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

European Society of Gastroenterology and Endoscopy Nurses and Associates

**ESGENA - Governing Board**

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Message from the Chair

First of all, I would like to wish you a very Happy New Year. Time really does seem to fly and as we enter the new year we reflect on the last twelve months of achievements, many of which are reported in this Newsletter.

You may have noticed that this and the last Newsletter have been produced in a format similar to a journal. The membership pages, which are confidential, are now separate pages so that you can circulate the Newsletter within your department for everybody to read. The new format has been possible due to profits from recent European conferences and to the brilliant work of the firm Medconnect, who are our new partners on this project. This has relieved the ESGENA Board Members from a lot of work and given us time to concentrate on other activities. Our long term goal is to move from a Newsletter to a Magazine and eventually to produce a European GI Nursing Journal with scientific articles. This will not be possible without your contributions so please look at your work and share any good practice, experience, successes and anything else you think might be of interest for the membership.

Our annual conference in Prague was a great success (see inside article). The number of registrants and presentations was well above expectations. Due to generous industry support we were able to put on a varied and interesting programme, including dummy workshops on Saturday, which will be repeated in Copenhagen.

The Job Profile so many of you have contributed to has now been published (November 2004 Issue of Endoscopy). This should help nurses all over Europe to define their position and area of responsibility. The work on the Core Curriculum is also progressing, as has the preparation of potential national education leaders via the Train-the-Trainer courses.

2005 will be a very special year for ESGENA as it is the 10th Anniversary of its foundation. The first interim Board was confirmed in Berlin in 1995, followed by formal elections in Paris in 1996. I have been privileged to have been involved as a Board Member since 1995 and have seen the society grow into a respectable, professional association thanks to the work and contributions not only from the Board Members but also from you – the Membership, along with the continued support from the Industry and the co-operation with ESGE and PCN. We are planning a celebration of our tenth anniversary in Copenhagen. As ESGENA is YOUR society we are hoping that many of you will attend and share in the festivities.

With best wishes for 2005.

Christiane Neumann,
President ESGENA

We would like to express our gratitude to our major sponsors who have continuously supported ESGENA financially. This has facilitated 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.
You may have noticed that this and the previous Newsletter have been in a new format: different layout, separate membership pages and more articles and information. I would like to take this opportunity to acknowledge and thank those who significantly contributed:

- As we made a profit from the last ESGENA conference we were financially able to implement our vision for a new, more magazine style newsletter with professional help from Medconnect. Medconnect designed the new layout (we had several options to choose from), did most of the final layout from Ulrike’s draft and also helped with a lot of the copy editing that Ulrike and I had done in the past.

- You - the members - also contributed more than before with information about the activities of your national societies. A special thanks to the Netherlands and Croatia. Lorenz Rudkin and Helene Herve-Desirat contributed additional useful websites to the Website Section. Contributions from you, the members, are particularly appreciated and we hope that this active participation by the membership will continue in the future.

- Last but not least I would like to thank Ulrike Beilenhoff who, in addition to the work she does as ESGENA Treasurer, has collected the articles for the newsletter from the authors and the industry, written several of the articles and reports and worked throughout the entire publication process with Medconnect, including approving the final version of the Newsletter before it went to print.

I very much hope that you enjoy our new Newsletter which promises, with your help and articles, to develop into a professional Newsletter. So please start writing!

Christiane Neumann,  
President ESGENA

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Tsunami - Asian Earthquake Disaster

We have all been saddened by the tragic events of the Christmas season and were deeply moved by the graphic, televised scenes of this traumatic event which resulted in the massive destruction of infrastructure and numerous deaths amongst the local population and tourists. Our thoughts are with the survivors and the families of the victims and the terrible plight they now face. We can hardly comprehend the scale of this tragedy and the number of lives lost as well as the suffering of those who survived. Asia and East Africa are facing an awesome challenge in the days and weeks ahead as attention turns from burying the dead to caring for the living.

On behalf of ESGENA we wish to express our deepest-felt sympathy to all who have suffered from this terrible tragedy. Our thoughts and prayers are with all those who are suffering, through injury and illness, the loss of a dear one or the uncertainty of what has happened to their beloved ones. Many ESGENA members have contacts and friends in these countries, not to mention family and friends who may have been on holiday there. Our deepest sympathy and heartfelt condolences go particularly to all of you who have suffered a loss.

Our thoughts are also with our nurse colleagues who will be stretched beyond belief by the never-ending demand for help, comfort and treatment. We express our respect for the selfless efforts of nurses and other health care workers in saving lives and caring for the wounded with limited resources and in difficult circumstances. Our frustration and helplessness can only be eased by our own contributions, for example, to the national and international disaster funds. On behalf of ESGENA we would like to encourage you all to show solidarity and to give generously.

Christiane Neumann  
President on behalf of ESGENA
1994 Oslo to 2004 Prague -
A Historical Review

Sometimes we must look into history to discover which aims have already been reached and why we need to share our knowledge. Things do not just simply exist! There are people who have a dream, who work in their free time in order to realise a vision. We need enthusiastic colleagues today and tomorrow in order to move forward and develop our European association.

10 years ago, the foundations of ESGENA were built. For those who have been members from the beginning, the following review might bring up fond memories, for those who have joined ESGENA more recently, this is a good introduction to the history of our association.

OSLO 1994: During the First European Conference for Endoscopy Nurses in Oslo / Norway, a small group of enthusiastic nurses met to discuss the possibility of forming a European society for Endoscopy nurses. The initiative was supported by Dr. Jean Francois Rey, France (ESGE-President). His encouragement was honoured with honorary membership in ESGENA. Through the support of the European Society of Gastrointestinal Endoscopy (ESGE) a working party was set up with the remit to write a constitution for the planned society. The group met twice during 1995 to draft the constitution. Members for an interim governing board were chosen and presented together with the final draft of the constitution to the delegates at the 2nd European Conference in Berlin/Germany in 1995. It was agreed to hold annual conferences at the UEGW.

PARIS 1996: The new group became the official European Society of Endoscopy Nurses and Associates. The first elections of officers to the Governing Board took place in Paris, France during the 1st ESGENA Conference in November 1996.

Birmingham 1997: At the 2nd ESGENA Conference the first achievements of ESGENA and projects were presented to the membership.

As the World Congresses of Gastroenterology and the 7th International SIGNEA-Meeting were held in September 1998 in Vienna, Austria, a European conference was not held.

Since 1999 ESGENA has held an annual conference each year:

- 1999 Rome
- 2000 Brussels
- 2001 Amsterdam
- 2002 Geneva
- 2003 Madrid
- 2004 Prague

ESGENA has over 6000 members in 38 countries. The ESGENA group members (national endoscopy nurses societies and nursing associations) have been very active in the past decade. ESGENA built up a data bank with a variety of information (databases for hospital placements and international speakers, information about national societies and specialist education for endoscopy nurses).

Strong links have been established with the European Society of Gastrointestinal Endoscopy (ESGE) which has supported ESGENA since its foundation. Representatives of ESGENA have participated in ESGE guideline committees looking at the hygiene and infection control as well as quality assurance in gastrointestinal endoscopy. In 1996 video tapes on reprocessing of endoscopes and accessories were produced under supervision of Dianelle Duforest-Rey, France. These tapes remain useful.

Since its foundation, ESGENA has been involved in ESGE-Workshops on Advanced Endoscopy (with live demonstrations) and has organised special courses for endoscopy nurses in Eastern and South European countries.

In order to advance the education of endoscopy nurses in Europe, ESGENA founded the ESGENA Education Working Group (EEWG) which is focused on advanced educational needs. The Group developed a European Job Profile and is working towards a European curriculum for endoscopy nursing. ESGENA has also started to support educational activities of membership countries. A special thanks to Christiane Neumann for her engagement in the Education Working Group. The financial support of Olympus Europe has made the work of the EEWG possible. In this context Ms Anja Schuster from Olympus Europe deserves a special thanks for her contribution.

Since 1997 ESGENA has published a bi-annual newsletter. Ms. Ulrike Beilenhoff started the first one and continued the editorial work for many years.

Within these 10 years, ESGENA has built a strong group of European nurses. We need this kind of European co-operation and communication now and in the future. Inform each other, share your knowledge and experience and work together. We need a strong team which can count on each other, respect the quality of the others and use our skills the best we can.

And we should never forget this is all for our patients’ benefit!

Christine Petersen, RN
Amsterdam, The Netherlands
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Report from ESGENA Conference
September 2004 in Prague

25-27 September 2004 in Prague

Prague, known as the “Golden City”, has enjoyed an unparalleled cultural renaissance. Amid Prague’s cobblestone streets and gold-tipped spires you will find one of the best preserved architectural cityscapes in Europe. New galleries, cafés and clubs are 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.

The 8th European conference of ESGENA was held on 25-27th September in conjunction with 12th United European Gastroenterology Week in Prague. 470 nurses from Europe, the Middle East, Australia, Canada and the United States used the opportunity to exchange experiences and knowledge.

On Saturday the ESGE postgraduate course provided interesting and highly qualified views of new endoscopic and surgical techniques with live demonstrations from the Ev. Krankenhaus, Düsseldorf, Hospital Erasme, Brussels and the Policlinico Gemelli, Rome.

The ESGENA conference commenced on Saturday with eight parallel workshops. This year the workshops contained highly practical elements with many opportunities for interaction. Two workshops offered hands-on-training with pig stomach, ERCP and lungs modules, developed by Dr. Martin Neumann, Erlangen, Germany (further information: www.ece-erlangen.de). Endoscopic techniques like haemostasis, polypectomy, ERCP and bronchoscopy could be practised under real conditions. Highly qualified tutors from Austria, Belgium, France, the Netherlands and Switzerland shared their experience with workshop participants and enabled hands-on training for all workshop participants. The professional organisation and preparation by Gerlinde Weilguny (Vienna), Michael Ortmann (Basle) and Dr. Neumann (Erlangen) laid the foundation for the success of the workshops. A special thanks to the industry which sponsored the workshop with endoscopes and accessories. The feedback from participants was so positive that ESGENA decided to continue with the workshops on the Erlanger Endotrainer at the ESGENA conference in Copenhagen.

The workshop on transcultural nursing discussed projects of foreign aid in Endoscopy and Gastroenterology. The Netherlands supported hospitals in Romania, the University Hospital of Basle built an endoscopy unit in Bangladesh, and a group of French students and nurses examined the eating habits in Africa.

A workshop on PEG discussed the role of the PEG nurse, training of PEG patients and support systems. Intensive interaction offered workshops on assessment of clinical competencies and “How to create a poster for conferences”. Two workshops, offered in Czech, were focused on patient monitoring and hygiene in endoscopy.

On Sunday the scientific programme offered mainly nursing orientated lectures in two parallel halls:

- Bronchoscopy
- Management
- Hot topic - Nurse Endoscopist
- Education
- Meeting needs of IBD patients
- Liver Disease
- Ethics in Endoscopy
Six free papers were presented at the free paper session. The best free paper presentation was determined upon the following criteria: education value, originality, logical construction, quality of presentation, quality of slides, responses to questions. The prize for the best free paper was free registration and 2 nights accommodation at the next ESGENA conference in October 2005 in Copenhagen, Denmark.

The winner was:

12 scientific posters presented studies, surveys, standards and case reports. The best poster was determined with the following criteria: education value, originality, logical construction, quality of presentation, responses to questions. The prize for the best poster was a camera from PENTAX.

The winner was:
A Day free from Glutaraldehyde but with Disinfected Endoscopes: Paradox or reality? Linda Ashurst, Bjørg Kjos and Egil Lingaas, Rikshospitalet, Oslo, Norway (see abstract).

A special thanks to PENTAX Europe for supporting this award.

A focal point in many discussions and sessions was the advancement and improvement of the role of the nurse. Controversial discussions were held about further specialisations for nurses working in Endoscopy and Gastroenterology. One session discussed previous experiences with nurse endoscopists. The plenary session took a critical look at the advancement of the nurses role in Endoscopy and Gastroenterology. One slogan that stimulated many discussions was “nurses do not want to be mini-doctors, but maxi-nurses”. That means, nurses should not orientate or compare their responsibilities and tasks with medical staff. The future of nurses will be focused on prevention and health education. This will also influence the future role of Endoscopy and Gastroenterology nurses.

The conference in Prague was very successful. ESGENA received positive feedback and constructive comments from participants. The scientific level increased compared to previous conferences. A special thanks to Christiane Neumann, as scientific secretary she invested an enormous effort in the preparation of the conference thus, the success of the Prague conference is also her success. The Czech colleagues in Prague were perfect hosts, very friendly and always helpful. It was a pleasant atmosphere which supported the multicultural exchange with friends.

On Monday two plenary sessions were focused on new technical developments and on the role of the nurse in the 21st century.

Ulrike Beilenhoff
Treasurer of ESGENA
New Job Profile of Dutch Endoscopy Nurses

Introduction
In 1997 the first profile was written for endoscopy assistants or endoscopy nurses. Since then there have been many new developments in the positioning of the different nursing specialities in The Netherlands. This required a review of the previous job profile. The new profile has specially been written for endoscopy nurses.

Background
There are 54 different organisations representing 55,000 nurses and other professional health care workers in The Netherlands. These 54 organisations are associated under an umbrella organisation called the AVVV. This organisation’s board has the authority to represent nurses and professional health care workers in both the professional and political context on issues that face nurses, health care workers and the entire area of health care. The AVVV especially focuses on common issues regarding the nursing/caring professions and professional practice.

Current situation
The common element in all of the sub-profiles is the existing nurse’s job profile. This is the recognised diploma. Since 1997 nurses are required to be registered in the BIG register. Those who are registered are allowed to carry the title “nurse”. Nevertheless, the procedure of registration is still not clarified. There are still open questions concerning the procedure of registration and the requirements which have to be fulfilled.

In 2002 the AVVV accepted the request from the Ministry of Health and started to create a standardised structure for the different sub-profiles of nurses and health care workers. Our Endoscopy nurses society SEVA joined the working group in September 2003. Three members of SEVA, assisted by a project leader of AVVV, began to write the new job description for endoscopy nurses. This was a lot of work. Every procedure and treatment needed to be described in the profile. In October 2004 the new job profile was ratified by the membership of SEVA.

Under Dutch law, the title “nurse” is protected. Only nurses with a proper diploma are allowed to use it. This has sparked many discussions within SEVA regarding the status of those members who are endoscopy assistants, but do not have a nursing diploma because in daily practice many of these assistants do the same work as endoscopy nurses. However, these assistants work under the supervision of the doctor, who takes the overall responsibility for their actions. As professionals nurses are responsible by law for their own actions.

Future
The basis of all further specialisation must be a common diploma. In 2005 all different courses and training programs existing for the different specialities should be analysed. This is necessary in order to clarify exactly which specialities exist and which training programs are necessary for each specialisation. This evaluation will be done for all different levels of specialisation. Hopefully, this will clarify the status of endoscopy nurses within the nursing profession.

Currently the Dutch Endoscopy Society SEVA reviews the job profile for endoscopy assistants who do not have a nursing diploma. It plans to finish its work in 2005.

Suzanne Swartz
Endoscopy nurse
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New Independent Croatian Association of Nurses and Medical Technicians in Gastroenterology and Endoscopy

The annual meeting of Croatian endoscopy nurses was held on 4-6 November 2004, at the Hotel Mursa in Osijek. The topics of our meeting were as follows:

1) Colorectal carcinoma
2) Professional stress and overexertion
3) Problems related to disinfection and sterilization in endoscopy rooms

The total number of participants was 141.

At the meeting of the Gastroenterology Section of the Croatian Nurses Association, it was decided to transform into an independent association, entirely autonomous from the Croatian Nurses Association. The name of the previous Section of Gastroenterology nurses has been changed into: The Croatian Association of Nurses and Medical Technicians in Gastroenterology and Endoscopy. New statutes were established. A bank account was opened for the new society. A new governing board was elected consisting of a chairperson, vice-chair, secretary and an executive committee, including 21 nurses from each Croatian county in order to link inpatient and outpatient care, nurses employed in private practice and in home care centers. The aim of the new society is to offer a higher quality of education to nurses and medical technicians and thus to improve patient care in Gastroenterology and Endoscopy. The activities of the new society will be performed in agreement and collaboration with the Croatian Nurses Chamber, the only authority in Croatia which can approve educational activities for nurses and medical technicians.

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Objective
Improving quality of our endoscopy unit by the introduction of practical training sessions for the entire team (gastroenterologists, fellows and nurses) in order to share experiences between disciplines, to improve skills and to benefit from the joint practice.

Methods
In our large volume, tertiary referral endoscopy unit, we have organized monthly training sessions for all endoscopists and nurses (maximum 20 per session divided in four groups) since 2 years. Five senior nurses (>5yrs experience) from our endoscopy unit have developed a training program consisting of four stations. Each station is supervised by one nurse and one experienced gastroenterologist. All trainees rotate between the 4 stations, spending at least 1.5 hrs at each station.

Station 1: Simbionix training (interactive computerised simulator). Knowledge of endoscopic procedures, hands-on training of equipment involved.
Station 2: EASIE model (pig’s stomach specimen with bleeding focuses) to practice haemostasis techniques.
Station 3: ERCP materials and knowledge of equipment.
Station 4: EASIE model (pig’s stomach specimen with duodenum) to practice ERCP-skills.

We developed a questionnaire to evaluate the usefulness of these training sessions. All trainees were asked to fill out a questionnaire before and after the training session. Results were calculated by comparing pre- and post training questionnaires.

Results
In the fall of 2003, 46 participants completed a training session and filled out their questionnaires before and after. Questionnaires showed that 40 out of 46 participants (92 %) reported an improvement in their skills at end of the training day.

Conclusions
Structured training sessions combining gastroenterologists, fellows and nurses show a very high success rate with regard to improvement of skills.

A day free from glutaraldehyde but with disinfected endoscopes. Paradox or reality?

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Background
Manual washing and final decontamination of flexible endoscopes in an endoscope washer-disinfector is common practice in all endoscopy units. National and international guidelines recommend a standardized protocol to achieve an endoscope which is safe for patients and personnel. The present study was undertaken to examine the microbiological quality of manual and automatic decontamination, and to compare the effect of a glutaraldehyde based process to a process with super-oxidized water.

Endoscopes and Washer-disinfectors
All endoscopes were of Olympus brand. Belimed and Olympus washer-disinfectors were used.

Methods
Samples for quantitative microbiology were collected aseptically before and after manual prewashing of the endoscopes and after final decontamination in the endoscope washer-disinfector. Sampling was done by separate flushing of all endoscope channels with broth containing neutralizers for glutaraldehyde and chlorine. The fluid was inoculated directly as well as after filtering through a membrane filter onto agar plates and incubated aerobically and anaerobically for 5 days. Colonies were counted and identified by conventional microbiological methods. Numbers were given as total number of colony forming units (CFU) per endoscope channel.

Results
So far 27 endoscopes have been examined (8 duodeno-, 12 gastro, 2 entero- and 5 colonoscopes). Bacterial growth after final processing in the endoscope washer-disinfector was detected in one or more channels in 12 of 27 endoscopes (44%). The degree of contamination varied between 3 and 1610 CFUs per channel. The dominating organisms were Gram positive cocci and Gram positive spore-forming rods. The air-water channel was contaminated in all cases (12/12), whereas additional contamination of the biopsy channel and the jet channel was found in 2 endoscopes. There was a trend towards more frequent contamination in endoscopes disinfected with glutaraldehyde (9/16 vs. 3/8).

Discussion
Although the degree of contamination was low in most cases, the frequent contamination of the air-water channel is disturbing. Studies are in progress to find out whether suboptimal manual cleaning or insufficient function of the washer-disinfector is the cause of the problem.
Set up and instruction of the endoscopy unit in Dhaka/Bangladesh

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Johannes Beltinger, MD, PhD Division of Gastroenterology, University Hospital Bruderholz and Basel

Introduction
The endoscopy unit in the ICDDR, B is actually based in the Travellers clinic. This clinic is an outpatient clinic within the ICDDR, B which offers a vaccination service and processes clinical specimens submitted by individuals and clinics within Dhaka for clinical pathology, microbiological and biochemical tests. The nursing staffs allocated to the travellers' clinic consists of one nurse which gives the vaccination and assists the endoscopic procedures. The endoscopes presented as a gift from the Foundation for the Promotion of Gastroenterological Research, Switzerland are 2 Pentax video-coloscopes and one gastroscope. It also includes an endoscope cleaner (mechanical distribution of the disinfectant through the endoscopes). The processor and light source and the video screen are 4 resp 5 year old equipment used by the Department of Gastroenterology in Basel.

Aim
Four nurses where chosen to be trained. One nurse responsible for the traveller’s clinic was experienced in assisting endoscopies, two other nurses have had basic training to assist in the procedures. One of these nurses spent a 2-week training in Japan in a busy endoscopy unit. One nurse who was assigned to attend the introduction of the equipment was an experienced staff nurse without prior experience in endoscopy.

Method
The first and most important steps where to introduce the nursing staff to the new equipment and the special precautions which are necessary in handling a video-endoscope. After unpacking and installation of the light source and the monitor, the nurses where trained to prepare the endoscope for a diagnostic procedure including checking the electrical equipment, connecting the air and water supply and the suction pump. All these functions had to be tested before the procedure. The functions of the monitor and light source were explained and retrained again, first by explaining the functions and later by practical examples simulating an diagnostic endoscopy. A step-by-step approach to problems which might occur during the procedure was trained. A list of the steps for the examination was prepared for later reference. During the introduction members of the Biomedical Engineering Unit (Head: Syed Saiful Huq) were present to be able to understand and repair minor problems related to the new equipment. The second step was to train the cleaning procedure.

Conclusion
The instruction of the nursing staff to assist endoscopic procedures was very successful and was attended with great interest. The nurses had already basic knowledge of the procedures and where especially introduced into the handling of video endoscopes. A long time was spent for the training of the cleaning procedures of the endoscopes.

Guidelines for Safe Care in Bronchoscopy

Christiane Neumann, Birmingham, UK

The talk will be based on the “Guidelines on Diagnostic Flexible Bronchoscopy” produced by the British Thoracic Society in 2001

The areas covered by these guidelines are as follows:
• Complications, contraindications and pre-cautions;
• Sedation and anaesthesia/analgesia;
• Cleaning and disinfection including glutaraldehyde usage;
• Staff safety;
• Bronchoscopy in the intensive care unit;
• Data collection and staff training;
• Patient satisfaction.

For a copy of the full PDF version of the guidelines - please contact: Christiane.Neumann@swbh.nhs.uk

References

Safety and sedation during endoscopic procedures. BSG 2004. This report was originally published in 1991 and has been updated by Dr Robin Teague on behalf of the Endoscopy Section Committee of the British Society of Gastroenterology. (www.bsg.org.uk)
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What can be delegated to unqualified personnel?

Ulrike Beilenhoff
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Background
In the majority of European countries levels of qualification of staff working in Endoscopy varies. In addition to qualified / registered nurses, it is possible and quite usual that a variety of ancillary personnel is working in Endoscopy units, such as doctor’s assistants, nursing auxiliaries, health care assistants, operating department practitioner, endoscopy technician as well as young persons doing their civilian service.

There are a variety of reasons to employ different levels of staff in Endoscopy:
• Shortage of qualified nurses
• Limited financial resources for personnel costs and staff recruitment
• Reduction of staff with higher qualification (“Qualified endoscopy nurses are too expensive”)
• Change in health care systems (Proliferation of new categories of health workers at all levels, creation of new qualifications at lower academic levels)
• In some countries doctor’s assistants traditionally work in GP’s offices and also assist during endoscopy procedure performed in these settings.

Delegation and responsibilities
The delegation of nursing tasks to unqualified staff has two main reasons: The shortage of qualified nurses has increased in many European countries. Parallel to this trend the overall workload in endoscopy has also increased significantly. Delegation to unqualified staff relieves nurses and gives them time to concentrate on more specialised tasks.

Endoscopy nurses are responsible to ensure the patient’s physical safety and psychological well-being before, during and after the procedure, to prevent any hazards or complications, including infections, and to ensure a patient-focused organisation and management of the endoscopy unit.

Before nursing tasks can be delegated, the following points have to be taken into account:
• Based on national regulations and guidelines, standards have to be developed in each department. They are directions for safe practice.
• Job descriptions for each position within the team should include clear statements concerning professional and legal responsibilities and line management (authority to delegate).
• The “unqualified” personnel need to be competent within their limits of knowledge and training. In addition to technical skills, they need to have basic education and specialised knowledge relevant for the delegated task. If the person has direct patient contact, they also need be trained in communicative skills.

• Independent from the professional qualification, each person is accountable in law for his or her actions and omissions. While ancillary nursing personnel have the responsibility to act safely and effectively within their sphere of competence and limits, nurses have the duty of direct or indirect supervision on a regular basis, with all its adherent legal consequences. It is essential to clarify in advance who has the professional, organisational and legal responsibility in case of complications.

Delegation in Endoscopy
In the majority of European countries unqualified staff is working autonomously in the following areas: registration desk, reprocessing area and transport of non-sedated patients. In other areas (e.g. patient care and assistance during procedure, recovery area, transport of sedated patients) unqualified staff can only work under supervision of qualified nurses, as their training does not give them the competence to work independently. Whatever area unqualified staff is working in, the legal responsibility for their delegated tasks ultimately lies with the trained nurse delegating, the department manager responsible for the job policies, and with hospital management consenting to this delegation.

Conclusion
If nursing tasks are delegated to unqualified staff, appropriate regulations need to be in place, delineation of working areas and responsibilities have to be defined, and legal accountability has to be clarified.

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Introducing a Quality Management System to an Endoscopy Environment

Staunton C., Fogarty M., GI Unit, Mater Misericordiae University Hospital, Dublin

Objective
To describe the experience of introducing a Quality Management System, i.e. the ISO 9001:2000®, to the Endoscopy environment.

Abstract
Quality in healthcare is described as those activities aimed at doing the right thing consistently, ensuring the best possible clinical outcomes for patients, customer satisfaction, staff retention and good financial performance (NSAI 2000). Quality Management Systems e.g. International Standard Organisation (ISO) & European Foundation for Quality Management (EFQM) Models, are frameworks adopted by organisations i.e. manufacturing or service, which direct and controls their quality activities.

Initial quality activities in healthcare were individual initiatives within organisations e.g. patient satisfaction surveys or patient information leaflets etc. Integrated systemic approaches e.g. ISO, or Benchmarking, were widely rejected or implemented reluctantly in a fragmented, erratic manner. The focus was on the quality of the organisation as opposed to the quality of clinical care delivered.

Evidence based practice changed this. Acceptance that best practice required a direct, demonstrative recent and robust evidence base and that the establishment of agreed standards and guidelines, as found in a quality system, would be the best means of facilitating delivery of consistently good clinical outcomes.

In 1997, the Gastro-Intestinal (GI) Unit at the Mater Misericordiae University Hospital applied and succeeded in attaining the International Organisation for Standardisation (ISO) accreditation i.e. ISO 9002®. Subsequently in 2003, following an audit the revised award i.e. ISO 9001:2000® was awarded. It is to date the only Endoscopy unit in Ireland with ISO accreditation.

This unit holds a strong commitment to quality in all aspects of patient service and clinical practice. The ISO formula was selected as it was considered to be more service orientated. Involving a multi-disciplinary team effort. All existing unit policies and guidelines had to be adapted to Standard Operational Procedures (SOPs), the basic working template of the ISO system. Every aspect of practice involved in the patient's pathway through the service, from referral to discharge, e.g. assisting at therapeutic ERCP or ordering replacement scrubs, were formulated and documented as SOPs. All these practices then are audited incrementally, ensuring the system is maintained and supported, while simultaneously identifying the need for change, and demonstrating a commitment to continual improvement.

In conclusion introducing a Quality Management System has been a positive and beneficial experience and limitations experienced with the ISO format may be addressed with the use of an alternative model such as European Foundation for Quality Management Award which has a greater emphasis on achievable results and leadership.

Colorectal Cancer prevention and the nursing role

Margaret Vance, Nurse Consultant in Gastroenterology, St Mark’s Hospital, Harrow, London, UK

Colorectal cancer is the second most common cause of cancer death in the UK after lung cancer. It is estimated that there are more than 34,000 new cases of colorectal cancer diagnosed in the UK each year and around 16,000 deaths. The survival rates for colorectal cancer in the UK are amongst the lowest in Europe and almost 20% lower than in the US. Poor survival rates for colorectal cancer in the UK has a correlation with the advanced stage at which most cancers are diagnosed.

Colorectal cancer is however potentially preventable as available evidence has shown that most colorectal cancers arise from previously benign adenomatous polyps and that resection of these polyps prevent cancer. In 2002 the baseline findings of the first UK randomised control trial examining the hypothesis that a single flexible sigmoidoscopy (FS) screening procedure offered to the general public around the age of 60 could lower the incidence and mortality of colorectal cancer. Baseline results from the trial indicate that a one off screening FS at the age of 60 gives a high yield of neoplasia in up to 15% of the trial population and could reduce the risk of fatal colorectal cancer by 60%. FS was demonstrated to be safe, acceptable to the public and feasible for national implementation. Findings conclude that the high detection rates of neoplasia within the distal colon will lead to a reduction in the incidence of colorectal cancer.

In 2002 the Secretary of State for Health made a public statement supporting the development and implementation of a national screening programme for colorectal cancer within the next 5 years. Any national colorectal cancer screening programme to be implemented will lead to an increase in the demand for endoscopic services to assist with the detection and treatment of colorectal neoplasia. In the UK there is already a recognised lack of medical manpower to provide endoscopy services for patients who are currently in the NHS system.

Nurse endoscopists have demonstrated their effectiveness in performing screening FS for colorectal cancer in the US. They have demonstrated clinical effectiveness in their endoscopic and clinical practice in the UK and their role is continually evolving to develop advanced endoscopic practice. Nurse endoscopists are ideally suited to provide a screening role as they have to demonstrate accuracy and effectiveness as part of their practice.
Health condition of endoscopy professionals: Results of a national enquiry

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Introduction
Nurses and doctors in endoscopy units work under high physical strain. The aim of our enquiry project was to evaluate their health conditions; the results of the survey may help to minimise professional health risks in endoscopy.

Methods
We mailed a validated questionnaire (“Freiburger list of complaints”) together with explanations to all members of our National Society of Gastroenterology and Hepatology (n=971) and to all members of the National Society of Endoscopy Nurses (n=210). This questionnaire contains 80 items in 10 groups; we added 25 questions regarding demographic and insurance data as well as on health problems considered typical for endoscopy. The ten groups of the questionnaire are related to problems and restrictions in general well being and emotions, as well as to those in the cardiovascular and gastrointestinal system, head-throat irritations, mental distress, sensory restrictions, joint and back pain, and skin problems.

Results
Only 8% of doctors but 35.7% of nurses returned the completed questionnaire. Of the doctors, 55% complained about back pain, 17% about varices, 15% about aching fingers and hands, 11% had troubles with their skin, 9% with their eyes and 8% suffered from hypertension. 5% mentioned hip pain and 4% tendovaginitis. In comparison to average values from the general population in the cardiovascular and gastrointestinal system, head-throat irritations, mental distress, sensory restrictions, joint and back pain, and skin problems.

Conclusions
Working in endoscopy units seems to be related to health restrictions above average, whereby nurses seem to be more frequently affected than doctors. They also had more days off work. The most prevalent problems are back pain, varices and aching fingers and hands. Further studies have to elucidate specific responsible factors for these problems and evaluate prophylactic measures.

Nurse’s evaluation of a system allowing intraductal exchange during ERCP

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Background
Co-working between GI assistants and physicians during ERCP is essential for difficult cases where fine manipulations of the guide wires are required for accessing biliary or pancreatic ducts. Former systems designed for saving time during exchange of devices were limiting the role of the GI assistant in this setting.

Patients and methods
As part of a multicenter trial, pilot evaluation of a new system called ‘FUSION’ (Wilson Cook Medical, Winston-Salem, USA) allowing intraductal exchange (IDE) was performed in our center, on a total of 37 patients requiring therapeutic ERCPs (EST: n=22; stones removal: n=10; dilatations: n=8; stenting: n=23; brushing: n=2). A total of 60 intraductal exchanges were successfully performed. In 14 cases, it was decided to move from the short to the long wire system successfully. Since the beginning, the nurse involved in this evaluation was prospectively noting the advantages and disadvantages regarding comparisons with previously used short wire system or classical system.

Results
The following advantages (A) and disadvantages (D) were noticed: A.

Possibility to move from the short wire technique with manipulations of the wire by the physician to the long wire technique with GIAssistant help at any time.
Placement of multiple stents using the same wire, without the need for replacement of the wires.
Short wires easier to handle by the nurses.
No need for wire handling by GIA during short wire guided exchanges.
Removability of stents on the wire in case of misplacement.
Compatibility with all the other systems.
D. Limited co-working possibilities during stent insertion on short wires.
IDE impossible in some very high stricture at the level of the hilum.

Conclusion
This new system allowing IDE offers similar possibility to the classical system while having some major technical advantages, especially for stent placement, with limited disadvantages concerning physician-nurse interactions.

Implementation of biotrack specimen tracking system into an endoscopy department

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Introduction
The taking of a biopsy is an important part of many endoscopic procedures. It is essential that all biopsies taken are correctly labelled to avoid misdiagnosis or the need for a repeat procedure.

Aim
The Biotrack system is a simple method of labelling specimens that helps nursing staff to reduce or eliminate errors. It provides a unique way of clearly identifying both the patient and the biopsy site.

Method
The Biotrack system was introduced into the Endoscopy Department in Nov. 2002 as a way of raising standards of practice by reducing the number of specimens that were returned by the Histopathology laboratory due to incorrect or unclear labelling. Each sheet of labels has three sections of identical labels, each with a unique 7-digit identification number and common biopsy sites pre-printed on them. A separate sheet is used for every patient and the labels are attached to the histology form, the patients nursing record and inside the specimen cassette. A label containing only the unique identification number is kept in a logfile with the patient details to allow for checking in case of a discrepancy. After the biopsy has been labelled, the sheet has the patient's name and number, the consultant and the date written on it, is signed by the nurse responsible for the specimen labelling and then filed in the patients medical notes.

Results
Prior to the introduction of Biotrack, there was some resistance to the implementation of this change by both nursing and medical staff. This was primarily due to concerns about additional paperwork causing delays to already busy endoscopy lists and to the perception that specimen labelling wasn’t really a problem. However, staff training was carried out and the system was only used on quieter lists for a three month trial period to allow staff time to familiarise themselves with it. Use of the Biotrack system has now become part of the routine for staff. Nurses like the system and feel that it gives them more confidence with labelling specimens correctly, especially when multiple biopsies are taken. Accountability for labelling and preparation of specimens for transfer to the laboratory is more clearly defined. When there is a discrepancy with labelling of a specimen, it is usually quick and simple to resolve.

Although the effectiveness of this system hasn’t been formally evaluated, it is clear to both Endoscopy and laboratory staff that the number of incorrectly labelled specimens has fallen dramatically.

Conclusion
Implementation of the Biotrack specimen tracking system into the Endoscopy Department appears to have had positive benefits to both patients and staff. Anecdotal evidence from pathology and Endoscopy staff indicates a significant reduction in specimen labelling errors. However, a full evaluation of the system by monitoring specimen labelling discrepancies before and after implementation of this system should be undertaken.

Carbon dioxide insufflation during colonoscopy: safe even in sedated patients?

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Background
Recent data have shown that use of carbon dioxide (CO2) insufflation during colonoscopy (instead of air), can reduce post-procedural pain significantly. The present study was designed to study the effects and safety of replacing air with CO2 also in sedated patients.

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insufflation during colonoscopy
reduce post-procedural pain
### Methods

102 consecutive patients scheduled for colonoscopy at our institution were randomly assigned to the use of either air (n=51) or CO2 insufflation (n=52). Endoscopist and patients were blinded. End tidal (ET) CO2, a non invasive parameter for arterial pCO2, was registered before, twice during and 10 minutes after the examination. Patient’s pain during examination and at 1, 3, 6 and 24 hour following examination was registered using a questionnaire with 100 – mm visual analouge scale (VAS).

### Results

Mean end - tidal CO2 values – AIR versus CO2 group

Mean end - tidal CO2 values – SEDATED v. UNSEDATED group

Pain during and after colonoscopy AIR v. CO2 group

**Conclusion**

CO2 insufflation is safe during colonoscopy also for sedated patients. CO2 was found to be superior to air regarding post - examination pain.

We thus recommend CO2 insufflation in colonoscopy for both sedated and non sedated patients.

### Nosocomial infection and nursing care related to endoscopic biliary prosthesis insertion


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**Introduction**

Many patients already present incurable disease when diagnosed with gastrointestinal neoplasias, such as neoplasms (pancreatic tumors, cholangiocarcinomas and metastasis) that obstruct the bile ducts. Relieving bile duct obstruction by endocopic methods is a valid alternative to surgery for patients with very advanced disease or those with a high surgical risk.

In our centre, the Infectious Diseases Unit follows a surveillance system for Nosocomial Infection (NI) in the Gastroenterology Service. An infection is considered nosocomial when it is not present either in the incubation period or clinical phase at the time of hospital admission.

**Aim**

To determine the incidence of NI related to (EBPI), and to establish the corrective measures before, during and after the procedure.

**Material and Methods**

Retrospective analysis included: All patients with (EBPI), from January 1996 to April 2002. Microbiological records: etiology and bacteria responsible for NI, antibiotic sensitivity of bacteria isolated in patients with (EBPI), on the 14 days post-procedure for early NI detection. We excluded patients coming from other hospitals or with cholangitis prior to the endoscopic procedure. Antibiotic prophylaxis was Cefoxitin 1gram i.v. 2 hours before and 6 hours after the endoscopic procedure. Nursing records and procedures related to the (EBPI), were reviewed.

**Results**

From a total of 350 biliary prosthesis in 276 patients, 203 in 163 patients met the inclusion criteria.

The incidence of cholangitis was 11/203 (5.41 %) and the average time per episode of cholangitis following biliary prosthesis insertion was 3 days (0.5 – 13). Some infections were polymicrobial. Bacteria isolated in blood were: 11 Enterobacteriaceae (3 Enterobacter cloacae, 3 Klebsiella pneumoniae, 2 Escherichia coli, 1 Klebsiella oxytoca, 1 Citrobacter freundii, 1 Serratia marcescens). 3 Nonfermentative gram-negative bacilli (2 Pseudomonas aeruginosa, 1 Stenotrophomonas maltophilia). 5 Enterococci (3 E. faecalis, 2 E. faecium). 1 Streptococcus (1Virdiand streptococcus). Bacterial sensitivity in vitro was 6/20 (30 %) for cefoxitine, 18/20 (90 %) for imipenem and 19/20 (95 %) for piperacillin-tazobactan. Nursing care was described in the nursing records before, during and after the procedure. Low compliance of some recommendations of cleaning and disinfecting strategies were detected and they were reviewed and corrected.
Constructivism in education

Eeva-Riitta Ylinen, MNSc, RN, Lecturer of Nursing, Kuopio, Finland, 2004; Email: eeva-riitta.ylinen@pp.inet.fi

“Humans can only clearly understand what they have themselves constructed” Giambattista Vico (1668-1744)

Constructivism is a philosophy of learning and a way of thinking. The emphasis is on the active and meaningful development of selves as well as systems. It means lifespan development and it is both social and cultural. Constructing meaning is learning. Meaning requires understanding wholes as well as parts. And parts must be understood in the context of wholes. Therefore, the learning process focuses on primary concepts, not isolated facts. Constructivism has its background in Cognitive psychology. Learning is a social, active, mental process of adjusting our mental models to accommodate new experiences. By reflecting on our experiences, we construct our own understanding of the world we live in. Each of us generates our own “rules” and “mental models,” which we use to make sense of our experiences. Constructivism involves language: the language we use influences learning. Learning is contextual because we learn in relationship to what else we know, what we believe, our prejudices and our fears. We need previous knowledge to learn and it takes time to learn: learning is not instantaneous. For significant learning we need to revisit ideas, ponder them, try them out, play with them and use them. We need motivation for learning; we have to know “the reasons why”.

The learner construct new ideas or concepts based upon their current/past knowledge. He/she selects and transforms information, constructs hypotheses and makes decisions and constructs knowledge for themselves, each learner individually and socially. The learner needs to do something (an active learner) because learning is not the passive acceptance of knowledge. He/she takes responsibility for own learning and becomes problem solver and her/his autonomy initiative and intellectual identity are accepted and encouraged. He or she is engaged in dialogue with the teacher and with other learners. Social discourse helps the learner to change or reinforce their ideas. The learner and the teacher should engage in an active dialog (i.e., socratic learning) The teacher gives opportunities to learn and he/she must understand the mental models that learners use to perceive the world and the assumptions they make to support those models. The purpose of learning is for an individual to construct his or her own meaning, not just memorize the “right” answers and regurgitate someone else’s meaning. Higher-level thinking is always encouraged in constructivism. The teacher encourages the learner to connect and summarize concepts by analyzing, predicting, justifying and defending their ideas. He/she provides opportunities for the learner to learn and uses raw data, primary sources, manipulatives, physical, and interactive materials. The focus is on the learner in thinking about learning He/she arranges required resources, acts as a guide to learners while they set their own goals and ‘teach themselves’ He/she has to provide activities which engage the mind as well as the hands and emphasize patients’ ability to solve real-life, practical problems.

References


The Basel Rotation Model for Endoscopy Personnel

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Introduction

With the development and increased use of fiberoptic endoscopy, the need for structured training and education among endoscopy personnel likewise increased.

• 1975 The first professional society for endoscopy personnel was founded.
• Since 1980, special professional societies for certified nursing staff (AKP) and nursing assistants (MPA) have become established.
• 1980 - 1990 First courses were held in “continuing professional education in the functional area of endoscopy,” including practical courses at external endoscopy departments
• 1998, the “European Endoscopy Nurses Forum (EENF)” was founded by ESGENA (European Society of Gastroenterology and Endoscopy Nurses and Associates).
• Since 2000, there has been a “gastroenterological endoscopy” continuing education module for nursing assistants (MPA) in Germany and Austria. However, Switzerland has had, to date, no structured training for endoscopy nursing staff.

Goal

The goal of the project is, for the area of gastroenterological and pneumological endoscopy in Switzerland:
1. to develop and offer an individually-tailored continuing education and training model with structured rotation courses, as well as
2. a complete continuing education course for AKP and MPA with a view toward developing and offering specialized professional training.
Method
Since 1998, individually tailored rotations have been offered; and since August 2001, these have been supplemented with a structured rotation catalogue.

One month before the rotation begins, participants choose from the catalogue that module they find interesting.

Based on this selection, an individual (max. 2 people) rotation program is set up that lasts between 3 to 10 days. This program specifically contains:

- Theoretical and practical instruction
- A "learn and teach" situation (After learning the method, they learn to teach it to others.)
- Active participation in the respective examinations and subsequent discussion with a mentor

Finally, each participant receives a written verification, signed by the Head of Continuing Training and Education as well as by the Medical Head of the Department, addressed to the participant's employee an rotation coordinator.

Results
Between May 1998 and Nov. 2004, a total of 45 rotations were made.

| Professional training of the participants: | 23 x AKP, 11 x MPA, 11 x Industry |
| Working location of the participants: | 13 x Hospital, 21 x Practice, 11 x Industry |

The following graphs provide information regarding the time frames required and the selected theme modules.

Conclusion
The rotation model described has proven itself as a useful method for continuing education and training.

This teaching form has the advantage that even when new techniques and methods are introduced, they can be learned and questioned in their entirety and in all of their complexity. The implementation of a structured, advanced training tailored to the individual needs is supported by a standardized rotation catalogue.

We should strive to achieve the integration of this teaching form as a future component of "Advanced Training and Education for Endoscopy Personnel in Gastroenterology / Pneumonology" for MPA and AKP.

Supporting the Hepatitis C patient.

Shiela Needs, Torquay, UK.

Abstract
Being diagnosed with Hepatitis C can be devastating for some patients. This session will discuss how the Clinical Nurse Specialist can support the patient and family and provide valuable information with regard to the virus, its transmission, lifestyle changes, further staging of the disease and treatments available. All of which are essential in order for the patient to make an informed choice with regard to further management and treatment of their disease.

Ethics Committees - The potential Role of Clinical Ethics Committees vs. Research Ethics Committees

Christiane Neumann, City Hospital, Birmingham, UK.

Introduction
Consideration of ethical issues in healthcare institutions has recently become an important and frequent part of discussions in healthcare, both at the level of the individual patient and in the community. A number of factors have contributed to this including, research into the mapping of the human genome, techniques for assisted reproduction and improved life support which offer new opportunities for treatment but which also raise ethical concerns.

Recent public revelations in the United Kingdom such as enquiries into organ donation and retention, HIV and hepatitis C infection in the blood transfusion service, the removal of organs of dead children at post-mortem examination without the consent of the parents, and the paediatric cardiac surgery inquiry at Bristol, have highlighted the importance of healthcare ethics. To protect the individual patient from unethical treatment or interventions, institutions have established two types of Ethics Committees: Research Ethics Committees (REC) and Clinical Ethics Committees (CEC). The function of these two types of committees is different, as is their legal power and often the location.

Research Ethics Committee (REC)
were established after the Second World War in the light of the Nazi Medical Experimentations, which neither sought consent from the participants nor protected them from unreasonable interventions and torture. RECs have been established much longer than CECs and according to the new European Law on Good Clinical Practice in research (GCP) all clinical trials have to be approved by RECs before commencement.

RECs concentrate on the ethical aspects of research. While medical treatment is in the interest of the patient, as the patient (hopefully) will benefit from the treatment, medical and nursing research cannot be in the patient's best interest as benefit is often unlikely or unknown and the patient might actually be harmed. REC concentrate firstly on the burden which is put on the patient, and if what is required can be ethically defended, and secondly, on patients having enough information about the study to give informed consent.

Clinical Ethics Committees (CEC)
have been a feature of the healthcare systems in North America since the 1970s and only more recently in Europe. The functions of these committees include policy development on ethico-legal matters, provision of individual consultation about specific clinical cases and the organisation of ethical education among clinical staff.

CECs provide support and advice to health professionals and patients on ethical issues arising from clinical practice or patient care. The support can take different forms; some institutions have formal committees and case reviews, others meet on demand and
Aims of this study were to determine the advantages and disadvantages of the parents being present and actively involved in the endoscopic procedure of their child.

Methods
Parents of 31 children (aged 1 to 17 years, mean age 10 years) that were (on their own request or the request of the child) (19) or were not (12) present at the endoscopic procedure filled out a questionnaire where they assessed their presence at the procedure by importance and their feelings at the procedure, the ones not present at the procedure listed their reasons for not being there.

Results
During the endoscopy in 68% the mother was present with their child, in 7% father was involved and in 25% no parent was present. According to the parents the most important factors are a qualitatively carried out procedure (97%), friendly medical staff (97%), clear instructions after the procedure (87%), explanation of the course of procedure (77%), presence of the parents (71%) and short waiting period (64%). During the procedure 58% of parents felt safe, 68% gained greater trust to medical workers, 68% felt they offered their child security, 16% felt helpless, 10% were scared, 3% of the parents felt nauseus. 20% of children aged from 9 to 17 years didn’t want their parents being present at the procedure, 7% of the parents didn’t have the courage to participate.

Conclusion
The study showed that parents being present at the procedure is equally important as other factors(sufficient information procedure, quality of the procedure, friendly endoscopic team, easy-to-follow instructions). Parents are pleased that they have a choice to be involved. Children are more relaxed, cooperate better and cope easier with the unpleasantness of the procedure if their parents are present, hence their presence is indicated and necessary.

Creation of an information sheet for patients undergoing PH-Metries

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Non having any information sheets for patients regarding this procedure, we decided to do one. It is functional exam allowing to measure the oesophageal Ph and thus exposition to acid during 24 hours. This exam is daily performed in our unit. This exam is performed for patients presenting gastroesophageal reflux, pyrosis and regurgitations, after conventional therapy with proton pump blockers failed. Other indications are unexplained nocturnal cough resistant to any antisecretion therapy. Contraindications are arrhythmic cardiac problems and important oesophageal varices.

Nurses role his role or her role is of high importance in preparing the patient physically and psychologically, as the exam requires his participation. The nurse welcomes the patient, informing him about the exam procedure, giving him advice for the next 24 hours and finally answering questions. She or he prepares the single use material for putting in the Ph metry tube, calibrating the device and installing the patient. She or he assists the physician, while he puts in the PH metry tube.

Technic interruption of medication before the exam, proton pump inhibitors should be stopped one week before the exam. Interruption of anticalcic drugs and nitrates after medical advice. The patient should be fasting for 6 hours before the exam. This exam is performed by placing a Ph metry tube after local nasal anesthesia. The tube is connected with a small box allowing a 24 hours registration of the ph. While carrying this device, the patient should live a normal life, but he should not drink any sparkling or acid drinks. Furthermore, he has to write down the eating hours, and the times he went to bed and got up.
Any symptoms like heart burning pain and cough should as well be written down. He comes then back 24 hours later for removal of the tube.

Quality improvement patient’s information for ERCP

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Introduction

Patients undergoing ERCP are at significant risk for complications. According to Dutch law, physicians are obliged to give patients detailed information, and sufficient time before any investigation, to consider and ask additional questions related to the procedure.

Objective

To compare the additional value of a newly designed questionnaire sent to the physician and patient prior to referral (group B), versus our current way of information (group A).

Patients

We plan to include 100 patients referred from other hospitals to our department for ERCP (for the first time or after failed attempt elsewhere).

Methods

The first 50 consecutive patients (group A) are at pre-assessment invited to fill in an 8-points questionnaire (yes or no), with the following questions:
1. did you undergo an ERCP before?
2. did your physician discuss the ERCP procedure?
3. are you aware of any complications?
4. was it possible to ask additional questions?
5. did you receive a brochure?
6. are you informed about alternatives procedures (other than ERCP)?
7. has attention been paid to continuation or discontinuation of your current medication?
8. what is your overall impression of the quality of information for the planned ERCP procedure?

In the second group of 50 consecutive patients (group B) a fax with detailed information and an ERCP brochure will be sent to the referring physician with the request: (I) to discuss with the patient: the procedure, complications, medication and alternative procedures, (II) to hand over the ERCP brochure and (III) to sign the informed consent and to return this to our department (via the patient).

Upon arrival in our hospital for the ERCP, patients explicitly are asked to fill in the questionnaire, mentioned in the group A paragraph.

Results

The study of group A was completed at the time of abstract submission. The results show that patients were not adequately informed. 72 % of the patients has been verbally informed by the referring physician and of that group just 36 % has been made aware of complications. 40% received a brochure. 20 % was informed about alternative procedures. 48 % attention has been paid to current medication. In the months July and August we will include the patients of group B.

Conclusion

Despite, the in our opinion quite poor patient-information (of the A group), 64 % informed us that they were satisfied with the quality of the information.

Incidence of language barriers in immigrant patients admitted to a general hospital in Barcelona

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In recent years there has been a substantial increase in the number of immigrant patients admitted to public hospitals in the city of Barcelona. Language difficulties and socio-cultural differences may influence treatment results in this patient group. The frequency of these socio-cultural phenomena in our setting is unknown.

Objectives

To analyse the incidence of language difficulties at several levels in immigrant patients admitted to a hospital and their correlation with demographic variables.

Material and Methods

A total of 69 immigrant patients admitted to the Gastroenterology Section of the Hospital del Mar between January 2001 and December 2002 were enrolled in the study. We determined age, sex, continent of origin, and level of difficulty with comprehension in Spanish (total language barrier) from data in nursing records.

Results

The average age of patients 43+2; (19-88) and 65.2% were men. Distribution according to continent of origin was: 24 Asia, 20 Europe, 14 America, 8 Africa and 1 Oceania. Only 19 patients (27.5% ) faced a total language barrier. These patients were younger than those without a total language barrier(35+2 vs. 46+2 years; p 0.005) and were mainly Asiatic (57.9% vs. 30%; p 0.003). The relationship to language difficulties and socio-cultural differences can not be evaluated from conventional nursing records.

Conclusions

We detected a total language barrier in 27.5% of immigrant patients admitted to our centre, the highest frequency being in Asians.

Further prospective studies are needed to determine the total language barrier in nursing diagnosis (NANDA).
The Guidelines of PEG Nurse practice in Kuopio University Hospital

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Background
Percutaneous endoscopic gastrostomies (PEG) have been performed in Kuopio University Hospital (KUH) since 1987. Nowadays PEGs are inserted to some 50 patients yearly. Patients come from various departments (e.g. neurological, oncological, paediatric) of KUH or from other institutions. For adults the procedure is done under local anaesthesia in the endoscopy unit and for children in general anaesthesia at the operating theatre. The timing of patient education concerning the procedure is planned individually.

The Role of the PEG Nurse
By increase of PEGs about 10 years ago it proved out necessary to educate a nurse for PEG issues. Patient inquiries showed that patients were willing to get more information about PEG already before the procedure. In the beginning one of the nurses in the endoscopy unit was trained to get experience of the PEG. By now all five nurses of the endoscopy unit are familiar with PEG matters. The PEG nurse is an assistant nurse: she assists the doctor in performing the gastrostomy. In addition, she changes the gastrostomy buttons and balloon-type tubes. The PEG nurse acts as a contact person to the patient, between patient’s relatives, doctors, ward nurses, dietician, general healthcare and other institutions, giving information about patient education and care. The most significant role of the PEG nurse is to act as a guide. The guiding process is multiphasic and it can last for weeks or months depending on the patient’s condition and need for PEG tube. The patient information is given before and after the procedure, when changing the PEG tube to a button or a balloon-type tube or removing the PEG tube. The patient is also taught to change the button or balloon-type tube by herself/himself. In case of problems, the patient is allowed to contact to the PEG nurse by telephone or by personal visit. The duties of the PEG nurse also include education and teaching of nurses of other hospitals and general health care. The PEG nurse also gives lessons on national education courses.

Conclusion
The guidelines of PEG nurse practice help in carrying out the primary nursing. Further, the patient can get quick expertise advice in case of problems. We have done in our endoscopy unit a quality assurance study of the guiding of PEG patients, home care advice, a video on using the PEG button, and guiding principles of the new PEG nurse.

Endoscopy performed by special trained nurses

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Introduction
In need of more endoskopists to diagnose colorectal tumours, as recommended by the Danish Institute for Health, our department have trained two nurses to perform flexible sigmoideoscopy. This is a method to take advantage of the experience of nurses already available in the department, and a good prospect of increasing qualifications as a nurse. It is important to notice, that the endoscopies are performed at the responsibility of a qualified gastroenterology specialist, who has delegated this procedure to the special trained nurses.

Method
To educate qualified nurses, a training programme was made containing a theoretical and a practical part. The endoscopic examinations, performed by the nurses, are recorded on a CD-rom and finally surveyed by a gastroenterology consultant.

The specialist trained nurse and an assistant nurse work together in the operating theatre. A nurse in the recovery room welcomes and prepares the patient to the examination, and finally she discharges the patient immediately after the examination. If the patient has been sedated, a short rest in the recovery room is usually required. The assistant nurse in the operating theatre cares for the patient during the examination, and she assists if biopsies are taken. Furthermore, it is her responsibility to clean and prepare the endoscopes during the day. If needed during the examination the nurse can call a gastroenterological surgeon for assistance. This is essential when discovering malignant tumours or inflammatory bowel diseases in order to start treatment immediately.

Results
We have independently performed sigmoideoscopy for a period of 18 month. During this period we have examined approximately 600 patients. An average of 9 patients is examined daily. Most of the patients suffer from irritable bowel syndrome, inflammatory bowel diseases and haemorrhoids, but frequently we discover colorectal tumours. There have been no perforations or other major complications to the procedures.

Conclusion
The period from referral to examination is reduced significant by allowing the special trained nurses to perform the endoscopies. We experience that the patients are satisfied to be examined by nurses.

Judged by the supervising surgeon, the quality of the examinations is at least as good as examinations performed by the gastroenterology surgeons at the hospital, who by the way are pleased with this arrangement. It leaves them available for other tasks during the day.
Pancreas pseudo cyst drainage using endo ultra-sound

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A PPC (Pancreas Pseudo-cyst) forms following an episode of pancreatitis, acute or chronic, or as a result of pancreas trauma. Many PPCs resolve within a few weeks without treatment, others increase in size and can cause much discomfort, pain, nausea and in some cases infection. Until the 1980’s the only way to treat unresolved cysts was surgery. Percutaneous drainage using x-ray is an alternative method of treatment. Since the 1980s drainage has been carried out endoscopically. This procedure proved to be quite risky with the possibility of bleeding or perforation causing leakage into the retro-peritoneal cavity. Since EUS became more popular in the late 1990’s an endo ultrasound would often be carried out immediately prior to the drainage procedure, this reducing risks considerably. Since 2000 there has been an endoscope available which can be used for the entire procedure.

The advantages of this endoscope for this procedure are:
• Only one endoscope is needed
• Endoscope imaging
• Ultra-sound imaging
• Doppler function
• Instrument lift
• Large instrument channel

Although EUS renders this procedure as significantly safer, the specialist and the endoscopy nurse have to be prepared for complications occurring during the procedure. The endoscopy nurses require experience and skill to assist in this procedure to ensure that everything goes smoothly.

Two endoscopy nurses are required to assist with this procedure:
One endoscopy nurse has the important task of preparing the patient for the procedure (in much the same way as for an ERCP) and cares for and monitors the patient during and immediately after the procedure. It is imperative that the patient lies very still and that the endoscope is held in position during the procedure. The nurse also makes a written report of medication given and after care.

The second endoscopy nurse is involved with preparing all the equipment and instruments necessary for the procedure and assists the specialist during the procedure. This requires concentration, skill and efficiency to avoid accidental removal of the guide wire or incorrect placement of the pigtail stents

The procedure is carried out as follows:
Using endoscopic imaging the bulging from the pseudo-cyst is located, if it is present. This is followed by ultra sound (US) imaging to measure the distance between the PPC and the stomach or duodenum wall and determine the optimal site of drainage. If no bulge is seen the cyst can only be visualised with US. At this point blood vessels can also be visualised to avoid them being punctured, in some cases the Doppler function is used at this stage. Using diathermy a small puncture is made into the cyst through the stomach or duodenum wall. The wire is removed from the diathermy needle and some fluid is aspirated from the cyst for laboratory purposes. After a guide wire has been introduced into the cyst a dilatation balloon is used to widen the puncture hole to allow for the introduction of at least 3 double pigtail stents and possibly a naso-cystic drain to allow for irrigation. The procedure is now completed.

Conclusion
Prior to and during this procedure many important routine nursing tasks are carried out by one endoscopy nurse. These tasks are important to promote the well-being and comfort of the patient allowing the other endoscopy nurse to concentrate on preparation of the technical side of the procedure. Especially in larger centres, the role of the endoscopy nurse is becoming more technical. Frequently our specialists are improving their techniques as new equipment and new instruments become available. As endoscopic nurses we have to make sure that we keep up to time with our specialists. Endoscopy nurses can improve their skills and knowledge by following specially formulated courses and visiting congresses. On the job training (which is given routinely in our centre) is important so that nurses are familiar with all the equipment used during intricate procedures in order to be proficient, to ensure that the procedure is completed in as short a time as possible in the interest of the patient.

We have a very demanding and dynamic profession. We have to keep our minds open and welcome new techniques with enthusiasm to keep up with the ever changing aspects in our profession.
The implications of change in decontamination of equipment for gastrointestinal endoscopy

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Introduction
All patients undergoing digestive endoscopy should be examined and treated without risk of infection or side effects that may result from inadequately reprocessed endoscopic equipment (ESGENA 1999).
In the last few years there have been new recommendations and guidelines for the decontamination of endoscopes and accessories. The key influence to change in practice has been the emergence of variant Creutzfeldt-Jakob Disease (vCJD). There is no known method of disinfection or sterilisation of equipment following exposure to prions.
Inadequate reprocessing of endoscopic equipment is a potential source of cross infection. Endoscopy induced infections are usually due to procedural errors in decontamination.

Objective
The objective of this paper is to discuss the issues of change in practice, in relation to the cleaning and disinfection of endoscopes and accessories.

Method
Reasons to implement change; Health and Safety, Infection Control issues, patient and staff safety, the legal implications of negligence, the provision of a medical device which is fit for its purpose following manufactures guidelines.
The issue of variant Creutzfeldt-Jakob Disease requires the change in practice to use single use cleaning brushes, biopsy forceps and port inlet valves.
The cost implications for single use accessories can be worked out using the number of procedures performed each year for cleaning brushes, the number of therapeutic upper and lower endoscopic procedures would relate to the number of biopsy forceps and inlet port valves required.

Summary
Undertake a risk assessment to quantify the risk. Patients' safety vs. cross infection vs. litigation. Prepare a business case with evidence for change to best practice with a cost evaluation. Work closely with Health and Safety and Infection Control for advice.

Conclusion
Single use brushes, guide wires and biopsy forceps should be used to minimise the risk of transmitting prion disease. Biopsy inlet seals should be discarded after the insertion of biopsy forceps, wires and snares.
There are legal implications, patient’s safety and evidence to support the change in good ethical practice.

References

**News from Industry**

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

Olympus Europa GmbH, Anja Schuster

The classic situation during biliary and pancreatic procedures: Assisting nurses have to handle a long guidewire while sliding Endo-Therapy devices along it to be inserted into the endoscope - a cumbersome and time consuming process that very often moves the guidewire out of position.

With the numbers and importance of biliary and pancreatic procedures on the rise, it was about time to rethink the whole ERCP procedure as we know it today. For this reason, Olympus set up an interdisciplinary team of dedicated engineers, doctors and designers. Initially the team analysed hundreds of ERCPs and identified three main procedural and ergonomic challenges:

1. Guidewire manoeuvrability
2. Guidewire positioning, and
3. Exchange and control of Endo-Therapy devices during the procedure

Based on this intensive research and analysis, the engineers, doctors and designers started development for a new ERCP approach. The result: The new V-System. With this system, Olympus is not simply offering a new tool for ERCP but proposing a whole new way of performing it.

The V-System combines three main innovations and benefits: The ability to lock the guidewire with the endoscope safely into place, an all new V-Holder™ for improved control and exchange of devices while the guidewire stays in place and a shorter guidewire – LinearGuideV™ – for better manoeuvrability and guidance. Plus a complete range of matching Endo-Therapy devices for biliary and pancreatic procedures.

The new V-Scope is basically a classic duodenoscope, like those employed every day for ERCP-procedures. What makes it different is a V-shaped groove at the tip of the forceps elevator. The dedicated guidewire LinearGuideV™ fits precisely into the V-groove and improves device manipulation to and from the bile and pancreatic ducts. The guidewire runs along the V-shaped groove, and – once positioned in the desired location – can be fixed and locked in place at the touch of the elevator lever. This way, Endo-Therapy devices can now be inserted and exchanged without the wire moving away from its position and sliding out of the papilla.

This locking into position also allows a shorter guidewire section outside the instrument: That not only means less handling of material for the nurse. It also adds a plus in hygiene, since less material comes into contact with non-sterile areas.

Thanks to the efficient design, the V-System gives full control to the physician over the Endo-Therapy devices during the exchange of instruments. The appropriate V-System Endo-Therapy devices are equipped with an additional half ring, by which they may be clipped to a specially developed V-Holder™ – the Endo-Therapy control device of the new V-System. The V-Holder™ plays an integral role for the overall system. It is mounted to the V-Scope and assists the operator in a very efficient way to control the guidewire and to exchange ERCP devices. V-System covers all technical and ergonomic aspects of biliary and pancreatic procedures – from start to finish - and thus is able to significantly facilitate ERCP.

The complete system brings more safety, comfort and confidence to the physicians in charge as well as to the assistants. Moreover, patients benefit from shorter surgery or treatment periods.

**V-System at a glance**

- One-touch-locking of guidewire
- Easier exchange and handling for ERCP instruments
- Shorter procedure time
- Less fluoroscopy needed
- Wide range of Endo-Therapy instruments

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**Pentax: Endomicroscopy - first confocal endomicroscopy system to visualise mucosa at a cellular level**

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With the PENTAX confocal endomicroscopy, microscope images of the body are possible even during endoscopy: With this new technology epithels, connective tissue and blood vessels of the mucosa of the colon can be visualised in the living organism in detail at a cellular level. In this way it is possible for the physician performing the examination to reliably diagnose or exclude an intraepithelial neoplasia during endoscopy without the need to take a tissue sample beforehand. The precision of the diagnosis is comparable to that following a conventional biopsy whereby the sample taken is then examined histologically. With this new method intraepithelial neoplasias can be diagnosed and differentiated from healthy tissue with an accuracy of 99% and that consequently endomicroscopy can be regarded as an equivalent to conventional histology. Worldwide more than 300 patients were examined until now. Beside 2 clinical abstracts and an oral presentation on DDW 2004 there is the first publication in GASTROENTEROLOGY currently in print (Kießlich et al). Also pathologists stated the endomicroscopy as a method with great potential which allows the endoscopist to differentiate between neoplastic and non-neoplastic epithels. It appears then that the main indications in the near future, in addition to colitis ulcerosa with its flat growing neoplastic focuses, are also Barrett’s oesophagus as conventional methods are not sensitive enough in this case. The market launch is scheduled for the beginning of 2005.
Endoscopic fundoplication for GERD

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Some patients with gastro-esophageal reflux disease have troublesome symptoms, which respond poorly to proton pump inhibitor or other drug treatments. Others do not want to take medications long term. The medical costs of treating reflux are high and if surgery was effective, safe and inexpensive it might be very cost effective.

Although laparoscopic or open surgical operations such as Nissen fundoplication for reflux seem effective in skilled hands, there are drawbacks to surgery. The main complications include impairment of swallowing, gas bloat, and a small mortality rate. A safer, less invasive, effective method for treating reflux using flexible endoscopes without incision and entering the peritoneal cavity might offer advantages for patients.

Working mechanism: Prerequisites for the invention of an endoscopic sewing machine were a method for passing a needle and thread through tissue, a method for catching the thread and then pulling the needle back through the tissue leaving the thread passing through the tissue. Other requirements included the development of methods for endoscopic knot tying, locking and cutting thread. All these were developed and modified for routine clinical use over some years (1-3). The basic rather simple stitch action in the current Bard Endocinch uses a hollow needle with a slot and a rod to force a metal tag, attached to thread, through the tissue once it is pushed and has penetrated tissue. To place a full-thickness stitch in human gastric tissue, a sewing suction capsule with a cavity of a tested inner diameter and depth is mounted on a conventional flexible endoscope, which is provided with an extra suction channel running outside along the scope. Suction applied through this channel will suck the tissue into the cavity. A 17 gauge needle mounted on a wire-would coil catheter is pushed through the stomach wall through an endoscope using a large handle to apply mechanical force, which is mounted on the tip of the accessory channel. The tag mounted on thread is then pushed in a hollow needle through a double layer of tissue. The tag is caught in a retention chamber in the capsule of the sewing machine. When the needle is withdrawn, the tag tilts and is caught within this chamber and the endoscope withdrawn pulling the thread through the tissue. To form plications, this procedure can be repeated. Once the sewing process is finished a knot pusher, performing a very small mechanism “collet and sleeve” is used to lock the thread. The same device, pushed through the accessory channel of the endoscope can cut the thread similar to a guillotine and in a single action and releases the knot.

Results

The device has been mainly used to treat gastro-oesophageal reflux disease. It has also been used to close oesophageal and gastric perforations and attach pH radiotelemetry capsules to the oesophagus, stomach and duodenum. Endoscopic gastroplasty is a minimally invasive surgical procedure for gastro-oesophageal reflux, which has been performed at flexible endoscopy without laparotomy or laparoscopy (4). Promising results have been reported in both European (5) and American series (6) using endoscopic sewing machine technology. Results of endoscopic gastroplasty performed in 107 patients with GERD were reported recently (6). It showed that this operation can improve reflux symptoms, measured acid exposure of distal esophagus and increase lower esophageal sphincter length and pressure. Symptoms assessed by DeMeester score improved from a median of 5 to 1 (p<0.05). Median lower esophageal sphincter length increased from 2-3 cms (p<0.05) and pressure increase from 5-8 mm Hg (p<0.05). Median % time pH < 4 decreased from 8.4 to 2.7 (p<0.05). A recent report described 22 patients, who completed their one year follow up (7). Pre procedure and 12 months post-procedure assessments included symptom scoring (DeMeester), upper intestinal endoscopy, oesophageal manometry and 24 hour oesophageal pH, and completion of quality of life (QOL) questionnaires. Heartburn symptom score was reduced from a mean value of 19.22 at baseline to 7.5 at 12 months (n=22) (p<0.0001). Regurgitation score reduced from a mean of 2.27 at baseline to 0.86 at 12 months (n=22) (p<0.001). Mean (SEM) pH DeMeester acid score was reduced from 44.1 (4.3) to 33.32 (4.73) (p=0.028) at three month post procedure. Percentage upright acid exposure and number of reflux episodes were also reduced significantly. Use of PPIs was reduced by 64% at 12 months post procedure. All QOL assessments showed significant improvement (p=0.01). Complications were relatively uncommon and included bleeding, over-sedation, and a single perforation. All transient post procedure complaints resolved within 72 hours in the latest study (7). The procedure can be performed in day-case patients, who can leave hospital few hours subsequent to the examination. A study using the sewing machine in 20 children showing impressing positive results will be presented at the BSG 2003.

Conclusion

There is, of course, room for improvement. More work is needed to make endoscopic suturing easier, quicker and more reliable. In my view the single most important next goal is to construct a device, which can place multiple stitches without the need to remove the endoscope between each stitch. However, the results presented show, that it seems to be a very effective method for the treatment of GERD in selected patients.

References

Nurses’ Role in Capsule Endoscopy

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Wireless video endoscopy or video capsule endoscopy is a novel non-invasive technique to investigate the small bowel in patients with obscure blood loss or other small bowel diseases.

The entire procedure, connecting the patient to the apparatus in the morning, and disconnecting the patient at the end of the day and analysing the stored capsule images, are time-consuming tasks for the doctor.

On our unit two nurses, a colleague and myself, both with more than twelve years experience in endoscopic images of the upper and lower GI tract perform this procedure.

The gastroenterologist, my colleague and I view the capsule video individually and make still photographs (thumbnails) of abnormalities.

After that we discuss our notes together.
In the near future we will be sufficiently trained enough so that the doctor can rely on our thumbnails and will not have to view the complete capsule video.

For the endoscopy nurse this procedure gives a new dimension and depth to our profession and a challenge detecting the lesions.

GI Nursing in the 21st Century

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GI Nursing in the last decade, has moved from Standing watching to Standing doing for endoscopy nurses, and also has seen development of specialist roles caring for patients with GI Cancers, inflammatory bowel disease, nutritional deficiencies, and establishment of nurse led services, and created patient benefits not least of which is faster access to services. But what are the possibilities and challenges for the future GI practitioner?

Advances in medicine and information technology bring higher public expectation, whether Health and Social care is funded from taxation, or via insurance based schemes, the pattern of demand and need is changing now, and will change further over the next 10-15 years. Economic review in the UK(1) recently demonstrated that the present pattern of service provision is not sustainable, and there needs to be a strategic shift to focus on prevention and early intervention and a step change in peoples responsibility for their own health and that of families and communities.

New legislation (2), encouraging greater public involvement in health care decisions, and a commitment to patient partnership working, will challenge and change the relationships and boundaries between the professionals and patients as the latter become more educated and informed through global media and internet sources.

Policy makers, professional groups and economists are beginning to form the Vision of the Future Nurse(3), the Expert patient,(4) recognising that those with chronic disease often know more about it than the professionals, and the Future Health worker(5).

Nurses communication skills and information interpretation, will be crucial and tested by new ways of working, telemedicine, and counselling of health risks associated with genetic makeup, as well as medication compliance, and life style advice in partnership with patients will play increasing roles in proposed screening programmes for colon cancer, the technical role of performing colonoscopy or sigmoidoscopy will require an increased number of endoscopists, but just as important a role will be by nurses testing the acceptability of such programmes, encouraging uptake of screening offered, and decreasing anxiety of possible diagnoses.

The future nurse and nursing teams are visualised as delivering integrated nursing across care settings. They will map, navigate, coordinate and follow the healthcare journey in partnerships with their patients and other members of the healthcare team, practicing without traditional boundaries of role or setting, but organised around integrated care pathways.

GI nurses already have some building blocks to move forward with this agenda, but need to work with their National nursing organisations, specialist groups, national and European, to develop in partnership with others, recognition and accreditation of specialist and core nursing competencies, promoting a positive image of the nursing contribution to health, to family, politicians, policy makers, the general public and future generations of nurses.

5. The Future Health Worker Liz Kendall and Rachel Lissauer. IPPR.org.uk
The EU health strategy and the opportunities for nurses and nursing

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Email: pcn@village.uunet.be Website: www.pcnweb.org

The European Public Health focus is shifting towards influencing the public and their attitudes and behaviour. Within this process, the population is an integral part, acting by empowerment. Empowerment of citizens only occurs when sufficient information is available to understand the condition, the changing needs, the options available and sources of information. This process of reform creates role opportunities and innovative processes. Gastroenterology & Endoscopy nurses meet many citizens undergoing colorectal cancer screening, and their role within the public health area needs to focus on bad nutrition, alcohol, smoking and obesity (EU Public Health Programme).

PCN coordinates the European project ‘Developing a continuing professional development programme in public health for nurses’ in which common standards (Bologna Declaration), evidence-based best practice in public health, free movement (Directive on Mutual Recognition) and equality issues within and between European Member States are key components for strengthening the role of nursing within public health. Public Health training in Europe has reached the level where we are developing a common understanding of the core competencies of professionals through networking and collaboration. Europe needs professionals who will be able to work in the new health monitoring system, having access to evidence-based training methods and exchange best practice, providing examples how to incorporate health and lifestyle education into the everyday working life.

The European nurses are a significant partner in achieving the Lisbon targets: to make the EU the world’s most dynamic and competitive economy. Health means wealth, not just in qualitative terms, but also in solid economic terms. A healthy society is a more confident and productive society, one that draws less on health care spending and welfare payments. Therefore, the policy formulation capacity of nurses within the National and European legislative process is the key to success.

The Standing Committee of Nurses of the EU (PCN) was established in 1971. PCN represents over one million nurses and is the independent voice of the profession. Members consist of national nurses’ associations from the twenty-five EU Member States. Associate Members are drawn from nursing associations in countries which are members of the Council of Europe. The mission of PCN is to safeguard the status and practice of the profession of nursing and the interests of nurses in the EU and Europe.
Websites of Interest for Endoscopy and Gastroenterology Nursing

ESGENA Newsletter No.14 provided a selection of websites focused on colorectal cancer screening. Lorenz Rudkin from Luxembourg submitted further websites on this subject. Thank you very much for your support.

<table>
<thead>
<tr>
<th>web address</th>
<th>Name</th>
<th>Country</th>
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<tbody>
<tr>
<td><a href="http://www.cancerscreening.gov.au/">http://www.cancerscreening.gov.au/</a></td>
<td>Australia Cancer Screening</td>
<td>Australia</td>
</tr>
<tr>
<td><a href="http://www.darmkrebsmonat.de">www.darmkrebsmonat.de</a></td>
<td>Colon cancer Patient information</td>
<td>Germany</td>
</tr>
<tr>
<td><a href="http://www.lebensblicke.de">www.lebensblicke.de</a></td>
<td>Colon cancer Patient + professional information</td>
<td>Germany</td>
</tr>
<tr>
<td><a href="http://www.who.int/cancer/publications/en/#guidelines">http://www.who.int/cancer/publications/en/#guidelines</a></td>
<td></td>
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<tr>
<td><a href="http://www.cdc.gov/cancer/colorctl/about2004.htm">http://www.cdc.gov/cancer/colorctl/about2004.htm</a></td>
<td>Center for Disease Control and Prevention, CDC- recommandations</td>
<td>USA</td>
</tr>
<tr>
<td><a href="http://www2.gastrojournal.org/scripts/om.dll/serve?action=searchDB&amp;searchDBfor=art&amp;artType=abs&amp;id=agast12">http://www2.gastrojournal.org/scripts/om.dll/serve?action=searchDB&amp;searchDBfor=art&amp;artType=abs&amp;id=agast12</a></td>
<td>American gastroenterological association- Guidelines</td>
<td>USA</td>
</tr>
<tr>
<td><a href="http://www.show.scot.nhs.uk/insd/">http://www.show.scot.nhs.uk/insd/</a></td>
<td>Colorectal cancer screening in Scotland</td>
<td>UK</td>
</tr>
</tbody>
</table>
**Transcultural Nursing**

A number of interesting websites on transcultural nursing were compiled by Helene Herve-Desirat, France. These websites from the UK, USA, Australia and France are written in English. They provide tools to approach care to multicultural patients while taking staff culture and the health care institution into account.

<table>
<thead>
<tr>
<th>web address</th>
<th>Name</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="http://www.culturediversity.org/">http://www.culturediversity.org/</a></td>
<td>International organisation</td>
<td>International</td>
</tr>
<tr>
<td><a href="http://learn.sdstate.edu/smyert/Sharemodule1sec4/ppframe.htm">http://learn.sdstate.edu/smyert/Sharemodule1sec4/ppframe.htm</a></td>
<td>The Sunrise Model</td>
<td>USA</td>
</tr>
<tr>
<td><a href="http://203.147.140.236/multicultural/guidelines/staff_patient.asp">http://203.147.140.236/multicultural/guidelines/staff_patient.asp</a></td>
<td>Transcultural nursing in the USA</td>
<td>USA</td>
</tr>
<tr>
<td><a href="http://203.147.140.236/multicultural/guidelines/staff_patient.asp">http://203.147.140.236/multicultural/guidelines/staff_patient.asp</a></td>
<td>Transcultural nursing in the USA</td>
<td>USA</td>
</tr>
<tr>
<td><a href="http://www.leeds.ac.uk/cers/">http://www.leeds.ac.uk/cers/</a></td>
<td>Centre for Ethnicity &amp; Racism Studies in Leeds</td>
<td>UK</td>
</tr>
<tr>
<td><a href="http://www.rcn.org.uk/resources/transcultural/adulthealth/sectionone.php">http://www.rcn.org.uk/resources/transcultural/adulthealth/sectionone.php</a></td>
<td>Guidelines</td>
<td>UK</td>
</tr>
<tr>
<td><a href="http://www.sunyit.edu/library/html/culturemed/bib/transcultural/">http://www.sunyit.edu/library/html/culturemed/bib/transcultural/</a></td>
<td>Trancultural nursing documents</td>
<td>USA</td>
</tr>
<tr>
<td><a href="http://tcn.sagepub.com/">http://tcn.sagepub.com/</a></td>
<td>Journal of Transcultural nursing</td>
<td>USA</td>
</tr>
<tr>
<td><a href="http://www.minkowska.com/eng/">http://www.minkowska.com/eng/</a></td>
<td>Portal of Mental Health and Cultures</td>
<td>France</td>
</tr>
</tbody>
</table>
Announcements of National and International Conferences and Workshops

CANADA
World Conference of Gastroenterology and SIGNEA Meeting
12 - 14 September 2005
Montréal, Canada

www.signea.org or www.onge.org

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

SLOVENIA
5th European Conference of Association for Common European Nursing Diagnoses, Interventions and Outcomes ACENDIO
7-9 April 2005
Bled, Slovenia

Information
World Congress Secretariat
c/o Congrex Holland bv
P.O. Box 302
NL-1000 AH Amsterdam, The Netherlands,
Fax: 0031 20 50 40 225
E-mail: wcog2005@congrex.nl

Conference language: English
Simultaneous translation in English, German, French and Slovenian

GREAT BRITAIN
British Society of Gastroenterology - Endoscopy Nurses Meeting
14-16 March 2005
Conference Centre Birmingham, UK

Information
www.bsg.org.uk

Conference language: English

GERMANY
Spring Conference of the German Society of Endoscopy Nurses and Associates (DEGEA) in conjunction with the Conference of the German Society of Endoscopy and Imaging (DGE-BV)
10-12 March 2005
Conference Centre Stuttgart-Killesberg, Germany

Information
www.cocs.de or www.degea.de

Conference language: German

FINLAND
8th European Congress of Enterostomal Therapists (ECET)
19-22 June 2005
Helsinki Fair Centre, Finland

Information
www.congrex.fi/ecet2005

Conference language: English
SWITZERLAND

3th National Congress from the Swiss Society for Endoscopy Nurses and Associates (SVEP/ASPE)
in collaboration with the First Meeting of the Swiss Society for Gastroenterology

23-24 September 2005,
Congress Centrum Lugano, Switzerland

Information
www.svep.ch

Conference language: German and French

BELGIUM

XXIIrd European Workshop on Gastroenterology and Endoscopy
with live video demonstrations

20-22 June 2005
Brussel Exhibition Centre, Brussels, Belgium

Information
www.live-endoscopy.com

Language: English and French

GERMANY

Autumn Conference of the German Society of Endoscopy Nurses and Associates (DEGEA)
in conjunction with the 60th Conference of the German Society of Gastroenterology (DGVS)

16-17 September 2005
Cologne, Germany

Information
www.dgvs.de or www.degea.de

Conference language: German

TURKEY

ESGE-Workshop on Advanced Endoscopy
with live video demonstrations

22-23 April 2005
Antalya, Turkey

Information
www.esge.com

Language: English
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.
Resolution™
Clip Device

The radiopaque Resolution Clip is engineered to enable opening and closing up to five times prior to deployment, aiding in repositioning of the clip.*

When repositioning is key.

www.bostonscientific.com

*Reopening and closing capability may be limited by clinical circumstances and patient anatomy, amongst other factors. ©2004 Boston Scientific Corporation.
Dear Colleagues,

On behalf of ESGENA and the Danish Society for Gastroenterology and Endoscopy Nurses, we have great pleasure inviting you to the 9th ESGENA Conference, which will be held during the 13th UEGW in October 2005 in Copenhagen.

As in previous years we are hoping to provide a full and varied programme – in order to stimulate meetings and discussions with colleagues from all over Europe. We are continuing the format of previous conferences as this has encouraged networking and communication between the delegates.

The conference will officially open 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.

On Saturday we will provide the opportunity to attend a choice of eight workshops organised in four parallel rooms. The workshops will be more practically focused and in smaller groups - up to fifty participants - to encourage discussion, questions and exchange of ideas. Following the success of the dummy workshops in Geneva and Prague, we will repeat these workshops in Copenhagen. For the local nurses we will hold some of the workshops in Danish; the others will be in English.

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

On Monday morning we will have two Plenary Sessions – lectures in just one hall, in order to bring the delegates together. Awards will be given for the Best Free Paper and the Best Poster and will be followed by the invitation to the next ESGENA conference. The trade exhibition will open on Monday at lunchtime and there should be enough time to browse the stands should the medical scientific programme not tempt you back into the lecture halls. Nurses are especially invited to visit the Learning Corner, which offers a large variety of "state of art" videos.

We hope to welcome you at the 9th ESGENA Conference in October 2005 in Copenhagen, Denmark.

Christiane S. Neumann
President of ESGENA

Brita Lindeberg
President of the Danish Society of Gastroenterology Nurses
ESGENA Call for Abstracts

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

Deadline for ESGENA abstract submission: **30th May 2005**

**General Information on ESGENA Abstract Submission**

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

Authors must conform to the following guidelines for abstract submission. **Those not conforming to the guidelines will not be considered.**

- Abstracts must be submitted (British spelling) and presented in **English**.
- Use font that is easy to read such as Times Roman, Helvetica or Courier.
- The abstract must not be more than 500 words long or must not fill more than one A4 page, using type in 12-point font.
- Abstracts will be reviewed by a panel of experts and may be selected for oral or poster presentations, or may be rejected. The time allotted for each oral presentation will be 10 minutes, followed by 5 minutes of question time.
- Notification of acceptance (for oral or poster presentation) or rejection by the Scientific Programme Committee will be emailed to the presenting author by 30th June 2005.
- Detailed information, guidelines and recommendations for oral or poster presentation, as well as day, time and room will be sent in due time to duly registered presenting authors.

**The abstract should be typed as follows**

- A brief title, which clearly states the nature of the investigation, with the entire title in capital letters
- Abbreviations should, if possible, be avoided in the title, but may be used in the text if they are defined on the first usage
- The authors’ names (full first name, surname) and the institution (hospital, university, organization, city and country, e-mail and fax number) where the research was carried out, with the name of the presenting author underlined
- Type in the top section of the abstract the title of the paper in capital letters
- Use single line spacing
- Do not leave blank lines between paragraphs
- Indent three spaces on the first line of each paragraph
- Include tables if necessary
- The abstract should be as informative as possible: state specific objective of the study, state method used (if pertinent), summarise results obtained and state conclusions reached
- Statements such as „results will be discussed“ or „data / information will be presented“ cannot be accepted
- Please ensure that your abstracts do not contain any spelling, grammar or scientific errors, as it will be reproduced exactly as submitted

- The abstract should have a nursing relevant content and should add to existing knowledge.
- The abstract should have a minimum of two relevant References
- The abstract should state two things the delegates could learn from your presentation
**Checklist for Abstracts**

As many of you have asked for guidelines regarding abstract submission we thought that you might find this checklist useful to see if you have complied with the requirements. Abstracts not conforming to the guidelines will not be considered.

<table>
<thead>
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<th>Abstract Sections</th>
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<tr>
<td>Title</td>
<td>which clearly states the nature of the investigation</td>
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<tr>
<td>Authors’ names</td>
<td>full first name, surname</td>
</tr>
<tr>
<td>Institution</td>
<td>hospital, university, organization, city, country, e-mail, fax number</td>
</tr>
<tr>
<td>Introduction</td>
<td>what is already known, what needs further study</td>
</tr>
<tr>
<td>Aim / Objective</td>
<td>aim of project, study etc.</td>
</tr>
<tr>
<td>Method used</td>
<td>if pertinent</td>
</tr>
<tr>
<td>Results / Findings</td>
<td>of Results / Findings</td>
</tr>
<tr>
<td>Summary</td>
<td>reached (what has been learned)</td>
</tr>
<tr>
<td>Conclusion(s)</td>
<td>minimum of two</td>
</tr>
<tr>
<td>References</td>
<td>two things you would like the reader to learn from your presentation</td>
</tr>
</tbody>
</table>

**Formatting**

<table>
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<tr>
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<th>in capital letters</th>
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<tbody>
<tr>
<td>Abbreviations</td>
<td>Abbreviations should, if possible, be avoided in the title, but may be used in the text if they are defined on the first usage</td>
</tr>
<tr>
<td>Authors</td>
<td>presenting Author underlined</td>
</tr>
<tr>
<td>Spacing</td>
<td>single line spacing</td>
</tr>
<tr>
<td>Language</td>
<td>must be submitted in English (British spelling), checked for spelling errors</td>
</tr>
<tr>
<td>Font</td>
<td>use 12 point e.g. Times Roman</td>
</tr>
<tr>
<td>Word Count</td>
<td>max. one A4 page, approximately 500 words</td>
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<tr>
<td>Content</td>
<td>The abstract should have a nursing relevant content and should add to existing knowledge</td>
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## ESGENA Programme

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<tr>
<th>SATURDAY 15 October 2005</th>
<th>SUNDAY 16 October 2005</th>
<th>MONDAY 17 October 2005</th>
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<tr>
<td><strong>Registration</strong></td>
<td>8:30-12:00 Scientific Sessions 1 - 4</td>
<td>8:30-12:00 Session 9 Plenary Session 1 + 2</td>
</tr>
<tr>
<td>15:30-17:00 Workshops 2-8</td>
<td>Lunch &amp; Poster Session Society Information Desks</td>
<td>Lunch</td>
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<tr>
<td><strong>ESGENA Welcome Reception</strong></td>
<td>13:30-17:00 Scientific Sessions 4 - 8</td>
<td>Visit of Exhibition Learning corners</td>
</tr>
<tr>
<td><strong>ESGENA General Assembly (Members only)</strong></td>
<td>17:15-18:15 ESGENA General Assembly (Members only)</td>
<td>UEGW - Welcome Reception</td>
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</tbody>
</table>
Boston Scientific
Clips: When Repositioning is Key

Gastrointestinal bleeding continues to be one of the most common emergencies in gastroenterology practice. The source of bleeding, in approximately 90% of the patients, is identified in the upper gastrointestinal tract, while the extra 10% is localized in the lower GI tract (9% in the colon and 1% in the small bowel). This explains why most of the lesions are accessible for endoscopic treatment.¹

Injection, thermal treatments and mechanical methods are the different endoscopic haemostatic treatments available. Among the mechanical methods, the haemostatic clips have experienced an important adoption rate in the endoscopy practice worldwide.

Indication
Clips are being used today for a large number of indications, most of which are related to bleeding. They are designed for prompt haemostatic effect. Several studies have been published relating to the safety and effectiveness of endoscopic clip placement.²³

Endoscopic clips have been indicated for placement within the Gastro-intestinal tract for the purpose of:

1. Haemostasis for:
   • Mucosal / sub-mucosal defects < 3 cm,
   • Bleeding ulcers,
   • Arteries <2mm,
   • Polyps < 1.5 cm in diameter,
   • Diverticula in the colon,
2. Endoscopic marking,
3. As a supplementary method, closure of GI tract luminal perforations <20mm that can be treated conservatively
4. Anchoring to affix jejunal feeding tubes to the wall of the small bowel.⁴

The Art of Innovation
Boston Scientific, a market leader in the endoscopy field, has recently introduced the new Resolution™ Clip, which offers a new set of features and benefits for physicians and nurses. These advantages include:

• Re-opening capability: The radiopaque Resolution™ Clip is engineered to enable opening and closing up to five times prior to deployment, aiding in repositioning of the clip at the lesion site.⁵
• Pre-loaded: Resolution™ Clip is designed to be ready-to-use, which is essential for emergency bleeding situations.
• 11 mm-wide jaw span: Intended to grasp a sizeable amount of tissue
• Familiar handle: Designed to deliver an intuitive actuation for opening and closing the jaws. Provides a tactile feedback upon closing of jaws, indicating that the clip is about to be deployed.⁶

Recent Clinical Study
A very recent clinical study was presented by Dr. Dennis Jensen et al from UCLA, which concluded that long-term clip retention was significantly higher with Resolution™ Clip.⁷

References
(3) Teo EK, Fock KM. J Gastroenterol Hepatol 1998; 13:320-1
(4) Resolution™ Clip Device – Instructions for use
(5) Re-opening and closing capability may be limited by clinical circumstances and patient anatomy, among other factors.
(7) Resolution™ Clip – Product Literature - Brochure Dennis M. Jensen et al. Randomized controlled comparison of hemostasis efficacy & retention rates of three types of hemoclips for bleeding canine ulcers. Poster #P566 ACG Poster Orlando, FL November 2, 2004

For further information please contact:
Jeff Dienhart
Boston Scientific International SA
Le Capitole,
55 Avenue des Champs Pierreux
TSA 51101
92729 Nanterre Cedex, France
Email: DienharJ@bsci.com
Fujinon: Double-Balloon-Endoscopy

The newly developed Double-Balloon-Endoscope (patent pending) from Fujinon has entered the market in April 2004. Since then, with this unique technique it has become possible to examine the whole small intestine non invasive and to intervene at the same time. This groundbreaking innovation has been developed based on the idea of Dr. Yamamoto, MD, Department of Gastroenterology of Jichi Medical School. This technology has defined the future standard in modern diagnosis of small bowel diseases.

Beside the first model EN-450P5/20 with a working channel of 2,2 mm, there is now another type available: Therapeutic Enteroscope EN-450T5 with a working channel of 2,8 mm. For both of these remarkable Enteroscopes, Fujinon offers specially developed accessories in order to support professional application and to complete the full service. The range of accessories includes capsule retriever and APC-probe, which has been developed in cooperation with Erbe.

Since January 2004, there have been taking place more then 20 internationally affected Double-Balloon-Workshops in ”Dr. Horst-Schmidt-Kliniken” in Wiesbaden, under the leadership of Prof. Ell. The resonance shows overwhelming acceptance of this unique system. Courses for 2005 are already planned.

In line of this year’s UEGW in Prague, 25.-29.09.2004 Fujinon has daily presented lectures regarding ”small bowel intervention” at the booth. Selected international speakers have enthusiastically introduced results of this technique. Last but not least did Fujinon a convincing Live-Demonstration at the ”ESGE Postgraduate Course” under the special direction of Prof. Christian Ell and Dr. Andrea May.

Indications for Double-Balloon-Endoscopy:
• Unexplained digestive bleeding
• Crohn’s disease
• Radiographic abnormalities of the small intestine
• Unexplained chronic diarrhoea and chronic abdominal pain
• Multi-generating polyps
• Difficult B2-ERCP’s

For further information please contact:
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Fax: +49(0)2154/924-290
Email: heyer@fujinon.de
www.fujinon.de
www.fujinon.co.jp
Thirty years after the first papillotomy by Demling and co-workers, ERCP is among the most challenging of endoscopic methods. The procedure is complex and needs substantial personnel resources. With the V-System, new ERCP devices are available, which enable an endoscopist to accomplish significantly more of the device manipulations independently, compared to previously. The first experiences at the Friedrich Ebert hospital, Neumuenster, are reported here.

Introduction
The V-System consists of a videoduodenoscope with a V-shaped Albarran lever. A 270 cm long guide-wire is fixed by the V-shaped Albarran lever. Thus, it is possible to change between endotherapy devices such as papillotomes, balloon catheters or stents without removal of the guide-wire from the bile duct. The specially designed Endo Therapy V-products are introduced via a special V-Holder which maintains the guidewire in place.

At present, ERCP-catheters, a specially designed guidewire, wire-guided papillotomes, Dormia baskets, extraction balloons and pre-mounted plastic stents are all available. The Friedrich Ebert hospital, Neumuenster, analysed twenty interventional ERCP investigations, using this new system, so far. All endoscopies were carried out by the same endoscopist and five nurses. A theoretical introduction took place before the first use of the V-system.

Results
Nineteen of twenty investigations were completed successfully. We performed 18 wire-guided papillotomies, twelve stone extractions with a Dormia basket and extraction balloon as well as four stent insertions. One tandem stent was inserted smoothly. One ERCP including papillotomy and stone extraction was performed with a patient, who had undergone a Billroth II resection several years ago. No complications arose.

Becoming familiar with the V-system did not cause any difficulties for the nurses or the endoscopist. The V-Holder can be easily fixed on the endoscope. The 270 cm long 0.035” guide-wire could be fixed safely in the V-Groove, so that dislocation of the wire from the bile duct should be an exception.

Continuous visual control of the papilla of Vater is important during the whole examination. The wire-guided papillotome and the extraction balloon could be safely inserted into the bile duct. The "CleverCut"- papillotome has an insulating coating on the proximal section of the cutting wire, in order to avoid uncontrolled cutting. We did however feel, that the means of guiding the basket over the wire could be improved – this seems a fragile construction and if damaged during the procedure, then the ability to guide the basket via the wire is lost. The basket unfolds smoothly and is mechanically stable when tightly grasping bile duct stones. The stent system can be safely inserted into the bile duct. However, stent removal is not possible due to a missing adjustment at the pusher. Here we see some improvement opportunities.

The improved hygiene standard due to the strongly shortened guide-wire is new as well. After becoming accustomed to the new procedural sequence, which needs approx. 5 examinations, one does not want to think about working without the V-system anymore.

The V-System is safe during application. In twenty applications, no complications were observed. The dosages of pre-medication were similar to those with conventional ERCP-systems. We did not register any complaints of discomfort from our patients, either.

This new procedure during ERCP also drew our attention to hygiene-standards in endoscopy. The occasional, possibly even unnoticed contamination of the ERCP wire by contact with the floor or other bacterially contaminated surfaces, should be avoided by the introduction of improved techniques. Short-wire systems are a possible way to achieve this aim.

For further information please contact:
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D-20097 Hamburg
Phone: +49(0)40 23773-825
Fax: +49(0)40 23773-5731
www.olympus-europa.com
Pioneering technologies at Medica 2004: BioEndoscopy® is transforming the world of conventional endoscopy

Hamburg, December 2004

In future PENTAX is set to increasingly influence the advances in endoscopy with innovative solutions to a significant extent. The most recent developments presented at Medica 2004 represent a breakthrough in the field of endoscopic diagnostics. These forward-looking technologies, which will already be marketable in 2005 in some cases, are specially summed up by PENTAX with the term BioEndoscopy®.

Endoscopy at a new level
The European market launch of the so-called “confocal laser endomicroscopy” (Endomicroscopy for short) is just six or so months away. The first clinical study into Endomicroscopy immediately resulted in publication in the renowned journal GASTROENTEROLOGY in September 2004 (Kießlich et al. Gastroenterology 2004;127:987-1000).

With Endomicroscopy it will be possible to see detailed microscope images of the epithelium, connective tissue and blood vessels of the mucous membrane at cellular level for the first time during endoscopy. Previous experience indicates that the resulting images will be comparable with histology in terms of quality, i.e. with the material removed during biopsy which is then examined by a pathologist using a conventional procedure following endoscopy. This represents an absolute breakthrough for endoscopy (for the time being gastroenterology). Pathologists also see Endomicroscopy as “a fascinating technique with great potential” (Prof. M. Stolte, Bayreuth): the endomicroscope technology developed by Pentax will allow endoscopists to differentiate between neoplastic and non-neoplastic cells.

For further information regarding PENTAX and its current technologies please contact:
PENTAX Europe GmbH
Dr. Daniel Zeidler
Marketing Manager
Medical Division
Julius-Vosseler-Str. 104
D-22527 Hamburg, Germany
Phone: +49(0)40/561 92-232
Fax: +49(0)40/560 4213
Email: zeidler.daniel@pentax.de
Internet: www.pentax.de
Products in the Fusion family include the following:

- Snap-on convenient Wire Locking Device with excellent seal and compatible with Olympus and Pentax endoscopes.
- .035" ultra short wire (185cm) with three-colour spiral and Aqua Coat tip.
- 6Fr-5Fr Tapered ERCP Catheter with distinctive glowing radiopaque tip.
- 5Fr tip Sphincterotome with excellent orientation and over-the-wire flushing capability.
- 7Fr-6Fr Tapered Pre-Cut Needle-Knife
- 7Fr Extraction Balloon with multiple sizing (8.5mm, 12mm, 15mm), radiopaque bands and "above" or "below" flushing capability.
- 5Fr and 7Fr Pushing Catheters compatible with our plastic stents.
- 8.5Fr and 10Fr OASIS Stent Delivery system with stent repositioning and multiple stent delivery.
- 4, 6, 8 and 10 millimeter reliable PET Dilation Balloon in three cm length with radiopaque markers for clear fluoroscopic visualisation.
- 7Fr, 8.5Fr and 10Fr Dilation Catheters with radiopaque bands and enhanced pushability for difficult stricture.
- 8Fr, 2.5cm Cytology Brush with specially angled bristles to enhance cell collection and 1.5 cm filiform tip to enhance navigation.
- Zilver Stent in usual sizes with 7Fr introducer, self-expanding, nitinol, non-shortening construction, uniform radial strength and maximal flexibility.

For Wilson-Cook, it was a great challenge to see what improvements we could bring to the practice of ERCP. With Fusion, we believe that we have brought new short-wire technology to the customers, with compatibility to long wire technique and other manufacturers' products, both of which will benefit customers and patients alike.

Simon Brouwers & Edmund Brennan
Wilson-Cook Medical Incorporated.
The new Pentax 80K 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

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Ultrasound-Endoscopes
Intubation-Endoscopes
Bronchoscopes
Naso-Pharyngo-Laryngoscopes
Cystoscopes
Ureteroscopes
Choledocho-Nephrosopes
Cholangio-Pancreaticoscopes
Autofluorescence-Bronchoscopy
ESGENA - Membership

GROUP MEMBERSHIP
National societies, groups or federations, who 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>€</th>
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<td>&lt; 50</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 €
In case of bank transfer, please add 10 € for bank transfer fees.

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

AFFILIATED MEMBERSHIP
Members from industry may join the society as affiliated members.
Membership fee 55 €

ESGENA - Membership Application

Membership Application

<table>
<thead>
<tr>
<th>Check Membership Level:</th>
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<tbody>
<tr>
<td>Group Membership</td>
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<tr>
<td>Individual Membership</td>
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<tr>
<td>Passive Membership</td>
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<tr>
<td>Affiliated Membership</td>
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</tbody>
</table>

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

ADDRESS:
NAME (Person / Group)

DEPARTMENT / HOSPITAL

STREET

POSTCODE / CITY

COUNTRY

TELEPHONE / FAX

E-MAIL

Please send this reply slip to:
Medconnect GmbH
Brünnsteinstr. 10
81541 Munich, Germany
Fax: +49 89- 41 41 92 45
Email: medconnect@medc.de