included a variety of lectures and live demonstrations. Christine Petersen gave an overview of “Education of Endoscopy Nurses in Europe”. Pilar Pérez-Rojo spoke about “Monitoring and Sedation” and “Health and Safety in Endoscopy”. Sylvia Lahey gave a presentation about “Cleaning and Disinfection of Flexible Endoscopes and Accessories” according to the ESGE / ESGENA European guidelines. Vassiliki Katsilaki gave an overview about “The European Job Profile of Endoscopy Nurses”. The participants contributed actively to the discussion. Vassiliki Katsilaki translated all presentations because the majority of Greek nurses did not speak English. In addition all English slides were translated into Greek. Vassiliki is to be commended for her very professional work.

Local nurses prepared the patients for the procedure. During the procedure an anaesthetist monitored the patients and performed sedation using Midazolam 5-7.5 mg and 1% propofol. During the examination one doctor was assisted by one local nurse and one ESGENA nurse. Two Italian nurses assisted in the ERCP room. One of the local nurses took care of the patient after the examination, the other nurse cleaned the endoscope immediately in the endoscopy room. After cleaning, the endoscope was reprocessed in an automated reprocessing machine.

The representatives of Olympus and Cook were a great support during these two days.

During the workshop the following procedures were performed:
- ERCP with treatment of biliary and pancreatic stones
- Endoprothesis in biliary and pancreatic strictures, including expendable stents in biliary strictures
- Bandligation for oesophagus varices
- Endoloop and clipping for haemostasis
- Endoprothesis of upper and lower GI strictures
- Echoendoscopy
- Fine Needle Aspiration (FNA) for the echoendoscopy
- Methyleen blue for Barrett oesophagus
- Argon Plasma Coagulation (APC) for the Zenker’s Diverticulum, angiodyasplasia and post-radiation enteritis

On Saturday 29 November, the Workshop was closed with an endoscopic quiz which was open to the audience and three winners were presented with a prize. Two candidates were invited to a workshop in Brussels, one candidate to Rome.

We had a wonderful time in Athens. It was again an experience to work and share knowledge with doctors and nurses from different countries. The hospitality and co-operation were great.

I would like to thank:
- Pilar Pérez-Rojo, Spain, Vice President ESGENA
- Christine Petersen, NL, first President of ESGENA.

Looking forward to the next workshop.

Sylvia Lahey
General Secretary ESGENA
Endoscopy nurse
Rijnstate Hospital in Arnhem
The Netherlands
ESGE-ESGENA Workshops on Advanced Endoscopy in Katowice

15-16th April 2004 in Katowice, Poland

The ESGE-ESGENA-Workshop on Advanced Endoscopy was held on 15-16th April 2004 in Katowice, Poland. Prof. Andrzej Nowak, President of ESGE, was course director and organised the workshop in co-operation with the Polish Society of Gastroenterology.

The workshop combined state-of-the-art-lectures and live demonstrations. The medical audience comprised about 150 gastroenterologists from Poland, Baltic countries, Czech Republic, Yugoslavia and Russia. A number of European experts gave lectures and treated patients during the live demonstrations.

A special nurses lecture programme was attended by about 90 Polish nurses. The nurses programme covered the following subjects:
- Patient preparation to endoscopic examinations
- Health & safety in endoscopy
- Reprocessing of endoscopes and accessories according to European guidelines
- Documentation in Endoscopy
- ERCP
- News from Industry

ESGENA delegates were:
- Christiane Neumann, United Kingdom
- Sylvia Lahey, Netherlands
- Ulrike Beilenhoff, Germany

Christiane Neumann chaired all nurses sessions together with Magorzata Karczmarczyk, President of the Polish Endoscopy Nurses Society. The lectures given by the ESGENA representatives were directly translated into Polish by medical doctors.

During the live demonstrations Sylvia Lahey and Ulrike Beilenhoff worked in the endoscopy department, helping the Polish nurses and assisting with some difficult procedures. The majority of procedures were assisted by the local endoscopy nurses team from Katowice. European experts performed all endoscopy procedures while local doctors arranged and organised everything in the background.

The university hospital of Silesia in Katowice has an endoscopy unit with a good standard, equivalent to standards in many Western European countries. The department is a teaching centre in Poland. The live demonstrations were transmitted from three different endoscopy rooms (upper and lower GI- and ERCP-room).

During the workshop the following procedures were performed:
- ERCP with treatment of biliary and pancreatic stones, pancreatic cyst drainage, biliary and pancreatic strictures, including expendable stents in biliary strictures
- Bandligation for oesophagus varices
- Endoscopic treatment of GERD
- Endoprothesis of upper GI strictures
- Colonoscopy with Polypectomy and Mucosectomy
- Echoendoscopy
- Argon Plasma Coagulation (APC)

The team-spirit of the hosting department was excellent. The teamwork of nurses and endoscopists was very good, even in stressful situations. Due to the special, warm, Polish hospitality, European nurses, endoscopists and representatives from industry felt very comfortable with the complete team. All in all it was a very relaxing and nice atmosphere, especially in the endoscopy department.

One should not forget, such a workshop means hard work for the hosting department. A lot of preparation is necessary concerning patients, department, equipment, transmission, organisation and logistics. During the workshop foreign endoscopists and nurses worked together with the local team. The communication with European guests had to be done in English. Knowing the workload and stress of such a workshop I can honestly say that the Polish endoscopy and organising teams did a great job.

I would also like to thank the European experts who worked with us in the endoscopy department. All of them were very patient, even in difficult situations.

This was of particular help to the local assisting nurses, who were not so fluent in English, thereby reducing their nervousness and uncertainty. Local doctors also assisted with translation.

The Workshop was sponsored by a number of companies. Olympus and COOK provided endoscopes and accessories. A special word of thanks is owed to representatives from Olympus Europe and COOK Europe. It was a very good co-operation, which is essential for smooth live-demonstrations.

Special THANKS to Prof. Nowak and his whole team. Based on the warm Polish hospitality and the good co-operation, we had a great time in Katowice. Thank you very much for the wonderful time and the hard work. It was a successful workshop.

Ulrike Beilenhoff
ESGENA-Treasurer
A visit to Pretoria, Johannesburg and Cape Town

Since 2001, a cooperation has been established between the South African and the Dutch Societies of Gastroenterology. Prof. Mulder, who worked in the Rijnstate Hospital in Arnhem, asked me on behalf of this cooperation, to invite two South African nurses to come to the Netherlands and to visit some endoscopy units. In March 2002, two South African endoscopy nurses, one from Cape Town and one from Bloemfontein, spent two weeks in the Netherlands. They visited the Rijnstate Hospital in Arnhem and the A.M.C. Hospital in Amsterdam and attended the National Conference in Veldhoven.

To reciprocate, Maré van Wijk, President of the S.A.G.I.N.S. (South African Gastro-Intestinal Nurses Society), invited me to South Africa in order to attend the Gastroenterology Congress from August 7th until 10th in 2003 at the Sandton Convention Centre in Johannesburg.

I visited the Unitas Hospital in Pretoria for two days. This is a beautiful and modern, private hospital. The endoscopy unit has large rooms and they work with a lot of disposable equipment. When the patient needs conscious sedation, it is given by an anaesthetist. Two nurses assist the Gastroenterologist. The nurses showed me all the departments of the hospital and I had the chance to see some of Pretoria. The people are very friendly. After visiting Pretoria, I attended the congress in Johannesburg. The congress started every morning at 7.15 a.m. During the congress there was a variety of presentations for example:

- Medication compliance of inflammatory bowel disease
- Achalasia
- Trichobezoar uncommon cause of intestinal obstruction
- Sedation in endoscopy
- Infection control and prevention of Multi Drug Resistance (MDR)
- Colorectal diseases in Africa
- Chromoendoscopy - interesting colours or a useful diagnostic aid

I was very impressed with the presentations and posters given by nurses. I gave a presentation about: “Flexible Endoscopic Treatment of Zenker’s Diverticulum”. There was also time to attend some sessions of the medical conference of S.A.G.E.S. and to visit the exhibition.

From August 10th to 20th, I visited Cape Town. Cape Town is a wonderful city with beautiful mountains on one side and the sea on the other side. I was impressed with this place. I visited several hospitals, the famous University Groote Schuur Hospital in Cape Town, the very old Victoria Hospital and the Military Hospital in Wijnberg. Most of the time I was at the large University Groote Schuur Hospital. In this hospital the world’s first human heart transplantation was performed by Prof. Barnard, on 3rd December 1967. I visited the famous transplant museum.

Miss Thorpe, the assistant director of nursing, asked me to give a presentation to all senior nurses about: “Nursing in the Netherlands”. After this presentation there was a lot of discussion about this subject.

Maré van Wijk, head nurse of the department of Surgical Gastroenterology, showed me around. I saw several endoscopy procedures. I felt as if I was at home. They performed the same procedures and worked the same way as we do. Unfortunately, they had to disinfect endoscopes and accessories manually in an open bowl with Glutaraldehyde, without any protection measures or ventilation systems, because there is not enough money to buy more equipment and to buy disinfection machines.

The University Groote Schuur Hospital is also a training centre for nurses. They organise workshops for endoscopy nurses e.g. about: Cleaning and Disinfection, ERCP and management of difficult procedures. I think that continuous training is very important. It is a good chance to learn from each other. It also makes our work more interesting.

I am very grateful for the hospitality the people in Cape Town showed me. I had a wonderful time in South Africa and I really appreciated their warm hospitality. In particular, I would like to thank Maré van Wijk for everything she has done for me. I will never forget them.

Sylvia Lahey
General Secretary ESGENA
Endoscopy nurse
Rijnstate Hospital in Arnhem
The Netherlands
During the most recent DDW 2004 in New Orleans, Wilson-Cook demonstrated a new ERCP concept called FUSION. The key characteristics of this system are based on the ability to do an IDE = Intra Ductal Exchange. This means that the device and wire can now be separated in the bile duct. This is possible due to a side hole located at 6 cm from the tip of all FUSION ERCP devices, which allows the wire (185 cm) to be separated from the device. This new concept introduces other benefits as it allows for more efficient procedures for doctors and nurses, thus improving the treatment of patients.

The concept has recently been clinically tested by 3 key Endoscopy University centres in Europe, prior to the launch. As reported in this study by professors Neuhaus (Germany), Costamagna (Italy) and Devière (Brussels) and others, a total of 42 patients with different clinical indications for ERCP treatment have been treated using the new system.

With the FUSION concept, the major advantages are (a) better wire guide control/torqueability and (b) a substantial reduction of wire guide length and (c) numerous innovative clinical possibilities. For example, multiple plastic stent placements can now be achieved using one delivery system and keeping the wire guide in place inside the bile duct, once deep cannulation has been achieved. A substantial reduction in time and effort is herewith possible, but average procedure success will also increase.

FUSION has been tested with major competitive products such as wire guides thus offering a large flexibility for physicians to combine different products from different providers. FUSION is also compatible with the existing traditional long-wire technologies.

Over the coming months, Wilson-Cook is dedicated to demonstrate and teach this new product line. Training of endoscopy nurses will be very critical, since their role in the ERCP procedure will further evolve. Nurses will become more actively involved in any procedure. The amount of 480 cm long-wire exchanges will reduce. The interaction and cooperation between endoscopy nurse and endoscopist will also change. The level of technical or product-related complications in any ERCP procedure will likely be reduced. The amount of fluoroscopy time used on patients as well as nurses and doctors could be reduced. A number of innovative treatment options are available with FUSION.

Wilson-Cook has always been a strong supporter of continuous training and education of physicians and especially nurses, involved in diagnostic and therapeutic endoscopy. With FUSION this is once more becoming very important. We look forward to bringing this product line to your attention in the near future. We believe that FUSION will further optimise endoscopic patient care, and that is our key motive.

Alex Wagteveld
Wilson-Cook Europe
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Abstracts of Invited Papers of 7th ESGENA Meeting, November 2003 in Madrid, Spain

Endoscopy in Inflammatory Disease Attention of Infirmary
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Inflammatory Bowel Disease is generally used to make reference to ulcerative colitis that affects the colon and Crohn’s disease that can affect the colon and the small bowel. It also includes a group of patients not well classified, defined as indeterminate colitis.

In these two entities exists a chronic inflammation of the intestine that evolves in a recurrent manner, being their etiology unknown.

Although the etiology is unknown, a series of factors related with the appearance of the illness exists, about the genetic bias, and environmental factors that unchain this disease.

Genetic factors: the epidemiologic studies provide clear evidence of the existence of genetic susceptibility for these diseases. The frequency of family history oscillates between 5.5 and 22.5%. The most important risk factor to suffer an inflammatory bowel disease is to have a relative with the illness. The relative risk for a brother of a patient with Crohn’s disease varies between 13 and 36, and between 7 and 17 for a brother of a person with ulcerative colitis. The patients with Crohn’s disease and family history usually manifest the disease at an earlier age than patients without family history.

The influence of the environmental factors in the ethiopathology continues to be one of the most difficult aspects to establish. Among the multiple studied factors, only the influence of the tobacco and appendectomy have been confirmed by several studies. Ulcerative colitis tends to appear in non smokers, while the tobacco increases the risk of suffering the Crohn’s disease.

Although patients tend to look for a relationship between the diet and these affections, there is no evidence that associate the appearance of inflammatory bowel disease with certain components of the diet, neither changes in the nutritious habits alters the evolution of these diseases.

Endoscopy is an mandatory exploration since it, besides valuing the aspect of the mucosa, allows the taking of biopsies that confirmed the diagnosis.

The endoscopic procedure is frequently long, because of the need to enter in the ileum and obtaining multiple biopsies. The endoscope should advance slowly to assure a correct vision of the mucosa. Rectifying the endoscope is often necessary and helps to complete the exploration and performed ileoscopy. Usually are young patients and often require anesthesia.

Wireless capsule endoscopy allows us to visualize the small bowel.

Psychologically these are patients that think a lot of their illness with depressive and anxiety episodes, that face another way of life and demand all the family attention they need.

The nurse develops an important role. The previous valuation and the infirmary cares are of help for the security and comfort of the patients. The creation of work units may contribute to improve the quality of these patients’ life.

Preparation of Patients with Chronic Diseases
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Introduction and Objectives
In the presence of an increase of aged patients and as a result of that the increase of pathologies associated to age, appear two problems: more probability of digestive endoscopy needed and more complications rate from chronic diseases. Form digestive endoscopy nursing role, we are forced to set up specifics preparation protocols for those patients, based on the present pathology and/or actual treatments. The communication’s objective is to show our experience and intervention guidelines at the preparation protocols of digestive endoscopies of patients with chronic diseases: cardiac, respiratory, renal, haematological, endocrine, neurological, infectious, psychiatric, known allergies, previous surgery, and particular digestive diseases.

Discussion
In the first place, we consider essential to the preparation protocol an adequate application form filled up with the reasons of the exploration, medical and surgical history, allergies, and concomitant treatments. We must pay attention to patients with clear contraindications to digestive endoscopy: the suspicion or the certainty about hollow viscera perforation, haemodynamic and/or cardio-pulmonary instability with vital risk. At recent surgery (less than 7 days), and recent heart attack we must value the need of diagnosis vs. risk. Referring to patients with neurological and/or psychiatric history would be necessary the intervention of an anaesthetist who achieves a previous preanaesthetic study. Besides, we must pay attention specially to patients with anticoagulant treatments to modify the dose according to the exploration (diagnostic or therapeutic). Moreover

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patients with cardiac prosthesis, immunodeficient, AIDS, or with some particular infectious diseases must modify specially the preparation. Furthermore, patients who heart suffer, renal and/or respiratory failure and important diarrhoea cases, need special preparation protocols.

Conclusion
Although the preparation protocols of digestive endoscopy explorations are well known, exist an important and growing group with chronic diseases who needs a specific information and preparation. In any case, nurses must be on the alert to identify and value any modification from standard protocols to an adequate situation.

Percutaneous Endoscopic Gastrostomy and Button Systems - Materials, Procedures and late Complications
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The placement of a percutaneous endoscopic gastrostomy (PEG) is a multidisciplinary decision. Depending on the underlying clinical problem and patient prognosis, the wishes of the patient and his or her family often weigh heavily on decisions regarding the appropriateness of enteral tube access and the material that will be used.

In our hospital PEG placement is carried out according to protocol. A brief explanation of the placement and removal is required to understand the importance of good follow-up care to avoid complications. Follow-up care during the first week and afterwards, with clear instructions for the patient, family, nurses and other caregivers is important.

When a gastrostomy is to be replaced with another device, knowledge of different materials that are available can help to decide which material can be used.

Late complications that can occur are: 1. Leakage of fluid; 2. Irritation of the skin; 3. Balloon-leakage; 4. Clogging of the tube; 5. Hypergranulation; 6. Dislocation of the tube in the first week; 7. Dislocation when the track is completely formed; 8. Migration of the balloon with obstruction of the antrum or duodenum; 9. Buried bumper syndrome.

Knowledge, prevention, recognition and management of these PEG-related problems, makes it possible to reduce the complication rate.

Conclusion
The placement of a percutaneous endoscopic gastrostomy is considered a very safe procedure. In general complications are rare and mild, but occasionally can be serious and life-threatening. Therefore it is important to educate patients, family, nurses and other caregivers in the placement and follow-up care of a gastrostomy, in order to avoid them.

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Important Changes Leading to Significant Improvements in Bowel Preparation for Colonoscopy Procedures
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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 were all 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.

Oral Hygiene pre percutaneous Gastrostomy Tube Placement
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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.

Discussions
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 the incidence and type of site infections 6 months after this change in practice.

Endoscopic treatment of Barrett:
Detection and treatment of early esophageal cancer.
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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.1 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.2

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.2,6 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.6 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


News from Pentax - New Technologies in the Field of Endoscopy for Improved Early Cancer Diagnosis

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It is still necessary to identify and biopsy pre-cancerous tissue changes, and finally to analyse them histologically with a microscope, by means of image generating endoscopy.

PENTAX is working on the development of new, innovative technologies which simplify diagnosis. The basis and the driving force behind all new developments advanced by PENTAX is many years of experience and expertise in digital technology, as well as in the field of precision optics.

PENTAX Cooperative Effort for the Development of 'Optical Coherence Tomography'

Since the year 2000, PENTAX has been working in cooperation with LightLab Imaging Inc. in Boston on optical coherence tomography (OCT) technology in the field of endoscopy. The development of OCT will serve to identify microstructures in gastroenterological
and pulmonological applications. 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. With the help of infrared light, image resolution can be improved 8 to 25-fold as compared to US. This extremely high resolution makes it possible to see even the smallest tissue changes within the mucosa.

Confocal Endoscopy in the Field of Gastroenterology
PENTAX has entered into a joint venture with OptiScan Imaging Ltd. in Melbourne in 2002 in pursuit of its second research emphasis, namely confocal endoscopy. The technology is utilized, for example, in early detection of intestinal cancer. Laser light is applied directly via the endoscope, and microscopically accurate real-time images of living cells can be generated in thousand-fold 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 which arrive at the processor are transformed into images. Thanks to thousand-fold 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. A reduction in the number of specimens taken for histological analysis is also anticipated as a result of the use of this technology. Early detection of intestinal cancer will thus be significantly facilitated.

Management of an Endoscopy Suite
Eric C. Pflimlin, Ludwig T. Heuss
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Introduction: With the development and propagation of fiber-optical endoscopy there is an increase of therapeutic possibilities and methods. These become more and more complex and time-consuming. Likewise organisation and management of the endoscopy suite becomes more demanding. Therefore the job profile for the head of endoscopy suites has become more demanding with regard to specialist knowledge, material expertise and continuing education.

Aim of this study is to point out the growing complexity of structures and procedures and the increasing demand on management skills for the head of an endoscopy suite.

Method: Analysis of annual reports of the endoscopy department of a tertiary university hospital. Analysis of the development of the workload and the personnel key for registered nurses as well as for physicians. Practical examples from the everyday life.

Results: The amount of endoscopic procedures has substantially rose. The team also grew, but on a lower rate. The time expenditure per investigation has developed inconsistent. The units became more complex and diversified

Conclusion: By the increasing complexity and the rising number of investigations the demands on the job profile of the head of endoscopy suites grew in the past years continuously. This challenge can be met only by professional management open to innovations, with a need to flexibility and a sense of practicability.

News from Olympus
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ET
In the area of Endo Therapy Olympus offers a wide range of disposable products.

Olympus and Terumo have jointly developed a guidewire for digestive endoscopy of the pancreas and bile duct. The Naviguide is a multi purpose combination wire for use during ERCP procedures. The wire is made from Nitinol, which ensures that the wire is kink resistant through even the most tortuous angles. A 10-cm section of the tip of the guidewire has a hydrophilic polymer coating which increases its passability when in contact with body fluids or water.

In the field of stone extraction balloon catheters Olympus launched the multi 3 Extraction Balloon. This innovative disposable balloon can be inflated to three different diameters (balloon sizes of one balloon: ∆ 8.5, 11.5, 15 mm) depending on the clinical need. Three preloaded syringes are included to select the appropriate size of the balloon.

The newly developed disposable SnareMaster in a soft version adds to up the current line up.

In the area of cleaning brushes, Olympus has a new disposable brush the BW 200T with a working length of 2200mm and is compatible to channel diameters of 2.0 to 4.2mm.

GI
Olympus (also) offers several new GI highlights like ScopeGuide, the 3D navigation system, built to increased patient comfort as well as to shorten insertion time during colonoscopy. The new gastrosopes GIF-1TQ160 and GIF-XTQ160 with a 3.7 and 6.0mm working channel respectively are now completing the EXERA range of therapeutic instruments, while the Olympus PSD-60 Endoplasma unit has been especially designed to provide electo coagulation and argon plasma coagulation tailor-made for Endoscopy.

EUS
EUS News: Olympus has recently launched the disposable EUS-FNA needle system, EZ Shot and is offering two new EUS...
endoscopes (GF-UC160P-AT8 and GF-UCT160-AT8) that can be connected to the high-end Philips HDI 5000 ultrasound system. Major benefit for staging of lung cancer is expected from introduction of the world’s first bronchoscope for EBUS-TBNA.

ETD
Olympus launches the ETD3 and sets a new standard in the fully automated and validated reprocessing of endoscopes as the only “true system supplier” in endoscopy.

The ETD3 is fitting all customer needs through the availability of four models: customer choice between conventional Glutaraldehyde or Peracetic Acid based reprocessing and between the ETD3 plus including automatic channel flow control and endoscope identification or the ETD3 basic without flow control and endoscope identification.

With the introduction of the Peracetic Acid based reprocessing the cycle time is significantly reduced to less than 30 minutes and the risk of protein fixation in the channels or on the outer surface of endoscopes is eliminated.

Remote access via ISDN modem secures an increased uptime of the ETD3 at reduced service costs. All parameters of the ETD3 process can be documented automatically ensuring hygienic- and legal safety.

How to optimise the schedule for endoscopy procedures?
Marie-Paule Leberet, Thérèse Kieffer (GIFE FRANCE)

Introduction
Quality of care in endoscopy rimes with safety, efficiency for the patient and the whole team. Procedure scheduling is a crucial point in quality management of endoscopy care. The patients’ well being must be a prioritised objective. However in a competitive healthcare setting other criteria have to be met. The aim of this presentation is to suggest possible ways of harmonizing different aims toward better patient care.

Summary
The main objective of procedure scheduling in the endoscopy setting is patient satisfaction based on quality of care. To achieve this different criteria have to be taken into account during procedure scheduling.

1/ Patients:
- History
- Possible infections (in France a priority is given to KJD)
- Indications of procedure
- Personal habits and needs.

2/ Multidisciplinary team:
- Availability
- Communication
- individual habits and needs.

3/ Endoscopy rooms
- Adapted to specific procedures

- Availability of equipment and surroundings

4/ Scopes
- Number of procedures related to number of scopes available
- Respect of scheduling decisions
- Scope repairs information

5/ Disinfection setting
- Schedule on the wall
- Sufficient number of scopes for the day
- Ongoing information on schedule changes

6/ Other equipment
- Sufficient
- Rigorous management of stock orders

7/ Scheduling staff
- Training
- Complete information about patients (history . . .)
- Communication with the rest of the team (verbal, written, computer, fax)

Conclusion
A serious preparation of the endoscopy procedure schedule taking into account the above mentioned criteria will develop quality of care to patients.

Bullying (Harassment, Mobbying) at work
- a problem to solve?
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The deep changes registered in work organisation are associated to an increase of work load and, as a way of achieve more productivity, workers are been forced to perform new exigencies. Those changes affect workers health negatively and generate new risks less visible but no less dangerous. A wrong work-organization influences worker health as well as worker behaviour and produces psycho-sociological risks, like violence at work and specifically harassment at work.

Mobbing or harassment at work is a part of a wider phenomena: violence at work. This concept goes further that physic violence, and includes other intimidating conducts. So, violence at work place would include, in addition to the physical aggressions, abusive and threatening verbal or physical conducts.

The English term “Mobbing” can be translated to Spanish like “Acoso” (harassment) to describe situations where a person becomes the target of the group to which he or she belongs, being persecuted by it. That produces important health problems, as much physical as psychic, being necessary in many cases the physical and psychological attendance.

As opposed to the dominant approach in mass media on the mobbing at work, that exclusively indicates it like a problem of victim and pursuer personality, our approach locates its origin in work organization problems. For that reason, next to the individual
solutions it is necessary to confront the problem proposing and impelling deep changes in the enterprise strategies of the work force management.

It is clear that the psycho-social environment quality is an important mobbing cause. Conflicts between functions, lack of interesting and stimulating work, negative climate between co-workers gives rise to situations that drive to a high risk of mobbing.

But far from the positions that consider the mobbing like a problem whose nature is exclusively of personality, mobbing can and must be prevented like any other factor of risk at work, through the legally established instruments for it. In this sense, the psycho-social risks evaluation articulates a key piece for the prevention, since it allows the detection of organizational problems in the companies and therefore facilitates the adoption of suitable solutions.

Mobbing consequences have different nature and can be projected on different scopes, since not only the worker health undergoes the effects of the harassment, but the own organization, the family, and the society in general will be affected.

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**Quality assurance by endoscopy standards**  
- security for patients and staff  
Michael K. Ortmann, Ludwig T. Heuss, Department of Gastroenterology, University Hospital, 4031 Basel, Switzerland

**Introduction**  
In Switzerland so far existed no generally accepted, structured standards for endoscopy nursing. Since 2003 a working group the SVEP/ASPE is developing standards for the gastroenterological and pneumological endoscopy following the standards of the WHO (1984) and the DBfK (1995).

It is the **Aim** of the project to develop standards, which correspond to the specific conditions and needs of the Swiss health care system and keep to the qualitative regulations of the EU. After an assumption by the national committees these standards could serve, as basis for certification procedures of endoscopy units in hospital and private practice as well. At the same time they form the basis, for the technical training for medical practice assistants and registered nurses in endoscopy.

**Method**  
Three working groups were formed with one group responsible person each. Subsequently, the standard topics were provided, which specified both the order and the time framework. Two standard variants were presented to the working groups as example. The groups compiled their drafts independently. After a first correction by the responsible persons of the SVEP/ASPE these standards are sent to the national specialist societies for gastroenterology and pneumology for revision.

**Results**  
until September 2003, the following standards were completed: upper GI: diagnostic, upper GI: therapeutic, lower GI: diagnostic and bronchoscopy: diagnostic.

**Conclusion**  
The technical developments in endoscopy demand permanent changes, to which the individual nurses and assistants have to adapt. Procedural standards should not be taken over uncritically for all times and situations. If they are to describe the current international and national requirements of practice they have to be critically analysed and regularly adapted.

**Endoscopy Nurses**  
**What training? What recognition?**  
Hélène Desirat, Paris, France

**Introduction**  
Endoscopy nursing has developed alongside with scientific progress in the design of endoscopes and medical skills. Specific tasks and thus knowledge and training are under the responsibility of nurses working in the endoscopy setting. Throughout the world this has been verified and on a European level ESGENA has worked over the past 4 years on a European job profile and core curriculum for endoscopy nurses. This study aims to analyse the situation of endoscopy nurses in France compared to some other European countries member of ESGENA.

**Study method**  
To answer the following question: “In France does endoscopy nursing care come under the responsibility of general care nurses specifically trained in this field, or operating theatre nurses, or do we have to create a new professional category of nurses?”

The following method of research was used:

**Hypothesis**  
The situation of endoscopy nurses in France is unofficial because of political and economical reasons but essentially because of the difficulties of nurses representation in endoscopy and on national basis.

**Enquiry**
- 250 questionnaires on training needs of French endoscopy nurses (2000)
- 50 questionnaires to French endoscopy nurses on why and how they wish to validate their specific competencies
- 3 interviews of OR nurses
- 6 interviews to the nurse representatives of 6 European countries of ESGENA.
- Interviews of nursing directors
- Interviews of gastroenterologists
- Analysis of French laws concerning nurses’ professional responsibilities
Results
The recognition of endoscopy nurses in France is at a stand still despite the wishes of a big number of this nursing category. The situation should develop either by the assimilation of endoscopy nursing to operating nursing or following the European trend the situation could remain a mix of different categories of nurses working in endoscopy with a possible common level of training as recommended by the European Endoscopy Nurses Education Workgroup.

Ethical Aspects of Colorectal Cancer Screening (CRCS)
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Introduction
Colorectal Cancer is the 2nd most common cancer in the Western World. Most Colorectal Cancers are slow growing and are potentially preventable if (pre-malignant) adenomatous polyps are removed, and curable if cancer is found early (i.e. localised to bowel wall) and removed by polypectomy or surgery. Therefore the WHO has stated that “Screening for Colorectal Cancer is justified”(1). The British Department of Health has now established Pilot Sites for CRCS by FOBT (2) and in the USA screening for all persons aged 50 and over has been established with faecal occult blood testing (FOBT) annually, +/- sigmoidoscopy every 5 years (3) or Colonoscopy every 10 years (AGA). Since 2002 Germany and Italy are carrying out CRCS by Colonoscopy. Although the early diagnosed individual benefits greatly form CRCS the ethical implications on society as a whole has not been considered.

Aim
To look at the Ethics of Colorectal Cancer Screening in terms of the 4 Principles: Benefice, Non-maleficence, Justice and Respect for Autonomy

Benefice - Do Good
There is no doubt that patients who are diagnosed early will benefit hugely. But healthy people who are found to have no cancer and are not at increased risk will not benefit.

Non-maleficence (above all - do no harm)
There are several methods available for CRCS: Faecal Occult Blood Testing, Sigmoidoscopy and Colonoscopy. Each of these methods has it’s own advantages and disadvantages. The more invasive and the more accurate the method is, the more likely is the potential for harm. This may be justified if a cancer is suspected but must be questioned if a potentially healthy patient is put at risk. There is some evidence that patients who have undergone CRCS may be at increased risk of cardio-vascular death. Apart from the harm that can be done from the invasive procedures, patients may suffer emotionally while waiting to hear if they have got cancer or not.

Justice
Screening also has major implications with regard to resource allocation. In the UK the cost per Cancer detected per life year = £10 000 (£ 20 000 for 2 life years). This cost may even be an underestimation. Moreover Screening by Colonoscopy with 60% uptake will require 10,000 extra Colonoscopy Sessions. This invariably will contribute to an increase of waiting lists and deprive patients with suspected colonic diseases early investigations. If more resources are put into screening other areas of healthcare may suffer. Cost anticipated in the UK in 1998 = £ 40 Million Pounds/year for Screening FOBT bi-annually. Individuals therefore are being used as a means to an end as 1000 people would have to be screened by FOBT for 10 years to prevent 1 death from Colon Cancer (Marshall 2000). There are chemo and dietary preventative measures available which have been shown to be beneficial with regard to cancer prevention. Resources would be better spent on health education, as these measures will also protect from other diseases, including cardio-vascular diseases.

Respect for Autonomy
When patients have symptoms they initiate consultation. However, screening means that health care professionals initiate contact, without the consent of the patient. Non-compliance with screening may have future implications as insurance companies may refuse to pay for cancer treatment if patients had refused screening.

Summary
Screened populations tends to be healthier and have lower rates of mortality for all causes (Gates 2001) – therefore gains from screening may be overestimated. Claimed benefits may have been also overstated as the 2 anticipated life years gained may refer just to earlier diagnosis (time lead bias). Earlier Diagnosis may lead to additional 2 years of investigations and worry without any increased life expectancy - Earlier might therefore not be better (time led bias). Resources needed may be better spent in Public Awareness and Health Education Programmes, Primary Care or on Research for blood tests or a magic bullet, etc.

Conclusion
CRCS although of benefit to the early diagnosed patient offers limited benefit to the population at large. CRCS may cause harm and even death in an unaffected population. Resources will have to be withdrawn from other health care facilities to benefit a few. CRCS is using an individual as a means to an end and does not Maximise Happiness.

Therefore population CRCS with the presently available means is not ethically justifiable

2. National Screening Committee. A Summary of the Colorectal Cancer Screening Workshops and Background Papers. DoH Sept. 1998
Relationship with Patients: How can we improve Empathy?
Amparo Marco-Gisbertistoló, PTA 1646100 Burjassot Valencia

Nursing is characterized for being a profession of services that provides care applying the knowledge and specific techniques from its discipline. In the daily work of our profession, we frequently experience the need of acquiring knowledge, skills and attitudes. The need of an emotional and human competence to manage fluently and efecacily the relationship with patients and make it a useful instrument.

In the last three decades, Empathy has been recognized as an appropriate, desirable, therapeutic and central component in the alliance nurse-patient. Infirmary educates have universally accepted it and they have incorporated the empathy educational model in the infirmary studies plans.

Empathy is an attitude or an interior willingness but it is also communication ability, and in the way it works, it is a key element to help us. The use or not of the empathy by professionals from the infirmary branch will affect the results that would be obtained with the patient. This could concentrate on the person and not only on his pathology.

There are debates in relation to how better to conceptualize the empathy: it can be a dimension of the personality, a felt emotion or an observable skill.

A simple empathy requires the therapist ability to feel the "private world" fo the patient as if it was his/hers. It also needs the ability of springing feelings and the oral gift to communicate this understanding in a language in tune with the patient's feelings.

It exists the need of creating an empathy measure that would value what nurses should do during its relation with patients. It would also be useful as a teaching tool and a new learning way.

The Role of the Nurse Educator
Eeva-Riitta Ylinen
MNSc, RN, Teacher of Nursing, Pohjois- Savo Polytecnic, Social-and Healthcare, Kuopio, Finland
e-mail: eeva-riitta.ylinen@pp.inet.fi

In today's constantly changing health care environment Kim’s typology's conceptual domains in nursing - client, client-nurse, practice, and environment help nurses focus on nursing realities and gives basis for examining scientific knowledge while focusing on the professional role of nursing. When educating patient the nurse-client domain is crucial and client-nurse relations is seen as human-to-human engagements with client and nurse as participants.

Developing nursing practice demands a long term commitment, skills, knowledge, and support to the achievement of best practice. Compassion, competence, confidence, conscience, commitment, courage and assertiveness are personal attributes of the professional identity of the nurse, which are connected with the caring legacy of nursing. Accordingly, development of the professional identity of nurses could be understood as professional and personal growth in caring, which implies moral maturity.

Giving information and patient education are integral to nursing roles. There is a need for health professionals to aid patients' access to high quality, evidence based written and oral information and education and to provide it to patients effectively. There is evidence that well-informed individuals are better able to manage their health and treatment, have better psychological outcomes and have fewer exacerbations of their condition and fewer hospital admissions.

In today's conditions staff educators role is seen as nurse / professional, educator / teacher, consultant / counsellor, coordinator / facilitator, change agent / motivator, opinion leader and evaluator / researcher. The role includes responsibilities, climate setting, communication, collaboration, and role development. Roles may be expanded by participating in committees across the hospital, focusing on perceptions of other staff outside own department. Keywords in staff development are educational goals within the framework of the strategic plans and mission of the institution. Effectiveness is achieved through careful planning, thought, and professionalism and application of the nursing process and learning theories to staff education. The consultation role and the importance of fostering a climate enhance professional growth. Research, resources, record keeping, and publication are recognized as additional components of the nurse educator role.

Nurses requires a variety of skills, as well as consideration of a range of influences on teaching and learning, sound knowledge of the topics discussed and resources available to support this information. The nature of what is given or said should be informed and evaluated by context and an appreciation of the patient's needs and readiness to deal with new information so that information seems more sensitive and timely, and may maximise its impact on patients' well being. Nurse should recognise the difference between giving information and education. Giving information can be a passive process, with no confirmation of whether the information is understood or how it has been received. Education, by contrast, implies a more active process, with confirmation that learning has taken place. Giving information is, therefore, only part of the process of patient education. Nonetheless, skilled information giving is still needed for education to be effective. In the future nurses need more and more computer technology to provide new solutions to patient education and to update their own education in practise.

References


Websites of Interest for Endoscopy and Gastroenterology Nursing

This issue of ESGENA newsletter provides a selection of web sites focused on colorectal cancer screening. We would like to thank all members who send us interesting links on this subject. If you know of any good and useful sites please let us know and we will include them in further issues. Thank you very much for your support.

<table>
<thead>
<tr>
<th>web address</th>
<th>Name</th>
<th>Focus</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="http://www.krebshilfe.net">www.krebshilfe.net</a></td>
<td>Österreichische Krebshilfe</td>
<td>Society web page</td>
<td>Austria</td>
</tr>
<tr>
<td><a href="http://www.prevencakrakoviny.cz">www.prevencakrakoviny.cz</a></td>
<td>Cancerprevention</td>
<td>Patient information</td>
<td>Czech Republic</td>
</tr>
<tr>
<td><a href="http://www.darmkrebs.de">www.darmkrebs.de</a></td>
<td>Colon cancer</td>
<td>Patient information</td>
<td>Germany</td>
</tr>
<tr>
<td><a href="http://www.krebshilfe.de">www.krebshilfe.de</a></td>
<td>Cancer aid</td>
<td>German Cancer Society</td>
<td>Germany</td>
</tr>
<tr>
<td><a href="http://www.krebsgesellschaft.de">www.krebsgesellschaft.de</a></td>
<td>Deutsche Krebshilfe</td>
<td>Society web page</td>
<td>Germany</td>
</tr>
<tr>
<td><a href="http://www.gesundheitsforum-bw.de">www.gesundheitsforum-bw.de</a></td>
<td>General information, links</td>
<td>Society web page, several guidelines available</td>
<td>Germany</td>
</tr>
<tr>
<td><a href="http://www.dgvs.de">www.dgvs.de</a></td>
<td>Deutsche Gesellschaft für Verdaunungs und Stoffwechselkrankheiten</td>
<td>Society web page</td>
<td>Germany</td>
</tr>
<tr>
<td><a href="http://www.AIGO.ORG/screening_ccr.htm">www.AIGO.ORG/screening_ccr.htm</a></td>
<td>AIGO-SIGE, Lega Italia</td>
<td>National colorectal cancer screening programme</td>
<td>Italy</td>
</tr>
<tr>
<td><a href="http://www.kreft.no/english">www.kreft.no/english</a></td>
<td>Norwegian Cancer Society</td>
<td>Society web page</td>
<td>Norway</td>
</tr>
<tr>
<td><a href="http://www.kreftregisterat.no">www.kreftregisterat.no</a></td>
<td>Nationwide cancer registry since 1954</td>
<td>Society web page</td>
<td>Norway</td>
</tr>
<tr>
<td><a href="http://www.bsg.org.uk">www.bsg.org.uk</a></td>
<td>British Society of Gastroenterology</td>
<td>Society web page, several guideline available</td>
<td>UK</td>
</tr>
<tr>
<td><a href="http://www.beatingbowelcancer.org">www.beatingbowelcancer.org</a></td>
<td>British institution deals with issues of colorectal cancer</td>
<td>Patient information</td>
<td>UK</td>
</tr>
<tr>
<td><a href="http://www.bowelcancer.tv">www.bowelcancer.tv</a></td>
<td>Lynn’s Bowel Cancer Campaign</td>
<td>Patient information</td>
<td>UK</td>
</tr>
<tr>
<td><a href="http://www.coloncancer.org.uk">www.coloncancer.org.uk</a></td>
<td>Cancer charity</td>
<td>Cancer charity</td>
<td>UK</td>
</tr>
<tr>
<td><a href="http://www.asge.org/gui/">www.asge.org/gui/</a></td>
<td>American Society of Gastroenterology</td>
<td>several guidelines on colorectal cancer screening and colonoscopy issues</td>
<td>USA</td>
</tr>
<tr>
<td><a href="http://www.cancer.org">www.cancer.org</a></td>
<td>American Cancer Society</td>
<td>Society web page</td>
<td>USA</td>
</tr>
<tr>
<td><a href="http://www.rollingtorecovery.com/colossalcolon.htm">http://www.rollingtorecovery.com/colossalcolon.htm</a></td>
<td>Colossal Colon</td>
<td>Patient information</td>
<td>USA</td>
</tr>
<tr>
<td><a href="http://www.ccalliance.org/">http://www.ccalliance.org/</a></td>
<td>Colo Cancer Alliance</td>
<td>Patient information</td>
<td>USA</td>
</tr>
<tr>
<td><a href="http://www.preventcancer.org/colorectal/">http://www.preventcancer.org/colorectal/</a></td>
<td>Cancer Research and Prevention Foundation (CRPF)</td>
<td>Variety of information and links</td>
<td>USA</td>
</tr>
<tr>
<td><a href="http://www.colorectal-cancer.net">www.colorectal-cancer.net</a></td>
<td>Colon Cancer Network</td>
<td>Variety of information, links</td>
<td>USA</td>
</tr>
<tr>
<td><a href="http://www.planetcancer.com">www.planetcancer.com</a></td>
<td>A world of support for young adults with cancer</td>
<td>Patient information</td>
<td>USA</td>
</tr>
<tr>
<td><a href="http://www.twodaymarch.org">www.twodaymarch.org</a></td>
<td>The Two-Day Colon Cancer March</td>
<td>National awareness campaign</td>
<td>USA</td>
</tr>
<tr>
<td><a href="http://www.olypmamusamerica.com/crcawareness">www.olypmamusamerica.com/crcawareness</a></td>
<td>Olympus</td>
<td>Industry</td>
<td>USA</td>
</tr>
</tbody>
</table>
Announcements of National and International Conferences and Workshops

**CANADA**

**World Congress of Gastroenterology and SIGNEA Meeting**

12 - 14 September 2005
Montreal, Canada

[www.anp2004.nl](http://www.anp2004.nl)

**Information**

World Congress Secretariat
c/o Congrex Holland bv
P.O. Box 302
NL-1000 AH Amsterdam, The Netherlands,
Fax: +31 20 50 40 225
e-mail: wcog2005@congrex.nl

Conference language: English

**GERMANY**

**34th Conference of the German Society of Endoscopy Nurses and Associates (DEGEA) in conjunction with the 59th Conference of the German Society of Gastroenterology (DGVS)**

2 - 4 September 2004
Leipzig, Germany

**Information**

[www.degea.de](http://www.degea.de) or [www.dgvs.de](http://www.dgvs.de)

Conference language: German

**SWITZERLAND**

**24th International Congress of the Swiss Society for Endoscopy Nurses and Associates (SVEP/ASPE) in collaboration with the 69th Meeting of the Swiss Society for Gastroenterology and Hepatology.**

September 10 - 11 2004
Montreux, Switzerland

**Information**

Mrs Elvira Seger
University Basel Gastroenterology/Pneumology, Spezialabteilung Endoscopy
Petersgraben 4, 4031 Basel, Schweiz
Fax: +41 61 265 5352, Tel.: +41 61 265 25 25
e-mail: eseger@uhbs.ch

Conference language: German, French

**GREAT BRITAIN**

**British Society of Gastroenterology - Endoscopy Nurses Meeting**

March 2005
Conference Center Birmingham

**Information**

[www.bsg.org.uk](http://www.bsg.org.uk)

Conference language: English

**GERMANY**

**Endo Club Nord Live Demonstrations from three Endoscopy Centres in Hamburg State-of-the-Art-Lectures**

5 - 6 November 2004
Congress Centrum Hamburg, Germany

**Information**

[www.endoclubnord.de](http://www.endoclubnord.de)

Conference language: English, German
Absolute control.

The new double-balloon method for examining the entire small intestine.

A leap forward – the new double-balloon endoscope allows endoscopy of the entire small intestine to be performed for the first time with all diagnostic and therapeutic resources. Examine the whole area without surgery, and with optimum image quality and maximum comfort – for both doctor and patient. Fujinon. To see more is to know more.
Autotome™ RX Rotatable Cannulating Sphincterotome
Take control

Autotome RX Cannulating Sphincterotome enables progressive tip orientation and provides the option of independent guidewire manipulation and locking by the physician.

For more information, please contact your local Endoscopy representative from Boston Scientific.

www.bostonscientific.com
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 Jarossova, Dr. Stapan Suchanek
Representing the Czech Nurses Group
Working in Digestive Endoscopy
8th Meeting of the European Society of Gastroenterology and Endoscopy Nurses and Associates (ESGENA)

GENERAL INFORMATION

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 7OH, England
Tel: (+44) 121 507 4095
Fax: (+44) 121 507 5581 OR 121 426 1773
e-mail: Christiane.Neumann@swbh.nhs.uk

SCIENTIFIC DEADLINES
30th July 2004:
Deadline for submitting abstracts

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

ORGANISATIONAL DEADLINES
1st June 2004
Deadline for early registration

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

KEY NOTES

SATURDAY, 25 SEPTEMBER 2004
Afternoon: eight workshops in four parallel sessions (two workshops 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
## ESGENA Scientific Programme

### ESGENA WORKSHOPS

**Saturday 25 September 2004**

Workshops are practical and can involve “hands-on” work.

<table>
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<tr>
<th>SATURDAY 25 September 04</th>
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<tbody>
<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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<tr>
<td>08:00 Registration opens</td>
<td>100 Seats</td>
<td>50 Seats</td>
<td>45 Seats</td>
<td>50 Seats</td>
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<tr>
<td>Registration &amp; Workshops</td>
<td>13:30 - 15:00 WORKSHOP 1</td>
<td>13:30 - 15:00 WORKSHOP 2</td>
<td>13:30 - 15:00 WORKSHOP 3</td>
<td>13:30 - 15:00 WORKSHOP 4</td>
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<tr>
<td>ENDOTRAINER</td>
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<tr>
<td>1 x Broncho-Trainer</td>
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<tr>
<td>1 x ERCP no x-Ray</td>
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<td>1 x Polypectomy</td>
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<td>1 x Haemostasis</td>
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<td>Language: English</td>
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<tr>
<td>15:00 - 15:30 Coffee</td>
<td>15:00 - 15:30 Coffee</td>
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<tr>
<td>Registration &amp; Workshops</td>
<td>15:30 - 17:00 WORKSHOP 5</td>
<td>15:30 - 17:00 WORKSHOP 6</td>
<td>15:30 - 17:00 WORKSHOP 7</td>
<td>15:30 - 17:00 WORKSHOP 8</td>
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<tr>
<td>ENDOTRAINER</td>
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<td>Language: English</td>
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<tr>
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<td>15:30 - 17:00 Coffee</td>
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### ESGENA Welcome Party & Opening of ESGENA Conference

**Brevnov Monastery**, Teresian Hall and adjacent rooms

*Transport: buses will be provided and will leave at 19:00 from the Prague Congress Centre. From about 20:30 - 21:00 shuttle buses will be provided back to the Prague Congress Centre.*
Saturday 25 September 2004

WORKSHOP 1
DUMMY TRAINING

13:30-15:00 Club A
Co-ordinators: Christine Petersen, Amsterdam, Netherlands
               Lorenz Rudkin, Luxembourg
Language: English

Content:
This workshop will offer hand-on-training at pig-stomach-modules, called “Endotrainer”, developed by Dr. Martin Neumann, Erlangen, Germany.

TABLE 1
BRONCHOSCOPY
Tutors:
• Michael Ortmann, Basle, Switzerland
• Björn Ferke, Basle, Switzerland
• Prof Dr. Michael Tamm, Switzerland

TABLE 2
ERCP NO X-RAY
Tutors:
• Gerlinde Weilguny, Vienna, Austria
• Herta Pomper, Vienna, Austria
• Prof. Andreas Puespoek, Vienna, Austria

TABLE 3
POLYPECTOMY (STOMACH & COLON)
Tutors:
• Sylvia Lahey, Arnhem, NL
• Pilar Perez-Rojo, Pamplona, Spain
• Dr. Chris Mulder, The Netherlands

TABLE 4
HAEMOSTASIS
Tutors:
• Dianelle Duforest-Ray, St. Laurent du Var, France
• Willy de Vriese, Bruges, Belgium
• TBC

WORKSHOP 2
PEG SYSTEMS AND PROBLEM SHOOTING

13:30-15:00 Club B
Chair: Marjon de Pater, Leiderdorp, The Netherlands
       Helen Griffiths, Hereford, UK
Language: English

Content:
Specialist PEG Nurse’s Role, Training of PEG Patients, Support Systems e.g. from Industry, Trouble Shooting, etc.

WORKSHOP 3
HOW TO CREATE A POSTER FOR A CONFERENCE

13:30-15:00 Club C
Chair: Christiane Neumann, Birmingham, UK
       Ulrike Beilenhoff, Ulm, Germany
Language: English

Content:
How to find a topic, write an abstract and produce a good conference poster.

WORKSHOP 4
CLEANING & DISINFECTION

13:30-15:00 Club D
Chair: Sylva Jarosova, Prague, Czech Republic
       Hana Kubu, Prague, Czech Republic
Language: Czech

13:30-14:00 Endoscan
Iva Kozakova, Prague, Czech Republic

14:00-14:30 Guidelines for disinfection in Czech Republic
Hana Kubu, Prague, Czech Republic

14:00-14:30 Disinfection of endoscope in practice
Sarka Marikova, Prague, Czech Republic
Dana Kuchynkova, Prague, Czech Republic
WORKSHOP 5
DUMMY TRAINING
15:30-17:00 Club A
Co-ordinators: Christine Petersen, Amsterdam, The Netherlands
Lorenz Rudkin, Luxembourg
Language: English

Content:
This workshop will offer hand-on-training at pig-stomach-modules, called “Endotrainer”, developed by Dr. Martin Neumann, Erlangen, Germany.

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• Pilar Perez-Rojo, Pamplona, Spain
• Dr. Chris Mulder, The Netherlands

TABLE 4
HAEMOSTASIS
Tutors:
• Dianelle Duforest-Rey, St. Laurent du Var, France
• Willy de Vriese, Bruges, Belgium
• TBC

WORKSHOP 6
TRANSCULTURAL NURSING -
How can we assess & address the needs of patients from different culture
15:30-17:00 Club B
Chair: Hélène Herve-Desirat, Paris, France
Eric Pflimlin, Basle, Switzerland
Language: English

TOPIC 1
Setting up an Endoscopy Unit in a developing country
• Eric Pflimlin, Basle, Switzerland

TOPIC 2
Nutritional deficiencies
• Hélène Herve-Desirat, Paris, France

TOPIC 2
Practical Support for developing countries
• Sylvia Lahey, Arnhem, The Netherlands

WORKSHOP 7
ASSESSMENT OF CLINICAL COMPETENCIES IN ENDOSCOPY
15:30-17:00 Club C
Chair: Di Campbell, Torquay, UK
Pat Bottrill, Newcastle, UK
Language: English

Content:
Demonstration and criteria setting for assessment in clinical practice

WORKSHOP 8
PATIENT MONITORING
15:30-17:00 Club D
Chair: Iva Kozakova, Prague, Czech Republic
Ludmilla Pavlatova, Hradec Kralove, Czech Republic
Language: Czech

15:30-16:00 Analgosedation in digestive endoscopy
Ludmilla Pavlatova, Hradec Kralove, Czech Republic

16:00-16:30 Monitoring of patient during the endoscopy
Sylva Jarosova, Prague, Czech Republic

16:30-17:00 Patient monitoring in practice
Lucie Stalova, Prague, Czech Republic
**ESGENA Scientific Programme**

**SUNDAY & MONDAY**

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<th>MONDAY 27 September 04</th>
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<tr>
<td><strong>HALL 4</strong> 150-250 Seats (Simultaneous translation into Czech)</td>
<td><strong>HALL 5</strong> 150-250 Seats (Simultaneous translation into Czech)</td>
<td>1- Small Hall 320 Seats 2- Club A+B 150 Seats (Language: English)</td>
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<tr>
<td><strong>SESSION 1</strong> BRONCHOSCOPY</td>
<td><strong>SESSION 2</strong> MANAGEMENT ISSUES IN ENDOSCOPY</td>
<td><strong>SESSION 9</strong> PLENARY SESSION 1 NEW TECHNIQUES AND DEVELOPMENTS IN ENDOSCOPY</td>
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<td>Coffee</td>
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<td>8:30 - 10:00</td>
<td>8:30 - 10:00</td>
<td>8:45 - 10:30 Small Hall</td>
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<td><strong>SESSION 3</strong> HOT TOPIC: THE NURSE ENDOSCOPIST</td>
<td><strong>SESSION 4</strong> MEETING THE NEEDS OF THE IBD PATIENTS</td>
<td><strong>SESSION 10</strong> PLENARY SESSION 2 GI NURSING IN THE 21 CENTURY</td>
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<td>BEST FREE PAPER AND BEST POSTER AWARD</td>
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<td><strong>SESSION 5</strong> FREE PAPER SESSION</td>
<td><strong>SESSION 6</strong> EDUCATION &amp; SPECIALIST TRAINING</td>
<td>INVITATION TO COPENHAGEN</td>
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<td>12:30 - 15:00</td>
<td>13:30 - 15:00</td>
<td>Visit of Exhibition Learning corners</td>
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<td>Coffee</td>
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<td><strong>SESSION 7</strong> LIVER DISEASE</td>
<td><strong>SESSION 8</strong> ETHICS IN ENDOSCOPY</td>
<td>Visit of Exhibition Learning corners</td>
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<td>15:30 - 17:00</td>
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<tr>
<td><strong>17:15 - 18:15</strong> ESGENA General Assembly (Members only)</td>
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<td><strong>19:30</strong> UEGW Welcome Reception</td>
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Sunday, 26 September 04

08:30 - 10:00
HALL 4
SESSION 1
BRONCHOSCOPY

Chair: Sylvia Lahey, Arnhem, The Netherlands
       Gerlinde Weilguny, Vienna, Austria

08:30 - 08:40
Welcome
Christiane Neumann, Birmingham, UK

08:40 - 09:10
A History of Bronchoscopy-
"From the Beginning of Bronchoscopy
 to EBUS (Endo-Bronchial Ultrasound)"
Michael Tamm, Basle, Switzerland

09:10 - 09:40
Guidelines for Safe Care in
Bronchoscopy
Christiane Neumann, Birmingham, UK

09:40 - 10:00
Infection Control in Bronchoscopy
TBC, Basle, Switzerland

10:30 - 12:00
HALL 4
SESSION 3
HOT TOPIC: THE NURSE ENDOSCOPIST

Chair: Dianelle Duforest-Rey,
       St. Laurent du Var, France
       Eeva-Riitta Ylinen, Kuopio, Finland

10:30 - 11:00
Ethical, legal & Professional Aspects
Di Campbell, Torquay, UK

11:00 - 11:30
Training Requirements (JAG)
Rachel Hodson, Hull, UK

11:30 - 12:00
Colorectal Cancer Screening by
Nurse Endoscopists
Maggie Vance, London, UK

08:30 - 10:00
HALL Amsterdam
SESSION 2
MANAGEMENT ISSUES IN ENDOSCOPY

Chair: Pilar Perez-Rojo, Pamplona, Spain
       Eric Pflimlin, Basle, Switzerland

08:30 - 08:40
Welcome
Pilar Perez-Rojo, Pamplona, Spain

08:40 - 09:10
What can we delegate to unqualified
personnel
Ulrike Beilenhoff, Ulm, Germany

09:10 - 09:35
Implementation of a quality system
(ISO 2000/9000) into an Endoscopy Unit
Mary Fogarty, Dublin, Ireland

09:35 - 10:00
Long-term experience with Propofol
Ludwig Heuss, Basle, Switzerland

10:30 - 12:00
HALL 5
SESSION 4
MEETING THE NEEDS OF THE IBD PATIENTS

Chair: Stanka Popovic, Ljubljana, Slovenia
       Michael Ortmann, Basle, Switzerland

10:30 - 11:00
Psycho social problems of patients
with IBD
Gabriele Moser, Vienna, Austria

11:00 - 11:30
Special needs of IBD patients
undergoing Bowel Investigations
Gerlinde Weilguny, Vienna, Austria

11:30 - 12:00
The role of the IBD Specialist Nurse
TBC
### 13:30 - 15:00
**HALL 4**
**SESSION 5**
**FREE PAPERS SESSION**

**Chair:** Lorenz Rudkin, Luxembourg  
Pat Bottrill, Newcastle, UK

**13:30**  
**HEALTH CONDITION OF ENDOSCOPY PROFESSIONALS: RESULTS OF A NATIONAL ENQUIRY**  
Gerlinde Weilguny, Vienna, Austria

**13:45**  
**INTEGRAL ENDOSCOPY TRAINING FOR GASTROENTEROLOGISTS, FELLOWS AND NURSES; THE ROLE OF NURSE-TEACHERS**  
Theo Pordon, Agaath Hanrath, Paul Fockens, Amsterdam, The Netherlands

**14:00**  
**NURSE’S EVALUATION OF A SYSTEM ALLOWING INTRADUCTAL EXCHANGE DURING ERCP**  
Sonia Dugardeyn, Dominique Delannoy, Jacques Deviere, Brussels, Belgium

**14:15**  
**IMPLEMENTATION OF BIOTRACK SPECIMEN TRACKING SYSTEM INTO AN ENDOSCOPY DEPARTMENT**  
Julia Wood, Oxford, UK

**14:30**  
**CARBON DIOXIDE INSUFFLATION DURING COLONOSCOPY: SAFE EVEN IN SEDATED PATIENTS?**  
A.B.Lynge, T.Kvamme, K.Sakshaug, G.Jonasdottir, L.Berger, H.Karlsen, A.Eigum, A.Lysaker, M.Kordal, B.Kjos, L.Aabakken, M.Bretthauer, Norway

**15:00**  
**NOSOCOMIAL INFECTION AND NURSING CARE RELATED TO ENDOSCOPIC BILIARY PROSTHESIS INSERTION**  

### 15:30 - 17:00
**HALL 4**
**SESSION 7**
**LIVER DISEASE**

**Chair:** Hélène Herve-Desirat, Paris, France  
Marjon de Pater, Leiderdorp, The Netherlands

**13:30 - 14:00**  
**Organising Study Days, Courses and Conferences**  
Hélène Herve-Desirat, Paris, France

**14:00 - 14:30**  
**Constructivism in Education**  
Eeva-Riitta Ylinen, Kuopio, Finland

**14:30 - 15:00**  
**Educational Placements (Hospitalisation)**  
Michael Ortmann, Basle, Switzerland

**15:30 - 16:00**  
**Supporting the Hepatitis C patient**  
Sheila Needs, Torquay, UK

**16:00 - 16:30**  
**Haemochromatosis and the nurse’s role**  
Helen Griffiths, Hereford, UK

**16:30 - 17:00**  
**The role of the Liver Specialist Nurse**  
Luz Galvez, Barcelona, Spain

### 15:15 - 16:45
**HALL 5**
**SESSION 8**
**ETHICS IN GASTROENTEROLOGY**

**Chair:** Stanka Popovic, Ljubljana, Slovenia  
Maggie Vance, London, UK

**15:30 - 16:00**  
**Debate: It is ethical to delegate medical duties to non-doctors if this is the only means of providing a health service.**  
Pro: TBC
Contra: Jean-Francois Rey, St. Laurent du Var, France

**16:00 - 16:30**  
**Ethics Committees - The potential Role of Clinical Ethics Committees vs. Research Ethics Committees**  
Christiane Neumann, Birmingham, UK

**16:30 - 17:00**  
**Ethical Dilemmas in Gastroenterology**  
Aksel Kruse, Aarhus, Denmark
**Monday, 27 September 04**

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<tr>
<th>Time</th>
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| 08:45 - 10:30 | Small Hall | **SESSION 9**
**PLENARY SESSION 1**
- New techniques & Developments in Endoscopy
  
**Chair:** Ulrike Beilenhoff, Ulm, Germany
Christine Petersen, Amsterdam, The Netherlands

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<tr>
<th>Time</th>
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| 08:45 - 09:40 |  | "Innovative ERCP Developments with Fusions and the implications for nursing staff."
Ed Brennan, Cook

**Nursing in modern endoscopy**
Thomas Carter, Boston Scientific

**Double Balloon Enteroscope**
Peter Jurkowski, Fujinon

**Changing the way ERCPs are performed: V-System**
Anja Schuster, Olympus

**Endomicroscopy - first confocal endomicroscopy system to visualise mucosa at a cellular level**
Daniel Zeidler, Pentax

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| 09:40 - 10:10 |  | **Endoscopic Nissen Fundoplication S**
Annette Fritscher-Ravens, Germany

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| 11:00 - 12:30 | Club A+B | **SESSION 10**
GI NURSING IN THE 21ST CENTURY
(Focusing on Disease Prevention)
  
**Chair:** Christiane Neumann, Birmingham, UK
Czech Nursing Organisation

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| 11:00 - 11:30 |  | The EU Health Strategy and the Role of Nurses and Nursing
Paul de Raeve, General Secretary PCN, Brussels, Belgium

**The Role of the GI nurse in 10-20 years**
Pat Bottrill, Newcastle, UK

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<th>Session</th>
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| 12:00 - 12:10 |  | Best Free Paper and Best Poster Award
Christiane Neumann, President, ESGENA
President Czech Endo Nurses Group

**Close of Meeting**
Christiane Neumann, President, ESGENA

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<th>Time</th>
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| 12:20 - 12:30 |  | Invitation to Copenhagen
Brita Lindeberg, President
Danish Endoscopy Nurses’ Group
News from Boston Scientific

DOES GUIDEWIRE CANNULATION REDUCE ERCP PANCREATITIS?

Balancing and minimising risks

We all know that any surgical procedure carries with it a degree of risk, and balancing this risk with the potential benefits for the patient is one of the key roles of the medical profession. In ERCP, pancreatitis is the most common complication, with consequences that can range from short stays in hospital to pancreatic necrosis, organ shutdown and even death.1

Certain pancreatitis risk factors are beyond the control of doctor or patient, such as female gender and young age. However there are some steps that the ERCP team can take to increase their chances of a complication-free procedure. Guidewire cannulation is one step that is still under discussion, and this question impacts ERCP nurses directly as they may well be the ones who control the guidewire for at least a part of the procedure.

Cannulation – A controllable risk factor?

One area where the ERCP team has some control of a risk factor is in papillary trauma. One study showed that pancreatitis occurred in 3% of cases when cannulation was “easy” (1-5 attempts) but rose to 13% when cannulation was “difficult” (>15 attempts).2 Clearly, experience in cannulation could reduce the number of attempts required. However, it is also possible that using a soft-tipped guidewire to cannulate could be less traumatic than using a sphincterotome or cannula. Another possible benefit of guidewire cannulation is that can reduce the need to inject contrast into the pancreatic duct, which more than doubles the risk of pancreatitis (see reference 1).

One reason why guidewire cannulation is still a point of discussion is that it is difficult to perform a trial that would eliminate all the other factors, such as skill levels and patient mix, that may lead to a successful procedure. However, evidence in favour of guidewire cannulation is building, with a paper showing greatly reduced rates of pancreatitis in guidewire-led cases published in June.3 While 20 years ago guidewire cannulation was almost unheard of, considerable numbers of doctors now use it as their main method of gaining access to the bile duct, and this number is still increasing.

A simple way of avoiding post-ERCP pancreatitis?

The fact is that there is no such thing as a risk-free ERCP, and of course doctors choosing to use this technique are always balancing the risk of complications with the benefit to the patient. However, while accepting these risks, efforts to minimise them make good sense for both the patient and the medical team. With this in mind, it seems likely that the trend towards guidewire cannulation will continue.

References

(3) Lella et al., A simple way of avoiding post-ERCP pancreatitis. Gastrointest Endosc 2004; 59:830-834
FUJINON

With the overtube being held by an assistant to prevent it from being withdrawn, the scope is then inserted further until it reaches the descending duodenum. The balloon on the endoscope is then inflated so that it maintains a stable position within the intestinal lumen. The overtube is advanced along the endoscope until the overtube tip enters the duodenum. The balloon on the overtube is then inflated to hold a stable position in the intestine. With both balloons inflated, the endoscope is gently withdrawn together with the overtube to straighten it. The balloon on the endoscope tip is then deflated, and the endoscope is advanced along the overtube, which is being held by the assistant, until the distal end of the scope reaches the ligament of Treitz. At this point, the overtube tip is fixed in a stable position in the duodenum, so that the scope advances further without becoming looped again in the stomach. After the balloon at the tip of the scope is inflated and fixed in a stable position in the intestine, the balloon on the overtube tip is deflated so that the overtube can be advanced again along the scope up to the balloon at the distal end. The overtube balloon is then inflated again and fixed in a stable position in the intestine, and the scope balloon is deflated so that the scope can advance. These procedures are repeated so that the balloons can be advanced and alternately fixed in stable positions in deeper and deeper locations. If complex loops form, the overtube can be gently withdrawn together with the scope with both of the balloons inflated.

THE DOUBLE BALLOON ENDOSCOPY TECHNIQUE:
1. Overtube and scope deflated
2. Overtube and scope inflated
3. Overtube is inflated and fixed
4. Scope is advanced
5. Scope is inflated, overtube is advanced
6. Overtube is inflated
7. Overtube and scope are withdrawn
8. Scope is deflated and advanced

For further information please contact:
FUJINON (EUROPE) GMBH
Halskestr. 4, D-47877 Willich, Germany
TEL.: +49(0)2154/924-0,
FAX: +49(0)2154/924-290,
www.fujinon.de, www.fujinon.co.jp
The main challenge in colonoscopic procedures still lies in guiding the flexible endoscope through the entire colon and avoiding frequent looping. Even for experienced specialists, straightening out loops can be tricky and time consuming. ScopeGuide™, a new Olympus product drastically improves this situation.

With the help of magnetic coils built into a colonoscope the shape and position of the instrument is continuously displayed in real time throughout the examination without the use of x-rays. The small magnetic fields generated are picked up by the antenna of ScopeGuide’s main unit and reconstructed into a schematic picture of the endoscope by the computer.

With ScopeGuide™ and the help of its external marker in the hand of the endoscopy nurse abdominal compression becomes easy and efficient while at the same time reducing the patient’s discomfort.

- Easy and safe loop elimination
- Increased patient comfort
- Easy abdominal compression
- No x-ray radiation

As public awareness of colon cancer increases, so too does the demand for effective methods of detection and prevention. Colonoscopy - today’s most viable technique - can now be more predictable and efficient with the help of ScopeGuide™.
Once again, New Orleans, Lousiana was host to the Digestive Disease Week from 15 - 20 May 2004. One of the main highlights of the year was the introduction of the confocal laser endoscopy system. For the very first time, this method makes it possible to obtain histological images of tissue during the course of the endoscopic examination.

Dr. med. R. Kiesslich (Mainz) presented the results of two clinical studies which employed the confocal system. In the first study, 42 patients who had undergone a polypectomy/surgery were screened for colorectal carcinoma. Comparing the confocal images with the histologically prepared biopsies, the confocal endoscopy showed a sensitivity of 97.4%, a specificity of 99.4% and an accuracy of 99.2% for the prediction of neoplasia.

The second study involved 41 patients and investigated the significance of confocal endoscopy for patients with colitis ulcerosa, in conjunction with (chromoendoscopy). Chromoendoscopy proved to be a highly effective supplementary method, with the help of which it was possible to unmask localised areas and detect neoplastic changes, which were then targeted by using confocal microscopy. Also in this study the histology was predicted with a sensitivity of 94.4%, a specificity of 95.6% and an accuracy of 99.3%.

The follow-up discussion proceeded to describe confocal endoscopy as summarised below:

- A breakthrough for endoscopic diagnostics
- Revolutionary portrayal of microscopic structures during the endoscopic examination
- Widespread use for
  - Screening (colorectal carcinoma)
  - Monitoring (colitis ulcerosa)
- Interpretation skills can be acquired and produce efficient diagnoses
- Option of optical biopsy comparable with conventional histology
- Safe method

In the medium term, there will therefore be no alternative to confocal endoscopy for gastroenterological centres.
The new *Pentax BoK Series* digital video endoscopes are setting new standards in endoscope hygiene. The range features detachable flexible distal tips, which allow free access for brushing of all internal channels and a new control body with an innovative surface design. Our Video Duodenoscope has a completely sealed bridge control wire, which offers significant advances in endoscope hygiene. To find out how Pentax can improve your procedures, Telephone: +49-40-56192-0; Fax +49-40-5604213; E-mail: medical@pentax.de or Internet: www.pentax-endoscopy.com
ESGENA - Membership

**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>Membership Fee</th>
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<tr>
<td>&lt; 50</td>
<td>30 €</td>
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<td>51 - 100</td>
<td>55 €</td>
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<td>101 - 250</td>
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<td>501 - 1000</td>
<td>405 €</td>
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<td>&gt; 1000</td>
<td>755 €</td>
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**INDIVIDUAL MEMBERSHIP**
Persons practising, managing, teaching or researching in gastroenterology and/or endoscopy nursing.

Membership fee 15 €

**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 €

**AFFILIATED MEMBERSHIP**
Members from industry may join the society as affiliated members.

Membership fee 55 €
**ESGENA - Membership Application**

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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:**

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Please send this reply slip to:

Petra Schindler, Medconnect GmbH, Brünnsteinstr. 10, 81541 Munich, Germany
Fax: +49 89-41 41 92 45, E-mail: petra.schindler@medc.de
E.S.G.E.N.A.

European Society of Gastroenterology and Endoscopy Nurses and Associates