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ESGENA NEWS

2013

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Articles published in the ESGENA News do not necessarily reflect the views of ESGENA.
MESSAGE FROM THE PRESIDENT

Dear Colleague,

In just a few weeks, nurses from all over Europe and overseas will meet in Berlin, Germany. The 17th ESGENA Conference will be taking place on October 12-14, 2013 during the 21st United European Gastroenterology Week.

Following the congresses in 1995 and 2006, this will be the third time that the medical and nursing community of Gastroenterology and Endoscopy meet in Berlin. Like the city of Berlin, ESGENA has changed and grown a lot in recent years. Nowadays ESGENA represents more than 7000 nurses in 44 countries within Europe and overseas. Over the years, ESGENA has developed various guidelines and technical statements in close co-operation with the ESGE. The ESGENA Education Working Group has developed a European job profile and a European Core Curriculum for Endoscopy nurses. A handbook about the organisation of different kinds of workshops has been initiated by ESGENA and will be published as a combined guidebook together with the ESGE.

Since 2006, ESGENA has offered clinical grants to registered European nurses who wish to undertake further clinical training in endoscopic techniques or gastroenterological nursing (see report on page 19). It has always been of great importance to ESGENA that specific aims and learning outcomes be defined for each grant and that the visit takes place in a specialised center. Criteria have been used for guest departments as an orientation, but have been quite varied from country to country. Over the years it has become clear that uniform criteria are necessary to create comparable and verifiable conditions. In 2012, the ESGENA Education Working Group (EEWG) developed common quality criteria for guest departments which led to the establishment of ESGENA training centers. The university hospital of Basel is proud to have been accepted as the first ESGENA training centre (see report on page 23).

In continued co-operation with ESGE, ESGENA supported the ESGE workshops in Budapest (November 2012) and Dubai (March 2013) with nurse tutors and special lecture programmes for endoscopy nurses.

Sedation management in gastrointestinal endoscopy varies between European countries according to their different legal frameworks and different healthcare systems. The ESGE-ESGENA-European Curriculum on sedation training in GI Endoscopy set standards for the training of non-anaesthesiologists, physicians and nurses, who are going to administer sedation during gastrointestinal endoscopy procedures and support the development of local or national recommendations and curricula.

Around 800 nurses from all over the world attended the ESGENA conference in Amsterdam in 2012. In this issue we recall some of the highlights of last year’s conference and honour the winners of the free papers and poster sessions. My special thanks go to the Dutch board. Their engagement and hard work ensured last year’s conference was a success. I would also like to particularly thank the speakers, chairmen, tutors, and free paper and poster authors, as their engagement made the congress come alive.

ESGENA decided to publish one issue of the printed ESGENA NEWS per year, to be published prior to the ESGENA conference, as it will be available during the UEG Week and gives ESGENA the opportunity to report on activities that have taken place throughout the year. The on-going communication with the ESGENA membership will be managed through the e-News and mailings.

Finally, I would like to thank the industry for their continued financial support of both the society and the conferences. Even more, ESGENA’s major sponsors as well as additional companies will again support the ESGENA conference with their expertise and material.

We hope to see many of you at the 17th ESGENA Conference in October 2013 in Berlin to meet international colleagues and to share your experience and knowledge. Michael Ortmann, ESGENA President
ESGENA NEWS

REMEMBER AMSTERDAM 2012 – FACTS ABOUT THE 16th ESGENA CONFERENCE

ESGENA held its 16th European conference from 30-22 October 2012 on the occasion of the United European Gastroenterology Week (UEG Week) in Amsterdam, the Netherlands. The conference was hosted by the Dutch Society of Endoscopy and GE Nurses and Assistants (V&VN Maag Darm Lever). ESGENA coordinated the overall programme, while the Dutch society was responsible for organizing the nurses’ welcome reception. With 16,168 participants, the UEG Week 2013 was very well attended (see Table 1). The majority of conference participants came from European countries. It was interesting to compare the top 10 attending countries from the medical and nurses side (see Table 2 and 3). In addition to European attendees, many medical participants also came from Japan, Russia, Brazil and China, while the majority of nurses attending came from central European countries (see table 2). Nevertheless the ESGENA conference was also attended by colleagues from Asia, Australia and Africa, as well as North and South American countries.

The 3-day programme combined
• state-of-the-art lectures
• lunch sessions
• several workshops with hands-on training and round table discussions
• live-transmissions

Saturday
Workshops on Saturday dealt with a wide range of topics in endoscopy and gastroenterology.
• Subjects offered in conjunction with the medical industry were hygiene and management of GI Bleeding
• ESGENA organised two workshops on educational aspects of GI function tests and creation of scientific posters
• The Dutch society offered three workshops on IBD, liver cirrhosis and nutrition via PEG

Table 1: UEG Week participants over the years

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>7,526</td>
<td>8,935</td>
<td>9,189</td>
<td>10,764</td>
<td>11,024</td>
<td>9,400</td>
<td>12,086</td>
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ESGENA

<table>
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<tr>
<th>Accompanying persons</th>
<th>393</th>
<th>613</th>
<th>481</th>
<th>772</th>
<th>672</th>
<th>507</th>
<th>766</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exhibitors</td>
<td>341</td>
<td>357</td>
<td>276</td>
<td>406</td>
<td>346</td>
<td>245</td>
<td>200</td>
</tr>
<tr>
<td>Press</td>
<td>1,444</td>
<td>1,727</td>
<td>1,646</td>
<td>1,883</td>
<td>1,720</td>
<td>1,707</td>
<td>2,681</td>
</tr>
<tr>
<td>Day tickets</td>
<td>120</td>
<td>105</td>
<td>100</td>
<td>116</td>
<td>75</td>
<td>84</td>
<td>94</td>
</tr>
<tr>
<td>Total Participants</td>
<td>9,824</td>
<td>11,938</td>
<td>11,652</td>
<td>14,470</td>
<td>15,074</td>
<td>12,263</td>
<td>16,168</td>
</tr>
</tbody>
</table>

The hands-on training on bio simulators was a very attractive event, with experienced tutors from various countries. In addition to bio simulators on pig organs, a new artificial dummy was used for ERP training.

The ESGENA Welcome Reception following the first conference day was a great opportunity to meet friends and colleagues in a relaxed atmosphere. In former days, the “Rode Hoed” was used as a church and a hut factory. This historical background gave a special atmosphere to this interesting location. The Dutch colleagues were an inspiration with their warm hospitality and offered a relaxed evening for everyone to enjoy.

Sunday
Traditionally, the scientific programme on Sunday featured eight parallel sessions in two halls. The main topics were
• Emergency management
• Bronchoscopy
• Quality assurance
• Hot topics in endoscopy
• GI diseases and Education

The bio simulator workshops continued on Sunday – again made possible by the highly motivated training teams.

The three lunch sessions focusing on hygiene, new techniques and bronchoscopy were very well attended.

Two free paper sessions provided 11 delegates the opportunity to share their experience and present their research projects. The poster session was another attractive aspect of the conference, with 23 posters from all over the world.

The best three free papers 2012 were:
1. Developments in endoscopy nursing in New Zealand – A vital component of a whole service quality improvement program
2. Establishing nurse endoscopist training in Australia
3. Results of a regional, nurse led inflammatory Bowel Disease (IBD) telephone helpline audit

The plenary Session on Monday morning gave an update on the latest developments, and the announcement of the best free paper and poster awards was made. The abstracts and posters of the 2012 winners can be found published in this issue (see page 10-17).

The best three papers 2012 were:
1. The right hand for the right press: Abdominal press during colorectal cancer screening
2. The hands-on training on bio simulators was a very attractive event, with experienced tutors from various countries. In addition to bio simulators on pig organs, a new artificial dummy was used for ERP training.
3. The best three papers 2012 were:

The papers and posters of the 6 winners are presented on the following pages (see page 10-17)

The meeting closed with an invitation to the next ESGENA conference in 2013.

ESGENA delegates also had an opportunity to visit the exhibition, which opened on Monday morning, and the UEGW conference offered further opportunities to catch up on the latest developments.

The 2012 ESGENA conference was very well attended and a successful event at which nurses exchanged their experiences in gastroenterology and endoscopy, made useful contacts with colleagues internationally and expanded the fascination of our profession.

Jadranka Brijak, ESGENA General Secretary
Ulrike Beilenhoff, ESGENA Scientific Secretariat

<table>
<thead>
<tr>
<th>The Netherlands</th>
<th>274</th>
<th>16</th>
<th>Canada</th>
<th>7</th>
<th>Australia</th>
<th>3</th>
<th>Malta</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belgium</td>
<td>102</td>
<td>16</td>
<td>Spain</td>
<td>7</td>
<td>Romania</td>
<td>7</td>
<td>Mexico</td>
<td>2</td>
</tr>
<tr>
<td>Denmark</td>
<td>53</td>
<td>13</td>
<td>United Kingdom</td>
<td>3</td>
<td>USA</td>
<td>7</td>
<td>Russia</td>
<td>2</td>
</tr>
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<td>Luxembourg</td>
<td>3</td>
<td>South Africa</td>
<td>2</td>
</tr>
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<td>Italy</td>
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<td>Iceland</td>
<td>6</td>
<td>Hong Kong</td>
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<td>3</td>
</tr>
<tr>
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<td>Greece</td>
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<td>China</td>
<td>3</td>
<td>Bulgaria</td>
<td>1</td>
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<tr>
<td>Portugal</td>
<td>19</td>
<td>9</td>
<td>Croatia</td>
<td>9</td>
<td>Brazil</td>
<td>2</td>
<td>Iraq</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 2: Top ten participating countries of the UEG Week 2012

| Germany         | 13 | 16 | Russia | 7 | France | 7 | Slovakia | 2 |
| Sweden          | 11 | 11 | USA | 6 | Jordan | 3 | South Africa | 2 |
| Italy           | 10 | 11 | Estonia | 5 | New Zealand | 6 | Sudan | 2 |
| Switzerland     | 10 | 10 | Sweden  | 4 | Turkey | 3 | Bulgaria | 1 |
| Norway          | 10 | 9  | Greece  | 4 | China | 3 | Iraq | 1 |
| Portugal        | 9  | 9  | Hungary | 4 | Brazil | 2 | | 2 |
Developments in endoscopy nursing in New Zealand – A vital component of a whole service quality improvement program

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

Background:
In 2010 the New Zealand (NZ) Ministry of Health (MoH) created the role of National Endoscopy Service Improvement Lead (NESIL). This sector based, MoH funded nursing position is to investigate, develop and centrally drive a quality improvement programme (QIP) in endoscopy services in NZ. This work is being conducted in conjunction with the National Clinical Lead GI Endoscopy (NCL), a medical appointment. NESIL is a unique role within nursing, endoscopy and the wider health services in NZ. After visiting every endoscopy unit nationwide these two leads produced a baseline “DHB Endoscopy Services Summary Report” in July 2011. The report highlighted the wide variation in the way endoscopy services are structured and delivered. In particular the report recognised the quality of endoscopy nursing varied greatly across the country including poor recognition of endoscopy nursing as a specialty, few refined endoscopy-based competencies for endoscopy and no development of senior nursing roles (MoH, 2011).

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

Method:
A development trial of a validated quality assurance system known as the Global Rating Scale (GRS) was recommended. The UK GRS standards were adapted to meet the NZ environment by an expert NZ working group. A twelve month development trial of the NZ GRS occurred in four hospitals in August 2011. The sites underwent an initial baseline self-assessment against the GRS standards and completed a six month assessment in April 2012. These results were up loaded onto the NZ GRS website by each site and followed by a visit from the two national leads to discuss and plan further quality improvement. On-going support has been given to each site to assist with service improvement throughout the trial. One of the domains of the GRS (Workforce) looks primarily at the nursing staff and is the focus of this presentation.

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

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

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

Learning Outcomes:
Understand the drivers, processes and pathway for collaboratively developing the EKSF in NZ. Understand how nursing fits into and is vital to a wider patient focused GIP.

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

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

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

Third place free paper award

Results of a regional, nurse led Inflammatory Bowel Disease (IBD) telephone helpline audit

Patterson Deborah, Houston Yasmin, Rawle Maxine, Rook Lisa for Yorkshire/Humber IBD Nurse Network, UK
Contact: deborah.patterson@bthft.nhs.uk

Introduction:

This article describes an audit of IBD Telephone Helplines which was carried out by the Yorkshire and Humber IBD Network. The Network is made up of IBD Nurses and Gastroenterologists from hospitals in the north east of England who aim to promote high quality care for patients with IBD through sharing best practice, and encouraging regional research and audit.

IBD is a chronic condition that is characterised by periods of relapse and remission. It is therefore important that patients are able to access expert, timely advice in between out patient appointments and in the UK, this service is commonly provided via a Telephone Helpline. Anyone who manages a telephone helpline will know that they can be unpredictable and time consuming, but they are also very important to patients who can see them as ‘a lifeline’.

Aims:

The aims of the Helpline audit were to quantify Helpline Activity by auditing:

• who calls and why,
• how much time were spent on dealing with the calls,
• the cost benefits of a helpline and
• how much time were spent on dealing with the calls,
• what might happen if the helpline did not exist.

Background:

IBD Telephone helplines in the UK developed alongside the IBD Specialist Nurse role which first appeared in the1990s and is now fairly well established across the UK. These pioneering Nurses realised from the beginning that the chronic, relapsing nature of IBD, meant that access to support via a telephone helpline was crucial.

2004 The role was endorsed by the British Society of Gastroenterologists and their Guidelines commented that patients saw helplines as a ‘central part of the IBD Service’ (Carter et al 2004).

2006 A review of the effectiveness of IBD Nurse Specialists (Woods et al 2006) found that Helplines reduced Out Patient attendances and length of stay and played a significant role (Woods et al 2006) found that Helplines reduced Out Patient attendances and length of stay and played a significant role in enabling patients to self manage their condition.

2004). The Royal College of Nursing undertook a national audit of IBD Nurses (Mason et al 2011), which explored the roles, responsibilities and activity of advanced roles in this specialty and one of their findings was that the nurses who participated spent an average of 18% of their time on helpline calls.

The IBD Nurses in the Network recognised that the helpline was a huge part of their role and felt it would be useful to try and increase their understanding of what it was being used for and its significance to their workload.

Results:

9 Hospitals took part, filling in a proforma for each call to the helplines during February 2012. The proforma included specific disease information as well as descriptions of the type of topics discussed and their outcome.

A total of 1187 calls ranging from 72 – 289 per site were audited. This table shows the calls broken down by Diagnosis/gender and age

<table>
<thead>
<tr>
<th>Calls by Diagnosis/Gender/Age</th>
<th>M</th>
<th>F</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crohns</td>
<td>257</td>
<td>355</td>
<td>512</td>
</tr>
<tr>
<td>Ulcerative Colitis</td>
<td>218</td>
<td>243</td>
<td>461</td>
</tr>
<tr>
<td>End stage/Recurrent Disease</td>
<td>29</td>
<td>40</td>
<td>69</td>
</tr>
<tr>
<td>Micronodular</td>
<td>1</td>
<td>14</td>
<td>15</td>
</tr>
<tr>
<td>Micronodular Diagnosis</td>
<td>14</td>
<td>15</td>
<td>29</td>
</tr>
</tbody>
</table>

The majority of calls were from people with Crohns Disease, more females than male and the age group most likely to call were between 26 and 35. 144 had been diagnosed for less than a year – it was anticipated that this might have been higher - and only 19 had communication difficulties such as language barriers, again we thought this might be higher as there are quite large ethnic populations in our area whose first language is not English. Unfortunately this might mean that these patients are not just using the helplines which is a concern.

Reasons for Helpline Call:

Most calls, as you would expect, were for disease management and then medication advice. 16% however were purely administration and probably did not need any specialist input, this included things like sending out blood forms, and rearranging appointments. However, it could be argued that some knownledge of the patient’s condition is important when rearranging appointments. 10% were phoning for results and the remaining 10% were queries which did not require a response and therefore 20% of calls did not require a response.

Change:

6% of calls resulted in tests being requested, another 18% requested repeat prescriptions. 8% were given test results which may relieve anxiety and/or ensure timely treatment and 8% covered a wide range of things, some of which were rather unusual including a call from a patient on holiday in Australia asking if he was ok to do a bungee jump!

Action Taken:

A third of calls were given advice on different aspects of managing their condition or medication. Once again, a significant proportion - 15% required some degree of administrative input. 8% were given an urgent appointment, 7% had their medication changed which might be increasing or reducing doses of an existing medication or prescribing a new treatment and another 8% simply required repeat prescriptions. 7% were given test results which may relieve anxiety and/or ensure timely treatment.

Time spent on Helpline calls:

Most calls took less than 5 minutes but time spent on the helpline is not always just the actual time speaking on the phone. Follow up can be quite time consuming as it might involve getting hold of notes, speaking to medical staff, writing to other Health Care Professionals etc. The majority however took less than 15 minutes to sort out with a small minority taking more than 45 minutes. Not surprisingly, the busiest day for calls was Monday - after the weekend, when helplines are not manned.

The amount of time taken up on helpline calls in the hospitals audited equated to between 11-40% of 1 full time IBD nurse’s hours. As mentioned earlier, a national UK IBD Nurse audit (Mason et al 2011) found that 16% of IBD Nurse hours were spent on helpline activities. The average for this audit was higher but the numbers of calls received by each hospital did vary quite significantly. It was interesting that some hospitals received a lot more calls than others (72 vs 289).

Of course, the numbers of calls vary from day to day, week and the unpredictability of helpline use can make them difficult to manage. Participants were asked whether they felt their helplines were manageable and majority said yes ‘most of the time’ but they all had periods when this was not the case, when they felt quite overwhelmed with the work it generated. It is therefore clear that they can take up a significant amount of time which needs to be taken into account when planning new posts and job planning existing roles.

Financial Implications:

In the UK, there is a tariff of £23 for non face to face outpatient attendances and telephone helpline calls can be included in this. However this has to be agreed with the local funding authority which is not always straightforward and therefore not all centres charge for their calls. In addition, some seem to charge for more calls than others, it can be quite difficult to decide which calls should be charged for and which shouldn’t. In the audit:

• 64% trusts charge for their calls. In addition, some seem to charge for more calls than others, it can be quite difficult to decide which calls should be charged for and which shouldn’t. In the audit:

<table>
<thead>
<tr>
<th>Proportion of Calls Charged</th>
</tr>
</thead>
<tbody>
<tr>
<td>25%-75% calls charged for by individual Trusts</td>
</tr>
<tr>
<td>38% of calls chargeable</td>
</tr>
<tr>
<td>£23 per call = £10,419 (£1012-£1932 per Trust)</td>
</tr>
<tr>
<td>3 trusts not charging may each have lost up to £28,000 per year</td>
</tr>
</tbody>
</table>

Consequences of not having a helpline:

Finally, patients were asked what they would do if they had no helpline to ring, it was putting them on the spot a bit but the majority said they would ring their GP next was nothing (which could mean their symptoms worsening and becoming more difficult to treat) 180 would have requested an early outpatient appointment, 141 rung the Consultant Secretary and 26 would have gone to A&E. 45 didn’t know what they would have done or this was not completed.
CONCLUSIONS: This preliminary study demonstrates that our abdominal press sequence is associated with optimal caecal intubation, requires short time and it is not influenced by physical features of the patient. We confirm that women have longer caecal intubation time. Further studies with control groups will be necessary but our positive experience shows that trained nurses in this procedure could contribute to achieve the highest colonoscopy success rate in short time.

REFERENCES:
1. Dpt of Medicine, Gastroenterology Unit, St Anthony Hospital, Padua; 2. Opt of Environment Medicine and Public Health, Institute of Regions, University of Padua, Italy

2013

WINNERS OF THE FREE PAPER AND POSTER AWARD

THE RIGHT HAND FOR THE RIGHT PRESS: ABDOMINAL PRESS DURING COLONOSCOPY.

EXPERIENCE OF A COLORECTAL CANCER SCREENING TEAM.


BACKGROUND: The adequacy of a colorectal cancer screening is strictly related to the successful caecal intubation rate and the time required to reach it. The positive outcome of the procedure could be increased by applying abdominal pressure in a due sequence throughout the colonoscopy, as reported in preliminary works.

AIMS: To find the best abdominal compression procedure to reduce the duration time of colonoscopy, increase the percentage of caecal intubation and reduce the patient discomfort.

METHODS: 100 (46 F and 54 M) consecutive patients gone for screening colonoscopy were enrolled in the study, mean age 60.7 yr (range 49-69). All colonoscopies were conducted under conscious sedation. Pentax HD instruments were used. Clinic and anthropometric data were collected. All nurses in our service were instructed to perform the abdominal compression sequence (APS) necessary to accomplish the endoscopy. This sequence requires two operators: one at the shoulders of the patient who cares for the advancement of the instrument and the other, positioned in front of the patient, who performs the sequence of abdominal compression. The patient is positioned on the left lateral side.

RESULTS: Cesareo et al (2010) described the abdominal compression technique (ACT): 1. First 15-20 cm: squeeze with left hand in right iliac fossa exerting pressure from outside to the contralateral side (limiting space, avoid the flagging of the sigma). 2. From 25 to 50 cm: keeping the position n. 1, with the right hand make a compression from the epigastrium downwards about 4 fingers above the navel, (to prevent the ascent of the instrument to the stomach). 3. From 50 cm up to the splenic flexure: compress slightly the right upper quadrant and epigastrium with the outer edge of the left hand while the right hand makes a compression from the outside inward in left hypochondrium (prevents the formation of the air loop in left iliac fossa). 4. At the transverse: if patient is placed supine, to compress the epigastrium with the right hand while the left hand compress below (to direct the instrument towards the hepatic flexure). 5. At the hepatic flexure: exert compression on the right upper quadrant with the right hand (to prevent the formation of the loop in hepatic flexure and thus facilitate the achievement of full caecal intubation).

CONCLUSIONS: These preliminary results demonstrate that our abdominal press sequence is associated with optimal caecal intubation, requires short time and it is not influenced by physical features of the patient. We confirm that women have longer caecal intubation time. Further studies with control groups will be necessary but our positive experience shows that trained nurses in this procedure could contribute to achieve the highest colonoscopy success rate in short time.

THE GRASS IS ALWAYS GREENER..? - Sharing nursing experience in hepatology

Baltzer R
Department of Hepatology and Gastroenterology V, Aarhus University Hospital, Denmark

Introduction
Advanced hepatology is, in Denmark, centralised at the Clinic of Hepatology at Rigshospitalet in Copenhagen and Department of Hepatology and Gastroenterology in Aarhus. Doctors from these departments have traditionally shared knowledge and experience to deliver qualified and evidence-based treatments. Nurses from the two departments have never established a similar structured cooperation.

A group of nurses from both departments were interested in investigating how knowledge-sharing could be organised and structured. In order to increase the awareness of new development potentials and integration in hepatic nursing, a peer group was established. A peer group of experienced nurses was organised as a small subgroup, incorporated in the organisation for nurses in gastroenterology.

Aims
The aim was to establish a structured cooperation and knowledge-sharing culture between the nurses from the two hepatology departments in Denmark, and to create a national network for nurses in hepatology.

Methods
To launch the cooperation, an exchange of nurses between the two departments was arranged. A peer group of experienced nurses was formed. A structured cooperation was established. A peer group from both departments were exchanged and compared.

Results
An annual conference focusing on advanced hepatology nursing was established. Nurses from both departments were invited to present and share their knowledge and experience. A peer group from both departments was invited to share their knowledge and experience.

Keywords:
- Hepatology
- Knowledge sharing
- Networking
- Cooperation

Conclusion
A structured cooperation and knowledge-sharing culture are advantages to both patient and staff, increasing regeneration and ensuring higher nursing standards. The exchange of nurses between highly specialised nurses is an effective way to utilise and extend the existing knowledge. Furthermore, knowledge from the nurses from different departments and countries contributes to a more versatile knowledge of hepatic nursing.

E-mail: Rikke Baltzer: rikkbalt@rm.dk

WINNERS OF THE FREE PAPER AND POSTER AWARD

WINNERS OF THE FREE PAPER AND POSTER AWARD

Third place free poster award
Moviprep® taken at split dose intervals is more effective than single dose preparation for to a morning colonoscopy: A literature review
Jennifer Hewson, University Hospital Limerick, Ireland

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

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

Method:
A literature review of CINAHL (Cumulative Index to Nursing and Allied Health Literature) was conducted for full text articles using phrases ‘bowel cleansing’ (138) ‘colonoscopy prep’ (6) and ‘advances in colonoscopy preparation’ (12). 6 articles were specific to split dose bowel prep. Data on patient tolerability, compliance and adequacy for AM/PM bowel prep was analyzed and reviewed.

Findings:
Linking the final dose of AM/PM bowel prep to 4-6 hours prior colonoscopy, increases adequacy of prep (Matro et al, 2010). Dietary restrictions on the day prior to colonoscopy ranged from low residue diet for breakfast and clear fluids versus thick liquid diet for lunch followed by fluids only and bowel prep was recorded as adequate (very good and good) in 72.9-95% of patients. Patient compliance ranged from 85-96%. Although patients are required to get up at 4am and recorded some sleep disturbance (25%) it is not statistically different to other preps. However, there is a statistical difference in patient’s pain/discomfort p=0.035 as split dose experience less discomfort but the incidence of nausea/vomiting and distension is insignificant. One study, Park D et al (2010) found that 93% of respondents would be willing to repeat the same bowel prep again.

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

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

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

References:
The ESGE-ESGENA Live Endoscopy Workshop took place in the Military Hospital in Budapest with transmission to Stefa- nia Palace and Cultural Centre.

The medical side of the workshop was organised by Prof. István Racz (from Győr, Hungary) as the ESGE Course Director and Dr. Tibor Gylkaires (from Budapest, Hungary). Close cooperation was established with me as the ESGENA Co-Director. The ESGENA team was completed by Marjon de Pater and Sylvia Lahey from the Netherlands and Wendy Waagenes from Denmark.

The workshop was marked by the strong cooperation between endoscopists and nurses, with nurse involvement in the case discussions for patient selection.

The local team, nurses and endoscopists, were prepared to work with the European guests as a team. Together with the representatives of Olympus, it was a perfect cooperation. Discussions were always possible and opinions accepted.

An important feature of the workshop was that procedures performed by Hungarian endoscopists were assisted by Hungarian nurses as they are used to working as teams in their daily routine, fulfilling European standards.

A total of 35 examinations were carried out with no patient complications. Simple procedures like EGD with biopsies were shown as well as complex interventions like EUS with FNA, complex EMRs, ERCPs, Zenker diverticulotomy and PGEM.

Of the 400 participants, 100 nurses were registered for the workshop.

After the live-sessions, separate lecture programmes were given for endoscopists and nurses. The following lectures were provided for nurses:

- • Methods and organisation questions of endoscopic interventions like EUS with FNA, complex EMRs, ERCPs, Zenker diverticulotomy and PGEM.

I arrived at the hospital on a Monday morning and received a very warm welcome not only from Michael Ortmann, who was to guide and teach me throughout the week, but from the entire staff of the endoscopic unit. This made the rest of my week so much easier and my experience all the better. The first day I was shown around the department and introduced to each member of staff. Then I was handed a block of blank paper and a pen so I could write down everything I was to experience during my stay.

This was a very successful and smoothly running event, where teams were built and friendships were formed. The team spirit was felt by everyone involved in this workshop. It never ceases to amaze me that it is possible to work together with colleagues from abroad to create something so serious and professional.

Herta Pomper, ESGENA General Secretary (2012), ESGENA Co-director/Budapest

My name is Sólún and I am an endoscopic nurse at the National Hospital of Iceland. Last September I was given the wonderful opportunity to visit the University Hospital in Basle, Switzerland. The one week visit was organised as an ESGENA Clinical Grant. I was given the chance to see and feel the work of endoscopic nurses in another country.

The main focus of my stay was bronchoscopy. I wasn’t there just to watch and observe, I was also there to work and learn. On average, I assisted five to six bronchoscopies a day for five days in a row, and it was a great experience. I got to do things I’m used to doing at home, and I got to do things I’d only heard about before but never seen. I was especially interested to see and do TBNA (transbronchial needle aspiration) with EBUS (endo bronchial ultra sound), mainly because my hospital has been given its first EBUS scope and we will start using it at the beginning of the year 2013. Therefore, it gives me a great advantage to have this experience.

The week passed by very quickly and I learned a lot in those five days. The question is: How can I implement what I learned in my own department? Definitely not by walking around saying that in Basel they do this and in Basel they do that. I can accomplish more by informing my colleagues about my experience in Basel and changing my own way of working in order to set a good example for my colleagues to hopefully follow.

Experiencing work in another country gives you a different perspective. I came to Basel ready to see new things and learn new techniques, maybe even with the illusion that everything was perfect over there, and kind of relieved that it wasn’t. Of course things are done differently in different places and in some ways they are better and in some ways they are not. I left Basel full of knowledge and experience in new techniques which I hope I will be able to use to the benefit of my patients and colleagues. This trip was on all accounts an excellent learning experience for me. And it, after my visit, at least one thing will change for the better in my endoscopic department, then this great invitation was definately worth it.

Sólún Palarsdottir, Iceland
ESGENA NEWS

12th TECNA COURSE FOR NURSES ENDOSCOPY IN BRISTOL, UK, MARCH 2013

The course was attended by 50 nurses, the majority of whom were from the UK, with further participants from Ireland, Spain and Croatia. As endoscopy and endoscopic techniques are continuously advancing, it is essential that nurses and technicians improve their skills and knowledge and become acquainted with the endoscopic material necessary to perform procedures. For this reason, I believe that participation in these courses is of great benefit for endoscopy personnel. The course combined lectures and hands-on workshops.

The first portion of the workshop consisted of lectures related to the application of thermal therapies, polypectomy, clipping, endolops and chroomeoscopy. Lectures were held in a simple and affordable format to explain use, purpose of use, the situation in practice and possible complications. The first set of lectures was followed by a practical presentation of the endoscopic accessories that were discussed in the lectures. Participants were divided into groups in order to offer an effective hands-on-training on all endoscopic equipment presented.

The second set of lectures included ERCP, endoscopic dilatation, foreign body removal and emergency situations in endoscopy and was also followed by hands-on-training on various advanced techniques. I found it is very useful to be shown by trained personnel to the correct use of material that we already use of might use in the near future. Attending the course provides a level of security and confidence in assisting in a team. The course is of benefit to nurses who have experience in endoscopy as well as young nurses acquiring new knowledge and skills.

I would like to take this opportunity to thank Jadranka Bršjak, the President of the Association of Nurses and Technicians of Gastroenterology and Endoscopy in Croatia, who made me aware of the possibility of attending the course and of its importance. I would also like to thank Michael Orlmann, ESGENA President, and the other members of the executive committee of ESGENA for giving me the opportunity to attend the course. And finally, many thanks to Dr. Ramasamy Saravanam for an extremely well organized course and, in particular, for the warm hospitality and kindness.

Ružica Ujaković, RN, KBC Split-Križine, Croatia

ESGENA TRAINING CENTRE – NEW CRITERIA

Since 2006, ESGENA has offered clinical grants to registered European nurses who wish to undertake further clinical training in:

- endoscopic techniques
- endoscopy nursing including sedation and monitoring
- GI function tests
- hygiene and infection control
- management of endoscopy unit
- gastroenterological nursing including care of specific patient groups (e.g. IBD)

It has always been of great importance to ESGENA that:

- specific aims and learning outcomes are defined for each grant
- the visits take place in specialised centres
- each grantee has a dedicated tutor during the visit

These broad criteria have been used as an orientation for guest departments.

Although the feedback from grant recipients has been very positive, the situation for grantees has varied greatly from country to country, and it has become clear that uniform criteria are necessary to create comparable and verifiable conditions.

In 2012, the ESGENA Education Working Group (EEWG), in which 25 ESGENA membership countries are represented by national delegates, developed common quality criteria for guest departments. These unified criteria led to the establishment of dedicated ESGENA training centres.

The following quality criteria have been defined for ESGENA training centres:

- Range of interventions
- Nursing care
- Legal restrictions
- Access to learning facilities
- Connections to ESGENA
- Qualifications of the tutors
- Defined aims and learning outcomes
- Range of interventions
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ESGENA NEWS

ESGENA-ESGENA WORKSHOP IN DUBAI, MARCH 2013

In January I was asked to participate in the workshop in Dubai. It sounded interesting, so I said yes, even though I was not sure at the time what I had agreed to.

In February I received more information about the workshop and the people I was going to work with. Among the other participants were three nurses from the ESGENA Board, Marjon de Pater (The Netherlands), Jadranka Bršjak (Croatia) and Jayne Tillett (UK).

On March 21st I left Copenhagen and made the six and a half hour flight to Dubai. Friday morning I met my colleagues for the first time and I very quickly felt part of the group. First we had to register at the conference center to see the location where the nurses’ meeting was to take place later in the afternoon. Around 40 nurses from throughout the UAE attended. It was the first time they had the opportunity to meet nurses from other hospitals both in the UAE and Europe. During the conference sessions, participants learned about education for endoscopy nurses and sedation in gastrointestinal endoscopy. We also received an update on decontamination as well as hands on training and troubleshooting with equipment from Pentax and Cook. The participants were very interested in the subject matter and got involved by asking relevant questions throughout the seminar.

On Saturday we arrived at the Rashid Hospital at 7.30 a.m. It was a little confusing at first, but turned out well in the end. At 9 a.m. we were ready to go live. We were spread out in three different rooms each with two live sessions in the morning and two in the afternoon. We performed EUS, ERCP, HALO, Colonoscopy and different types of treatment. Saturday evening all participants were invited to attend a dinner party at Mina Salem Hotel.

The following morning the live sessions started at 9 a.m. at Rashid Hospital. Nurses circulated to experience the different procedures. At five in the afternoon we were done and everyone was a little tired. In the evening a bus tour was arranged for an exciting city tour.

I had a great time. The conference was very well executed and the contents very relevant to my profession. My friendly colleagues Marjon, Jayne and Jadranka also contributed to making my first workshop a great and memorable experience. They instantly welcomed me and made me feel at home in their group, even though they had all traveled together before. I appreciate the whole experience and I sincerely look forward to going again.

Anne Bøtter, Copenhagen, Denmark

Legal restrictions

Due to legal restrictions, hands-on training is not available in many countries, because the grantees are not registered as nurses in the respective country. In these cases, guest nurses may still participate in clinical work as observers, learning from their colleagues.

Connections to ESGENA

It is very important to the ESGENA governing board that a training centre works together closely with the European society and that European guidelines and standards are followed. ESGENA should be known in the department. Therefore, it is essential that at least one team member is active within ESGENA, e.g. as:

- Member of the ESGENA governing board
- Member of the ESGENA Education Working Group (EEWG)
- Tutor at ESGE-ESGENA hands-on training courses during conferences
- Tutor at ESGE-ESGENA workshops with live demonstrations
- Speaker or chair at ESGENA conferences

Each training centre must have a dedicated contact person, who acts as coordinator for both ESGENA and the individual grantee.

Qualifications of the tutors

In many countries a formal qualification for tutors is available. The supervising tutor should have experience in teaching and expertise in Endoscopy.

Defined aims and learning outcomes

It is very important to ESGENA that individual aims and learning outcomes are defined for each grantee. A combination of theory and practice supports the achievement of these objectives.

Access to learning facilities

In order to enable self-directed learning, access to a library and internet is desirable. The availability of literature supports the learning process. During the stay, the guest nurse can independently complete and extend her/his background knowledge.

Training centres usually have separate classrooms with appropriate technical equipment for theoretical instruction. In bigger hospitals classrooms are often used across disciplines.

Practical training requires extensive endoscopy specific equipment including light sources, endoscopes and a wide range of endoscopic accessories. Larger training centres usually have appropriate training facilities, possibly with commercial or home-built training models. Videos and interactive learning models such as dummies support the teaching of practical content.

Separate training rooms are helpful to avoid occupancy of endoscopy rooms used in daily routine.
**ESGENA NEWS**

**ESGENA TRAINING CENTRE – NEW CRITERIA**

**Team support**
A key issue for a training centre is the support of the management and the various teams involved:

- The approval of the hospital management and the director of nursing are essential because a training centre binds human and financial resources. Costs for staff and equipment should be factored in to the budget. The legal situation should be clarified in general and individually for each grantee (what is the status of the grantee – observer or part of a team; where are limits and possibilities to learn?)
- The support of the multi-disciplinary endoscopy team is essential, as a guest always causes a certain amount of stress and workload, which should be borne by the team. The aim is that the grantee feels comfortable and can learn.
- Support for the medical management is necessary to coordinate patient and procedure related aspects. In addition, physicians naturally teach during interventions.
- Optimally, the teaching and hands-on training is scheduled in the endoscopy lists. ESGENA is aware that the implementation is more difficult in times of staff shortage.

**Accommodation**
Finally, the grantee needs support in finding accommodation. Language courses can be combined with the grant, but their costs cannot be covered by ESGENA.

**Application**
Departments are asked to apply in writing for recognition as training centres. The ESGENA governing board shall decide whether the defined quality criteria are met. The application form assesses structural requirements and the overall organization. The application forms must be completed with the signatures of the management.

Ulrike Beilenhoff  
ESGENA Scientific Secretariat

**BASEL BECAME 1st ESGENA TRAINING CENTRE**

In the last five years, the endoscopy department of the University Hospital Basel has often been selected for grants. Fifteen of 35 formally conducted ESGENA grants were completed in Basel.

The University Hospital meets the new criteria as defined for ESGENA training centres.

The endoscopy department in Basel combines Gastroenterology and Thoracic Medicine with a wide range of examinations. As a pioneer in the establishment of non-anesthesia administration of propofol (NAAP), the team in Basel was trained during the first studies on this topic and has gained many years of experience. Therefore, many grantees come with the specific desire to expand their experience in dealing with sedation and patient monitoring. Further specializations of the department are hygiene and management of endoscopy units.

Connections to ESGENA
For 14 years, Basel has had strong connections and co-operation with ESGENA through Eric Pfimlin, Nurse Manager of the Endoscopy Unit, Michael Ortmann, Leader of Continued and Advanced Education, and other team members. Michael Ortmann has been an ESGENA board member since 2002 and is the current ESGENA President. As the national delegate, he represented Switzerland in the ESGENA Education Working Group (EEWG). Since spring 2013, Evi Baumann, from the same department, has had this position.

In 2002, Michael Ortmann and Eric Pfimlin initiated the hands-on training on bio-simulators made with pig organs. They have since organised and chaired this hands-on training at the ESGENA conferences and UEG Week. Both Michael and Eric have marked the high quality of this hands-on training with their training skills and endoscopic experience. Over the years many of the nurses from the Basel team have worked as tutors.

Michael Ortmann and Eric Pfimlin have worked as tutors at ESGE-ESGENA Workshops with live demonstrations in a number of Eastern European countries. Based on their initiative, ESGENA established the co-operation grants which support co-operation between two countries.

**Aims & learning outcomes**
In Basel, a goal-oriented learning concept with theory and practice has been established for many years. ESGENA grantees have rated this structured learning as particularly effective.

**Access to learning facilities**
As a creative thinker, Michael Ortmann has developed homemade dummies - simple and cost effective - on which endoscopic techniques can be practiced. The department has appropriate training facilities which enable an interactive learning situation.

**Team support**
The team support by physicians and the hospital management has given nurses the opportunity to take a pioneer role within ESGENA. This support is evident in the mutual recognition of the work of other professional groups.

**Symposium with the official award**
On 27 June 2013, the official recognition as an ESGENA training centre was announced at a special symposium in Basel. The symposium was very well attended with more than 100 participants.

The ESGENA was represented by Marjon de Pater, Amsterdam, Treasurer ESGENA, and Ulrike Beilenhoff, Ulm, Scientific Secretary of ESGENA.

The ESGE was represented by Prof. Thierry Poncin from Lyon, who underlined the close cooperation between ESGE and ESGENA in congresses, workshops and guideline development. ESGE also runs various training centres located throughout Europe.

Marjon de Pater and Ulrike Beilenhoff

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2013

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Therapeutic possibilities, due to the rapidly developing techniques within endoscopy, where procedures become more and more advanced, demands qualified personal to assist in these procedures.

The assisting personal in endoscopy creates a bridge between the high demands of modern advanced techniques with sedation and close patient contact and observation during the patient's entire stay in the endoscopic department.

There is a need for training centers where assisting personal can receive qualified training in the many facets and specialized functions within endoscopy. This is very important, as the endoscopic assistant's role has developed into a very comprehensive and decisive one in the outcome of the procedure.

Therefore, the Board of ESGENA and the endoscopic department in Basel at Universitätsspital presented this afternoon Symposium to launch the first European training center for endoscopy personal.

There were several international guest speakers, as well as local speakers, invited to contribute to the symposium. Eric Pflimlin, Manager of the Endoscopy Department in Basel, spoke about the management of an endoscopy department. There are many competing demands that must be kept in balance in order to have a successful endoscopy department. It is a field in rapid development, so education is very important in order for personal to be properly qualified for the challenges that they are presented with on a daily basis within the department. One must also juggle the constant demands of keeping costs as low as possible while keeping efficiency as high as possible.

Prof. Dr. Thierry Ponchon, ESGE General Secretary, from Lyon, spoke about the management of an endoscopy department. There are many competing demands that must be kept in balance in order to have a successful endoscopy department. It is a field in rapid development, so education is very important in order for personal to be properly qualified for the challenges that they are presented with on a daily basis within the department. One must also juggle the constant demands of keeping costs as low as possible while keeping efficiency as high as possible.

Marjon de Pater, ESGENA Treasurer, from AMC, Amsterdam, Holland, and Ulrike Beilenhoff, ESGENA’s Scientific Secretary, from Ulm, Germany, spoke about the changes in the endoscopy nursing profession, citing the nurse endoscopist as an example. The nurse endoscopist is a growing profession that is here to stay. It should be supported in order to meet the growing demands for endoscopic procedures as a part of cancer screening. It is widespread in England and growing in Northern Europe. There is much work to be done to support the need of the nurse endoscopist and nurse endoscopist’s role in the development of endoscopy.

Uwe Weber, Manager of the Institute for Nurse Education in Bern, spoke about endoscopy training in the educational landscape that is found in Switzerland. He compared the educational systems in Switzerland with those in Germany, pointing out the many differences.

Dr. Ramasamy Saravanan, TECNA Course Director/Organiser, UK, spoke of the experiences of the TECNA Training Program in England. England has been a forerunner as far as the nurse endoscopist is concerned. TECNA provides therapeutic endoscopy courses for endoscopy nurse assistants and nurse endoscopists. In the near future, there will be a course in endoscopic lesion recognition and imaging. This is a very important aspect of endoscopy – recognizing what one is seeing! Dr. Saravanan has established a vast library of pictures of lesions found during endoscopic procedures. This provides the basis for a course in the recognition of a wide range of lesions in the gastrointestinal tract.

Dr. Thorsten Luecke, General Manager of European Training and Education, Olympus Europa SE & Co. KG, Hamburg and Dr. Ulrike W. Denzer, Gastroenterologist, University Hospital Hamburg-Eppendorf, spoke about ENDO CLUB Academy Hamburg and the importance that industry plays in furthering the education of doctors and nurses in the endoscopic field.

Ulrike Beilenhoff, ESGENA Scientific Secretary, Ulm, spoke about the criteria of ESGENA Training Centers. Together with Marjon de Pater, ESGENA Treasurer, AMC, Amsterdam, she awarded the ESGENA Endoscopy Training Center Certificate to the Endoscopic Department at Universitätsspital Basel.

All in all, it was a very informative afternoon, filled with interesting and inspiring lectures.

Wendy Waagenes, Denmark
Dear Colleague,

On behalf of ESGENA, the German Society for Endoscopy Nurses and Assistants (DEGEA) and the German Nursing Association (DBfK), it is our great pleasure to invite you to the 17th ESGENA Conference, which will be held during the 21st United European Gastroenterology Week from October 12-14, 2013 in Berlin, Germany.

Following conferences in 1995 and 2006, this will be the third time that the medical and nursing community of Gastroenterology and Endoscopy meet in Berlin. This year the Governing Mayor of Berlin, Klaus Wowereit, takes over the patronage of the ESGENA Congress.

Like the city of Berlin, both UEG and ESGENA have changed significantly by increasing their activities and hosting one of the premier meetings within the field. The ESGENA conference is not only an opportunity to meet colleagues from throughout Europe, but also from North and South America, Africa, Asia and Australia. The exchange with nurses from all over the world combined with the opportunity to attend the medical programme of UEG Week makes the ESGENA conference an exceptional educational event.

The three day ESGENA conference will include state-of-the-art lectures, free papers & posters, lunch sessions, several workshops with hands-on training and live transmissions covering current topics in gastroenterology and endoscopy. The German hosts, DBfK and DEGEA, both members of ESGENA, combine the political work of a nursing association with specialised activities in endoscopy, and this interesting combination will also be reflected in the programme.

We hope to welcome you to the 17th ESGENA Conference in October 2013 in Berlin, Germany.

Michael Ortmann, President of ESGENA, Ulrike Beilenhoff, President of DEGEA and Prof. Christel Bienstein, President of DBfK

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ESGENA Workshop 2013.
Functional diagnostic tests for GERD patients.

Date: Saturday, October 12, 2013
Time: 14:00 - 15:30
Room: Saal 6

UEGW 2013
Berlin, Germany
International Congress Center Berlin

Speakers:
PD Dr. Jutta Keller
GI Nurse Sven Scherzberg
Israelitisches Krankenhaus
Hamburg, Germany

The role of a nurse in GI functional diagnostic tests:
- Tests available for patients suspected of having GERD
- Demonstrations:
  - High Resolution Manometry (HRM)
  - Ambulatory reflux monitoring:
    - pH-impedance catheters
    - Bravo® capsule-based
- Instruction and cooperation with the patient

To register or for more information, please visit www.ueg.eu/week/esgena
Monday, 14 October 2013
Hall 3
Language: English

08:30 - 10:30
SESSION 9
New techniques and developments in Endoscopy
Presentation by major sponsors
Scientific Lectures
Best free paper and best poster award
Invitation to the next conferences
Details: Page 36

Coffee Break 10:30 - 11:00
Visit of exhibition, ESGE learning area, UEG Week sessions
Lunch 12:30 - 14:00
Visit of exhibition, ESGE learning area, UEG Week sessions
Coffee Break 15:30 - 16:00
Visit of exhibition, ESGE learning area, UEG Week sessions

The EPK-i7000 video processor
Expand your possibilities for optical diagnosis.

- Full i-scan Management
  Individually tailored i-scan settings to meet your current and future needs for enhanced detection and complete pattern characterisation.

- Twin Mode
  Supports the detection and demarcation of lesions, all details may be seen at once. Teach your fellows on how to interpret clinical images.

- HD+ Video Recording
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**DETAILED PROGRAMME**

**WORKSHOPS ON SATURDAY 12 OCTOBER 2013**

1. **Workshop 1: Sample size & quality (FNA & biopsy): Endoscopy and pathology perspective**
   - **Aims & Content:** The clinical workshop aims to educate nurses on the importance of sample size and quality in EUS FNA and biopsy procedures and the impact on clinical diagnoses and patient treatment algorithms. Nurses will increase their knowledge on the different sample preparation techniques and the stages of sample processing in the pathology lab. Description:
     - Presentation from physician’s perspective
     - Presentation from pathologist’s perspective
     - Hands-on training session

2. **Workshop 2: Challenges of GI bleeding**
   - **Aims & Content:** Being both confident and knowledgeable during a GI bleed is crucial. Good training is also a key factor to safely manage the bleed. This workshop aims to increase your knowledge of the different types of GI bleeding, as well as provide hands-on training.
     - Presentation on various GI bleeds, the realities and how to cope with them (30 mins)
     - Hands-on training covering injection, clipping, ligation and thermal therapy (60 mins)
     - Two language areas for the hands-on training (German and English)

3. **Workshop 3: Functional diagnostic tests for GERD patients**
   - **Aims & Content:** This session will focus on the role of a nurse in GI functional diagnostic tests and will:
     - Give an overview of tests available for patients suspected of GERD
     - Demonstrate how to perform a technically good esophageal High Resolution Manometry (HRM) procedure
     - Demonstrate ambulatory reflux monitoring with pH-impedance catheters and wireless BRAVO capsule
     - Show importance of instructing and cooperating with the patient for useful results

4. **Workshop 4: Management & quality improvement**
   - **Aims & Content:** The Workshop combines lectures and discussions:
     - Patient safety in Endoscopy
     - Team meetings with debriefing – an instrument of quality improvement
     - Perspectives for staff working in Endoscopy

5. **Workshop 5: Hands-on training on bio simulators**
   - **Aims & Content:** Hands-on training on bio simulators (pig models) under the supervision of highly experienced tutors. Participants will have the opportunity to perform endoscopic techniques on the following topics:
     - OGD with injection techniques, ligation, clipping, APC
     - Colonoscopy with Polypectomy, EMR and APC
     - ERCP with stone extraction and stenting

6. **Workshop 6: Surveying the colon: Advances in diminutive polyp removal**
   - **Aims & Content:** Colorectal cancer is the second leading cause of death in men and women worldwide. Proper screening and removal of diminutive polyps is critical. It is important to understand the prevalence of diminutive polyps during colonoscopy, the importance of detecting and removing these growths early, and the various polypectomy techniques. This presentation will briefly introduce you to the following topics:
     - Background and types of polyps
     - Colorectal cancer
     - Polypectomy and polyp resection techniques, including cold snaring
     - Submucosal injection therapy
     - Polyp removal
     - Bleed management

7. **Workshop 7: Endoscope hygiene - the importance of cleaning**
   - **Aims & Content:** This workshop will give:
     - A view into study data about manual pre-cleaning aspects
     - Show importance of cleaning and cleaning efficacy during automated endoscope reprocessing
     - Practical view about pre-cleaning and cleaning in the endoscopy department.
     - Today endoscope reprocessing is focussing on automated cleaning and disinfection procedures. However, the pre-cleaning right after use of endoscopes is still an essential step within the workflow of endoscopes from patient to patient.

8. **Workshop 8: New development in EUS guided FNA**
   - **Aims & Content:** Hands-on training using bio simulator (pig model) - basic techniques in FNA. Furthermore, the participants will learn the concept of using multiple needles to reduce procedure time during FNA. A new concept of exchanging different needles in one patient without losing the position of endoscope and needle will be explored.

9. **Workshop 9: Patient care in Endoscopy**
   - **Aims & Content:** The Workshop combines lectures and practical demonstrations:
     - External abdominal pressure
     - Thermoregulation – what can we learn from other specialties
     - Patient positioning prevents complications

10. **Workshop 10: Hands-on training on bio simulators**
    - **Aims & Content:** see programme above, Workshop 5

**DETAILED PROGRAMME**

**WORKSHOPS ON SUNDAY 13 OCTOBER 2013**

1. **Complication management**
   - **Aims & Content:** Endoscopic complications in OGD and Colonoscopy – what can we learn from it?
   - **Aims & Content:** Endoscopic closure of gastrointestinal holes and leaks
   - **Aims & Content:** How can we minimise the risk of ERCP
   - **Aims & Content:** How can we decrease the oversight of neoplasie and G1 lesion

2. **Bronchoscopy**
   - **Aims & Content:** COPD illness and Bronchoscopy
   - **Aims & Content:** Bronchial Theraplastie – a new treatment for asthma patients
   - **Aims & Content:** Complications and Emergency situations in Bronchoscopy
   - **Aims & Content:** Application of oxygen in patients with pulmonary disease

3. **Updates in gastroenterology**
   - **Aims & Content:** Psychological eating disorders: anorexia, bulimia nervosa
   - **Aims & Content:** Diverticulitis - diagnosis and therapy
   - **Aims & Content:** Feacal transplantation
   - **Aims & Content:** Probiotics for intestinal diseases

4. **Education**
   - **Aims & Content:** Developing frameworks in Endoscopy and Gastroenterology: The good, the bad and the useful
   - **Aims & Content:** Modular design for nurse education
   - **Aims & Content:** Implementation of the European curriculum in sedation in GI Endoscopy

5. **Management in endoscopy**
   - **Aims & Content:** Freedom of movement in the EU: The opportunities and challenges of working and living in another EU country
   - **Aims & Content:** Intelligent light – relaxed atmosphere in Endoscopy
   - **Aims & Content:** Endoscopy training in Africa – a report
   - **Aims & Content:** CO2-Insufflation – where is it at benefit?

6. **Quality assurance**
   - **Aims & Content:** Good solutions for stone extraction
   - **Aims & Content:** Improving quality in colonoscopy
   - **Aims & Content:** Unusal findings during Endoscopy
   - **Aims & Content:** Reprocessing problems with biopsy vavles

7. **Free paper**
   - **Aims & Content:** Reducing total tumourad time of recovery process in an endoscopy unit: A lean management strategy
   - **Aims & Content:** Risk management in Endoscopy Unit: The nursing contributions
   - **Aims & Content:** Pathway program for newly hired nurses in Gastroenterology and digestive Endoscopy
   - **Aims & Content:** Stop the line – presence of mycobacteria in final endoscope rinse water
   - **Aims & Content:** Monitoring the effectiveness of cleaning in flexible gastrointestinal endoscopes using the methodology of detection of ATP through bioluminescence

8. **Lunch Sessions**
   - **Aims & Content:** New techniques & developments
     - **Aims & Content:** ESD - make it easy! A new KS-Instrument for endoscopic submucosa dissection (Karl Storz GmbH)
     - **Aims & Content:** FUSE™ - Full Spectrum Endoscope (endochoice)
     - **Aims & Content:** Treatment of Barrett’s oesophagus patients with Radiofrequency Ablation (Covidien)
     - **Aims & Content:** Latest Update on Olympus EndoTherapy devices: Bits and pieces that make your life easier (Olympus Europa SE & Co. KG)
     - **Aims & Content:** Olympus Endoscapsule - system overview and patient preparation (Olympus Europa SE & Co. KG)
     - **Aims & Content:** EndoCot: New therapeutic solutions for gastrointestinal Endoscopy (MRM-TECH Europe)

9. **Hygiene & infection control**
   - **Aims & Content:** Overtures – the underestimated part of the process chemistry in endoscope processing (Chemische Fabrik Dr. Weigert GmbH & Co. KG)
   - **Aims & Content:** Automated endoscope drying and storage cabinets - what are the benefits for me? (STEELCO S.p.A)
   - **Aims & Content:** Benefit of storage cabinet for heat sensitive endoscopes in a chemical setting (Soluscope S.A.S)
   - **Aims & Content:** Valves - the single story (Medivators GmbH & Co. KG)

10. **Bronchoscopy**
    - **Aims & Content:** Interventional Pulmonology, diagnostic and therapeutic procedures in bronchoscopy - a hands-on session with 4 training stations:
      - **Aims & Content:** BAL, brushing and biopsy in a ventilated pig lung model
      - **Aims & Content:** Classical TBNA for cytology and histology samples on anatomical and functional models
      - **Aims & Content:** Peripheral sampling with the guide sheath technique in an anatomical, functional model
      - **Aims & Content:** Foreign body removal with different forceps and objects with anatomical models.

Poster please see next page.
Take complete control of all your GI stenting procedures.

When you have the precise control to deliver some of the most innovative metal stents throughout the GI tract, you can directly impact the quality of patient care. And that’s what the Evolution family of stents gives you: the market’s only delivery system with controlled release and recapturability. Now perform your esophageal, duodenal, colonic and biliary procedures with more control and precision than ever before.

Cook Medical—Delivering the clinical advantage.

*Warning: The safety and effectiveness of this device for use in the vascular system have not been established.
Over the last 30 years, endoscopy has become an essential tool in diagnosis and therapy for digestive diseases. Technical developments and complex procedures require continuous education on a regular basis. In addition to lectures, seminars and conferences, workshops are very popular for continuous training in endoscopy as workshops give the opportunity to connect specialized knowledge with practical training. Although it is recognized that full competence requires practice with patients in a clinical setting, workshops provide good learning environments to start the process of training technical skills.

In response to requests from several European countries, the ESGENA Education Working Group (EEWG) and the ESGE Education Committee have developed a handbook for organizing different kinds of workshops which aims:

- to provide a framework for planning, delivering and evaluating different kinds of workshops for teaching digestive endoscopy, namely equipment skills workshops, dummy workshops and live demonstrations
- to support national nursing societies, educational institutes and individual departments within Europe in optimizing structured practical training for both nurses and physicians working in gastroenterology and endoscopy.

**Definition:** A workshop is a training session which may cover some minutes to several days in length. It emphasizes problem-solving, practical demonstration, hands-on training and requires the involvement of the participants. Workshops in endoscopy are helpful tools for teaching new staff or updating staff in new equipment and techniques.

### Content of handbook

The organization of any teaching event has uniform organizational steps covering planning, preparation, delivery, assessment and evaluation of the event. Each step needs to be clarified and performed in chronological order.

**Essential points are:**

- the clarification of aims and expected learning outcomes for a dedicated target group,
- a detailed planning and
- a structured teaching plan.

The assessment of participants and the evaluation of the event are essential tools of quality assurance and the basis for improvements.

Three different groups of workshops were identified:

#### Equipment skills workshops

Equipment skills workshops are mainly focused on technical aspects of endoscopic procedures. They also cover aspects of patient care relevant for the respective technique, health and safety issues for patient and staff (e.g. for diathermia, handling of sharp instruments, personnel protection measures) and hydrogen aspects (e.g. disposal, reprocessing). Equipment skills workshops are often used the first level training.

### Dummy workshops

Dummy workshops include any kind of dummies for practical training. Dummy workshops offer practical training of technical skills on any type of dummy. Dummy training enables the training of technical skills, which combines handling of equipment and assistance during procedures. The use of special equipment can be trained under realistic simulations. The effect of endoscopic techniques becomes transparent. Single procedures or scenarios can be simulated. Dummy workshops are aimed at familiarizing staff with safe use of equipment and to provide basic and advanced practical training.

1. **Home-made dummies**

   Simple home-made dummies can combine meat, vegetables (e.g. pepper), fruits (e.g. oranges, strawberries, grapes), sweets (e.g. wine guml, foreign bodies (e.g. coins, marbles, stones, nuts), plastic (e.g. tubes), paper (e.g. boxes or parcels) or medical equipment (e.g. bowls). Their use is described in Table 1.

   Michael Ottmann from the University Hospital in Basle, Switzerland, developed effective and simple dummies. Their construction is described in the handbook (see picture 1 and 2).

2. **Commercial dummies**

   Commercial dummies are simple and advanced dummies that are commercially available. Manufacturers produce plastic dolls to demonstrate the easy and effective use of their equipment or to train endoscopists and nurses in the use of equipment. Artificial and computerized dummies are available as plastic dolls or single organs. Endoscopists and surgeons have developed examples of biological and artificial dummies.

   - **Biological dummies** are bio simulators that combine plastic dolls with organic material and organs (see picture 3).
   - **Artificial dummies** combine plastic dolls with artificial material that simulate organs:

#### Table 1: Choice of dummies

<table>
<thead>
<tr>
<th>Procedure to be trained</th>
<th>Choice of dummy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hot biopsy</td>
<td>Meat, biological dummies</td>
</tr>
<tr>
<td>Biopsy, brushing</td>
<td>Meat (with lumen), wine gams, tubes, biological dummies</td>
</tr>
<tr>
<td>Injection</td>
<td>Orange, white wine gams, meat with lumen, biological dummies</td>
</tr>
<tr>
<td>Haemostasis (clipping, APC, ligation, loops, bicap, etc.)</td>
<td>Meat, biological dummies, wine gams</td>
</tr>
<tr>
<td>Polypectomy, EMR, ESD</td>
<td>Meat and biological dummies (to train in cutting), Wine gams (to test the closing of the snare) and mushrooms</td>
</tr>
<tr>
<td>Endoscopy, ligation</td>
<td>Meat, wine gams, biological dummies, mushrooms</td>
</tr>
<tr>
<td>Dilation, stenting</td>
<td>Plastic models, tubes, biological dummies</td>
</tr>
<tr>
<td>PEG</td>
<td>Simple plastic model, dolls, biological dummies, artificial dummies</td>
</tr>
<tr>
<td>Foreign body removal</td>
<td>Pepper, plastic tubes and boxes filled with wine gams, marbles, stones, coins, etc.</td>
</tr>
<tr>
<td>FNA, fine-needle biopsy</td>
<td>Orange with thick skin</td>
</tr>
<tr>
<td>ERCP</td>
<td>Biological dummies, plastic models from industry and home made dummies</td>
</tr>
</tbody>
</table>

- **Computerized systems** simulate complex body functions in order to train whole endoscopic procedure rather than simple techniques. Computerized systems combine routine diagnostic procedures with related advanced therapeutic techniques.
- **Live animal models**, mostly pigs, are only used for training of complex techniques, e.g. Natural Orifice Transluminal Endoscopic Surgery (NOTES) or Endoscopic Submuscular Dissection (ESD). These trainings are performed in dedicated training centres.

Dummy workshops are helpful tools to train new staff and to train specific techniques. If new staff members are to be trained, dummies can be used as the second level of a structured programme, after becoming familiar with the equipment itself. It is recommended that new staff receive intensive training (tutor: student ratio = 1:1).

Advanced staff who is trained on new equipment or who is receiving updates, do not need the same intensive attention as new staff, because they already have key competencies in endoscopy. Therefore a tutor: student ratio of 1.5 – 10 per dummy may be sufficient.

A mix of experience should be avoided on one dummy. Beginners, experts, new staff and students should be split into different groups, if possible.

### Live demonstrations

Live demonstration is defined as any teaching event which involves as patient as the “observer” is a person not directly involved in the procedure and patient care. This includes events such as:

- **In-house departmental training** of member(s) of staff:
  - Teaching a new member of staff or a visiting nurse/doctor in the procedure room,
  - Clinical teaching demonstration of new equipment by an industry representative with additional staff attending and live demonstration element
- **Demonstrations in the clinical room**
- **Live single events**
- **Endoscopic procedures transmitted into a local seminar room during a course or workshop**

**Bigger events on national or international level**

- **Live demonstration transmitted into a big lecture hall**
- **As stand-alone or during a conference, like ESGE Workshops**
ESGENA NEWS

Quality in Endoscopy Obesity & nutrition

April 4 - 5, 2014 – Prague, Czech Republic

Registration, Abstract and Case presentation submission now possible!

The combination of highly communicative teaching with a strong, support- 

tive faculty is the key to success for “Quality in Endoscopy” symposia. In 

cooperation with the European Society for Clinical Nutrition and Metabo-

lism (ESPEN), ESGE is pleased to announce that our series of Quality in 

Endoscopy symposia continues and that the next meeting with the topic 

“Obesity & nutrition” in spring 2014 in Prague is now online.

Important deadlines:

Abstract submission deadline: January 5, 2014
€ 500 travel grants plus waived registration fees for top accepted abstracts.

Case submission deadline: January 5, 2014
One author per selected case presentation will receive a reduced regis-

tration fee.

Early registration fee deadline: January 26, 2014

ESGE Individual Members, ESPEN Members and ESGENA Members are 

eligible to receive a substantial registration fee reduction.

Online registration deadline: March 30, 2014

More information regarding the programme, faculty, abstract and case sub-

mission may be found at www.quality-in-endoscopy.org or contact:
info@quality-in-endoscopy.org.

ESGE and ESPEN would like to encourage you to take part in this interac-

tive, innovative meeting. We look forward making this a memorable event 

to welcoming you in Praguet.
What’s New?

New Rotatable Retrieval Device

Boston Scientific recently launched the new TWISTER™ PLUS Rotatable Retrieval Device, which comes with a short throw handle designed for nurse and technician comfort.

This three dimensional net is fully rotatable and designed to facilitate retrieval of polyps, EMR/ESD fragments, food bolus and foreign bodies. It is available in two loop diameters, 22mm and 28mm. The device’s 360º rotation – 1:1 ratio to both directions – is designed to facilitate and shorten the procedure with minimal scope manipulation.

Our Continuous Commitment to Education

Boston Scientific is supporting the 17th ESGENA Conference at the 2013 UEG Week in Berlin. Our clinical workshop aims to educate nurses on the importance of sample size and quality in EUS FNA and Biopsy procedures and the impact on clinical diagnoses and patient treatment algorithms. Nurses will increase their knowledge of the different sample preparation techniques and the stages of sample processing in the pathology lab.

Workshop title
Sample Size & Quality (FNA & Biopsy): Endoscopy and Pathology Perspective

Time and location
Saturday October 12, 2013 14.00-15.30 in Hall Roof Garden

Speakers
Dr. Laurent Palazzo, Gastroenterology Dept., Clinique du Tincalot, Paris, France
Dr. Monique Fabre, Medical Bio-Pathology Dept., Institut de Cancérologie Gustave Roussy, Villejuif, France

Description
• Presentation from the Physician’s perspective
• Presentation from the Pathologist’s perspective
• Hands-on training session

New Training Programme for Endoscopy Nurses

Boston Scientific recently launched, in Europe, its Professional Development Programme (PDP), a platform of training modules designed to further advance the clinical and technical knowledge of endoscopy nurses and technicians. To date 2,500 nurses and technicians have participated in over 300 sessions in more than 12 European countries. Training sessions have also been conducted at both a country and regional level in the United States, Asia Pacific and South America. The Programme is endorsed by the European Society of Gastroenterology and Endoscopy Nurses and Associates (ESGENA).

Visit www.youtube.com/BostonScientificEndo to watch procedural videos

1 According to ASTM F2503 in a static magnetic field of 1.5 and 3 Tesla. For a complete list of conditions consult the Directions for Use.

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ENDO-179101-AA Aug 2013
In order to better understand the needs of our customers in the reprocessing of flexible endoscopes, PENTAX Medical held customer workshops in the US, Canada and Germany, during which a total of 28 nurses and reprocessing technicians, seven administrative staff members/biotechnicians, and four doctors were questioned.

The workshops focused on addressing, in small groups, the subject of endoscope reprocessing as well as the other daily procedures in the endoscopic practice. As a teaser for the workshops, PENTAX Medical showed a film which reflected various everyday situations in endoscopy units in a number of hospitals.

After the film, different questioning techniques were used to find out what the individual groups’ biggest challenges and needs were in their daily tasks. In the process, people with diverse functions within the hospital sat down together at one table and had in-depth discussions about their daily experiences on the job, each professional group gaining insights into the others’ perspectives.

One of the most frequently mentioned problems was faulting reprocessing personnel for an endoscope being unavailable or breaking during an examination. Participants expressed their desire for reprocessing support and an automated documentation process.

The participants considered the following steps during reprocessing to be the most difficult and/or the most time-consuming:

- Leak test and tracking
- Leak test and brushing

PENTAX Medical’s objective is to apply the results from the customer workshops to the design of our products. This will enable us to develop customer-oriented products that meet our customers’ reprocessing requirements and support them in their daily work.

**Valves, the single story**

Endoscope valves are vital, sophisticated devices that require regular meticulous cleaning procedures. There are over 30 steps to proper manual cleaning and reprocessing of Biopsy, Air/Water and Suction valves, which can make the cleaning process difficult, if not impossible.

The DEFENDO™ Single Use Valve Family is designated as a sterile, single use alternative to reusable valves. The use of disposable valves offers the ability to eliminate the meticulous, time consuming steps required to reprocess these parts correctly and ultimately reduces the risk to patient safety.

- Eliminate manual cleaning and reprocessing of reusable biopsy valves
- Help create consistent practices
- Reduce the potential for errors

New introduced to this broad array of products are the innovative MEDIVATORS Endoscopy Procedure Products. All products are disposable infection control products and intended to replace the necessity of sterilizing and reusing numerous components in gastrointestinal endoscopy procedures.

**Study results** indicate that a significant number of reprocessed valves were not reprocessed according to recommended practices for high level disinfection. Additionally, study results show that a significant number of reprocessed and patient-ready valves were not according to the guidelines and procedures published by Olympus, Fujinon and Pentax.

**Conclusion:** Test results demonstrate that the majority of patient-ready, reusable endoscope air/water and suction valves do not meet the high-level disinfection criteria for semi-critical medical devices.


For more information please visit our booth in the UEG Week exhibition area or alternatively send us an email at: csnl@medivators.com.
ESGENA MEMBERSHIP

Active group membership
National societies, groups or federations which represent the interests of gastroenterology and endoscopy nurses and endoscopy associates based in a geographic European country. To prevent undue dominance of countries with several national groups, each internationally recognised European country has the right to cast one vote, regardless of the number of group memberships a European country possesses.

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

Passive group membership
National societies, groups or federations which represent the interests of gastroenterology and endoscopy nurses and endoscopy associates based in a Non-European country. These groups have no right to vote and cannot nominate one of their members to hold office.

- Members: < 50 51 - 100 101 - 250 251 - 500 501 - 750 751 - 1000 > 1000
- Fee: 20 EUR 35 EUR 75 EUR 155 EUR 355 EUR 555 EUR 705 EUR

Individual membership
Persons practising, managing, teaching or researching in gastroenterology and endoscopy nursing. Individual members have no right to vote, to prevent undue dominance of countries with a large number of individual members. Individual members have the right to stand for office if they are based in a European country.

- Membership fee: 15 EUR

Passive membership
Persons who used to practise, manage, teach or research in gastroenterology and endoscopy nursing and who have maintained an interest in this field. Passive members may not vote or hold office.

- Membership fee: 10 EUR

Affiliated membership
Members from the industry may join the society but may not vote or hold office.

- Membership fee: 55 EUR

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Reduced rate for orders > 100 10 EUR per copy
For Non-Members 20 EUR per copy

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Please contact: info@esgena.org
Achieving positive patient outcomes through *Procedural Excellence* requires a confident and well-trained clinical team.

At Boston Scientific, we provide best in class training and education to thousands of nurses and technicians throughout the world as well as provide sponsorship support to GI nurse societies.

We recently launched the Professional Development Programme (PDP), a series of in-service training courses designed to further advance the clinical and technical knowledge of endoscopy nurses and technicians. To date, 2,500 people have participated in that programme in more than 12 countries throughout Europe.*

To learn more about our training and education programmes and other value-added services, contact your local representative or visit www.bostonscientific.com/endo-nursepub.

*Data on file