ESGENA

European Society of Gastroenterology and Endoscopy Nurses and Associates

# ESGENA NEWS

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

*European Society of Gastroenterology and Endoscopy Nurses and Associates*

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

European Society of Gastroenterology and Endoscopy Nurses and Associates

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*ESGENA Governing Board (from left to right)*
*Silvia Lahey, Michael Ortmann, Stanka Popovič, Mette Olesen,*
*Christiane Neumann, Ulrike Beilenhoff*

We are grateful to all of the authors for submitting their articles. Their contributions have made this issue of the ESGENA newsletter possible.
Articles published in ESGENA News do not necessarily reflect the views of ESGENA.

## Message from the President

*Ulrike Beilenhoff*

Firstly, I would like to wish all of our members a very happy new year for 2007. This is my first message as the 'new' president of ESGENA. Some of you might think, 'Strange – wasn't she President a few years ago?' It's true, I was also president previously, from 1998 to 2002.

I would like to thank my predecessor, Christiane Neumann, for all she has achieved as President during the last 4 years – both for ESGENA and for individual colleagues such as myself. Her commitment and energy have been exceptional. In her capacity as the scientific administrator of the ESGENA meetings, she has been the person who has really organized the ESGENA conferences for the last 10 years. Anyone who has ever organized a conference can imagine the kind of energy, idealism and hard work that is needed to keep on doing this for 10 years. Christiane has really influenced on the image of ESGENA with her visions, ideas and professional convictions. With her educational and scientific background, she has been one of key persons in the development of the ESGENA job profile, the core curriculum, guidelines and political statements. She has now stepped back to the 'second line.' As an ESGENA Councillor, she will be continuing her work on the ESGENA Board for another term, but with the clear focus on teaching the 'new ESGENA generation.'

The next 2 years will be an interim phase in which it is intended that other members of the Board should take over more and more tasks and responsibilities. The focus during my presidency of ESGENA will therefore also be on providing guidance and information to colleagues on the ESGENA Board and in the ESGENA education working group. I am confident that our colleagues will do a great job.

I would also like to thank Gerlinde Weilguny, who has now retired from her duties with ESGENA. During her period as Editor, the design and content of ESGENA News improved notably. It was Gerlinde who initiated the development of the new ESGENA logo. Since 2003, she has been involved in organizing the ESGENA Dummy workshops. I would like to thank her for the tremendous commitment and loyalty that she has shown.

Our thanks also go to the industrial companies providing sponsorship for ESGENA (see box) for their continuing financial support both for the Society and for its conferences. Without this support, the progress ESGENA has made during the last few years would have been almost impossible.

We live in an interesting and ever-changing time in which increased patient needs and demands are having to be met with reduced resources, as most European countries are short of both staff and money. In some European countries, nurses working in endoscopy and gastroenterology are still having to fight for official recognition and for good working conditions. In other European countries, however, endoscopy and gastroenterology nurses now have an opportunity to raise their profile by taking on new tasks and responsibilities that were originally reserved for physicians. Our professional profile is sure to change during the next few years, and ESGENA will be ready to take an active part in this process at a European level.

I look forward to serving the society as its President and to a year of continuing fruitful cooperation and friendship.

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We would like to express our gratitude to the major sponsors who continue to provide financial support for ESGENA. Their support has made various activities possible for the Society, including the European conference, and we are most grateful for their support:

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## Letter from the Editor

*Mette Olesen*

As this is my first issue as Editor of ESGENA News, I would like to introduce myself. I have been an endoscopy nurse for 17 years and work as a specialist nurse at a university hospital in Copenhagen. My interests include education and training for endoscopy nurses, and I have been involved in various courses for endoscopy nurses in Denmark. I have also attended the ESGENA Education Working Group, and have been a member of the ESGENA Board since 2005.

In October 2006 I had the opportunity to attend a conference for gastroenterology nurses in Denmark. It was a very good conference, with a large number of dedicated participants. I was very impressed by the speakers, who presented their projects and experience at a very high level. Nurses can improve their skills through sharing their knowledge and expertise with colleagues, as developments over the last 10 years have shown.

I hope that I will be able to support such developments from my position as Editor, and I would like to encourage nurses to write contributions to ESGENA News. My hope is that it will be possible to include articles written by nurses representing every aspect of gastroenterology in future issues of the newsletter.

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## Report on the ESGENA Conference

(21-23 October 2006, Berlin)

*Dana Kuchynkova*

The venue for the 10th annual ESGENA Conference was the International Congress Centrum (ICC) in Berlin, and the conference was held in association with German nurses' groups to coincide with the 14th United European Gastroenterology Week (UEGW) meeting. Berlin is a welcoming, dynamic and cosmopolitan city where East meets West, and nurses attending the conference had an opportunity to sample the city's atmosphere and variety and to visit some of its sights and tourist attractions. A total of 390 participants from Europe, the Middle East, Asia, Canada and the United States attended the conference.

The official conference programme started on Saturday 21 October, with 10 workshops organized in five parallel sessions. Two of these were held in German for the local nurses, while two workshops involved practical experience on the EndoTrainer using dummies. Topics focused on during the workshops included reprocessing of devices, minimizing ERCP complications, advanced tools for ERCP and endoscopy, capsule endoscopy, endoscopic submucosal dissection, ergonomics and documentation in endoscopy. It was not easy to make a choice from all of the interesting topics that were being presented simultaneously.

The conference itself was officially opened with a welcoming ceremony and party held in the 'Alte Kommandatur' in the famous street Unter den Linden – and the friendly atmosphere of the meeting on a warm Saturday evening had a positive influence on the whole conference. Many thanks go to our German colleagues for their hospitality.

The ESGENA scientific programme started on Sunday 22 October, in two parallel sessions with a wide range of subjects, focusing on gastroenterology nursing, education and specialist training, hygiene and infection control. The programme also included two free paper sessions and a poster session.

The free paper on 'Telephone follow-up for patients with coeliac disease,' given by Elaine Horne from Hereford, UK, received the Best Free Paper award, and the poster presentation on 'Pre-assessment of patients on the wards having an endoscopic procedure' by Sylvia Miles from Cardiff, UK, won the prize for the best poster.

New techniques and developments in endoscopy were presented in the ESGENA plenary session held on Monday 23 October, and the conference closed with an invitation to attend the 11th ESGENA conference, which is to be held in Paris in October 2007.

Our compliments and thanks are due to the ESGENA Board, the tutors at the workshops, the speakers, the industrial companies providing sponsorship, and the host nursing associations, along with special thanks to all the individuals who helped make the conference a success.

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## Report from the ESGENA Dummy Workshops at the 2006 ESGENA Conference

*Mette Olesen*

A variety of workshops were offered in five parallel sessions during the ESGENA conference in Berlin on Saturday 21 October 2006. The ESGENA Workshops on the EndoTrainer provided hands-on-training on pig dummies, in which it was possible to receive training in different endoscopic procedures. A dummy is a torso or doll featuring a stomach, liver, or colon from a pig. The pig organs are specially prepared to allow training in different endoscopic procedures.

The participants were able to choose which procedures they wanted to practice. Specially trained nurse tutors, along with doctors, were available to teach the workshop participants, and company representatives were present to help and answer questions about their equipment. The eight different dummy tables provided at the dummy workshop were attended by about 40 participants. There was an atmosphere of activity, enthusiasm and concentration in the room, and a lot of questions and interesting discussions could be heard at all of the tables. The whole session was very professionally arranged, and Michael Ortmann and Eric Pflimlin from Basle, Switzerland, did a great job as coordinators.

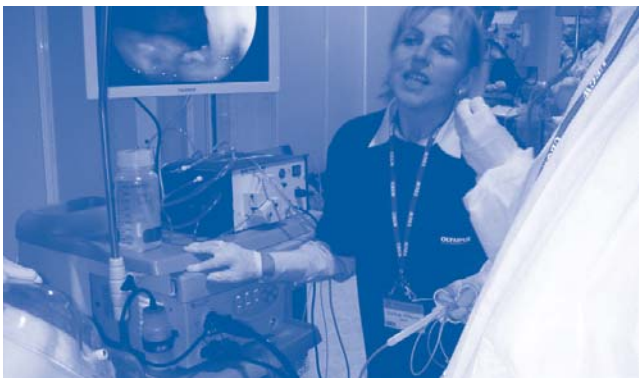
*Pilar Rojo (Spain) and Sylvia Lahey (NL) demonstrate ERCP equipment*

*Malene Brandt and Gitte Christensen in a discussion with Willy De Vriese about PEG*

On the day before the workshops, ESGENA also offered a special training meeting for the nurse tutors involved in them, covering the topics of: cultural awareness; the role of the nurse tutors; aims and learning outcomes, teaching techniques and session planning for dummy workshops; how to motivate participants; worst-case scenarios (such as how to remain focused on nursing topics, how

to remain in control even if one of the participants starts to dominate the workshop, how to solve technical problems, etc.)
I spoke to one of the nurse tutors at the workshop, Jadranka Brljak from Croatia, after the workshop.

*Local anesthetic injection - doll model*



*Gerlinde Weilguny teaching ERCP techniques*

ESGENA: Have you ever been a tutor at an ESGENA workshop before?
JADRANKA: No, it was my first time as a tutor for ESGENA. I was working on the ERCP dummy, where we demonstrated gallstone removal.
ESGENA: What do you think about this type of teaching?
JADRANKA: I like it, because I can share my knowledge and skills with other nurses and show them my way of doing procedures. Also, it's important for patient safety that nurses should be able to improve their practice.
ESGENA: Did you find it useful to receive coaching beforehand on carrying out training in the nurses' course before the workshop?
JADRANKA: Yes, very much. I learned, for example, how to keep the group concentrated on the demonstrated technique. The coaching made it easier for me to figure out what is important and what is not important for nurses during this type of training session.
I also spoke to Malene Brandt and Gitte Christensen from Copenhagen after the workshop.
ESGENA: Which procedure did you choose?
GITTE: We chose the percutaneous endoscopic gastrostomy (PEG) table.
ESGENA: Did you learn anything new?
MALENE AND GITTE: It was exciting to try different procedures, and to see new equipment functioning. There were a lot of interesting discussions. In Denmark, we go to the patient's home to change PEG tubes, and therefore we often need simple ways to solve complicated problems. It is different in other European countries, where you use a guidewire and X-ray to change a PEG tube. We did not agree with everything that we saw, but we learned a lot by discussing the different ways of doing things.
ESGENA: Is there anything that you think can be improved during the workshop?
MALENE: We would have liked to try using the gastroscope ourselves.
ESGENA: Would you like to participate in a similar workshop again?
GITTE: Yes, very much so.

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## Foundation of a New Society for Gastroenterology and Endoscopy Nurses in Bosnia and Herzegovina

*Rifija Omercajic*

It is my great pleasure to announce that the Association of Gastroenterology and Endoscopy Nurses in Bosnia and Herzegovina (AGENBiH) was founded at a national meeting held in February 2006. Members of the associations' governing bodies were also elected at the meeting. A further meeting was held in June 2006 to make final preparations for AGENBiH's first national educational meeting, which was successfully held in Tuzla on 27–28 September 27 2006, during the Second Congress of Gastroenterohepatology in Bosnia and Herzegovina.
The meeting was extremely well visited by both members and non-members from all parts of Bosnia and Herzegovina, and by several members of the national societies in Croatia and Slovenia. The main topics discussed were disinfection of endoscopic devices, educational prospects for nurses in Bosnia and Herzegovina, and the role of the nurse in novel endoscopy procedures. The meeting was a great success, as the excellent feedback we have had confirms.

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## 17th Annual Slovenian Conference: Practical Training in Gastroenterological Endoscopy

*Stanka Popovič, Tatjana Gjergek and Anica Forštnariič*

A conference on 'Practical Training in Gastroenterological Endoscopy' was held on 16–17 June 2006 at the beautiful venue of the Hotel Metropol in Portoroz in Slovenia, on the Adriatic coast. Under the auspices of ESGENA and in cooperation with the ECE Training Centre, the conference was jointly organized by the endoscopy nurses' section of the Slovenian Nursing Association, the Slovenian Medical Association, the endoscopy section of the Slovenian Association for Gastroenterology and Hepatology, and the Departments of Gastroenterology and Abdominal Surgery at Izola General Hospital.

Slovenian doctors and nurses working in gastrointestinal endoscopy held well-attended combined sessions on the first morning of the conference, concerned with the topics of education and training, management, hygiene, ergonomics, and new techniques in endoscopy. On the afternoon of the first day and the following morning, doctors and nurses collaborated very actively in dummy workshops – with doctors helping nurses and nurses helping doctors. Four dummies were available for upper and lower gastrointestinal procedures and ERCP for beginners and experts. There were three Olympus corners and one Pentax endoscopy corner.

The meeting was a great professional success for the nurses, with doctors seeing that nurses were able to organize very practical and useful education and training meetings. Usually, teams in our country work in a strongly hierarchical system, and our hope is that better cooperation in endoscopy teams will be possible in the future.

The meeting was also a good social event, and everyone enjoyed watching the 'Flips' dance group and listening to good music during the conference dinner. We are very grateful to ESGENA Vice-President Michael Ortmann and his colleague Eric Pflimlin, from Basle, Switzerland, who provided invaluable assistance for us.

The sponsors of the meeting included Olympus, Cook, Pentax, Krka (Novo Mesto, Slovenia), Mercator, Pliva, Johnson & Johnson, Medicoengeneering, Tosama, Inn, AstraZeneca, Altana, and Sanolabor.

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*Michael Ortmann, Eric Pflimlin, Anja Schuster with the local organization team*

## International Symposium on Endoscopic Ultrasound

(28–30 June 2006, Okura Conference Centre, Amsterdam)

*Sylvia Lahey*

The 15th International EUS symposium was held on 28–29 June 2006 in the Okura Conference Centre in Amsterdam, located on the Amstel canal near Amsterdam's financial, cultural and entertainment centre – with a splendid view of Amsterdam from the upper floor. The endoscopic ultrasound (EUS) programme was officially opened by the symposium's President, Prof. Paul Fockens of the Academic Medical Centre (AMC) in Amsterdam.

Some 800 participants from all over the world attended the symposium, and the scientific programme included events for gastroenterologists, pulmonologists and chest surgeons, along with live demonstrations transmitted from the Academic Medical Centre (AMC) in Amsterdam. The live demonstrations were transmitted from three endoscopy rooms in the hospital, with support from eight nurses, two medical assistants and two disinfection assistants. With good interdisciplinary collaboration, the live demonstrations went well, both in the hospital and in the Okura conference centre.

*EUS 1: Dutch colleagues at the welcome reception of the EUS conference*

*EUS 2: Sylvia Lahey, NL (left) and Brenda Furgenson, USA, (right) chairing a session*

*EUS 3: Hedwig Kos, NL, giving her presentation*

Sixty nurses took the opportunity to attend a separate nurses' programme, which included a variety of medical, nursing, ergonomic and psychological topics. The chairs for the nurses' programme were:

- Monique van den Bergh (general head nurse in the endoscopy department of the AMC) and Dr. Jacques Bergman (gastroenterologist at the AMC)
- Ann Duflou (endoscopy nurse) and Dr. Marco Bruno (gastroenterologist at the AMC)
- Brenda Ferguson (staff nurse and endoscopy nurse from the Medical University of South Carolina, USA)
- Sylvia Lahey (ESGENA General Secretary and endoscopy nurse at Rijnstate Hospital in Arnhem, Netherlands)

The presentations on the nurses' programme were given in English by nurses and physicians from America, Italy, Korea, the United Kingdom and the Netherlands, and the programme included the following subjects:

- EUS and esophageal tumours
- Patient care around esophagus/EUS
- Submucosal tumours
- Safety of fine-needle aspiration (FNA) during EUS
- Accuracy and patient preferences in evaluating perianal fistulas using hydrogen peroxide enhancement
- Three-dimensional endoanal ultrasound and endoanal magnetic resonance imaging
- How feasible is subspecialization for diagnosis?
- Psychological aspects
- Pancreatitis and pancreatic tumours and EUS
- EUS-FNA diagnostic yield for malignancy in solid pancreatic masses
- Coeliac plexus neurolysis
- Future prospects up to 2010

Nurses from the AMC gave presentations on the following topics:

- Drainage of pancreatic pseudocysts (Marion Thomson)
- Drainage of pancreatic pseudocysts with multiple stents using a double-wire technique (Agaath A. Hanrath)
- Scopes, probes and accessories (Theo Pordon)
- Ergonomics and endoscopy (Hedwig Kos)

The reception was held in the Okura hotel, and the official faculty dinner was held in the Shuttersgalerij at the Amsterdam Historical Museum. The participants were transported to the museum in an old-timer tram, returning to the hotel after diner in a horse tram.

For me, taking part in this successful symposium was a rewarding and instructive experience, and our thanks go all the organizers.

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## ESGE and ESGENA Workshops on Advanced Endoscopy

(14-15 September 2006, Zagreb, Croatia)

*Stanka Popovič*

An international workshop on diagnostic and therapeutic digestive endoscopy was held at the Clinical Hospital Centre in Zagreb, Croatia, in September 2006 under the auspices of ESGE and ESGENA and in conjunction with the Croatian medical and nursing societies. Prof. Roland Pulanic (Croatia), and Prof. Jacques Devière (Belgium), were the course directors. The ESGENA delegates were Jadranka Brljak (Croatia), Sonia Dugardeyn (Belgium), Theo Pordon (Netherlands) and Stanka Popovic (Slovenia).

Some 100 nurses – mostly from Croatia, but also from Bosnia–Herzegovina and Hungary – attended the workshop. The nurses' lectures were held in parallel with the medical programme, with the following topics:

- New developments in endoscopy (Theo Pordon)
- The role of the gastroenterology assistant in biliopancreatic endoscopy (Sonia Dugardeyn)
- Microbiological testing in endoscopy – surveillance in Slovenia (Stanka Popovic)

Sonia Dugardeyn, Theo Pordon and Jadranka Brljak assisted with procedures in the X-ray room, while local nurses and myself worked in the gastroscopy and colonoscopy rooms. The local nurses worked very hard and professionally. The following procedures were demonstrated during the live demonstrations:

- Therapeutic ERCP – stone extraction, dilatation, stenting
- Diagnostic and therapeutic EUS
- Percutaneous endoscopic gastrostomy (PEG)
- Colon polyps – polypectomy
- Esophageal varices – band ligation

The organization, cooperation and communication among doctors, nurses, technicians and representatives of Cook and Olympus were excellent.

At the end of the course, I had an opportunity to say a few words on behalf of ESGENA, and I am grateful to all of the European and local colleagues who worked with us during the workshop. ESGENA is happy to be able to take an active part in these workshops, as they promote endoscopy nursing and provide an

*Sonja Dugardeyn, Prof. Jacques Deviere and Thomas Marek with local doctors*

# What exactly does “push the wire forward” mean to you?

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*Jadranka Brljak, Stanka Popovič, Prof. Pulanic with local nurses and doctors*

important opportunity for nurses to learn from each other, to establish networking, to exchange experience with different countries and to discuss new developments in diagnostic and therapeutic endoscopy.

On behalf of ESGENA, I would like to thank the whole organization team. Special thanks go to Prof. Pulanic, Jadranka Brljak and all of the local nurses and clinicians, who all did a great job. I would also like to thank the sponsors, Cook and Olympus, who supported the meeting and donated all the equipment and accessories used.

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# Guidewire Cannulation in ERCP

*M.J. Bruno, MD, PhD*

**Introduction**

Endoscopic retrograde cholangiopancreatography (ERCP) is an advanced endoscopic investigational and interventional technique aimed at the biliary tree and the pancreatic duct. Since the introduction of magnetic resonance imaging (MRI), which is a noninvasive technique that provides excellent diagnostic images of the biliary tree and pancreatic duct, ERCP nowadays is mainly performed with therapeutic intent. The key to performing a successful ERCP is cannulation of the desired duct – i.e., the common bile duct (CBD) and/or pancreatic duct. If cannulation fails, ERCP fails. There are many different techniques for cannulation, such as repetitive probing with a catheter, use of specialized cannulas, or use of (rotatable) papillotomes [1]. All of these techniques can be employed with or without a guidewire. There are many opinions as to which method is preferable. In view of the importance of cannulation for successfully completing ERCP, it is remarkable how few studies have been conducted on this subject. The ideal technique for duct cannulation should incorporate (in order of desirability): the highest success rate in selective cannulation, the lowest complication rate (e.g., post-ERCP pancreatitis), and the fastest cannulation time. There is now accumulating evidence that the use of a guidewire and a papillotome for selective cannulation of the CBD meets these requirements.

*This article was submitted by Boston Scientific*

**Use of a Papillotome with a Guidewire for Selective Cannulation**

A prerequisite for optimal cannulation is the position of the catheter (guidewire) relative to the papillary orifice. The use of a sphincterotome offers the opportunity to obtain a more optimal angle for selective cannulation in comparison with a standard cannula. Indeed, in a randomized trial including 100 patients, Schwacha and co-workers showed that the use of a sphincterotome resulted in a significantly higher cannulation rate of the CBD in comparison with a standard cannula (84% versus 62%) [2]. In a randomized trial including 47 patients, Cortas and co-workers demonstrated that cannulation with a sphincterotome was not only significantly more successful (97% versus 67%), but that there was also a significant reduction in cannulation time and in the number of attempts for selective cannulation [3]. In a prospective cohort series, Michopoulos and co-workers showed that using a sphincterotome with a guidewire, a high rate of selective cannulation of the CBD was achieved (95%), with a low incidence of pancreatitis (2.3%) [4]. Bailey and co-workers reported on 304 patients from an ongoing randomized study comparing cannulation with a sphincterotome with or without a guidewire, and reported that a significantly higher rate of initial selective cannulation was achieved with the latter (70.6% versus 82.8%, P = 0.012) [5]. The incidence of pancreatitis did not differ. Lella and co-workers reported equally high rates of selective cannulation (> 95%) with a sphincterotome with or without a

guidewire, but observed significantly reduced rates of post-ERCP pancreatitis when a guidewire was used [6].

The available literature data provide evidence that papillotome and guidewire-assisted cannulation of the CBD is a technique that provides more successful selective duct cannulation in comparison with other cannulation techniques, without compromising safety and even minimizing complication risks. Newly introduced systems of biliary devices and accessories with multiple lumens, open channels and short wire technology allow optimal control of the guidewire in order to achieve selective duct cannulation – either by the nurse at the level of the guidewire introducer at the proximal end of the catheter, or by the endoscopist after the wire has been separated from the open channel at the level of the locking device.

**Pancreatic Duct Guidewire for Selective CBD Cannulation**

Guidewires can be used not only for direct cannulation of the CBD, but also indirectly by placing the guidewire in the pancreatic duct. The guidewire exposes and stabilizes the ampulla and common channel by stretching it, thus facilitating cannulation of the CBD. This can also be achieved by placing a small temporary pancreatic duct stent. Maeda and co-workers randomly assigned 53 patients, when conventional cannulation had failed after 10 minutes, to either persisting with the usual technique or placement of a pancreatic guidewire [7]. There was a statistically significant difference in the success rates in favor of using a pancreatic guidewire (93% versus 53% successful cannulation). The use a pancreatic guidewire for CBD cannulation raised some concerns about the possibility of an increased risk for post-ERCP pancreatitis. Gyokeres and co-workers, however, showed that the incidence of post-ERCP pancreatitis was similar in patients in whom cannulation of the CBD was performed with or without a pancreatic guidewire (7.3% versus 8.3%) [8].

**Summary and Conclusions**

There is accumulating and convincing evidence to support the use of a (rotatable) papillotome and a guidewire for a more successful selective duct cannulation, while minimizing the risk of post-ERCP pancreatitis. The use of a pancreatic guidewire to facilitate cannulation of the CBD appears to be a valuable and promising technique, but further studies are awaited before its definitive role within the armamentarium of cannulation techniques can be determined. For more information about ERCP cannulation techniques, the reader is referred to the comprehensive in-depth review article by Freeman and Guda [1].

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# Abstracts from the 10th ESGENA Conference

(Berlin, 21-23 October 2006)

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## BEST FREE PAPERS

***Category: Oral Presentation –***
***Presented on 22 October 2006 in Berlin***

### Telephone Follow-up Clinic for Patients with Coeliac Diseasee

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

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

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

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

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

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

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

***Category: Poster Presentation –***
***Presented on 22 October 2006 in Berlin***

### Pre-assessment of Patients on the Wards Having an Endoscopic Procedure

*Sylvia Miles, Abdul Mohamed, Jayne Tillett (Endoscopy Unit, University Hospital of Wales, Heath Park, Cardiff, Wales, UK; tel.: 02920745519, fax: 02920746346; milesfatima@aol.com*

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

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

**Objective:** The objective was: to provide informed consent through the education of inpatients about their endoscopy and the care they would receive throughout the procedure; to improve the efficiency of the endoscopy unit and facilitate the smooth diagnosis and treatment of inpatients by educating the ward staff about the procedures and the necessary preparations.

**Methods:** A monthly audit was done to identify the number of patients' cancellations and reasons given. A pilot study was also undertaken by a questionnaire to see whether inpatients knew the procedure they were having and the risks factors, prior to giving consent. The results of these two studies were then used to formulate a pre op / procedural assessment form which included the check list and care plan. A letter was sent to all the wards informing the staff that the endoscopy team would be undertaking pre-assessment of inpatients attending the endoscopy unit. An experienced endoscopy nurse would visit the ward patients and pre assess the patient with the date and approximate time of procedure. The nurse would give patient an explanation of procedure, gather pertinent information and answer any questions pertaining to the procedure and also to allay patients' fears. Information leaflets of the procedure will be given to patient and informed consent obtained. The nurse looking after the patient will be asked to sit in on the pre-assessment. All documentation will be filed into patient's notes. Close liaison was carried out with the Unified Assessment Project manager to implement this change.

**Results:** A pilot study carried out at the unit identified that 30% of

inpatients considered that they were not given sufficient chance to ask questions before their endoscopy. 60% of the patients were not given any literature and 75% of patients said they would prefer an endoscopy nurse to visit them on the ward prior to their procedure. A pilot study has been undertaken to design the care plan to its full potential. Teaching sessions have been implemented for the ward staff and endoscopy staff on how the documentation works.

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

## ABSTRACTS OF FREE PAPERS AND POSTER SESSIONS

### Investigating the Efficiency of Manual Cleaning and Endoscope Washers Using Adenosine Triphosphate Hygiene Monitoring System

*Melvin Ortiz. Jayne Tillett (Cardiff and Vale NHS Trust, Endoscopy Unit, University Hospital of Wales, Cardiff, South Glamorgan United Kingdom. Tel no. 02920745519 Fax no. 02920746346 mhelvs@yahoo.com)*

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

**Aims/objectives:** The general aim of the study is to improve the clinical practice in the process of decontamination of endoscopes by measuring evidence of ATP present in the scopes. The study has attempted to answer the following null hypotheses: A, there is no significant difference in the reduction of ATP from post manual cleaning to post AER of gastroscopes and the colonoscopes; B, there is no significant difference in the reduction of ATP from pre manual cleaning to post manual cleaning.

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

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

Conclusion: The results corresponded well with the theoretical predictions ,that there will be a reduction of ATP in the biopsy channel of the endoscopes after cleaning and disinfection. However, the efficacy of cleaning depends on the number of factors which includes: a, nature of the device being processed; b, the extent and nature of the soiling to be removed; c, the temperature; d, mechanical energy (time, output, duration); e, detergent; f, the nature, volume, concentration and temperature of the disinfectant solution. It is hoped that this study will stimulate further work in the field.

**References:** ATP Hygiene Monitoring SytemSURE II. Northavon business centre, Bristol, Health edge solutions limited.

Rider et al. (2003). B Cell-based sensor for rapid identification of pathogens. Science, 301:213-215.

### Double Balloon Enteroscopy: Implementing a New Examination Method in an Endoscopy Unit

*Tanja Andre´s, Karin Poulsen (Gentofte University Hospital, Niels Andersensvej 65, DK-2900 Hellerup, Denmark , E-mail karinpoulsen806@hotmail.com)*

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

**Implementing a new examination method:** Implementing the double balloon enteroscopy was different from how we usually work when implementing something new. Normally one learns from a more experienced nurse; this time, we had to gather the experience ourselves. We had three main areas to work with: care for the patient before, during, and after the examination; information to patients and colleagues; the endoscope and examination procedure. 1. The care does not differ very much from what we do at other examinations, but with an examination time of up to 2 hours, special care has to be taken of the patient. When implementing a new examination method, there will be things that have to be changed. The most important change we have made, is changing from doing the procedure as an outpatient procedure, to

having all the patients admitted to hospital the day before the examination. On admission to the ward, the patient is seen by a surgeon and an anaesthesiologist. The haemoglobin is checked, and if needed, the patient is given a blood transfusion. If the examination is performed through the colon, the patient is given a bowel cleansing with dinatrium phosphate. 2. In order to inform our patients as well as possible before the examination, we have produced information leaflets, which are sent to the patients when they are referred to us. To ensure that the nursing staff on the wards know about the examination method, we have produced an information paper together with a short checklist. In the endoscopy unit we now have a detailed description of the examination, and a written teaching plan, to ensure that the nurses who are going to learn the procedure have all the information necessary. In May 2006, we where invited by the hospital to give a lecture at a nursing symposium about double balloon enteroscopy. 3. We were introduced to the endoscope and the examination procedure by Dr. P. Vilmann, who performs the examination, and by the Danish representative of Fujinon, the manufacturing company. After working with the double balloon enteroscope for a year we visited VU Medisch Centrum in Amsterdam, and had two very inspiring days.

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

**References:** Yamamoto H, Kita H. Double-balloon endoscopy: from concept to reality. In: Gastrointest Endosc Clin N Am. 2006 Apr; 16(2):347-61.

May A, Nachbar L, Wardak A, Yamamoto H, Ell C.: Double-balloon enteroscopy: preliminary experience in patients with obscure gastrointestinal bleeding or chronic abdominal pain. In: Endoscopy. 2003 Dec; 35(12):985-91.

## Implementation of a Computerized Nursing Care Plan for Standardized Care in Inflammatory Bowel Disease

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

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

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

**Results:** Elimination: Confirmed interventions (CI): 87.7%; Graphs (G): 39.9%; Progress Charts (PC): 48.8%. Pain/analgesia: CI: 89.9%; G: 75.5%; PC: 66.6%. Nutrition/fluids: CI: 93.28%; G: 84.4%; PC: 35.5%. Perianal hygiene: CI: 22.2%; G: 0%; PC: 0%. Rest/sleep: CI: 81.1%; 0%G:%; PC: 0.4%. Information: CI: 71.1%; G: 0%; PC: 0.2%. Recommendations at discharge: 14 of 15 patients (93.3%) were given the recommendations at discharge.

**Conclusions:** We observed that the present computerized nursing care plan for standardized care in our IBD patients:1) Aids nurses determine how, when and what care should be given in accordance with a standardized plan. 2) Shows a trend to repeat information. 3) Indicates a lack of correlation between the CI screen with the graphs and progress charts. Although our computerized nursing care plan for standardized care has facilitated nursing care and records, the results obtained have evidenced the need to modify the programme.

**References:** 1. Diagnósticos Enfermeros por necesidades. Virginia Henderson

2. Guia de práctica clínica. M.A. Campos Osaba y cols. Fundación Jordi Gol

3. Proceso de Enfermería y Valoración. M.A. Campo Osaba

Two things the delegates could learn from the presentation: Nurse records. Nursing care plans IBD.

## A Structured Approach to Nurse Education: Endomucosal Resection (EMR) and the Development of Nursing Practice in Endoscopy

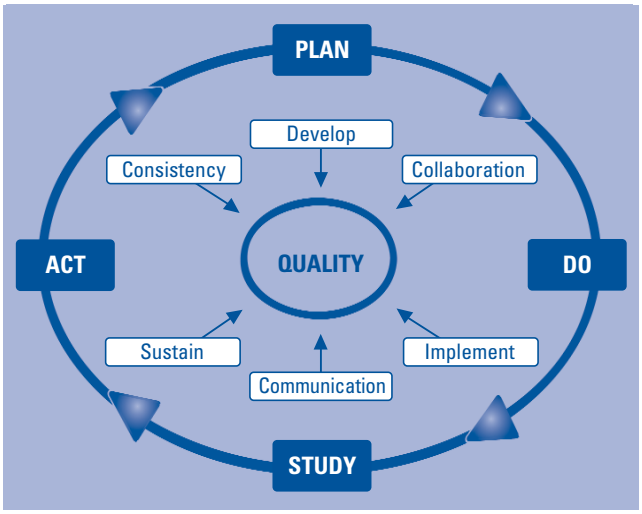
*Jo Corrigan, Stella Dobson , Rachel Rawnsley and James Meadows (Endoscopy, Leeds General Infirmary, Leeds Teaching Hospitals Trust, Leeds, LS1 3EX, UK. Jo.corrigan@leedsth.nhs.uk. Fax: 01133922312)*

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

**Aim:** Our aim in developing EMR practice was to have an approach inclusive of nursing and junior medical staff. To this end we initially focused on three areas: What is EMR? When/why is it performed?

How is it performed?

**Objective:** It was clear that a focused development in practice was required. The drivers for this included: new techniques and accessories; need to extend limited knowledge base for this procedure; practice beyond the routine diagnostic and therapeutic work; increasing demand for EMR; nurses accountability; quality assurance; patient satisfaction.

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

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

**Learning Objectives:** (1) A standardized approach to service delivery promotes quality and patient satisfaction. (2) Collaborative practice development encourages and supports multidisciplinary working.

**References:** Ono H, Kondo H, Gotoda T, Shirao K, Yamaguchi H, Saito D, Hosokawa K, Shimoda T and Yoshida S (2001) Endoscopic mucosal resection for treatment of early gastric cancer. Gut:48;225-229.

Hurlstone DP, Sanders DS, Cross SS, Adam I, Shorthouse AJ, Brown S, Drew K and Lobo AJ (2004) Colonoscopic resection of lateral spreading tumours: a prospective analysis of endoscopic mucosal resection. Gut:53;1334-1339

## Nurse Endoscopy Training at Ersta Hospital, Sweden – the Initial Experience

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

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

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

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

**References:** Joint Advisory Group on Gastrointestinal Endoscopy (JAG) Drew P Hughes MAP Hodson R Monson JRT Wedgewood

KR Kaur Suthie GS (1998) A prospective UK evaluation on the first training programme for nurse endoscopist. GUT 43:5, 711-714.

## Should Endoscopy Nurses Be Trained in Ethical Theory?

*Timothy James (University of Central England, Birmingham, UK, timothy.james@uce.ac.uk, Fax +44 121 331 6438)*

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

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

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

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

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

Endoscopy nurses, therefore, ought to receive more training in ethical theory. It will be suggested that, by enabling nurses to make more consistent and effective ethical decisions, such training: would protect patients' autonomy better; would protect patients' dignity better; would protect patients' safety better; would protect nurses better.

Learning outcomes: At the end of this presentation participants will: be aware of the practical effects of different ethical theories on some everyday aspects of endoscopy practice; and have some strategies for developing their expertise on issues at the interface between ethical theory and nursing practice.

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

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

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

## An Evaluation of the 'Cut and Push' Method of Percutaneous Endoscopic Gastrostomy (PEG) Removal

*Sarah Harnden1, Susan Merrick2, Shishir Shetty1, Preti Chopra1, Phil Clamp1 and Suneil Kapadia1 ( 1Dept. of Gastroenterology and Dept. of Nutrition and Dietetics2, Royal Wolverhampton Hospital NHS Trust, Wolverhampton WV10 0QP, sarah.harnden@rwh-tr.nhs.uk; fax 01902 695738)*

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

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

**Method:** Patients requiring removal of Freka 15 fg PEG tubes were identified by Dietetic and Head and Neck Services and the Endoscopy unit. Exclusion criteria: known gastrointestinal (GI) motility disorders, GI structuring, immobility or inability to give informed consent. Patients were nil by mouth (or PEG) for 6 hours prior to removal. The fixation plate was released and the PEG tube rotated and advanced into the stomach lumen (to exclude buried bumper syndrome), the catheter cut close to the stoma and the remnant pushed into the gastric lumen with a 14 fg nasogastric tube. Patients were kept nil by mouth for 2 hours, on clear fluids for the remainder of the day and asked to look for the remnant in the stool. Patients were contacted at day 7 and abdominal X ray arranged (same day) for those who had not seen the remnant. If the remnant was seen on plain X ray, the patient was contacted on day 14 and a second X ray ordered if the patient had still not seen the remnant.

**Results:** 42 patients were recruited over 29 months: 38 Head and Neck and four others (stroke, head injury, cystic fibrosis and lung cancer). Day remnant passed/patient numbers: +1 / 5; +2 / 13; +3 / 4; X ray day 7 / 18; X ray day 8 (bank holiday) / 1; X ray day 14 / 1. 40 patients passed the remnant by day 7, all by day 14 and no adverse events occurred.

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

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

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

**Expected Learning Outcomes:** 'Cut and push' is a safe method of removing Freka 15 fg PEG tubes in ambulant patients. Cut and push' has significant cost savings over endoscopic PEG removal, particularly if carried out by a nurse or dietician.

## Incidence of Clostridium difficile in a Hospital Digestive Disease Service

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**Introduction:** C. difficile is a spore-forming, gram-positive anaerobic bacillus that releases two toxins: toxin A (enterotoxin), responsible for most diarrhoea associated to antibiotics; and toxin B (cytotoxin). The two appear to act synergically. The organism had been isolated from diverse natural habitats including soils, hay and sand, as well as from dog, cat, reptile and human feces. Since 1977, it is known as the etiological agent of pseudomembranous colitis associated to antibiotics.
**Aims:** To determine the incidence of C. difficile in patients with gastroenteritis, and evaluate nursing care measures.
**Material and methods:** We studied all patients who presented gastroenteritis during hospitalization and in whom C. difficile toxin A (+) was isolated in the study period: 01/01/1999-02/28/2002 An epidemic outbreak of C. difficile enteritis appeared in the Service in 1999. We determined the isolation measures necessary to avoid the transmission of C. difficile and the possible appearance of further nosocomial epidemic outbreaks.
**Results:** Following the implementation of these measures no further epidemic outbreaks have been noted. All the cases of nosocomial infection for C. difficile has been sporadic. During the study period , 653 microbiological exams of feces samples from 359 patients with gastroenteritis were performed; C. difficile toxin A (+) was isolated in 17 cases and toxin A (-) in 636.
**Conclusions:** Implementing isolation measures to avoid contact transmission together with standard protection was effective in containing the outbreak. All patients improved clinically with Metronidazole treatment. Implementation of a nurses' alert programme and supervision of the antibiotic prescription policy has prevented the appearance of new epidemic outbreaks.
**Results:** L. Alcalá Hernández y E. Bouza Santiago. Infecciones por bacterias anaerobias esporuladas. Capítulo 44. Pag 471. Tratado SEIMC de Enfermedades Infecciosas y Microbiología Clínica. V. Ausina Ruiz, S. Moreno Guillén. Buenos Aires; Madrid: Médica Panamericana (2005)
Prevention and Control of Nosocomial Infections. Fourth Edition. Richard P. Wenzel. Lippincott Williams & Wilkins.
Hospital Epidemiology and Infection Control. C. Glen Mayhall
Hospital Infections. Fourth edition. Jhon V. Bennet, Philip S. Brachman. Lippincott – Raven
Two Things: Isolation measures to prevent nosocomial infection.

## A Comparison of Patient Experience of Colonoscopy and Flexible Sigmoidoscopy: a Qualitative Study Using a Semi-structured Interview

*Mrs Irene Dunkley (Hinchingbrooke Hospital, Huntingdon, Cambridgeshire, United Kingdom. Tel 01480 363521 Fax 01480 363636 – Irene.Dunkley@Hinchingbrooke.nhs.uk)*

The purpose of this study is to explore the issues patients have in undergoing lower gastrointestinal endoscopy procedures. A qualitative approach was used, using a semi-structured interview to gain insight into the patient experience. Comparison of the patient's experience of colonoscopy and flexible sigmoidoscopy was undertaken to identify any differences and similarities between the two groups. A convenience sample of ten patients attending the endoscopy department of a District General Hospital (DGH), were recruited into the study; six in the colonoscopy and 4 in the flexible sigmoidoscopy. Local research ethics committee approval and Trust approval has been obtained. The findings of this qualitative research may have implications for informing the modality for colorectal cancer screening programmes, for current local practices; endoscopy service provision and future research.
**Aim of research:** To explore and compare the patients' experience of colonoscopy and flexible sigmoidoscopy. Identify any problems or concerns patients have in complying with preparation for procedures. Identify any problems or concerns patients have about the procedure itself. Identify any problems or concerns patients have about having the procedure either with or without the use of sedation. To identify any problems or concerns patients have with access to services locally.
Outcomes: To identify any patient education needs regarding endoscopic procedures. To identify any changes needed in service provision for endoscopic procedures. To inform any changes to current practices as a result of patient views on services locally. Compare the patients' experience of flexible sigmoidoscopy and colonoscopy to inform the modality for colorectal cancer screening.
**Outcomes:** To identify any patient education needs regarding endoscopic procedures. To identify any changes needed in service provision for endoscopic procedures. To inform any changes to current practices as a result of patient views on services locally. Compare the patients' experience of flexible sigmoidoscopy and colonoscopy to inform the modality for colorectal cancer screening.
**Results:** Five themes emerged from data analysis of patient interviews: 1. Procedure experience. 2. Bowel preparation. 3. Understanding and information. 4. Choice and access to services 5.Interactions with staff – these themes are complex and interlinking. Data analysis suggests that sedated patients who were symptomatic were more likely to remember some of their procedure. Patients with previous cancer diagnosis reported more anxiety. Patients who were having screening procedures were less anxious and had no recollection of their procedure. Anxieties came from a variety of sources and were experienced by both patient having flexible sigmoidoscopy and colonoscopy. Oral bowel preparation caused patients concerns; the effects influenced the patient experience of both colonoscopy and

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

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

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## Bone Density (DEXA) Scan in Newly Diagnosed Coeliac Patients under the Age of 45 Is Unnecessary in the Absence of Additional Risk Factors or History of Previous Fragility Fracture

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

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

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

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

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

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

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

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

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## Endoscopic Treatment of Benign Strictures of the Gastrointestinal Tract – the Role of an Endoscopic Nurse

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**Background and Aims:** Strictures of gastrointestinal tract (GIT) are often found in patients undergoing endoscopic examination. Strictures are either benign or malignant. Benign strictures are usually treated endoscopically using different techniques. The new possibility has brought the use of a self-expandable plastic stent (Polyflex) for oesophageal strictures. The aim of our study is to present our own experience with endoscopic treatment of benign gastrointestinal strictures with special attention to the role of endoscopic nurses.

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

**Methods:** Main results are summarized in the table.

*Table: Capsule endoscopy findings in the obscure gastrointestinal bleeding patients*

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

For dilatation of peptic strictures, we use the 'through the scope' CRE balloons (Boston Scientific). A nurse fills these balloons with water using a special pistol. Long strictures are dilated with bougies (Cook). Patients with achalasia or patients with severe dysphagia following fundoplication are treated using Rigiflex balloons (Boston Scientific). An endoscopist fills these balloons with air and a nurse must counterbalance the tension on the balloon. We have reported two complications (bleeding and oesophageal perforation). Both were successfully treated endoscopically (clipping). In one patient with resistant peptic stricture, we have placed a self-expandable plastic Polyflex stent (Rüsch). A nurse puts together the introducing system to make possible to place a stent.

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

## ABC Holistic Care in Emergency Endoscopic Retrograde Cholangiopancreatography (ERCP)

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

**Method:** NKC institute is a tertiary care centre serving people in southern Thailand with all kinds of endoscopic procedures for diagnosis and treatment of hepatobiliary and gastrointestinal diseases. The policy is to provide service at all time for those requiring emergency investigation and treatment. The concept of ABC holistic care is translated into emergency service of ERCP which is considered the most risky procedure performed in GI endoscopic unit. This concept includes: 1. A – Action. Prompt response is a key success factor in emergency situation. On call, the endoscopy team should include a senior nurse as a leader for holding the emergency situation. A set of equipment will be prepared on the basis of an ongoing emergency checklist. 2. B – Belief. People in southern Thailand are mixed with Buddhists and Muslim. Patients' belief has its values for relieving pain and stress. Relatives have an opportunity to pray or touch their loved one until reaching the ERCP room. 3. C – Care which incorporates the 4 Cs as follows; a. Collaboration. Endoscopy nurses have a role to collaborate with an endoscopist regarding patients' condition and expected therapeutic result. Ward or emergency room nurses were asked in brief over patient's physical and psychosocial problems. b. Communication. Proficient endoscopy nurse will timely notice the concern of patient and relative. Their belief and preference should be identified and responded as appropriate. Written instruction or information regarding hepatobiliary disease and RCP procedure would help relieve relative's anxiety during waiting. c. Cooperation. Sedation will facilitate ERCP procedure. Monitoring of patient's vital signs, oxygen saturation and EKG is mandatory. Endoscopy nurse is required to cooperate and work well along with an endoscopist during the procedure. d. Continuum of care. Endoscopy nurse will accompany the patient until reaching the ward. Information about ERCP finding and procedure will be transferred to the ward nurse. Post-ERCP visit should be scheduled until the patient is discharged from the ward.

**Case study:** A 50 year-old Buddhist married woman was set for an emergency ERCP. She was febrile, lethargic and sepsis with hyperbilirubinemia and coagulopathy. Patient's husband accompanied her to the endoscopy room. Exchange of information

between senior nurse and her husband was done to relieve his insecurity and stress. During waiting, instruction sheet was given to him to provide information about ERCP and hepatic biliary disease. Extraction of common bile duct stones was successfully performed under sedation with meperidine and diazepam. Patient's husband was able to touch patient during transferring her back to the ward. This is the time for endoscopy nurse to talk and discuss with her husband regarding to the treatment given and discharge plan. Her husband agreed with nurse for using meditation as a tool to relieve pain and stress. Information of her condition and treatment performed was transferred to the ward nurse especially the effect of sedation. Post-ERCP was uneventful. Patient gained in consciousness and was able to have meal on the next day. Endoscopy nurse and endoscopist were together on schedule for post-ERCP visit until the patient was discharged from the ward.

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

## Drainage of Pancreatic Pseudocysts with Multiple Stents Using a Double Wire Technique

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

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

**Procedure:** We have developed two techniques to place multiple guidewires. The first technique uses the 10Fr cystotome. After the pseudocyst has been accessed with the tip, the needle is removed. The first wire is then placed through the sheath of the needle. After the 10Fr outer sheath of the cystotome has been advanced into the cyst, the inner catheter is removed and a second wire can be placed. Now the outer sheath is also removed and two wires are in place inside the pseudocyst and the first stent can be placed. The second technique uses the guiding catheter of a Fusion Oasis 10 system, to perform an intracystic exchange (I.C.E.). For this technique the Fusion catheter is loaded over the first centimetres of the wire and exits the port 2.5 cm from the distal end. The Fusion catheter is advanced into the pseudocyst. Subsequently the wire is pulled back under radiological guidance until it leaves the Fusion catheter (I.C.E.). Now the stylet of the Fusion catheter is removed and replaced by a second wire, which is also advanced into the cyst. Once the second wire has also entered the cyst, the catheter can be removed by pulling it out of the endoscope. Two wires are now appearing side-by-side from the cystogastrostomy. It is now possible to place two stents or to repeat the procedure to place more wires.

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

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

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## Effectiveness of the Programme of Anorectal Biofeedback in the Treatment of Anal Incontinence in Our Environment

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

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

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

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

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

relationship is probably essential for these good results.

## The Necessity for Special Care Nursing for Patients in Hepatitis C Virus Treatment

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

**Objective:** To form a nursing team specialized in the care of hepatitis patients. The unification of working methods. The unification of information.

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

**Results:** Creation of a nursing team specializing in the treatment of hepatitis (GEAPH) patients. Four sessions, each of approximately three hours duration Identifying common problems. Creating three working groups: information, registers, patient guide Reaching a consensus and consolidating the above mentioned aspects.

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

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Two things delegates could learn from the presentation: The importance of patient education. The importance of specialized nursing in the care of hepatitis patients.s.

## Quality of Life and Chronic Liver Disease Questionnaire in Cirrhotic Turkish Patients

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

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

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

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

## Endoscopic Examinations in Gastroenterology: Why Suffer?

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**Background:** Endoscopic examinations are invasive procedures, causing pain and discomfort. In order to lessen patient suffering and to win their cooperation, medications are given to lightly sedate the patient and lessen the pain (e.g. Midazolam and Pethidine). At times, these medications are not sufficient and require higher than customary dosages. Some patients who undergo the examination describe it as a traumatic experience –

which leads to a refusal to undergo the test again in the future, if required. In addition, there are certain circumstances under which the attending physician is obliged to stop the procedure due to patient anxiety and lack of cooperation. Today, there are drugs available that allow the patient to be more heavily sedated during the examination, such that the patient cannot feel pain, he fully cooperates and the time of the examination is thus shortened. The drugs used for deep sedation and pain relief are: Ketamine and Propofol. These drugs have a short half-life and therefore the recovery period is also shorter. These drugs must be administered by an anaesthesiologist thus increasing the cost of the examination. On the one hand the use of deep sedation increases the cost of the examination but is necessary; on the other it is of great importance to the patients. This fact necessitates our examining the various treatments given to reduce patient fear and pain; and identify the groups of patients who need heavy sedation in order to perform endoscopic examinations.

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

**Methods:** The research was designed as a comparative descriptive study. The sample included two groups of patients that underwent endoscopic examinations (colonoscopy and /or gastroscopy) in the Gastroenterology Unit of the Hadassah Medical Centre – Ein Kerem. Each group included 82 patients. In the first group pain treatment included the use of Midazolam and Pethidine and in the second the pain was treated with Propofol and Ketamine, administered by the Anaesthesiology Service. The evaluation tool included two questionnaires. The first checked various aspects of the procedure including: patient behavior and haemodynamic and respiratory stability of the patient. This questionnaire was completed by the nurses and physicians present during the procedure. The second questionnaire documented various indicators such as level of pain during the procedure; the patient's memories of the procedure; and his willingness to repeat the procedure in the future using the same pain treatment method. This questionnaire was completed by the patient.

**Results:** Primary results of the study indicate that the patient group which underwent heavy sedation reported no pain, and no patient anxiety or resistance was noted during the procedure. Some of the patients in this group had undergone the examination in the past, under light sedation but the examination was stopped due to intolerable pain or the patient considered the procedure too traumatic an experience. The other group underwent endoscopic examination with light sedation. The majority of the group reported an absence of pain during the procedure, a percentage suffered mildly and a smaller percentage reported high levels of pain. It should be noted, that in some of the patients..

## Nursing Consultation as an Important Factor for Patient Satisfaction in Screening Endoscopy

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

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

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

**Results:** Table 1: Patients' feeling concerning the procedure after receiving nursing consultation All patients judged completely positive about the nursing consultation, they felt better informed about the procedure and taken seriously in their individuality. All patients voiced significantly less anxiety prior and during the colonoscopy.

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

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

*Table 2: Patients' feeling concerning nursing consultation*

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

**Conclusions:** The results show significantly increased overall patient satisfaction in patients having a nursing consultation before undergoing screening colonoscopy. This effect is mainly based on a higher patient information level, which also leads to a decreased anxiety prior and during the procedure. Through this reduced anxiety level possible complications might be avoided, for e.g. less sedation might be needed or the procedure itself might be less traumatic. Additionally, more patients might agree to undergo a screening colonoscopy if they are better informed.
**Learning outcomes:** Nursing consultation leads to a better patient information and therefore to less anxiety prior and during endoscopy. Through a more thorough explorative talk individual risk factors are easier detected and can be individually responded to.
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## The Typical Patient Experience of OGD and Colonoscopy

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**Introduction:** As endoscopy nurses we have a worldwide goal: to provide high-quality care maintaining dignity, to provide a safe environment conducive to restoring and maintaining health, and to be a resource for the physicians for treatment, diagnosis and management of their patient with gastrointestinal disorders. The management of our endoscopy unit is influenced by the individual care given to our in- and outdoor patients, innovations and new techniques in the practice of therapeutic endoscopy as well as our high production level. In our hospital, most diagnostic procedures are performed without sedation, allowing patients to return to their homes as soon as possible. It's exciting to hear how patients experience these overwhelming examinations, from the moment they make an appointment, the information they get pre-procedure, the procedure and the follow-up care.
**Objectives:** At the conclusion of this presentation, the participant will be able to: Recognize the importance of good patient information; Discuss the (dis-)advantages of performing a diagnostic GI-procedure with and without sedation; Describe the effects our high production level has on the management of our endoscopy unit.
**Method:** 300 questionnaires were distributed in 2005 and evaluated. The inquiry was composed from the moment the patients heard from the doctor that they had to have the examination till the follow-up care. They also could describe how they experienced the procedure and made a choice about sedation or not, if they had to have the examination again in the future. In this period we were situated on two locations, and had to merger within a year. To identify possible differences, the same amount of questionnaires were distributed on both locations.
**Conclusion:** Most patients preferred diagnostic procedures like an EGD or sigmoidoscopy without sedation, even when they had moderate complaints. But, good patient information is essential and inevitable. Colonoscopies however, were often preferred with sedation. In my opinion, when sedation is given it should be at the level of conscious sedation. Differences in this inquiry depend on the individual patient and the gastroenterologist performing the procedure. The outcome of our procedures can be reviewed and discussed with our patients. It gives them more insights of possible abnormalities or illness. Even with our high production level, we are able to provide high-quality care. We are well organized and the overall satisfaction of our patients is very good. Finally, the discussion after this presentation may focus on possible differences, hopefully resulting in a worldwide higher standard in delivering care in a job we love the most: GI Nursing!

## Acceptance and Satisfaction of Screening Colonoscopy: a Triple Centre Evaluation in Germany

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**Introduction and aims:** In Germany in October 2002 the screening-colonoscopy was introduced into the national programme for colorectal cancer prevention for asymptomatic subjects older than 55 years. The colonoscopy is an established low risk examination for symptomatic patients, but there is not enough literature about acceptance and satisfaction in asymptomatic patients (1, 2, 3). The study was designed to determine whether there are differences in men or women who participate in the screening-colonoscopy, how the patients were informed about the new prevention-strategy with the screening-colonoscopy and to analyze the acceptance of different bowel preparation in outpatients of 3 practices for gastroenterology in Germany.
**Methods:** 300 consecutive patients (3-5/2006 – 100 in each centre) were prospectively given a questionnaire and a prepaid envelope after the screening colonoscopy, with the request to complete the questionnaire at home and to send it back to the evaluating practice. Data was extracted from the questionnaire.
**Results:** Out of 272 questionnaires (91%) a total of 263 questionnaires were included, because 9 were invaluable because of mistakes. Of these, 48% were male and 52% were female. We found no significant differences in the 3 centres, so the items were evaluated all together. The general practitioner did the main part of the work in informing patients about the screening-colonoscopy (m=79%; f=57%). Discussing about prevention strategies was more frequently relevant in gynaecologists (46%) than in urologists (10%). Patients informed themselves in advertising and media in 44% (m= 13%; f=31%). In the private surrounding of patients the colonoscopy is an open theme in 30% (multiple answers were possible). The bowel cleansing was done with Golytely RSS (Endofalk®) in 2 centres and with Phosphosoda (Fleet®) in 1 centre. 83% (m=90%; f=75%) were satisfied with the bowel cleansing procedure. 50% of male and 30% of female had no fear

because of the examination. 44% of men and 53% of women were worrying about the result of the colonoscopy. Women (26%) had more fear about pain concerning the colonoscopy compared to men (14%). Patients felt well informed about the colonoscopy by the gastroenterologist (95%). They plan to talk free and easy about their colonoscopy with family members (83%) as well as with friends (88%) or at work (45% of employed patients). Patients who undergo screening-colonoscopy participate in other cancer screening programmes in nearly 90%.

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

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

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## Compliance Scoring System in Nursing Evaluation of Patients with Hepatorenal Syndrome: Do We Have Tools to Assess Prognosis?

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

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

**Results and discussions:** All data was electronically collected and submitted to statistical validation using professional statistical software. At the end of the study we found that compliance was in average satisfactory (2.167 ± 0.023). There is a good statistical correlation between lower degrees of hepatic encephalopathy and good and excellent compliance ($p<0.0001$). Child-Pugh scores did not have significant interference with compliance ($p=0.1543$) but unfavourable progression of disease can be well predicted by low compliance scores ($p=0.0332$). Finally, fall in diuresis and rapid weight increase had a good predictive value for unfavourable prognosis ($p=0.0035$, $Chi2=12.262$) while rapid encephalopathy aggravation did not correlate with fatal evolution in patients with HRS.

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

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## Level of Information to Patients with Crohn's Disease and Ulcerative Colitis before Treatment with Infliximab

*Yvonne Krogager, Lene Neergaard, Charlotte Kühnel, Lise Olsen, Margarita Elkjær, Natalia Pedersen, Gudlaug Eiricksdottir, Kirsten Espenhein, Pia Munkholm (Herlev Hospital, Gastroenterology department, University of Copenhagen, Denmark. yvkr@herlevhospital.kbhamt.dk, +45 44883722)*

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

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

**Results:** Preparation of the script was in progress during 3 meetings and final minor corrections done at the shooting. The movie of how to prepare the infusion and the patient information and infusion movie at the site was processed during 24 hours working. The animation movie was done at a professional computer laboratory not situated at Herlev hospital. Hereafter film editing was done primarily by professionals in collaboration with the staff the subsequent 2 weeks. The total cost of the video was 40.000 Euros provided after application for an unrestricted grant from Foundation of Schering-Plough, Denmark. The concept is now being validated via our 110 patients which were treated from 1999-2006 at Herlev. 10 consecutive patients at the Day hospital Unit were validated after SI and INF infusion. 10 patients were validated after SI, CD-ROM and INF infusion.

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

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## Evaluating the Quality of the Endoscopy Service Using a Patient Questionnaire

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

**Objective:** To review the quality of the service using the Gastrointestinal Endoscopy Satisfaction Questionnaire (GESQ). To obtain the patients own personal view and experience of having an endoscopic procedure.

**Method:** The project team felt all upper and lower GI procedures should be included in the study, which would be strictly confidential with no patient identification. The size of the study was to include 100 patients over a two week period, allowing all the endoscopists lists to be covered in February 2006.The type of questionnaire used was the GESQ in a tick the box format of 21 questions. The questionnaire was given to the patients on the day of their procedure with a covering letter asking them to complete the form 24 hours after their procedure and return in the stamped address envelope to the unit. All patients were asked if they were happy to take part in the questionnaire. A daily record was kept of the total letters sent out per list.

**Results:** The project team were very pleased with the return and compliance with the study, of 84 questionnaires out of 100.An example of some of the results looking at information, pain and discomfort. 61% of the patients found the information sent to them before the procedure very easy to understand. 60% found the information very useful and answered their questions about the procedure. 75% felt they had the opportunity to ask questions before their appointment. 54% found the explanation easy to understand. 37% of the patients experienced mild pain during the procedure. 38% of the patients no discomfort after the procedure. 62% overall patient satisfaction with the procedure.

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

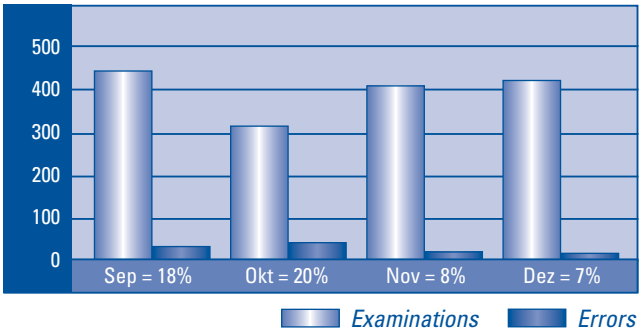
**Reference:** Gastrointestinal Endoscopy Satisfaction Questionnaire (GESQ) University of Wales Swansea copy right CHIRAL.

## Booking of and Preparation for Endoscopic Examinations – How Well Were Our Standards Observed?

*Heide Berndt, Uli Eckert (Gesundheit Nord gGmbh, Klinikum Bremen Mitte, D-28201 Bremen, Germany, Fax: 0049-421-4975740, Uli-eckert@web.de)*

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

*Graphic*




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

## Influencing Outcomes – Has a Structured Approach to Percutaneous Endoscopic Gastrostomy (PEG) Placement Made a Difference?

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

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

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

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

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

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

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

## Gastroenterology Unit in General Hospital: Improving the Service

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**Background:** The Gastroenterology Unit at the Hadassah Medical Centre – Ein Kerem serves a wide population of ambulatory and hospitalized patients. The Unit is active five mornings a week and is available for emergency cases seven days a week. Monthly, approximately 700 patients are treated with a wide range of interventions that require precise advance preparation in order to be successful. Until about a year ago, the Gastroenterology Unit was characterized by overcrowding and less than pleasant physical conditions, overwork and lack of structured methods for treating patients prior to their arrival for an intervention. The year 2004 saw the beginning of preparedness for, and building of procedures to improve the service and the guidance given to patients. Many changes were instituted, related to work methods, service quality and treatments. These changes were derived from the desire to make the Unit more efficient and to provide better service and treatment to its patients. The changes included: (1) Empowering the nurses to be responsible for the sub-divisions within the Unit. (2) Defining specific job responsibilities for each nurse, at each station, throughout the work day. (3) The creation of a structured educational guidance programme which includes: written materials that are used both in the hospital and in the community. (4) Structured discussions take place, according to a known schedule, on subjects that are related to situations and conflicts affecting the Unit's ability to provide quality service. (5) The crystallizing of the Unit's staff as a learning group, working

together to solve problems in real time and having the patient's good and welfare as its focus. (6) Significant improvement in the Unit's physical conditions.

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

**Results:** The results of the surveys indicated a certain degree of improvement in each of the measures that were checked, with some showing significant improvement. During the Conference, we will present the process which led to improvement in the quality of service provided for the patients' welfare.

## The Evaluation of the Turkish Endoscopy Nurses and Technicians' Practices

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

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

**Results:** One hundred-thirty (64.7%) of the participants were using pulse oximeter during the endoscopy session. One hundred-five (52.2%) of the participants were using both midazolam and dolantin;78 (38.8%) were using midazolam; 8 (4%) were using propofol; 7 (3.5) were using none of the premedication; and 3 (1.5%) were using other premedications for the sedation and/or analgesia. Injection of the premedication was performed by gastroenterologists in 30 (14.9%) of the questionnaires, by nurses in 142 (70.6%), by anaesthetists in 23 (11.4%), by anaesthesia technicians in 6 (3%). One hundred seventy-three of the participants did not know the antidotes of the employed sedative drug. One hundred ninety-seven (98%) of the participants acknowledge the patients before the endoscopy. One hundred forty-six (72.6%) of the participants have the informed consent of the patients before the procedure. Eighty-three (41.3%) of the participants had cardiopulmonary resuscitation education. One hundred thirty-seven (68.2%) of the participants were using disinfectant with glutaraldehyde; 28 (13.9%) without glutaraldehyde; and 36 (17.9%) other disinfectants. One hundred twenty-eight of the participants followed a guideline of disinfection. Ninety (44.8%) of the participants were performing the microbiologic surveillance in every three months.

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

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## Cleaning Advances in Flexible Endoscopy

*Eric C. Pflimlin, Margot Brenneisen, Michael K. Ortmann (Department of Gastroenterology, Universitätsspital, 4031 Basle, Switzerland, EPflimlin@uhbs.ch)*

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

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

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

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

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

## Evaluation of the Cleaning and Disinfecting of Endoscopic Equipment in a General Hospital

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**Background:** The use of endoscopic equipment in diagnostic procedures and treatments has dramatically increased in recent years and so too the spread of infections to both patients and staff via this equipment. Hospital acquired nosocomial infections are one of the most serious problems facing hospitals. The rate of acquired infections in the Western World is estimated at between 5-10 percent of all hospitalizations. The cleaning and disinfecting of equipment is an important aspect of preventing nosocomial infections. In our Hospital, cleaning and disinfecting techniques are based on Israel Ministry of Health and US – CDC procedures with an emphasis on using 'user friendly' methods and materials, while keeping costs in mind. In cooperation with infection prevention nurses, we drew a number of samples from endoscopic equipment which showed bacterial growth. Our findings are primarily as a result of the lack of appropriate work conditions and overcrowding which hampered our ability to optimally clean and disinfect the equipment. With the passing of time and the Unit's move to its new location in the Medical Centre, we intensified our efforts to better protect our patients and staff from nosocomial infections. There was a need to: plan and organize cleaning and disinfecting protocols according to accepted standards; train the staff; define areas of responsibility and authority; verify the staff's knowledge and perform random tests on equipment.

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

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

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

**Conclusions and Recommendations:** In order to prevent the spread of germs to patients and staff via endoscopic equipment there is a need to train the staff and take periodic random samplings on an ongoing basis. At the Conference we will present our work plan as well as the results of the random samplings.

## Nursing Supporting the Endoscopic Management of Elderly and Advanced Aged Patients with Extrahepatic Biliary Tree Stones

*Moschota Kristalia., Tsachalis Theodore., Christoforidis Emmanuil., Mpoukouvala Kalliopi., Betsis Dimitrios (4th Surgical Department, Aristotle University of Thessaloniki, Greece; Endoscopic Unit, 4th Surgical Department, Aristotle University of Thessaloniki, Greece, seneka21@med.auth.gr)*

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

**Methods:** Between 1996 and 2005, 695 consecutive patients with choledocholithiasis underwent ERCP in our Endoscopic Unit. Among them there were 383 elderly and advanced aged patients with a median age of 79 years (range 75-101) offered: Endoscopic Sphincterotomy, bile duct stones clearance, placement of bile duct prostheses or naso-biliary tube. Risk factors that were recorded in our study were the age in 42 advanced aged patients (range 89-101 years), cardiopulmonary and/or neurological disorders in 105 and 44 patients respectively, diabetes mellitus in 44 patients, as well as the presence of chronic renal failure in 14 patients. A concrete protocol was used for patient observation concerning the post-ERCP complications within 24 hours after their transfer to the surgical ward. Emphasis was given in the recognition of these complications individually, with recognition of clinical picture, via estimation of their haemodynamics, attendance of temperature chart, serum glucose measurements, and determination of fluids balance.

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

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

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# Invited Presentations

## Breaking Bad News to Patients and Significant Others

*Ellen HERVE (Nurse Educator, France)*

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

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

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

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

## Assessment of Quality of Life in Gastroenterology

*Christiane Neumann, Birmingham, UK*

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

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

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

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

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

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

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

Although QOL measures have been an advance in that the patient can have an input in the assessment of his/her condition, it has led to development of QALYs and their use in rationing

health care. Quality-Adjusted Life Years, or QALYs, are a measure of the benefit of a medical intervention. QALYs are controversial as the measurement is used to calculate the allocation of healthcare resources based upon a ratio of cost per QALY. As a result some people will not receive treatment as it is calculated that the benefit to their quality of life is not warranted by the cost. The application of HRQOL therefore can be a blessing in clinical practice as it takes the patient's limitations and responses to a condition and its treatment into account, or a curse if it is used to ration health care.

**References:**

List of instruments by pathology/disease:
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WHOQOL (1995) The World Health Organization Quality of Life assessment: position paper for the WHO. Special issue on Health-related Quality of Life: what is it and how should we measure it? Social Science and Medicine, 41:1403-1409
Ware JE, Kosinski M, Keller S. SF-36 Physical and Mental Health Summary Scores: A User's Manual. Boston: The Health Institute, New England Medical Center, 1994
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Hauser W, Grandt D (2001) Measuring quality of life in gastroenterology-concepts, instruments and problems. Z Gastroenterol. Jun;39(6):475-81.

## Nurse-led Follow-up in GI Disease

*Helen Griffiths, MSc, RGN, Cert MHSC, Nurse consultant (Gastroenterology, Hereford Hospitals NHS Trust)*

Whatever the political context of service improvement and delivery the aim of nursing according to Orem (1995) is related to: 'The patient's need and ability to undertake self care, to sustain health, recover from disease and injury or to cope with their effects'.

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

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

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

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

**References:**

British Society of Gastroenterology (2006) Care of Patients with Gastrointestinal disorders in the United Kingdom, A strategy for the future. London, BSG.
Orem, D.E (1995) Nursing: Concepts of Practice (5th Edition). New York, McGraw Hill
Hatchet E (2003) Nurse –Led Clinics, Practice Issues. London, Routledge.

## Nurse Endoscopy – What Training is Necessary?

*Di Campbell (Torbay, UK)*

**Learning outcomes:** After this session attendees should be able to: 1. Appreciate the need for structured training for Nurse Endoscopists. 2. Describe the key components of a robust training programme for Nurse Endoscopists.

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

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

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

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

The practical skill of performing endoscopy is a very important element in development of every endoscopist and in the UK

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

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

**References:**

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

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

## Diseases of the Small Bowel – Manifestation and Investigations

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

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

Small bowel diseases present in three different ways: 1. Malabsorption as a result of abnormal small bowel mucosal function; 2. Diarrhoea and abdominal pain without malabsorption. 3. Mechanical obstruction of the small bowel.

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

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

Investigation of suspected small bowel disease:

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

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

## Is It Good or Bad for You – the Alternative Diet Talk?

*Prof. Alastair Forbes (University College, London)*

There are some gastrointestinal diseases in which diet is closely linked to pathogenesis and other in which 'abnormal' diet is clearly identified as causal agent. Diverticulosis/appendicitis and gall stones belong in this category as well – obviously – as alcohol-related problems.

There are also links between GI cancers and diet:

- Oesophageal cancer and diet: Fastest increasing malignancy in the West – link with Barrett's and reflux and with Western diet.
- Gastric cancer and diet: Still v. frequent malignancy in the East – H. pylori and genetic element – high risk in Japan but falling rapidly with adoption of Western habits and diet.
- Pancreatic cancer and diet: Associated with coffee – and linked to k-ras tumour-associated oncogene. Mutations more common in coffee drinkers (82.0% v 55.6%) mean of only 2 cups/day. But coffee protects against breast cancer in women with BRCA mutations on lifetime basis with same amount of coffee, and also appears to protect against Type 2 diabetes.

• Biliary cancer and diet: Uncertain magnitude of association but also rising rapidly in most countries.
• Hepatoma and diet: Main dietary risk is from poorly stored peanuts contaminated with aflatoxin.
• Small bowel tumours and diet: Rare and no definite associations found but failing to keep to a gluten free diet certainly puts coeliac patients at high risk of intestinal tumours (lymphoma and carcinoma)
• Colorectal carcinoma and diet: Experimental human work shows clear risk from peanut lectin. Even 100 g of peanuts each day for 5 days increases rectal cell turnover (by 40%) and probable cancer risk increase as a result.
• However peanut lectin from regular consumption of peanuts, peanut butter and true nuts reduces risk of type 2 diabetes by over 25%. Edible mushroom lectin however is a different lectin which inhibits colon cancer cell lines and cell proliferation
• Acute diarrhoeal illness in children: Effective interventions based on folk remedies include: a) stem bromelain from pineapple stem – effective against infectious diarrhoea, and is an effective anthelminthic in rodents. Has also been shown to have an effect against UC in case reports; b) banana pectin – effective in acute diarrhoeal illness in children (250g green banana/kg feed) – and reduces fluid loss in chronic diarrhoea. Occlusions – still much to learn – don't dismiss 'old wives' tales'.

## MRSA in Endoscopy – What is Really Necessary?

*Bernhard Meyer (Ecolab GmbH&Co OHG, Reisholzer Werftstr. 38-42, 40589 Düsseldorf, Germany)*

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

## New ESGE–ESGENA Guideline on Validation of Reprocessing Cycles According to prEN ISO 15883

*Ulrike Beilenhoff (Ferdinand-Sauerbruch-Weg 16, D-89075 Ulm, Germany, e-mail: UK-Beilenhoff@t-online.de)*

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

**The aims of this guideline are:** To support individual endoscopy departments and clinical service providers to establish local standards and protocols for validation processes for WDs. To support national societies and official bodies to develop national recommendations for the validation of reprocessing flexible endoscope processes.

**Quality assurance systems of WD differentiate between three parts:** 1. The type test is the responsibility of the manufacturer and checks that the WD complies with prEN ISO 15883. 2. Validation is the responsibility of the clinical service provider and has to be performed before the WD is used in daily routine. It proves that the whole reprocessing process gives reproducible results and consist of three different parts: a) The Installation qualification (IQ) is the process of obtaining and documenting evidence that the WD has been supplied and installed in accordance with its specifications. b) The Operational Qualification (OQ) is the process of obtaining and documenting evidence that the installed WD operates within pre-determined limits. Different parameters are checked (e.g. leak test, the flow control function, temperature). c) The Performance Qualification (PQ) is focussing on the in-use-testing condition of the WD. Endoscopes used in clinical practice should be reprocessed following the day-to-day standardized reprocessing protocol. Microbiological tests should be performed to test the PQ. 3. Routine tests are the responsibility of the clinical service provider and ensure that the required performance standard is delivered consistently at all times. Routine tests cover the check of technical parameters on the WD and microbiological tests on endoscopes used in daily routine. For performing microbiological tests on endoscopes it is recommended to follow the 'ESGE-ESGENA-Guideline on Microbiological Surveillance Testing

in Endoscopy'. The guideline encloses examples of different check lists.

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

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

**References:**

Pr EN ISO 15883

ESGE-Guideline for Process Validation and Routine Tests of Reprocessing Endoscopes in Washer Disinfectors according to Pr EN ISO 15883 Part 1, 4 And 5. submitted for publication in ENDOSCOPY 2007

ESGE-ESGENA-Guideline ESGE-ESGENA-Guideline for Reprocessing Quality Assurance 'Microbiological Surveillance Testing in Endoscopy', submitted for publication in ENDOSCOPY 2007

## The Importance of Optimal Hand Hygiene

*Kristel Smits, Endoscopy Nurse (Gelre Ziekenhuizen, Apeldoorn , The Netherlands, apeldoorn@smitsk.demon.nl, fax: +31 (0)55 581 8376)*

**Objective:** It's easy and simple, yet vital to our health and the importance that is underestimated in the day to day working life. The hand hygiene of the (endoscopic) nurse is one of the most important factors in the fight against hospital infections. The facts are that 65% of hospital infections are directly connected to insufficient hand hygiene. This is the most neglected regulation that could prevent hospital infections. Every year thousands of patients die due to hospitals infections that in turn cost millions of euros and thousand of extra hospital beds. For example: in Great Britain hospital infections cost 5000 deaths a year, in Belgium 3000 deaths and in Holland up to 1000 deaths. Optimal hand hygiene is essential, but what is lesser known is the preference for the use of hand alcohol that has an enormous germ reduction effect. Patients with a reduced immune system will benefit greatly from this.

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

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

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

**References:**

www.medinews.be 'Operatie schone handen'

www.refaja.nl 'Het voorkomen van ziekenhuisinfecties'

www.WIP.nl 'Werkgroep infectiepreventie'

## Complications during ERCP – Prevention and Management

*Theo Pordon, Amsterdam, NL*

'There is no kind of medical specialism that depends so much on the quality and skills of the assistant than endoscopy' (Prof. Jacques Devière, Erasmus Hospital, Brussels). Most of us know that this statement is true. We have our own responsibility in handling equipment, like guide-wires, needle-knives, injection needles and so on.

What complications can occur during ERCP? How can we prevent them? Our first concern of course is the patient. Second best are our technical skills. In the presentation we will discuss:

- Assessment of the ERCP patient
- Preparation of the patient
- Preparation of the ERCP room
- Papilla bleeding
- Major bleeding
- Impacted stone
- Breaking of the Dormia basket
- Dangers of electro-surgery
- Perforation of duodenum
- Perforation in liver
- Migrated stents
- Stones or stents blocking the working channel or suction-knob

## Migration of Nurses Internationally – Implications and Ethical Concerns

*Franz Wagner, MSc (German Nurses Association DBfK, 1st Vice-President of ICN; Berlin, wagner@dbfk.de)*

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

development of migration and its impact on health systems and individuals worldwide.
Migration always existed. Patterns of migration in the 21st century are more complex and people move on more quickly. There are more women among immigrants today. The transfer of money by emigrants to their home countries exceeds the amount of money given in support by governments worldwide to developing countries.
Every individual nurse has the right to improve her life and make a better living. If she finds a work place where her competencies are more appreciated in every way she has the right to move on. However, there is the risk that emigrating nurses (and other health professionals) may cause deteriorating health services in the country they are leaving. Most countries of the developed world face a shortage of health care personnel. Is it acceptable to solve our problems by damaging the poor part of the world? We have to find a balance globally between the need of rich countries, the desire of individuals for better living and the need of the people in poor countries for health care provision.
WHO expressed its concern by stating, 'The loss of human resources through migration of professional health staff to developed countries usually results in a loss of capacity of health systems in developing countries to deliver health care equitably. Migration of health workers also undermines the ability of countries to meet global, regional and national commitments, such as the health-related United Nations Millennium Development Goals, and even their own development.
Data on the extent and the impact of such migration are patchy and often anecdotal and fail to shed light on the causes, such as high unemployment rates, poor working conditions and low salaries.' WHO, 2004
ICN has developed ethical guidelines for the recruitment of nurses. These guidelines have been adopted by health ministers of the Commonwealth and many nursing groups. http://www.icn.ch/psrecruit01.htm Migrants are vulnerable. It is the responsibility of us all to protect our colleagues wherever they come from. At the same time we need to protect the public by safeguarding the quality of health care.

## How to Support Colleagues in Developing Countries

*Sylvia Lahey, Rijnstate Hospital, Endoscopy Unit, Wagnerlaan55, 6815 AD Arnhem, the Netherlands E-mail: sylvia.lahey@planet.nl*

**History:** In 1991, the Dutch Society of Gastroenterology organized a congress called 'the Holland Digestive Disease Week'. The board of the Holland Digestive Disease Week decided to spend a part of the money left over at the end of this congress to help young gastroenterologists from Eastern Europe with their education. A special fund was set up, the East Europe Fund, subsidize improvements in the level of education. Gastroenterologists from Eastern Europe and later also from South Africa and the Middle East came to the Netherlands for a two weeks course on gastroenterology.
In 1992 the first courses were organized by Prof. Nelis in the Sophia Hospital in Zwolle and Prof. Mulder in the Rijnstate Hospital in Arnhem. Since 1996 about 10 nurses have been invited to visit the endoscopy unit of the Rijnstate Hospital in Arnhem. Since 1995 more than 150 endoscopes have been sent to developing countries, mainly fiber endoscopes but also video endoscopes and endoscopy accessories. Ever since then I have been involved in supporting gastroenterologists and colleagues in developing countries.
How can we support colleagues in developing countries?
- Invite foreign nurses to attend your national congress. It is important to communicate and to share experiences with each other.
- Invite them to workshops with hands-on training and live demonstrations.
- Support them with teaching material like books, papers, standards and European guidelines.
- Support gastroenterologists and endoscopy nurses by collecting good working endoscopes and endoscopy equipment.

**Aims:** The aims of our support are:
- To improve the level of endoscopy treatment and care in developing countries
- To advance the implementation of new techniques and treatments in the underprivileged countries
- To advance the education of endoscopy nurses and doctors in developing countries

**Legal aspects:** If you send endoscopy materials, the legal aspects in your country and the receiving country have to be taken into account.
**Ethical aspects:** Never forget that all equipment, sent to colleagues in developing countries, must be safe for the patient. All equipment should be ready for use and should fulfil all safety requirements.
**Conclusion:** Supporting gastroenterologists and endoscopy nurses in developing countries is worthwhile. By sending endoscopes and accessories, the gastroenterologists will be able to treat more patients. This will enable them to earn more money and to invest in better endoscopy equipment and safer procedures. By teaching and showing different ways of working, organizing workshops and sending teaching material, the treatment and care in endoscopy will be improved.

## Expanded Roles for Nurses – the UK experience/Erweiterte Aufgaben für Pflegepersonal – die britische Erfahrung

*Christiane Neumann (Birmingham, UK)*

Seit Anfang der neunziger Jahre gibt es für Schwestern in Großbritannien die Möglichkeiten, sich beruflich weiterzubilden, und ehemals ärztliche Aufgaben zu übernehmen. Dies hat sich im folgenden Rahmen und unter den folgenden Vorraussetzungen entwickelt:
Nationale Vorraussetzungen waren die Kooperation und Einwilligung der:
- Medizinischen 'Royal Colleges'
- Nationalen Pflegeverbände (wie z.B. DBfK, DPV, ÖKV)
- Nationalen Registratur / Lizenz (z.B. Kammer)

Außerdem wurden ein gesetzlicher Rahmen und national anerkannte Ausbildungskurse an Universitäten entwickelt. Kliniken erfüllen die folgende lokale Voraussetzungen:

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

Nicht jeder Schwester steht diese persönliche Weiterentwicklung zur Verfügung. Es müssen auch persönliche Vorraussetzungen erfüllt werden wie z.B.:

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

Die Ausbildung wird dann auf die speziellen Aufgaben zugeschnitten:

- Masters Degree in 'Advanced Practice' (2 Jahre) – alle
- Universitätskurs in 'Nurse Prescribing', wenn Rezepte verschrieben werden,
- Universitätskurse für die speziellen klinischen Eingriffe, wie z.B. 'Nurse Endoscopist', chirurgische Eingriffe, und für relevante klinische Fachbereiche, usw.

Ausserdem muss nachgewiesen werden, dass stattfinden:

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

**Zusammenfassung:** Studien haben gezeigt, dass entsprechend ausgebildete Schwestern / Pfleger, die gleichen Kompetenzen & Wissen wie ein vergleichbarer Arzt in dem bestimmten Bereich haben, dass Patienten oft Schwestern bevorzugen, und dass durch die vermehrte Patientenschulung, Patienten mit chronischen Erkrankungen weniger oft einen Rückfall haben. Kosten für die Patientenversorgung sind im allgemeinen nicht weniger, da höhere Gehälter gezahlt und weniger Patienten pro Stunde gesehen werden, da das Pflegepersonal zusätzlich Patientenschulung macht. Für praktische Eingriffe, die vom Pflegepersonal übernommen werden, bedeuten oft das 'Deskilling' von Jungärzten. Am Ende ist es eine ethische & politische Entscheidung – was und an wen delegiert wird – wenn nicht genug Ärzte vorhanden sind, um die Patientenversorgung zu garantieren.

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

**Weiterführende Literatur** 'Nurse Practitioners' – Your Questions Answered; Royal College of Nursing, May 1997

Guidelines for the training, appraisal and assessment of trainees in GI endoscopy – JAG 2004 (http://www.thejag.org.uk)

Hatchet E (2003) Nurse-Led Clinics, Practice Issues. London, Routledge.

## Electronic Documentation as an Instrument of Quality Assurance

*Jo Corrigan (Leeds General Infirmary, Leeds., UK)*

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

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

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

There are a variety of software packages available for recording endoscopic activities and procedures and the assessment of the quality of this, however a large number of these only allow electronic recording of the endoscopic procedure and do not incorporate the nursing element of patient's endoscopic journey. The need for electronic documentation which incorporates every aspect of the patients journey and, allows recording of the nursing intervention was identified by the quality assurance group at the Leeds General Infirmary and has been an ongoing development within the Leeds General Infirmary (U.K.) since 2001 in conjunction with Fujinon. As a result we now have a robust quality assurance programme (ADAM) which allows both medical and nursing documentation to be recorded electronically, and updated and modified on a regular basis by the users following regular audits. This has been rolled out to the other three endoscopy units within the Trust and is an ongoing process which forms part of our continuous quality assurance programme.

**References:**

Department of Health (2001) Guide to consent for treatment.

National Endoscopy Team (2005) Endoscopy Global Rating Scale.

N.H.S. Estates (1997) HTM20/30 Health Technical Memorandum 2030

## Scores in Nursing Documentation

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

| Risk of Patient | Endo R- 1 (low risk = 1 point) | P | Endo R- 2 (medium risk = 2 points) | P | Endo R- 3 (high risk = 3 points) | P |
|---|---|---|---|---|---|---|
| Procedure related Risk | Upper GIT Sigmoidoscopy. | | ERCP, Colonoscopy, Broncho | | Therapeutic procedures | |
| Patient related Risks | | | | | | |
| Vital signs | Stabile vital signs, Spontaneous breathing | | Compensated conditions (pulse, blood pressure, difficulties in breathing | | In stabile vital signs Shock symptoms Artificial respiration | |
| Mobilization | Complete independence | | Help in personnel hygiene, transfer and positioning | | immobile, total dependence transfer by staff | |
| Communication | Patient is orientated | | Patient is partly disorientated Premeditation | | Patient is disorientated | |
| Total points: | | | | | | |

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

make the individual risks of patients transparent and should document medical and nursing actions.

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

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

The Endoscopy-Risk-Score (4) developed by German endoscopy nurses combines the Hvidrovre score and the EDRS score (see table)

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

- Increase the risk awareness of endoscopy staff
- Assess the individual risk of patients before undergoing endoscopic procedures
- Calculate staff recourses
- Decide on proper prophylactic measures
- Plan nursing actions before, during and after the procedure
- Compare the clientele of different endoscopy departments

**References:**

American Society of Anesthesiologists (ASA). New classification of physical status. Anesthesiology 1963;24;111

Holm C, Rosenberg J. Pulse Oximetry and Supplemental Oxygen During Gastointestinal Endoscopy: A Critical Review. Endoscopy 1996; 28; 703-711

Ritter J. Spitzenpersonal gleich Spitzenqualität? Krankenhaus Umschau. 1 / 1999, 32-35

Beilenhoff U. et al. Pflegedokumentation in der Endoskopie. Endopraxis 1-4, 2005

## Education of New Staff / Einarbeitung neuer Mitarbeiter

*A. Wurster (Stuttgart, Germany)*

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

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

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

# Announcements of National and International Conferences and Workshops

## AUSTRIA

**Annual Conference of the Austrian Society of Endoscopy Nurses and Associates (IVEPA)**
14 July 2007, Innsbruck, Austria
Information: www.ivepa.at
Conference language: German

## BELGIUM

**Gastroenterology and Endotherapy European Workshop: 25th Anniversary**
18-20 June 2007, Brussels, Belgium
Information: www.live-endoscopy.com and www.esge.com

## CZECH REPUBLIC AND SLOVAKIA

**Slovak and Czech Endoscopy Days**
1-3 June 2007, Trencianske Teplice, Slovakia
Information: Hana Kubu, tel. +420-224 076
E-mail: hana.kubu@seznam.cz

**Endoscopy Nurse in 2007 – expert conference**
15 November 2007, Prague, Czech Republic
Information: Hana Kubu, tel. +420 224 076
E-mail: hana.kubu@seznam.cz

## FRANCE

**Advanced Course in Interventional GI Endoscopy Techniques**
4-6 June 2007, Strasbourg, France
Information: www.esge.com

## GERMANY

**9th International Symposium on Diagnostic and Therapeutic Endoscopy, with live demonstrations and state-of-the-art lectures**
2-3 February 2007, Düsseldorf, Germany
Information: www.esge.com and www.cocs.de

**Spring Conference of the German Society of Endoscopy Nurses and Associates (DEGEA) in conjunction with the 37th Conference of the German Society of Endoscopy and Imaging (DGE-BV)**
22-24 March 2007, Munich, Germany
Information: www.dge-bv.de or www.degea.de
Conference language: German

**Autumn Conference of the German Society of Endoscopy Nurses and Associates (DEGEA) in conjunction with the 62nd Conference of the German Society of Gastroenterology (DGVS)**
14-15 September 2007, Bochum, Germany
Information: www.dgvs.de or www.degea.de
Conference language: German

## HUNGARY

**ESGE–ESGENA Workshop on Advanced Endoscopy: Live Demonstrations and State-of-the-Art Lecturess**
15-16 November 2007, Györ, Hungary
Information: www.esge.com

## SPAIN

**EURO EUS 2007 Seville**
4-5 May 2007, Seville, Spain
Information: www.esge.com

**XI Course for Endoscopy Nurses in Gastroenterology**
28 May-3 June 2007, University Hospital, Barcelona, Spain
Information: mesabate@clinic.ub.es and pperezrojo@unav.es
Language: Spanish

**XVI Meeting of the Spanish Association of the Endoscopy Nurses and Associates (AEEED)**
24 November 2007, Ciudad Real, Spain
Information: mesabate@clinic.ub.es and pperezrojo@unav.es
Language: Spanish

## UNITED KINGDOM

**Annual Conference of the British Society of Gastroenterology and Endoscopy Nurses Meeting**
26-29 March 2007, Glasgow, UK
Information: www.bsg.org.uk

## FORTHCOMING UEGWS / ESGENA MEETINGS

**15th UEGW 2007 / 11th ESGENA Meeting**
27-31 October 2007, Paris

**16th UEGW 2008 / 12th ESGENA Meeting**
October 2008, Vienna

**17th UEGW 2009 / 13th ESGENA Meeting**
London, date not yet fixed

# Invitation to Attend the 11th Meeting of the European Society of Gastroenterology and Endoscopy Nurses and Associates (ESGENA)

- In association with the French Society of Endoscopy Nurses (GIFE) in Paris, France
- 27–29 October 2007, in conjunction with the 15th United European Gastroenterology Week (UEGW)

**Words of Welcome**

On behalf of ESGENA, the French Society of Endoscopy Nurses (Groupement des Infirmiers et Infirmières pour la Formation en Endoscopie, GIFE) has great pleasure in inviting you to attend the 11th ESGENA Conference, which will be held during the 15th United European Gastroenterology Week (UEGW) meeting in Paris in October 2007.

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

On Saturday 27 October, there will be an opportunity to attend a choice of eight workshops organized in four parallel sessions. The workshops will be more practically focused and in smaller groups – up to 50 – to encourage discussion, questions and an exchange of ideas. Some of the workshops will be held in French, for the local nurses, while the others will be in English.

Following the success of the dummy workshops at previous conferences, ESGENA will be providing dummy workshops especially for nurses on the Saturday. In cooperation with the ESGE, dummy workshops will be provided in the form of team training on the Sunday (for doctors and nurses from a single department).

The conference will open officially with the ESGENA Welcome Reception on Saturday evening. In the past this has been a most enjoyable, informal evening, with an opportunity to meet colleagues and friends from all over Europe and overseas.

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

The ESGENA Plenary Session, with lectures in a single hall, will be held on the Monday morning to bring together all the delegates, and will end with the prize-giving for the best free paper and the best poster presentation, followed by the invitation to attend the next ESGENA conference.

The trade exhibition will open at lunchtime on Monday, and there should be enough time to browse the stands if the medical scientific programme does not tempt you back into the lecture halls. Nurses are particularly invited to visit the Learning Corner, which offers a large variety of 'state-of-the-art' videos.

We look forward to welcoming you to the 11th ESGENA Conference in Paris in October 2007.

*Ulrike Beilenhoff (President, ESGENA)*
*Marie-Ange Bibollet (President, GIFE)*

**SCIENTIFIC SECRETARIAT**

European Society of Gastroenterology and Endoscopy Nurses and Associates (ESGENA):
**Ulrike Beilenhoff**
Ferdinand-Sauerbruch-Weg 16
89075 Ulm, Germany
Tel. +49 - 731-950 39 45
fax +49 - 731-950 39 58
e-mail: UK-Beilenhoff@t-online.de

**CONGRESS ORGANISATION AND EXHIBITION**

**CPO Hanser Service GmbH**
Paulsborner Straße 44
14193 Berlin, Germany
Tel: +49 - 30 300 66 90
fax: +49 - 30 305 73 91
e-mail: uegw2007@cpo-hanser.de

**CONGRESS VENUE**

**Le Palais des Congrès de Paris**
2, place de la Porte Maillot
75017 Paris, France
Web: www.palaisdescongres-paris.com

**INFORMATION AND REGISTRATION**

www.uegw.org and www.esgena.org

**DEADLINE FOR SUBMITTING ABSTRACTS**

30 May 2007

**REGISTRATION**

| | |
|---|---|
| Early registration: | 185 up to 15 May 2007 |
| Late registration: | 200 up to 15 September 2007 |
| On-site registration: | 250 after 15 September and on-site |

To register for the ESGENA Conference, please register on-line through the official congress web site at www.uegw.org.

## SCIENTIFIC PROGRAMME

### Saturday 27 October 2007

Afternoon:
eight workshops in four parallel sessions (two in French)
All day:
ESGE Postgraduate Course with live endoscopy transmissions
Evening:
ESGENA Welcome Reception & Opening of ESGENA Conference

### Sunday 28 October 2007

All day:
ESGENA scientific programme
Evening:
ESGENA General Assembly and opening reception for the UEGW Conference

### Monday 29 October 2007

Morning:
ESGENA Plenary Sessions and scientific programme
Afternoon:
trade exhibition and learning centre

### Poster Sessions

ESGENA scientific posters will be displayed on Sunday 28 October 2007. Authors will present their posters between 12 noon and one o'clock.

### Conference Language

The official language of the ESGENA Conference is English. Some of the workshops on Saturday 27 October will be held in French for the French-speaking participants.

### Coffee and Lunch

There will be coffee breaks for all registered participants in the ESGENA meeting from Saturday afternoon until Monday lunchtime. Lunch will be served for all registered participants on Sunday and Monday.

### Exhibition

Registered participants in the ESGENA meeting will have access to the trade exhibition from Monday 29 October 2007 until Wednesday 31 October 2007.

### UEGW Core Programme

Nurses are welcomed to attend the medical lectures included in the UEGW core programme, at no extra charge.

### Annual General Meeting

The ESGENA Annual General Meeting will be held on Sunday 28 October 2007. It will only be open to members of ESGENA.

### Social Events

All nurses are cordially invited to attend the ESGENA Welcome Reception and the official opening of the 11th ESGENA Meeting on the evening of Saturday 27 October 2007. The evening will be arranged by the local organizers. Attendance at the Welcome Reception is included in the ESGENA registration fee.

## CALL FOR ABSTRACTS

Participants wishing to submit abstracts for the ESGENA Conference can do so only in electronic format, by sending a Microsoft Word document containing the abstract by e-mail to Ulrike Beilenhoff: UK-Beilenhoff@t-online.de
The deadline for submitting abstracts for the ESGENA Conference is 30 May 2007.

### General Information on Submitting Abstracts for the ESGENA Conference

Participants are invited to submit original scientific abstracts for oral or poster presentation. Accepted abstracts will be published in the ESGENA Abstract Book and on the ESGENA web site.
Authors must observe the following guidelines for abstract submission. Abstracts that do not conform to the guidelines will not be considered for review.

- Abstracts must be submitted in English (with British spelling) and must be presented in English.
- Use a font that is easy to read, such as Times Roman, Helvetica, or Courier fonts.
- The abstract must not be more than 500 words long or must not fill more than one A4 page, using type in a 12-point font.
- The abstracts will be reviewed by a panel of experts and may be selected for oral or poster presentations, or may be rejected. The time allotted for each oral presentation will be 10 minutes, followed by 5 minutes of question time.
- Notification of acceptance (for oral or poster presentation) or rejection by the Scientific Programme Committee will be e-mailed to the submitting author by 30 June 2007.
- Detailed information, guidelines and recommendations for oral or poster presentation, as well as the day, time and room of the presentation, 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) at which the research was carried out, with the name of the presenting author underlined.
- Type the title of the paper in capital letters in the top section of the abstract.
- 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 the specific objective of the study
  State the method used, if pertinent
  Summarize the results obtained
  State the conclusions reached
  Statements such as 'results will be discussed' or 'data/information will be presented' are not acceptable

- Please ensure that the abstracts do not contain any spelling errors, grammatical errors, or scientific errors, as the abstract will be reproduced exactly as submitted.
- The abstract should have content relevant to nursing and should add to existing knowledge.
- The abstract should have a minimum of two relevant references.
- The abstract should state two things that nurses attending the conference can learn from the presentation.

### Checklist for Abstracts

As many people have asked for guidelines regarding abstract submission, we thought the following checklist might be useful to help authors check whether they have complied with the requirements. Abstracts not conforming to the guidelines will not be considered for reviewing.

| ABSTRACT SECTIONS | CHECKED |
|---|---|
| **Titel,** clearly stating the nature of the investigation | |
| **Authors** names (full first name, surname) | |
| **Institution** (hospital, university, organization, city, country, e-mail and fax number) | |
| **Introduction** (what is already known, what needs further study) | |
| **Aim/Objective** | |
| **Method** used | |
| **Results** / findings | |
| **Summary** of results / findings | |
| **Conclusion(s)** reached (what has been learned) | |
| **References** (minimum of two) | |
| **Learning outcomes** (two things you would like the reader to learn from your presentation) | |
| **Formatting** etc. | |
| **Title** in Capital Letters | |
| **Abbreviations** should be avoided in the title if possible, but may be used in the text if they are defined on the first usage | |
| **Presenting author** author underlined | |
| **Single line spacing** | |
| **Abstracts** must be submitted in English (with British spelling) and checked for spelling errors | |
| **Use a 12-point font** e.g. Times Roman | |
| **500 words** – max. one A4 page | |
| **Content** The abstract should have nursing-relevant content and should add to existing knowledge. | |

## ESGENA Programme

**SATURDAY, 27 October 2007**

REGISTRATION

13:30 - 17:00
6 parallel Workshops in English:

**Hygiene & Infection Control**

**How to improve our Communication**

**2 ESGENA-Workshops with Hands on-Training on biomedical Simulators**

**4 Workshops organised by industry on new techniques and developments**

**Two Workshops in French on Haemostasis, EMR & ESD**

ESGENA WELCOME RECEPTION

**SUNDAY, 28 October 2007**

8:30 - 17:00
8 Scientific Sessions in two parallel Halls:

**Education and Training in GE and Endoscopy**

**Colonoscopy**

**Ethics**

**GI Patient Care**

**Management in Endoscopy**

**Update on Endoscopic Techniques**

**Two free paper Sessions**

**Poster Sessions**

17:50-18:50
ESGENA GENERAL ASSEMBLY
(members only)

UEGW - Welcome Reception

**MONDAY, 28 October 2007**

8:30 - 12:00
Session 9

**Plenary Sessions on the new Tequniques and the Developments**

Lunch

**Visit of Exhibition**

**ESGE Learning Centre**

**UEGW Core Sessions**

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## News from Industry

OLYMPUS

### OLYMPUS ENDOSCOPY TECHNOLOGY: HDTV TECHNOLOGY AND NARROW BAND IMAGING FOR ENDOSCOPY AND MINIMALLY INVASIVE SURGERY

High-definition television (HDTV) was a hot topic in the run-up to the FIFA World Cup. Yet, up to now only a few people across Europe are able to receive this high-definition imaging in their living rooms. The situation in medical technology is completely different. Only a year after the sales launch, more than 1,200 European hospitals are already able to use Olympus' HDTV technology in endoscopy and minimally invasive surgery.

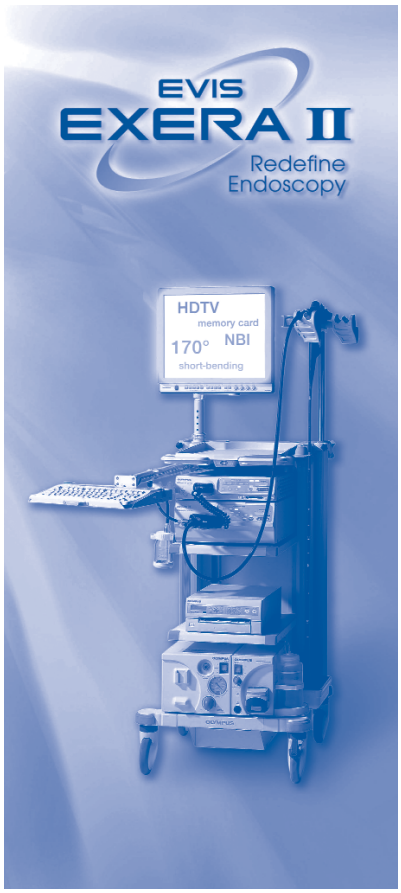
The crucial benefits of EVIS EXERA II for doctors working in endoscopy are the markedly improved image quality, which enables a detailed view of surface structures and gives more precise information about the symptoms and diagnosis. Thus hospitals can work more efficiently and more cost-effectively, as follow-up examinations to confirm diagnoses can potentially be reduced. Moreover, they offer increased patient safety, as minimally invasive operations using HDTV prevent damage to nerves and healthy tissue.

**Early diagnosis of bowel cancer especially important**

HDTV generates high-definition images which are not comparable to the transmission technology used in endoscopy up to now. A completely HDTV-compatible video chain is a prerequisite for brilliant image reproduction. With 1,080 effective, horizontal scanning lines, HDTV contains four times as many pixels per image as the conventional NTSC (480) and PAL (567) television systems. The increased pixel density results in a clear, regular picture whose remarkable detail and natural color reproduction are not marred by grainy resolution that occurs with lower-density resolution. This outstanding quality and the life-like pictures make HDTV ideal for demanding imaging procedures like endoscopy. Experts describe these vivid images as the "3-D effect" of HDTV.

**Narrow Band Imaging improves contrasts**

In conjunction with the NBI (Narrow Band Imaging) technology developed by Olympus, the surface structures of tissues which were hitherto obscured can now also be made more visible. A quick technical summary: NBI technology uses vibrant blue and green colors to achieve the image intensification. The narrowband filters that NBI uses do not reach the lower layers of tissue and are absorbed well by the blood vessels. As a result, the areas with light reflection (mucous membrane) and the areas with no reflection (blood vessel) can be distinguished from one another and displayed with higher contrast. This enables malignant changes to be diagnosed even earlier. Up to now, these sunken lesions, which are sometimes flat, could only be visualized using specific color techniques, so-called chromoendoscopy. Using NBI technology, this time-consuming and costly procedure will no longer be necessary in future, because NBI can be switched on at the touch of a button and used any time diagnostic results are unclear.

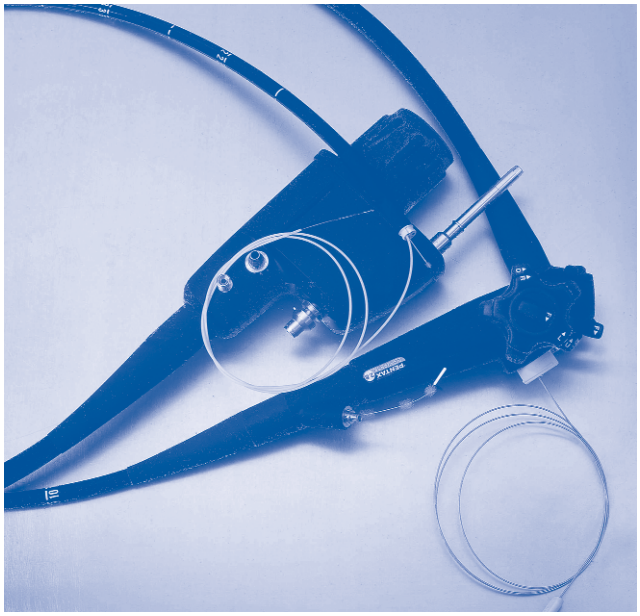



**For further information please contact:**

**OLYMPUS MEDICAL SYSTEMS EUROPA GmbH**
Wendenstr. 14-18
20097 Hamburg, Germany
email to: flexible.endoscopy@olympus-europa.com
**www.olympus-europa.com**

## PENTAX Medical Education Centres

Three established European Clinics and PENTAX LIFE CARE are keen to make a contribution to future developments in high-quality research and teaching in the field of endoscopy.
To work continuously on an improvement of the medical situation focussing on education and training is one of the major goals of the Medical Education Centres covered by PENTAX Campus in Europe. Together with each Centre we are committed to providing high quality education for all participants. When combined with the academic part of the training, the clinical component addresses the needs of the profession students, nurses, clinical facility, academic programme and patients.
The academic programme and the clinical facility both have the responsibility to assure that only qualified trainers enter the profession. The professional organisations have set standards for training that must be met by the academic and clinical programmes.
Each Medical Education Centre boasts its own application field and provides all of the most important training modules. Trained by professional experts at inspiring locations all over Europe you get the exclusive opportunity to learn and understand innovative technologies and see established methods from a perspective you never had before. PENTAX offers you this exclusive access – all you have to do is get ready for the next generation of innovative medicine.

**For further information please contact:**

**Pentax Europe GmbH**
Life Care
Julius-Vosseler-Str. 104
22527 Hamburg / Germany
E-Mail: medical@pentax.de
**www.pentaxeurope.com**

GIVEN® IMAGING

*Expanding the scope of GI*


## LATEST PRODUCT INNOVATIONS FROM GIVEN IMAGING®

Given Imaging is redefining gastrointestinal diagnosis by developing and marketing innovative, patient-friendly products for detecting gastrointestinal disorders. The Company's Given® System consists of three central components – the PillCam® capsule endoscope that the patient swallows, the DataRecorder that captures the images taken by the capsule and the RAPID® workstation that allows a physician to view the images and make a diagnosis.

**The Given Imaging PillCam® family of video capsules:**

- PillCam® SB:
  Enables non-invasive, direct visualization of the entire small intestine.
- PillCam® ESO video capsule:
  Provides visual examination of the esophagus.
- PillCam® COLON:
  Enables visualization of the colon. Given Imaging and received CE Mark in the European Union in October 2006.

The new PillCam® COLON: Data from a single-center prospective pilot study conducted by investigators at Erasme University Hospital in Belgium comparing PillCam® COLON with colonoscopy were presented at the UEGW 2006. The investigators concluded that PillCam® COLON visualized the entire colon in the majority of cases and provides encouraging sensitivity and negative predictive values for the detection of significant lesions.

The capsule, which measures 11 mm by 31 mm - roughly the size of a large vitamin pill, has tiny cameras at each end that capture 4 images a second for up to 10 hours. Each camera contains automatic lighting controls and offers considerably enhanced depth and breadth of view.

The PillCam® Platform is an efficient, patient-friendly and clinically-proven diagnostic platform that provides accurate visualization of the gastrointestinal tract in its natural state.

**For further information please visit:**

**http://www.givenimaging.com** or
**http://www.capsuleendoscopy.org.**

FUJINON

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## THE BEST OF BOTH WORLDS: FUJINONS NEW ENDOSCOPIC ULTRASOUND SYSTEM.

### The all-in-one concept for gastroenterology.

**Fujinon is turning visions of the future into reality: ultrasound examinations with 360° technology with state-of-the-art image quality, something which until now has only been possible with endoscopic investigations. Thus Fujinon is underlining once again its position as forerunner in the development of innovative medical technology and makes VISIONARY ENDOSCOPY complete.**

Ultra-modern technology from the world of ultrasound endoscopy for radial and convex scanning. And the leading video-endoscopy quality from Fujinon for detailed and absolutely razor-sharp images. All combined in one unique system. The first and only dedicated endoscopic ultrasound system.

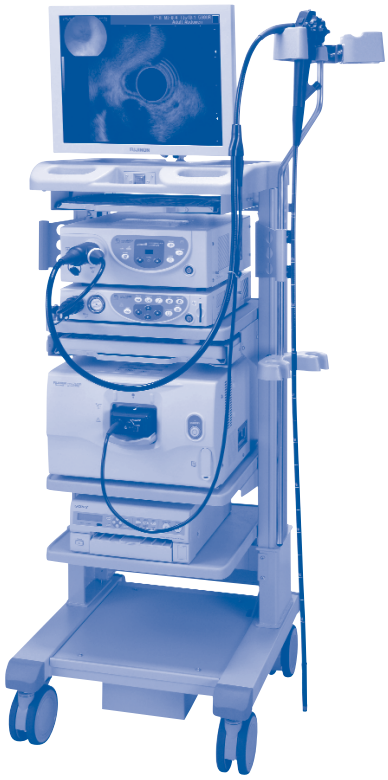
Specially developed for ultrasound endoscopes, the SU-7000 processor with integrated compact flash card reader makes high-quality ultrasound diagnosis simpler and more precise than ever before. The system can be operated easily using an integrated keypad and an image-in-image function which allows you to show two images simultaneously. In addition, the SU-7000 is equipped with a range of technical innovations for maximun image accuracy. The colour doppler function provides haemodynamic information about the areas being examined. The patented digital image optimisation mode eliminates fuzziness. And the variable boardband frequency spectrum of 5-12 MhZ which can be selected enables you to produce detailed images of the stomach wall and other organs such as the pancreas.

The new endoscopes contain all the operation features of the tried and tested G5 endoscopes. The low weight, ergonomic shape and optimum arrangement of the elements make using the endoscopy as pleasant as possible an experience for the doctor. One of the persuasive features of both devices is an excellent tangent-bend radius for maximum flexibility and the high-resolution super CCD chip, the best currentöy available in high-definition.

In addition, one of the persuasive features of the electronic 360° EG-530UR radial ultrasound endoscope is its slender exterior diameter of 11,4 mm and a tangent-bend of 180° . As a result, using the ultrasound endoscope is almost as simple as carrying out a conventional endoscopic examination. The longitudinal EG-530UT FNA ultrasound endoscope, with which convex scanning is also possible, was developed for therapeutic interventions. The endoscope additional has a large working channel of 3,8 mm and is equipped with an Elbarran lever.

Fujinon provides perfection from one source. For further information regarding the ultrasound system please contact the following address.

**Fujinon (Europe) GmbH**
Halskestrasse 4
47877 Willich, Germany
Tel.: +49(0)2154/924-0
Fax: +49(0)2154/924-290



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### To order additional copies please send this reply slip to:

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The ESGENA Secretariat will contact you via e-mail to arrange payment

## ESGENA Membership

### GROUP MEMBERSHIP

Group membership is open to national societies, groups or federations that represent the interests of gastroenterology and/or endoscopy nurses and endoscopy associates. The fees for group membership depend on the number of members in the organization:

| Members | Fee |
|---|---|
| < 50 | 30 € |
| 51 - 100 | 55 € |
| 101 - 250 | 105 € |
| 251 - 500 | 205 € |
| 501 - 750 | 405 € |
| 751 - 1000 | 605 € |
| > 1000 | 755 € |

### INDIVIDUAL MEMBERSHIP

Individuals practising, managing, teaching, or researching in gastroenterology and/or endoscopy nursing:
Membership fee 15 €

### PASSIVE MEMBERSHIP

Individuals who have formerly practised, managed, taught, or researched in gastroenterology and/or endoscopy nursing and who have maintained an interest in the field:
Membership fee 10 €

### AFFILIATE MEMBERSHIP

Members from the industry may join the society as affiliated members:
Membership fee 55 €

## Please send this reply slip to:

Medconnect GmbH, Brünnsteinstrasse 10, 81541 Munich, Germany.
Tel.: +49-(89)-4141 9240, fax +49-(89)-4141 9245, e-mail: medconnect@medc.de

## Membership Application

**Tick the desired membership level:**

☐ Group Membership ☐ Individual Membership ☐ Passive Membership ☐ Affiliated Membership

I would like to receive information about ESGENA membership, including the constitution of the Society, membership application forms, and information regarding payment of fees.

**ADDRESS DETAILS:**

NAME (Person / Group)

DEPARTMENT

HOSPITAL

STREET

POSTCODE

CITY

COUNTRY

TELEPHONE

FAX

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