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ESGENA Governing Board

President

Ulrike Beilenhoff
Ferdinand-Sauerbruch-Weg 16
D-89075 Ulm, Germany
Tel. +49-731-950 39 45
Fax +49-731-950 39 58
E-mail: UK-Beilenhoff@t-online.de



Left to right: Ulrike Beilenhoff, Silvia Lahey, Jayne Tillett, Jadranka Brljak, Michael Ortmann, Stanka Popovic and Mette Olesen

Vice-President

Michael Ortmann
Leader of Advanced and
Continued Endoscopy Education
University Hospital of Basel
Endoscopy Department
Petersgraben 4
CH 4031 Basel, Switzerland
Fax: +41-61 265 24 05
E-mail: MOrtmann@uhbs.ch

General Secretary

Sylvia Lahey
Rijnstate Hospital
Endoscopy Unit
Wagnerlaan 55
6815 AD Arnhem
The Netherlands
Tel. +31-880058888
E-mail: sylvia.lahey@planet.nl

Treasurer

Stanka Popovic
University Medical Centre
Dep. of Gastro. Surgery
Zaloska 7
1000 Ljubljana, Slovenia
Fax +38-615421900
E-mail: sm.popovic@siol.net

Councillors

Jadranka Brljak
Head Nurse
Gastroenterology Unit
Dept. of Internal Medicine
KBC Zagreb Rebrow
Kispaticeva 12
10000 Zagreb, Croatia
Tel. +38-512388189
Fax +38-512420100
E-mail: jadranka.brljak@zg.t-com.hr

(Editor of *ESGENA News*
and the ESGENA web site):
Mette Asbjørn Olesen
Nurse Manager of endoscopy unit
Hillerød Hospital
Dyrehavevej
3400 Hillerød, Denmark
Tel. +45-48296599
E-mail: meol@hih.regionh.dk

Jayne Tillett
Diagnostic and Treatment Manager
Forest Hospitals
Gloucestershire PCT
Lydney & District Hospital
Grove Road, Lydney,
Gloucestershire GL15 5JS, UK
Tel. +44-1594598259
E-mail: jayne.tillett@glos.nhs.uk

Editorial Office

ESGENA Executive Secretariat

Medconnect GmbH
 Brunnsteinstrasse 10
 81541 Munich, Germany
 Tel. +49-89-4141 9241
 Fax +49-89-4141 9245
 E-mail: info@esgena.org

Please contact the Editorial Office
 for any inquiries regarding
 advertisements or articles.

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Articles published in *ESGENA News* do not necessarily reflect the views of ESGENA.

Publications and Deadlines

ESGENA members are invited to report on activities in their own countries on the ESGENA web site, in *ESGENA News* and in the *ESGENA e-News*. The various publication dates and deadlines for submitting announcements, articles and reports are:

Deadlines for submitting material for publication

	Publication date	Deadline for submitting articles, reports and announcements
ESGENA e-News 2009-2	May 2009	15 April 2009
ESGENA e-News 2009-3	October 2009	15 September 2009
ESGENA News 2009-2	September 2009	1 August 2009
ESGENA Membership Pages no. 12	September 2009	1 August 2009

Please send the information to the ESGENA Executive Secretariat:
 Medconnect GmbH, Brunnsteinstrasse 10, 81541 Munich, Germany
 Tel. +49-89-4141 9241, Fax +49-89-4141 9245, E-mail: info@esgena.org

Message from the President

First of all, I would like to wish all readers of *ESGENA News* a happy, healthy, and successful year in 2009. Looking back on 2008, I can say it was a very busy and successful year for ESGENA. A number of publications were issued:

- The European Core Curriculum for Endoscopy Nursing was published after 5 years' work. It is available on the ESGENA web site (www.esgena.org) and as a CD-ROM from the ESGENA Secretariat.
- The ESGE–ESGENA guideline on cleaning and disinfection in gastrointestinal endoscopy was updated and published in the November issue of *Endoscopy* (2008;40:939–57).
- ESGENA developed a statement on nurse endoscopists in order to recommend a structured, university-based training programme and to protect nurses against ad-hoc initiatives.
- The ESGENA statement on staffing levels gives guidance on how to identify deficiencies in staffing levels, how to improve the level of patient care, and how to enhance education and training for endoscopy staff. Both statements are also available on the ESGENA web site.

The first ESGENA Technical Skills Workshop was held in May 2008 in Iceland. The new project was initiated by Michael Ortman (from Switzerland), who has a great deal of experience in running hands-on workshops. The 3-day workshop in Iceland was attended by around 30 nurses and was a great success (see the report in the previous issue of *ESGENA News*, no. 22). ESGENA also contributed to ESGE–ESGENA workshops with live demonstrations held in Izmir (Turkey) and Sofia (Bulgaria; see the report in this issue), providing a number of highly qualified nurse tutors. I was delighted that we were able to provide a number of new nurse tutors for these projects.

The ESGENA conference in Vienna was a great success. Nearly 500 colleagues enjoyed the special atmosphere of the Austrian capital and its great hospitality. I would especially like to thank Herta Pomper and Gerlinde Weilguny for their helpful, committed and uncomplicated cooperation before and during the conference. It was really a great pleasure to work with them. The success of the ESGENA conference is always the result of professional teamwork, with high-quality presentations by the chairmen, speakers, tutors, and free paper authors. The positive feedback from participants in Vienna showed that we achieved this, and my thanks go to everyone who was actively involved in the conference. It was a very special moment for many of us during the Annual General Assembly in Vienna when Christiane Neumann was awarded honorary membership of ESGENA for her exceptional work for ESGENA (see the report in this issue).

ESGENA has already started to work closely with the Society of International Gastroenterological Nurses and Endoscopy Associates (SIGNEA) and the Endoscopy Associates Group of the British Society of Gastroenterology (EAG-BSG) to organize the joint GI Nurses 2009 meeting, which is to be held in London during Gastro 2009 (21–23 November 2009).

The meeting will combine the traditional structures of the European and world conferences and will offer some interesting new formats. The preliminary announcement and call for abstracts are enclosed with this issue. We hope to welcome as many members to London as possible.

My thanks also go to our sponsoring biomedical companies for their continuing support and loyalty. Their financial and personal support is always vital for achieving the Society's various projects. Without their support, ESGENA's activities and the ESGENA conference would have been almost impossible.

The coming year will again be an interesting and busy one for ESGENA. We will be continuing to support the ESGE workshops with live demos. ESGENA would also like to organize a second ESGENA Technical Skills Workshop, and we are hoping to receive applications from membership countries. The combination of state-of-the-art lectures and hands-on training in small groups is a very effective way of providing training in endoscopic skills. We would like to involve more colleagues from different European countries in these ESGENA activities. We will need the support of experienced ESGENA members as tutors and speakers in order to achieve the two different projects. Nurses who are interested in helping us as nurse tutors are invited to contact the ESGENA Governing Board.

As a combined ESGENA–SIGNEA conference, GI Nurses 2009 will be a very special event, with the EAG-BSG as the local hosts. We will be offering a number of interesting features at the London meeting and would also very much appreciate receiving a large number of interesting abstracts for the conference. We hope that many members will be able to come to London to meet up with international colleagues and share their experience and knowledge.



Ulrike Beilenhoff

Ulrike Beilenhoff

E-mail: UK-Beilenhoff@t-online.de

ESGENA Honorary Membership for Christiane Neumann

The first Honorary Member of ESGENA was Dr. Jean-François Rey from France, who supported the foundation of ESGENA and has always been a stalwart partner for the Society. Another figure who made an incomparable contribution to the development of ESGENA was Christiane Neumann.

Christiane was born and grew up in Germany and moved to Bristol in the United Kingdom during the 1970s. She was one of the pioneers of endoscopy nursing in the UK, working in Bristol and Birmingham. Although she has now retired from clinical work, she is still very active in university teaching, in various ethics committees, in the national colorectal cancer screening programme and in Joint Advisory Group (JAG) accreditation of endoscopy centres.

Christiane was one of the founding members of ESGENA in 1996 and held the following positions in it with professionalism, distinction and commitment:

- 1996–1999 General Secretary
- 1999–2002 Vice-President
- 2002–2006 President
- 2006–2007 Councillor

With her background in education and science, she initiated many ESGENA activities. She shaped ESGENA with her analytic way of working, her vision and ideas, her commitment and energy.



Christiane Neumann receiving her honorary ESGENA membership in Vienna, October 2008.

She invested a great deal of work in ESGENA's education working group and was co-author of various ESGE–ESGENA guidelines. As chair of the scientific committee, she organized the ESGENA conferences between 1996 and 2006. This is an impressively long period, and everyone who has ever organized a conference will be able to appreciate the scale of her contribution.

Christiane's enthusiasm and commitment have been so important for ESGENA that the ESGENA Governing Board decided to award her honorary membership of the Society. The award was presented during the Annual General Assembly in Vienna and I would like to express our thanks and appreciation to her again here.

Ulrike Beilenhoff

E-mail: UK-Beilenhoff@t-online.de

Impressions from the 12th ESGENA Congress in Vienna, 18–20 October 2008

After the World Congress that was held in Vienna 10 years ago, it was great to be back again in the wonderful city of Vienna with its rich culture. The conference was held in the same venue as before, at the Austria Center, and the contrast between the two events clearly showed the extent to which ESGENA has progressed from its initial phase to become a well-established organization for continuing education.

The high quality of the presentations, workshops and posters was a sign that many committed people had been working together for years to raise the standards of nursing care and research in gastroenterology. The 481 participants from all over Europe (see table at the end of this article) – and from as far away as the United States, Brazil and Thailand as well – were proof of the successful work carried out by ESGENA's Board and members over the years. Together with the Austrian Society of Endoscopy Nurses (Inter-

essensverband Endoskopiepersonal Austria, IVEPA), a compact and varied conference programme was presented.

The meeting began on the Saturday morning with live demos from the United European Gastroenterology Week postgraduate training programme. The afternoon featured two sessions with four parallel workshops. In conjunction with the medical industry, subjects discussed included hygiene surveillance, capsule endoscopy, HF surgery and stricture management. Key ESGENA members explained the English quality assurance model, and in another workshop hands-on training in how to make simple dummies was provided. Most attractive of course were the two sessions of hands-on training in endoscopic techniques using biosimulators. Dozens of highly qualified and committed endoscopy nurses from all over Europe were available to provide assistance and training for colleagues.

After the first full day, we enjoyed the Welcome Reception. This was a lively evening in the pleasant atmosphere of a typical Vienna *Heurige* (wine tavern), with a folk music group and plenty of tasty Austrian food. It was an ideal event for meeting old acquaintances from all over Europe and the world, as well as for making new contacts. This was the only occasion at which most of the participants were united, and it was very clear



The Austria Center, Vienna, venue for the 12th ESGENA Congress.

– again in the same location as last time – how much ESGENA has grown over the past decade.

On Sunday, the scientific programme contained eight parallel sessions held in two halls. The main topics dealt with were sedation,



A rickshaw at the Austria Centre during the Vienna Congress.

pediatric patients, gastroenterology patients, psychology, education and management. Two free paper sessions gave 12 courageous delegates the opportunity to share their local experience and research. The abstracts are included in this issue of *ESGENA News* and on the web site so that readers and participants can discover or remember the many interesting presentations.

The biosimulator workshops also continued in the morning for doctors and in the afternoon for nurses – again made possible by the highly motivated training team.

The poster exhibition was another attractive aspect of the Congress. Several national societies offered posters introducing themselves, and the structures, activities and benefits of ESGENA were presented. Eighteen scientific posters from around Europe as well as from Israel, Turkey, Brazil and Thailand demonstrated the ever-increasing quality of nursing research. Several posters addressed aspects of sedation, while others were about bowel cleansing, patient information, nurse-performed endoscopy and nursing in hep-

atology. Some described suggested improvements for endoscopic techniques as well as other nursing care subjects. Original titles like 'Propofol – the patient's best friend during endoscopy' and 'The neighbor around the corner' (prostate cancer detection during colonoscopy) caught our attention. The presenters' research skills and originality were remarkable, and discussions around the posters led to interesting insights. All of the posters were evaluated carefully by a jury, but unfortunately only one was able to win the prize – a digital camera for the Danish authors of 'Nurse-led rehabilitation clinic for patients with chronic hepatic insufficiency'.



St. Stephen's Cathedral.

At the general assembly in the evening, there was a special highlight in addition to the usual agenda: Christiane Neumann was awarded honorary membership in appreciation of her many years of hard work and effective commitment for ESGENA. This was very well deserved, in view of her rich experience in endoscopy nursing over decades and the invaluable contributions she has made to the Society's structure and many of its documents. Without Christiane's commitment, ESGENA would not yet have developed to such a high level.

On the Monday, there was a plenary session in the morning on new techniques and developments, followed by the announcement of the best free paper and the poster awards, as well as an invitation to the next Congress in London. For the fortunate ones who still had time and energy, there was an opportunity in the afternoon to visit the ESGE Learning Area, to listen in to a few UEGW sessions and to discover new developments during a stroll through the exhibition halls.

In addition to the wide variety of information it provided, this year's ESGENA Congress was yet another successful event for gastroenterology nurses to meet and exchange ideas with each other, to contact colleagues internationally and to enhance interest in our profession.

Lorenz Rudkin
Association Luxembourgeoise du Personnel en Endoscopie
(ALPE), Luxembourg

ESGENA conference participants by country

Australia	3	Estonia	8	Jordan	3	Saudi Arabia	1
Austria	17	Finland	3	Latvia	3	Serbia	2
Belgium	53	France	4	Luxembourg	10	Slovenia	7
Brazil	2	Germany	21	Malta	1	Spain	16
Bulgaria	1	Greece	8	Monaco	1	Sweden	18
Canada	4	Hungary	6	Netherlands	67	Switzerland	18
China	2	Iceland	6	New Zealand	1	Thailand	1
Croatia	8	Ireland	16	Norway	21	Turkey	3
Czech Republic	4	Israel	11	Portugal	19	United Kingdom	14
Denmark	49	Italy	33	Romania	9	USA	7
						Total	481

Report from the ESGE–ESGENA Live Demonstration Workshop in Sofia, Bulgaria, 21–22 November 2008

When I was invited to take part in the ESGE–ESGENA Live Endoscopy Workshop held in Sofia in November, I already had some experience in performing live endoscopy training in my own endoscopic unit, but had never worked at a hospital in a different country before. After a preliminary meeting with the rest of the

team at United European Gastroenterology Week (UEGW) in Vienna, I was looking forward to working with Michael Ortman, Jane Tillett and one of my own colleagues from home, Anne Elsborg. I felt confident that we would be a good team and ready

for the challenges the workshop would bring – and this proved to be very much the case.

The workshop was held over 2 days, combining live endoscopy and lectures. It was a joint ESGE–ESGENA event for doctors and nurses, with six doctors travelling to Sofia in addition to our team of four nurses. There were separate lectures for the doctors and nurses, providing an opportunity to focus on the different topics relevant to each profession. The four of us also held a workshop for the local nurses on the third day, after the main event.

The workshop, held at the Military Medical Academy (MMA) hospital in Sofia, was worlds away from my everyday life in the endoscopy unit at Bispebjerg Hospital in Copenhagen. We spent a day at the hospital listening to presentations of all the cases and deciding which ones to take. The local unit presented us with 36 cases, and we carried out 30 procedures during the workshop. The procedure rooms we used were the operating rooms for laparoscopic surgery, so the local nurses were also not in their usual workplace. I thought they did an incredible job, considering the conditions. It was new to all of us and we quickly established good teamwork, despite the lack of a common language. Most of the time there was someone around who could translate. The workshop on the Sunday was very well received by the local nurses, and the participants seemed to get a lot out of it. There was an interpreter present, which was a great help for getting questions answered – otherwise a lot can also be taught by doing!

After the experience in Sofia, I have seen my own everyday working life from a different perspective. It is good to go and have a first-hand look at what is happening in other places and reflect on what you take for granted in your own daily work. It was very rewarding to work with the local nurses in Sofia, and they were very appreciative of our efforts.

We also had an opportunity to take part in some Bulgarian folk dancing at a reception on the Friday evening, which was great fun and helped in establishing contacts and friendships.

Wendy Waagenes
Endoscopy Nurse, Bispebjerg Hospital, Copenhagen, Denmark
E-mail: ww02@bbh.regionh.dk



Endoscopy team with European experts at the ESGE–ESGENA Live Demonstration Workshop 2008 in Sofia

Abstracts from the ESGENA Conference 2008

Accepted abstracts received free registration at the ESGENA Conference. There were three assessors who judged the oral presentations and poster sessions. The assessment criteria were:

- **Relevance:** is the paper relevant to nursing (directly or indirectly)?
- **Accuracy:** is the information up to date and are sources of evidence stated?
- **Evidence-based:** this means that the information is based on reliable evidence, which in turn is based on high-quality research.
- **Clarity:** is the information clearly communicated?
- **Educational value:** e.g., will it improve practice/services for patients, knowledge, etc.?
- **Evaluation:** is the paper just descriptive, or has there been some evaluation?
- **Originality:** does the paper provide new information, or does it have a new approach of some type to an old problem, or does it provide something useful for other people's practice, etc.? (Not just repetition of something well known.)
- **Presentation:** e.g., logical, stating aims/objectives, methods, results, summary and conclusions, etc.
 - Statements such as "results will be discussed" or "data will be presented" are not acceptable.
 - Time-keeping (within the allotted time).
 - Clear and well presented.
- **Research vs. clinical:** research abstracts need to have the appropriate format – describing an audit, intervention tested, etc., with evaluation of effectiveness. Clinical papers

describe a change of practice (and should also be evaluated for effectiveness or compliance with guidelines).

- **Quality of presentation:** were the slides or poster easy to read?
- **Compliance with abstract submission guidelines:** does the abstract comply with the instructions given (including aims, methods, results, conclusions, references, learning outcomes, etc.)?
- **Responses to questions:** was the presenting author able to answer any questions?

Prizes to be won:

- The presenters of the Best Free Paper – Oral Presentation win free registration and two nights' accommodation at the next ESGENA conference.
- The presenters of the Best Free Paper – Poster Presentation win a digital camera.

Details on how to submit an abstract for the next ESGENA conference are given in the ESGENA conference announcements in this issue and on the ESGENA web site (www.ESGENA.org).



We would like to thank Pentax Europe for sponsoring the ESGENA Free Paper Sessions.

Best Oral Presentation Award presented on 19 October 2008 in Vienna.

The education of patients with home parenteral nutrition

Chantal Bakhuysen RN, Gwenda Veenboer RN, Ward F7 Zuid, Gastrointestinal and Hepatology Diseases, Academic Medical Centre, Amsterdam, The Netherlands

Introduction: On the ward we train 10 patients on a yearly basis in the use of total parenteral nutrition (TPN) given through a central venous catheter (CVC) at home. In The Netherlands there are two academic centres who provide this training. The patients need to use TPN due to intestinal failure. Our group of adult TPN patients is 60 out of a total of 120 nationwide. The nutrition support team (NST) of the AMC is the practitioner in charge. The tasks of our medical ward are: to educate and train the patients, admit the patients when complications occur and function as a 24/7 back-up for patients when the NST is out of office. The last couple of years we have seen a growth in the amount of these patients. The goal of the education and training is to give the patients tools to live an independent life with more quality. This is done by teaching the patients how to take care of their CVC, recognising and dealing with complications and to educate them about the effects on their

social lives. Training is done by nurses who have had specialized training.

Aims: Improving the education of the patients and thereby increasing their independency and satisfaction (quality of care). Improving the competence and satisfaction of the nurses at the ward regarding training patients.

Methods: We evaluate the stay in hospital and the training with all patients using a standardised questionnaire. We had a group evaluation with TPN patients led by an independent conversationleader. In Holland this is also known as a 'mirrormeeting'. We organize regular training for our nurses to keep their knowledge regarding the training of the TPN patients on a high level.

Results: Patients on the whole are satisfied with the quality of nursing but we aim to improve. The training of the nurses themselves is now standardized; a theoretical part of 2 hours, a practical part of 2 hours. The first time a nurse educates a patient she will be supervised by a nurse already experienced. In the near future a DVD and an interactive website will be made by the NST to support the patients. In the group evaluation patients told us that they are satisfied with the support of the ward during their stay and as a back-up function. The one thing they missed while being admitted was the possibility to keep themselves occupied while they were not training. Now the activity counsellor is actively involved.

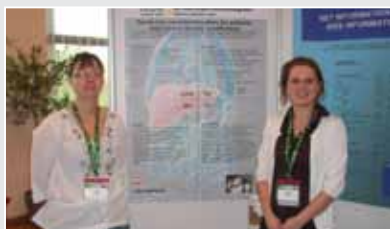
Conclusions: The outcome of the different evaluations show that we give our patients a good quality of care but there is always

room for improvement. Therefore we will continue to evaluate our care given. We have to anticipate on the (possible) growth of this group of patients. To educate this patient group gives our nurses an added value to their profession.

References:

The treatment of intestinal failure with HPN of children and adults. A.H.J. Naber et al. *Ned Tijdschr Geneesk* 2005, 149 (8), 385-390
Can home parenteral nutrition be provided by none specialised centres?: the Dutch experience. C.F. Jonkers et al. *Clinical Nutrition* 2005, 24, 526-527

Best Poster Presentation



Award presented on 19 October 2008 in Vienna

Iben Asmussen Lisbjerg and Jeannette Agregaard Jensen, winners of the Best Poster award.

Nurse-led rehabilitation clinic for patients with chronic hepatic insufficiency

Iben Asmussen Lisbjerg, Steen Vadstrup and Winnie Soegaard, Department of Gastroenterology, Holbaek Hospital, Holbaek, Denmark

Introduction: Nurse-led rehabilitation clinics have improved the outcome of patients in several areas of medicine such as heart failure, chronic lung failure and malignant disease (1,2). We wanted to intensify the follow up and to measure different quality assurance parameters in patients with chronic hepatic insufficiency, which were therefore enrolled in a nurse-led rehabilitation clinic after having been treated in a stationary unit for an attack of acute hepatic encephalopathy.

Aims & methods: The patients were booked for a visit of 15 – 30 minutes by a specialist nurse from our stationary department with 1-4 weeks intervals. Standard blood samples including serum alcohol were measured each time together with clinical parameters such as cerebral function, muscular function, coordination, body temperature, pulse, blood pressure and abdominal circumference. Special attention was drawn on the possibility of recurrent infection in these patients due to their defective immune system. Also the state of nutrition was monitored and extra protein drinks added if necessary. Life style changes, alcohol abstinence and daily life activities were discussed at each visit. The patients could be referred by the nurse to the stationary unit at all times.

Results: Until now 9 patients have been enrolled, age 47 – 63, mean 61, F/M ratio 3/6. All had chronic hepatic insufficiency on basis of alcoholic cirrhosis. The follow up period was of 7 months, mean 4 months the patients were very satisfied with the clinic and

the close physical relationship with the stationary unit and more satisfied compared to control in the normal out-patient clinic. During the period of observation, none of the patients died: Four patients were acutely referred several times to the stationary unit due to infection (3), ascites (2), anaemia or bleeding episodes (2). One of the patients was referred 8 times. New episodes of acute encephalopathy were recorded in 2 patients. Four of the 9 patients were referred for evaluation of liver transplantation at the University clinic in Copenhagen but no one has been transplanted yet.

Conclusion: Nurse-led rehabilitation clinics have not yet been reported in patients with chronic hepatic insufficiency and the present data seem to be the first from such a clinic. The data show that this type of clinic in close relation to a stationary unit is attractive for patients with chronic hepatic insufficiency and it seems as if the patients will benefit from such a tight control with doctors and nurses with special knowledge of liver diseases.

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Stromberg A et al. Nurse-led heart failure clinics improve survival and self care behaviours in patients with heart failure. Results from a prospective randomized trial. *Eur Heart J* 2003; 24: 1014-23.
Wong FK, Chung LC. Establishing a definition for a nurse-led-clinic: Structure, process and outcome. *J Adv Nurs* 2006; 53: 358-69.

Abstracts of ESGENA Free Paper Sessions

Nutrition to patients suffering from severe alcoholism – an interdisciplinary success story

Dorthe Melgaard, Marianne Toppenberg, Regionshospitalet Viborg, Viborg, Denmark

Background: Many patients admitted to the medical gastroenterological ward are in a poor condition and are poorly nourished. This patient group has frequently a long history of alcohol abuse. The hospitalisation of these patients is often lengthened considerably and often complicated by infections due to their poor nutritional status. Their mental capacities are often affected to such an extent that they neither show an interest in nor are active in relation to their illness. These patients can show very little inclination to collaborate in the improvement of their nutritional status which can be a challenge to nurses both in regards to their own motivation and the effort involved. This can lead to them querying the amount of resources used of this particular group of inactive patients.

Objectives: To share positive experiences with improving the nutritional status of malnourished patients with long-term alcohol abuse. To demonstrate the many aspects of nursing involved in caring for these patients. To demonstrate that it pays to use time and energy on this patient group.

Method: Success was experienced in improving the nutritional status of an extremely malnourished during a 5-month hospitalisation. During this process many positive experiences were gained from individual, interdisciplinary and goal-oriented nutrition therapy. This motivated health care staff to increase their efforts with similar patients. The long-term treatment of four patients over the last two years has resulted in the accumulation of a great deal of experience and knowledge and armed staff with the belief that an improvement of the nutritional status of these patients is possible.

Results: Using an individualised nutritional strategy four patients showing severely malnourishment on admission were successfully discharged with a much improved nutritional status. During nutrition therapy both patients and health-care professionals will encounter difficult periods. Implementation of various motivation strategies both in relation to the patient and health-care professionals is an imperative. A goal-centred approach in relation to these patients has led to an increase in knowledge and in interdisciplinary care to patients on this ward. An awareness of the hospitalised patient's psycho-social status is of extreme importance as this has a bearing on the continued success of nutrition therapy and advice after discharge.

Conclusion: All health-care staff on the ward have become very conscious of the important role of nutrition. Nurses have acknowledged the challenges of caring for this group of patients but have seen that good results are possible. A heart warming story like this shows it is possible to help the most marginalised groups in society.

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- Stratton R.J., Green C.J, Elia M. Disease-related malnutrition: An evidence-based approach to treatment. Danish summary. August 2003. Nutricia.
- Sundhedsstyrelsen 2005. Vejledning til læger, sygeplejersker, social- og sundhedsassistenter, sygehjælpere og kliniske diætister. Screening og behandling af patienter i ernæringsrisiko.

Implementation of new technology in hepatic nursing through development of standard nursing care plan for Prometheus liver support treatment

Gitte Kastberg Andersen, Department of Medicine V, Aarhus University Hospital, Denmark

Introduction: New technologies in hepatic treatment are developing rapidly and demanding new strategies for the nursing as well. Prometheus liver support is a new treatment and set of guidelines for the treatment and the specialized nursing in relation to the patients with liver failure were needed to insure a high level of nursing standard. At Aarhus University Hospital, Danish patients, - suffering from acute liver failure, are offered a liver support treatment called Prometheus, which supports the liver and removes toxins until liver transplantation is available. In some cases the liver support is so efficient that the patient is regarded cured from the acute liver failure. The treatment is performed in collaboration between doctors and nurses. Each treatment has duration of approximately 8 hours and is often performed in series of 3 treatments. Patients are totally immobilized during treatment due to dialysis-catheters in v. Jugularis or v. Femoralis. Prevention of the

risks during immobilisation is essential as is monitoring the patient's cerebral, renal, hepatic and nutritional status. Thus, both technical skills and specialized hepatic knowledge is needed for the nurses involved.

Aims: To implement tools to define, optimize, document and continuously improve the nursing skills in the field of liver support treatment.

Materials and methods: Information retrieval from relevant databases: CINAHL, Cochrane library, PubMed, ScienceDirect, British Nursing, Blackwell Synergy and BMJ journals.

Results: No materials on nursing guidelines regarding Prometheus liver support were found. However, material on basic renal

dialysis was added to our scientifically based knowledge about hepatic nursing and led to the development of a standard nursing care plan, including the Glasgow Coma Scale, individual nutrition plan and monitoring of urine and stools. In addition, check lists for the nurses performing liver support were developed. Both tools have become an important part of the daily nursing and have led to a more exact definition and evaluation of patient needs. Nursing staff, patients and relatives have appreciated the detailed and structured nursing care plan. Using the plan optimises the treatment by documenting the specialized nursing this treatment demands. During treatment, the nurse can more readily predict any approaching needs of the patient. Additional resources can be used to serve the individual needs of the patient or the technical aspects of the liver support.

Implementation of a gastroenterological semi-intensive observaton unit improves the quality of nursing in patients with hepatic coma

Astrid Reher-Langberg, Jens Noppenau, Christian Homann, Department of Internal Medicine I, Division of Gastroenterology, Bispebjerg Hospital, University of Copenhagen, Denmark

Introduction: During 2006 a gastroenterological semi-intensive observation unit (GIO) was established in our department. Besides specific treatment guidelines, the implementation of GIO involved a more specific instruction to competent nurses on treatment of critically ill gastroenterological patients, especially patients with liver failure and hepatic coma.

Aims and methods: The aim was to evaluate whether 4 specific nursing parameters had improved after the introduction of GIO: active enteral or parenteral nutrition within 72 hours of admission; registration of possible decubitus ulcers; achievement of soft stool; arrangement of meeting and conversation with the patients' relatives within 72 hours of admission. All patients admitted with hepatic coma in our department during 2004 – 2005 and patients admitted after the implementation of GIO from the beginning of 2007 until April 2008 were included in our retrospective study.

Results: 44 patients were included, of which 27 were before the implementation of GIO and 17 were after. Active nutrition was performed in 16 (54%) patients before GIO and in 16 patients after GIO (94%), $p = 0.015$; registration of possible decubitus ulcers in 11 (41%) vs. 7 (41%), $p = 1.0$; soft stool in 7 (26%) vs. 15 (88%), $p = 0.005$; a meeting with the patients' relatives in 13 (48%) vs. 10 (59%), $p = 0.194$.

Conclusion: The development of standard nursing care plans in the early phase of presenting new technologies is advantageous to staff and patients alike, insuring a high nursing standard.

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Conclusion: The establishment of GIO shows a significant improvement in active nutrition and achievement of soft stool, both being among key nursing modalities in patients with hepatic coma. Additionally, although not statistically significant, better results were obtained for earlier communication with the patients' relatives. Registration of possible decubitus ulcers was the same in both groups and represents a field for improvement in near future.

Key messages: Establishment of a GIO unit for hepatic coma patients raised the level of nursing on key parameters such as nutrition and obtaining a soft stool. In order to achieve and sustain a high quality of nursing in critically ill patients with hepatic coma, we believe it is necessary to implement specific nursing guidelines in addition to specific treatment guidelines.

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A prospective multicentre study on short and long-term complications of percutaneous endoscopic gastrostomy (PEG) in Italy

Maurizio Giacomini⁽¹⁾, Giorgio Benedetti⁽¹⁾, Francesca Valent⁽²⁾. (1) S. Maria degli Angeli Hospital, Gastroenterology and Endoscopic Digestive Ward, via Montereale, 24 33170 Pordenone; (2) University Hospital of Udine, Institute of Hygiene and Epidemiology, via Colugna 50, 33100 Udine, Italy.

With the collaboration of: Costa G.^(*), Imperiali G.⁽⁺⁾, Bilardi C.⁽⁺⁾, Conio M.⁽⁺⁾, Ermacora N.^(*), Berretti D.⁽⁺⁾, Michelis C.^(*), Aldrighetti F.^(*), Audino M. R.^(*), Cervetto M.^(*), Mantero E.^(*), Nieddu M.^(*), Sciancalepore N.^(*), Solari M.^(*), Ferretti M.^(*), Ferronato A.⁽⁺⁾, Madia D.⁽⁺⁾, Fontana E.^(*), Iori G.^(*), Giacometti O.^(*), Franchini P.^(*), Guido E.⁽⁺⁾, Bastarolo D.⁽⁺⁾, Tincani M.^(*), Cavallaro G.E.^(*), R. Conigliaro⁽⁺⁾ (*)RN (+) MD (^) MSPH

Introduction: Percutaneous endoscopic gastrostomy (PEG) is commonly used to allow enteral nutrition in patients with impaired oral intake of foods and fluids. Mild and severe complications may occur as a consequence of the use of PEG tubes.

Objective: To estimate the frequency of complications among the patients of 9 Italian centres.

Methods: All patients undergoing a PEG tube placement between August 1, 2006, and December 31, 2007 in the 9 centres and consenting to the research were prospectively enrolled in the study. They were followed for 6 months and vital status and the onset of complications were actively assessed by the gastroenterology nurses 1 week, 1 month, and 6 months after the tube placement procedure through a structured form. Mortality of patients after 6 months and the risk of various types of mild and severe complications at each time were calculated. Multivariate logistic regression was used to evaluate risk of death at 6 months associated with characteristics of the patients, of the tubes, and of the centres. The associations between the occurrence of complications at each time and characteristics of the patient, of the tube, and of the type of nutrition were assessed through Fisher's exact tests and, where possible, multivariate logistic regression.

Results: 297 patients were enrolled. Median age was 73 years. Swallowing impairment was the most common indication for PEG (80.5%). Laryngological occluding conditions (12.0%), oesophageal occluding diseases (4.7%), and face traumas (2.7%) were less common. 6-month mortality was 29.9%, most deaths (57.3%) occurring between 1 and 6 months after PEG tube placement. In multivariate analyses, the only factor associated with mortality was neoplastic comorbidity (OR=2.2, 95%CI: 1.0-4.7). The risk of complications, consistent with other studies (1, 2), was 19.6% in the first week after PEG tube placement, 17.0% from 1 week to 1 month, and 15.3% from 1 to 6 months. The most frequent complications at each time regarded the stoma. After the first month, the frequency of abdominal complications (e.g. nausea, vomiting)

resulted greatly reduced, whereas complications regarding the tube (e.g. obstruction, breakage, deformation) resulted greatly increased as compared with earlier times. At all times, the risk of complications was significantly lower in patients using industrial preparations for enteral nutrition and in those using the pump system than among the others.

Conclusions: This is the first Italian study estimating the frequency of complications in patients with PEG tubes and identifying factors associated with increased risk, thus providing useful indications to nurses taking care of these patients. The finding that patients with industrial nutrition and pump delivery have less complications could serve for nursing scientific societies as the basis for reviewing their guidelines. Further research is needed to better characterize the complications and their risk factors and to explore additional aspects related to PEG such as quality of life of the patients. Given the relatively high mortality of patients with PEG, often due to their underlying conditions, careful patient selection is warranted by a multiprofessional team including gastroenterology nurses.

Learning outcomes: Mortality in PEG patients was mainly affected by neoplastic comorbidity. The distribution of different types of complications varied with time and the frequency was lower when industrial preparations for enteral nutrition and the pump delivery system were used.

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Job stress and coping strategies in patients with subjective food hypersensitivity

^{1,2}Ragna Lind, ^{1,2}Kristine Lillestøl, ³Hege Randi Eriksen, ^{4,5}Tone Tangen, ^{1,2}Arnold Berstad, and ^{1,2}Gülen Arslan Lied,

¹Institute of Medicine, University of Bergen, ²Division of Gastroenterology, Department of Medicine, Haukeland University Hospital,

³Department of Biological and Medical Psychology, University of Bergen, Norway, ⁴Institute of Clinical Medicine, University of Bergen,

Norway, ⁵Department of Psychiatry, Haukeland University Hospital, Bergen, Norway

Objective: Subjective food hypersensitivity is a prevalent condition. In most cases its aetiology is obscure. According to Karasek's job strain model (1) and the Cognitive Activation Theory of Stress (2), job stress and coping strategies could play a role. We therefore hypothesized that subjective food hypersensitivity and its psychological and somatic co morbidities would be related to job stress, coping strategies and satisfaction with work environment.

Methods: Sixty-four patients with subjective food hypersensitivity were compared with 65 age and sex matched control persons from the general population. All participants filled out questionnaires focusing on job demands and decision latitude, psychosocial factors related to work environment, coping strategies used to solve problems, and subjective health complaints during the last month.

Results: Mean age of participants was 38 years, women were over-represented (83%). Compared with controls, patients scored significantly less on job stress ($P=0.01$) and job demands ($P=0.02$), and significantly higher on authority over job decisions ($P=0.04$). Coping strategies and satisfaction with work environment did not differ significantly between the two groups. Compared with controls, patients reported significantly more subjective health complaints and scored higher both on psychological distress and

somatic co morbidity ($P=0.0001$), and these subjective health complaints were unrelated to job stress and coping strategies.

Conclusions: The present results corroborate our prior findings of significantly increased scores on subjective health complaints in patients with subjective food hypersensitivity (3). Our hypothesis that a mismatch between job stress and coping ability could explain the patients' subjective health complaints was not verified. Implication for practice: Patients with subjective food hypersensitivity have much psychological and somatic co morbidity (subjective health complaints) and impaired quality of life. Job stress and coping strategies do not explain the patients' food hypersensitivity or subjective health complaints.

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Preparation for colonoscopy in hospitalized patients

Nehama Horev RN, BSc, Bracha Chadad, RN, Negba Segal, RN, Ilana Shemesh RN, MSc, Meli Mor, RN, Shlomit Plaut, RN, Gerald Fraser, MD, Alex Geller, MD, Eyal Gal, MD, Yaron Niv, MD, FACP, AGAF, Department of Gastroenterology, Rabin Medical Center, Beilinson Hospital, Petach Tikva & Sackler Faculty of Medicine, Tel Aviv University, Israel

Introduction: Successful colonoscopy depends on adequate cleansing of the colon before the procedure. Inadequate preparation will lead to cancellation of the procedure and a new appointment. This compromises patient safety and decreases quality of care and cost effectiveness.

Aim: To isolate factors that affect successful preparation, especially in older, severely ill and bedridden patients. To examine the possible differences in quality of preparation between ambulatory and hospitalized patients. To evaluate the impact of a staff education program on the preparation of hospitalized patients for colonoscopy.

Methods: 407 consecutive patients (303 ambulatory & 104 hospitalized) referred for colonoscopy in 2002, and 415 consecutive patients (310 ambulatory & 105 hospitalized) referred for colonoscopy in 2003. A questionnaire consisted of 7 sections prepared for each patient. Nurses completed details concerning demographic data, comorbidity and type of preparation. Gastroenterologists

performing the colonoscopies completed details related to quality of preparation and colonoscopic findings. All patients completed a questionnaire relating to satisfaction. Between the two periods, hospital staff received an education program to improve colonoscopy preparation. Comparison of all parameters between the two groups and between time periods was performed.

Results: Comparison by group: Hospitalized patients were older, more dependent, and had more chronic diseases than the ambulatory patients. Polyethylene glycol was used significantly more often for colonoscopy preparation in hospitalized patients than in ambulatory patients (53.1% vs 8.8%, $p=0.0001$). The hospitalized group was characterized by more incomplete and repeat colonoscopies, less adherence to preparation instructions, and more cases of poor preparation. Comparison by time period: The education program had no impact on quality of preparation. Rates of complete colonoscopy, repeat examination, and poor preparation, before and after education program, were 80.9%, 19.0% and 31.1% versus 80.7%, 19.2% and 31.1%, respectively (table 1).

Patient satisfaction score was higher in the ambulatory group than in the hospitalized group, 90% versus 79.4% respectively ($p=0.0001$)

Summary: Hospitalized and ambulatory patients are selected population with differences in age, levels of dependence and prevalence of chronic diseases. More hospitalized patients received more polyethylene glycol for preparation. The preparation was significantly more effective in ambulatory than hospitalized

Total quality management in gastrointestinal endoscopy nursing assessment of patient's appropriateness for sedation-free colonoscopy

Jadranka Brljak, Division of Gastroenterology, Department of Medicine, Zagreb University Hospital Centre, Kišpaticeva 12, Zagreb 10000, Croatia

Introduction: Colonoscopy represents a valuable procedure in diagnosing pathology of the colon. Several risk factors for difficult colonoscopy have been recognised. Regarding patient, predominant factors are age, sex, pre-procedural anxiety and history of previous intra-abdominal surgical operation, whereas poor colon preparation, duration of the procedure and less experienced endoscopists are most prominent technical factors. As majority of colonoscopies in Croatia are performed without sedation, patient satisfaction and completeness of the procedure might be unsatisfactory, affecting its quality.

Aims: As part of quality management program, analysis of practice at our institution was done in a prospective manner. Attention was given to patients' characteristics which influence the successfulness of sedation-free colonoscopy.

Method: Routine practice was monitored during a period of three months. Colonoscopy was offered to all patients, exclusion criteria being only colonoscopy done within past 6 months and unsigned informed consent. The colon preparation was the same for all patients. All Colonoscopies were sedation-free and performed by skilled endoscopists (>200 procedures annually). All patients were interviewed with a prepared questionnaire. Demographics, anthropometrics and medical history were collected prior to procedure, duration of the procedure was recorded, and patients' feeling of pain was assessed on visual analog scale from 1 (no pain) to 5 (worst pain). Colon preparation was assessed on a semi-qualitative scale: excellent (no stool), satisfactory, poor, bad (formed stool preventing passage).

Results: Colonoscopy was offered to 250 patients, of whom 125 were inpatients. Mean age of patients was 57.8 years (+/- 14.7), and there were 46.6% female patients. A total of 181 colonoscopies were successful (72%). The main reasons for premature ending of the procedure were poor preparation (36/69 pts, 52%) and

patients. An intervention program for hospital staff had no impact on the quality of preparation.

Conclusion: Preparation for colonoscopy in hospitalized patients should be improved. This may be difficult because many patients have significant co-morbidity and bedridden. Current preparation methods in severely ill patients need to be revised to account for the specific problems in this group.

pain (32/69 pts, 48%). Poor preparation was noted among 10% of inpatients (12/125), and 20% of outpatients (24/124). Multivariate regression analysis indicated female sex (OR 2.59 CI 95% 1.31-5.09), and thinner waist (OR 0.97 CI 95% 0.95-0.99) as predictors of pain, as opposed to history of abdominal surgery (OR 0.20, CI 95% 0.06-0.69) which was predictor of tolerability.

Conclusion: Our study confirmed recognised reasons for unsuccessful colonoscopy: inappropriate colon preparation and pain. Female sex and thinner waist were predictors of pain, whereas previous colon resection was predictor of tolerability. These attributes are now part of pre-procedure assessment of a patient's appropriateness for sedation free-colonoscopy. Furthermore, as part of quality management, several activities were set up aiming to improve the quality of service: leaflets and instructions for colon cleansing were reviewed, and the procedure is orally explained to patients. For older inpatients (>75 yrs) and those with impaired mobility, duration of cleansing was prolonged from 2 to 3 days. These activities will require further evaluation during a determined future period with the objective to increase the colonoscopy success rate over 70%

Learning/outcomes: 1. Nurse has a proactive role in pre-procedure assessment of patients in assessing the risk of pain; 2. How good are we?, Is the colonoscopy success rate of 70% good enough?

Key words: endoscopy, colonoscopy, nurses, sedation

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Targeted intervention for education patients in the gastroenterology unit

Sigal Shafran-Tikva¹, Luba Lutzky¹, Dimitry Lavrov¹, Dafna Levian¹, Yael Dotan-Veeder¹, Halad Lafi¹, Sara Marcus¹, Racheli Horvitz¹, Anna Surin¹, Felix Meyerson¹, Nurit Porat² ¹Gastroenterology Unit, ²Coordinator, Clinical Quality in Nursing, Hadassah University Medical Center Ein Kerem

Introduction: Various procedures are performed in the Gastroenterology Unit for diagnosis, early detection and treatment; including invasive procedures for which prior preparation at home is essential. For a majority of outpatients the examinations themselves are a cause for confusion, fear, embarrassment and modest increases in anxiety as are the expected results (Jones, 2004). Patient education mediating the stress experience by reducing their perceived anxiety (Eberhardt, 2006) have become an integral part of the pre-procedure preparation.

Aims: To evaluate patient satisfaction regarding the guidance they received; To examine the quality improvement activities (i.e. the intervention)

Methods: Using convenience sampling we conducted three surveys. The first took place prior to the intervention in 2005 (N=98). Two additional surveys were undertaken following the intervention: in 2006 (N=112) and in 2007 (N=101). The survey population included patients who underwent various procedures in the Unit. A questionnaire was used to evaluate patient satisfaction of the guidance provided in the Unit prior to each of the procedures. The survey tool included 24 questions and was meant to be completed anonymously by the patient prior to being discharged home. The questionnaire evaluated on different levels: patient satisfaction from the guidance for example: nutritional instruction; complications; the manner in which the procedure was performed; pain, and the like. Additionally, the questionnaire included personal demographic details.

Results: In general, the results of the primary questionnaire (prior to the intervention) showed that approximately 70% of the patients were very satisfied from the guidance, yet they felt that there was room for improvement.

Intervention: As a result of the survey's findings, a number of quality improvement activities were initiated aimed at training

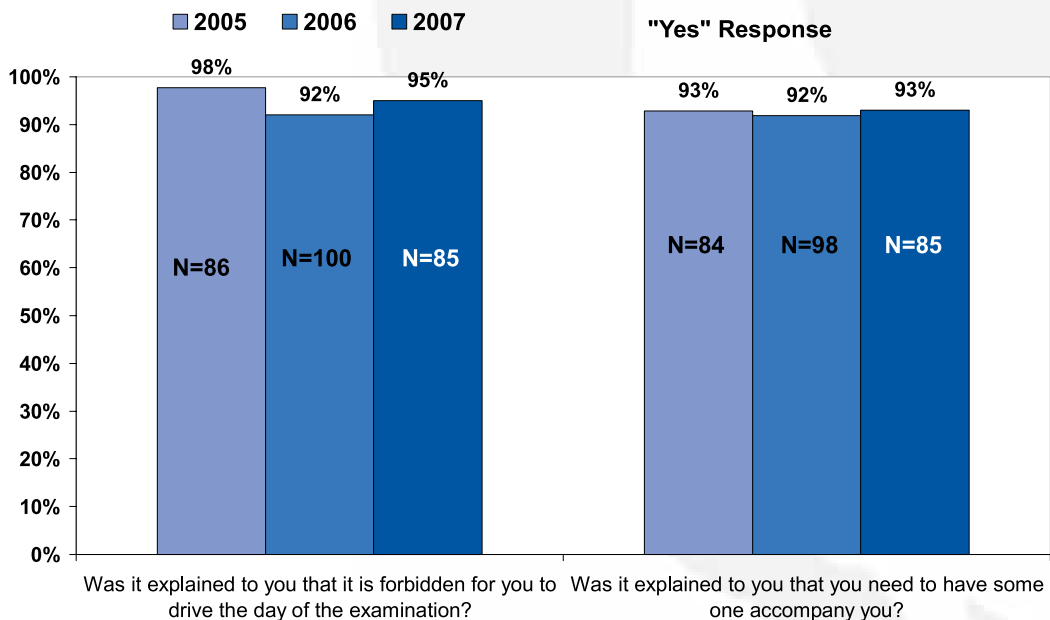
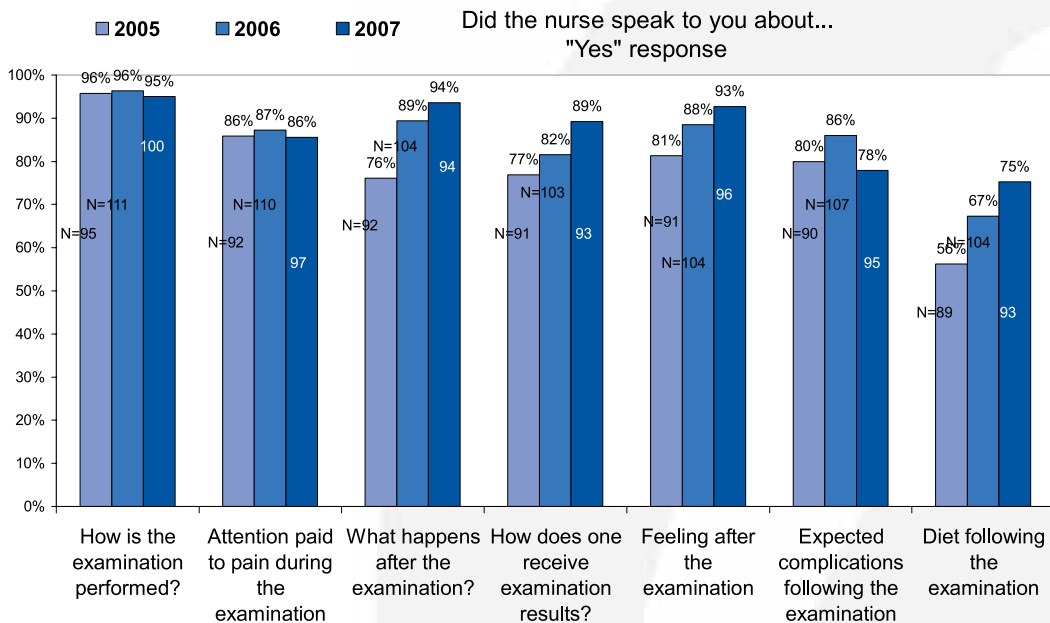
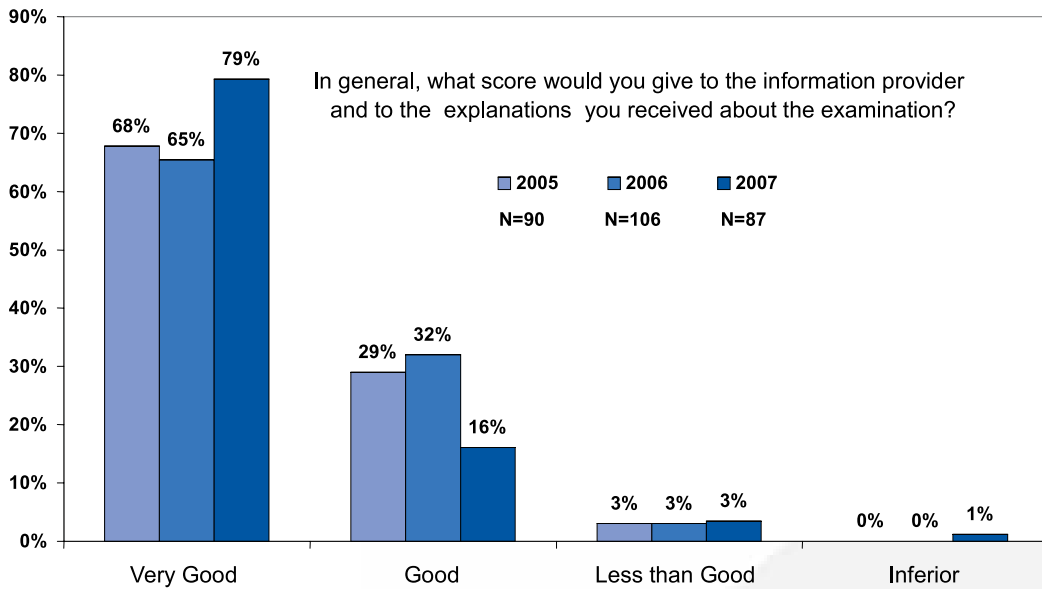
the unit's nursing staff to provide unified and structured guidance e.g. workshops in patient education which included simulation exercises, workshops to improve staff knowledge including questionnaires to identify the staff's knowledge, preparation of informational pamphlets for the staff and the preparation of tools for implementing and documenting the guidance. So too, there was a change in nursing work methods including: assigning a nurse to each stage of the guidance. In parallel, patient informational handbooks were prepared for each of the procedures performed in the Unit. These handbooks which were provided to patients at the time of test scheduling were also accessible to the public on the Hospital's website.

Results: In evaluating patient satisfaction from the guidance following the intervention in the two additional surveys, it was found that there was a certain degree of improvement in most measures checked e.g. in the first survey, 76% of the patients noted that they received information regarding what would happen following the test. In the second survey 86% noted that they received this information and in the third survey 94% noted that they received this information.

Conclusion & recommendation: The findings of the surveys reflect the fact that investing in staff development, providing tools which are uniform and structured, and changing work methods contribute to improved patient satisfaction from the guidance received.

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Hepatitis C – knowledge assessment among nursing hospital staff

Kalnizki Osnat RN, BA, Institute of gastroenterology, Assuta Medical Center, Tel -Aviv, Israel, Sufugo Henia RN, BA, Institute of gastroenterology, Sheba Medical Center, Ramat-Gan

Introduction: Hepatitis C virus (HCV) is the main indication for liver transplantation. Its prevalence in the general population is 1%. In most cases, the infection has no clinical symptoms. Exposure to this infection disease requires extensive knowledge regarding the etiology, risk factors, prevention of spreading among patients and medical staff.

Objective: To examine the knowledge about HCV among Israeli hospital nursing staff. A steering committee will use these examination results to build an intervention program in order to qualify the staff.

Methods: A questionnaire was spread among hospital internal and surgical departments nursing staff. The questionnaire included 20 questions regarding general knowledge of HCV, its risk factor, epidemiology, and prevention. Some other question examined the specific education given to patients and medical staff, and demographic details of the participator.

Results: Seventy participators answered the questionnaire; there were 7 males and 63 females. Their educational status was distributed as follows: 34% percent were registered nurses, 54% were BA, and 12% were MSC. Fifty-five percent underwent advanced qualification and 20% had management position. The average period of service was 13+_12 years (range 1-36 years). Distribution between internal and surgical departments was equal. Analysis of answers revealed a lack of knowledge among the medical nursing staff in few subjects regarding HCV: 40% failed the HCV general

knowledge questions, 20% were not aware of the risk factors, and 20% of the participators were wrong about the prevention ways. The most problematic subject was patients' guidance. The more experienced nurses (>10 years) showed significantly less knowledge than younger nurses. There were no differences between nursing staff of internal and surgical departments.

Conclusions: Lack of a vaccine and prophylactic treatment for HCV requires development of education and advisory programs in order to reduce the viral spread among high risk populations, and minimize chronic liver disease among infected patients. The role played by the nursing staff in reducing viral spread and minimizing chronic liver is important. Therefore an education advisory program should be encouraged.

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Ergonomics in digestive endoscopy

Linden, Ane I., Baptista, Márcia E., Muller, Suzana, Hospital de Clinicas de Porto Alegre- Brazil – linden@sinos.net

Digestive endoscopy have brought many benefits to the patients. However, we must see some important aspects from the worker's perspective. Even though the digestive endoscopy just take a short scheduled time, it can cause some injuries in personnel. In our endoscopy unit, we have many complains from physicians and nursing staff members, such as neck pain and low back pain. Moreover, they said that this complains are very common due to position in which they have to maintain during the procedures, sometimes demanding flexion contractures and joint motion. Besides, nursing staff have specific complains, such as carrying too much weight during their activities, like stretchers and video equipments.

Aims: The purpose of this study was to evaluate working conditions in our endoscopy unit, and eventually to implement some improvements.

Method: At first, we took some notes about the staff most common physical complains. After that, we asked a physical therapist to search into our unit about bad working conditions, or other conditions which might cause some harm.

Results: The results were surprising. We realize that several changes in our working environment must be done. Since we cannot change the number of patients attended, neither our equipments, the physical therapist give many suggestions and improvements, as well as an exercises program that our staff should consider, in order to prevent injuries. Simple solutions, like small adjustable feet supports could provide relief to the most common complains. Moreover, the physical therapist suggested stretching movements in order to preserve muscle strength and avoid discomfort. As a result of this study, we have learned that for maximal benefit, workers must take a commitment to maintaining the

program at endoscopy unit. Some of these exercises and adjustable supports are very simple to apply. One additional thing that we have learned from this study is that even though the physicians cannot avoid some repetitive grasping or rotatory motions during the endoscopy procedures, we can prevent fatigue and pain, just acting in accordance to ergonomic adjustments.

Learning outcomes: In order to improve quality of life in working environment, we have to adjust some equipments and routines in digestive endoscopy. Otherwise, we can have many labourer

absenteeism. Prevention of workers diseases is always a good manager strategy. Also, from what we gather, the activities we have in endoscopy unit can be very demanding, thus this program established by the physical therapist is a helpful proposition.

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Reprocessing of endoscopic equipment – a survey in European countries

Ulrike Beilenhoff, Ulm, Germany

Several European guidelines have been published covering hygiene and infection control in Endoscopy (1-3). These guidelines should be adapted to national guidelines and / or to unit specific protocols for reprocessing. In 2000 a survey evaluated the reprocessing of endoscopic accessories in Europe (4).

Aims: The aims of the survey were to evaluate the compliance with European guidelines and to compare data from different European countries and to identify any changes between 2000 and 2008.

Method: A questionnaire was developed focused on national practice, not on specific departments.

Results: The questionnaire was sent to all ESGE and ESGENA membership countries (44 countries). 26 responded (59.1%). In 16 of 26 countries (61.5%) a variety of national guidelines were established covering reprocessing of endoscopes and accessories, staff protection measures and periodic microbiological tests. 10 countries (38.5%) had no national guidelines, but adapted American (2) or European guidelines (8) to unit specific protocols. In 9 countries (34.6%) the majority of endoscopy departments used automated washer-disinfectors (WD) for endoscope reprocessing only. In 15 countries (57.7%) both, manual and automated systems, were used. In 2 countries (7.7%) endoscopes were reprocessed only manually. Recommendations for reprocessing of accessories varied greatly from country to country. Microbiological surveillance was recommended in 17 countries (65.4%), but with great variations in the protocols. Specific training of staff was recommended only in 13 countries (50%). Comparing the data from 2000 and 2008, only a few changes could be identified. Even Aldehydes are still the most used disinfectants with 80.4%, the use of alternatives increased significantly: PAA from 26% to 61.5%, electrolytically generated disinfectants from, 8.7 to 15.4%. Automated reprocess-

ing cycles are established in more countries. In 15 countries (60%) current national guidelines clearly recommend the use of WD for endoscope reprocessing. A trend to single use accessories can be identified, 11 current national guidelines (42.3%) recommended the use of single-use accessories.

Summary & conclusion: The survey showed that all countries adapted the European guidelines into their national guideline. Many national variations were apparent, especially in reprocessing of endoscopic accessories and in microbiological surveillance. There is a need for staff education in automated reprocessing of endoscopes, in standardised reprocessing of accessories, in staff protection measures and in the performance of regular quality control in order to establish the European standards.

Learning outcomes: The conference participants will be aware of the variety of recommendations in Europe, will be able to compare their national guidelines with other countries, and will get input for possible improvements in their countries.

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Beilenhoff U. Reprocessing of endoscopic equipment in Europe – an overview. Oral presentation at the ESGENA Conference 2000 in Brussels

Abstracts from ESGENA Poster Round I – Preparation, Sedation and Discharge

Patients' perceptions on the use of name wrist band in outpatient services at NKC Institute of Gastroenterology and Hepatology

Siriporn Ratanaalert RN, Sopa Boonviriyaya RN, Waraporn Jarupan RN, Sulee Sangnil RN, Reonkhun Chotirat RN, NKC Institute of Gastroenterology and Hepatology, Songklanagarind Hospital, Hat-Yai, Songkhla 90110 Thailand, Email: siriporn_nkc@yahoo.com

Background: Error in patient identification is a major risk in ambulatory endoscopic services. Name wrist band is commonly used to prevent this error but there is no existing study in relation to patients' perceptions to the value of wrist band use.

Objective: To study patients' perceptions on the value of name wrist band and its benefits on improving patient safety.

Method: Ambulatory endoscopic procedures were performed with 3,168 cases in 2007 at NKC institute. Name wrist band was formerly applied to inpatients, but has recently been introduced to all patients including ambulatory endoscopic services since 2007 in accordance with the hospital safety goal policy. Patients

were routinely informed by endoscopy team about wrist band and treatment plan. Adult patients who received endoscopic procedure were asked to fill up the questionnaire about perceptions of the wrist band use before going home. Patients with any language barriers were excluded from study.

Result: A hundred patients were enrolled in this study during 27 May- 13 June 2008. There were no patient's identification errors during the study period. Fifty two percent of respondents were male. The majority of procedures given to patients were panendoscopy, colonoscopy and flexible sigmoidoscopy of 41%, 35% and 12% respectively. The result was shown in table I.

Perceptions on wrist band use	Yes	No
You understand objectives of the name wrist band use	89	11
You find that name wrist band is useful for your treatment	95	5
Your doctor sees the importance of name wrist band	94	6
Your nurse makes use of the name wrist band, e.g., before giving medications or procedures	98	2
Your identification on the wrist band is correct	100	0
The name wrist band makes you feel irritated, less private, annoyed, painful	0	100
You wish to keep your name wrist band as a souvenir	54	46

From the result, knowing the objective of wrist band use was significantly related to patients' participation in identification process by the endoscopy team, such as their names on wrist band, and an awareness of safety in using wrist band by nurses or physicians ($P < 0.05$). All patients appreciated in wearing the name wrist bands. Age and sex were not significantly related to their different perceptions ($P > 0.05$). Further study is needed if information leaflet or other communication tools might increase the patients' perceptions. Name wrist band could be redesigned in response to patients' needs, such as for use as complimentary souvenirs.

Conclusion: Positive perceptions of patients on name wrist band will enhance their participation in using this personal identification and thus improve the endoscopic/patient safety. Name wrist band may be redesigned to serve patient's needs, while information about its application may enhance cooperation among patients.

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The use of ethyl chloride spray and professional nursing approach in pain and anxiety control in endoscopy

N.Tüzomay, D.Sabuncular, B.Açıl, B.Sengül, E.Tankurt, Izmir Kent Hospital Turkey

Objective: By reducing the fear and anxiety occurring in patients before the procedure in the endoscopy unit by professional nursing approach and lowering their levels of anxiety. On the other hand, the efficiency of ethyl chloride spray on patient as alternative application for reducing the pain during the procedure of opening vascular access has been investigated.

Method: 147 patients of whom the endoscopic intervention were performed between the dates of January 1- February 29 were chosen. The research data were collected by the endoscopy nurse before starting the procedure and after the procedure by questionnaire method. Additionally, the information pertaining to intravenous interventions have also been recorded on this questionnaire form. The relief felt by the patient with the explanation of the application to be made has also been specified in the given questionnaire items, our results were compared with the annoyance the patients felt from the medical practice made in another center without applying such a professional approach.

Results: How long did you wait before you were taken into the procedure? I did not wait 120 (81,6%) patients, I waited a little 24(16,3%) patients, I waited for a long time 3(2,1%) patients. Have you been sufficiently informed about the procedure? Yes 134 (91,2%) patients, 8 (5,9%) foreign national patients have been informed in English. Since 5(3,7%) patients were hemorrhagic and mentally confused, their relatives were informed. In hand interventions, the dorsal Venus arch ((DVA) 10 (6,8%) interventions, cephalic vein(HCV)9(6,1%) interventions, broad vein (HBV) 6 (4,1%) interventions, basilic vein (HBV) 7 (4,8%) were used.Arm interventions: Cephalic vein (ACV) 70 (47,6%) interventions, basilic vein (ABV) 45 (30,6%) interventions have occurred. To 147 patients,

ethyl chloride spray was not used before vascular access was opened. After vascular access was opened, the pain perception of all patients was scored according to the numerical evaluation scale (Numerical Rating-Scale-NRS).Between March 1-31, 2008 ethyl chloride spray was used before the vascular access was opened in 110 patients. In this group, in 100 patients cephalic vein, in 10 patients basilic vein has been used. The NRS pain score averages of the patients on whom ethyl chloride was not used were determined as 2,96 + 2,52 and the pain score of the patients to whom ethyl chloride spray was used as 2,4 + 2,54. No significant statistical difference has been found between the pain perceptions of the patients on whom ethyl chloride spray was used and not used. (t = 1,603), SD = 256 p>0,0005).

Conclusion: It has been seen that the ethyl chloride spray used before venous line placement was not statistically significant in regard to reducing the pain. Giving information to the patients in the endoscopy department about the procedure, helped very much to the tolerance of patient and minimized the level of disturbance caused by the endoscopic intervention. We believe that this kind of high quality nursing service helps to relieve the anxiety of the patients in the endoscopy waiting line.

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The neighbour around the corner – a model for an early detection of prostate cancer in the Gastroenterology Unit, Hadassah Ein- Kerem Medical Center

Shafran – Tikva Sigal^{1,2}, Lysy Yosef¹, Goldin Eran¹, Greenberg Dan²; ¹Gastroenterology Unit, Hadassah University Medical Center Ein Kerem, Jerusalem, Israel; ²Department of Health Systems Management, Ben-Gurion University of the Negev, Beer-Sheva, Israel

Background: Cancer of the prostate gland is the second most prevalent lethal form of cancer in men, after lung cancer.¹ Early detection is critical as there are radiology treatments and surgical procedures available for focused cancer which has not metastasized. Approximately half of those diagnosed with prostate cancer will develop metastases which cannot be treated. Early detection and preventing disease progression should be considered life saving activities. According to the guidelines of the American Cancer Society, men over the age of 50 should have their PSA level checked and undergo a rectal examination.² However, during routine check-ups by family physicians, rectal examinations are infrequently performed. During routine rectal examinations in patients undergoing lower digestive system examinations in the Gastroenterology unit, palpitation of the prostate gland can be performed and serve as an additional tier in the early detection of prostate cancer.

Goals: To evaluate the feasibility of routine rectal examinations for early detection of prostate cancer in the Gastroenterology Unit of the Hadassah University Medical Center and follow-up by family physician. The study evaluated various pathological findings in the prostate gland; a number of new cancer cases which were diagnosed as a result of the survey check-ups in the Unit; and certain patient compliance parameters with regard to gastroenterologists' referrals to family physicians for further urological examination.

Methods: The study population was chosen using convenience sampling of men, over the age of 50, who were electively referred to the Hadassah Medical Center, Ein Kerem for a lower digestive system examination. During the rectal examination, the physician estimated the size, structure and texture of the prostate gland. Demographic details, relevant medical history, rectal examination results and recommendations from the gastroenterologist for follow-up, were collected via a structured questionnaire. Patients with positive pathological results were referred to their family physician for treatment and follow-up. These patients were prospectively surveyed by telephone, regarding examinations performed

by family physicians and referrals to urologists, at 6 weeks and 3 months following the procedure.

Results: The study population included 554 males between the ages of 50 – 79 who had not previously been checked for early detection of prostate cancer by their family physician and/or by an urologist, and arrived at our Gastroenterology Unit to be examined for various reasons. In 145 (26.1%) of the patients the gastroenterologist found a pathological mass in the prostate gland. A significant relationship was found between men with prostate findings and age and origin but not education. The group with prostate findings was referred to their family physicians for further examinations. Of the 134 patients who went to their family physician, 58 (43.3%) remained with their family physician for observation and monitoring and 76 (56.7%) were referred to urologists for further examination. Three of the patients (3.9%) who were referred to urologists were diagnosed as suffering from prostate cancer at early stage.

Conclusions and recommendations: Our study indicates that the suggested model is applicable, efficient, easy to implement and can be introduced with minimal investment of resources. Rectal examinations by a gastroenterologist should be part of the process for early detection of prostate cancer as well as cooperation between family physicians and gastroenterologists and high patient compliance to gastroenterologists' recommendations. Therefore, it is possible and even recommended to implement the model in other gastroenterology units both in Israel and abroad. It is also recommended that a special gastroenterologists' training program for performing complete rectal examinations be implemented.

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Polyethylene glycol solution for colon cleansing: 3 or 4 liters?

Valentina Lapina, Daiga Muceniece, Paula Stradina Clinical University Hospital, Riga, Latvia

Polyethylene glycol solution (PEG) is widely used for colon cleansing prior colonoscopy. Unfortunately high recommended amount of PEG solution influence patient acceptance and compliance (1). Aim: evaluate clinical usefulness of diminished PEG solution dosage (3 l instead 4 l as recommended for Fortrans®, Ipsen).

Method: Retrospective analysis of Endoscopy unit Date basis colonoscopy 5782 protocols from 2002-2006 was done. For similarity we selected only PEG solution produced by Ipsen (Fortrans®).

Included were total colonoscopy or ileocolonoscopy protocols. Patient's gender, age and prior abdominal surgery included in analysis.

Results: Overall for 1509 investigations were used 3 l and 1883 – 4 l of PEG. Compared colon cleaning grades accordingly Ring's 3 l and 4 l groups statistically was non significant. Summarizing excellent and good colon cleaning we get a paradoxical result – 32.4% in 3 l group and 21.4% in 4 l group. Although this result is

statistically significant we need personalized colonoscopy protocols for further analysis. Analyzing patient age influence on colon cleansing we found similar picture – 40 years old and youngest 3 l PEG was better and, surprisingly, poor colon cleaning percentage were very low (9.2%) compared with 14.4%; $P < 0,05$) from 4 l group. Comparing with the youngest patients group, for patients over 60 significant benefit of 4 l cleaning is established: 1) excellent preparation 7:1 ($P < 0,05$); 2) poor preparation 14.3% against 18.8%. Statistically significant difference for female gender between 3 and 4 l groups were not found. Man colon cleaning with Fortran's 3 l and 4 l were very similar, but in 4 l group significantly more excellent cleaned colon cases ($p < 0,05$). For patients without or with one or two abdominal surgeries there were no differences. Therefore our data didn't differ from similar but prospective controlled study of 110 patients.

Summary: Overall colon cleansing before colonoscopy between patients preparing with 3 or 4 l of Fortran's didn't differ. For oldest

patients prepared with 3 l constantly cases with poor colon cleaning arise. For excellent colon cleaning 4 l is preferable in all cases except younger than 40 years males.

Take home message: Colon cleansing with 3 litre of polyethylene glycol solution is good for younger patients, especially younger than 40 years. For patients older than 60 years we recommend use only regimen with 4 litres of polyethylene glycol solution.

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Changing practice of sedation during endoscopic ultrasound: propofol versus midazolam

Daniela Burtea, Monica Busoi, Mihaela Calita, Malos Anca, Gabi Fedak, Research Center of Gastroenterology and Hepatology, University of Medicine and Pharmacy Craiova, Romania

Introduction: Endoscopic ultrasound (EUS) is routinely performed in several reference centers throughout the world. The type of sedation procedures is however variable and the use of propofol sedation is increased in view of an improved efficiency of the procedures. Large prospective studies demonstrated that propofol provides significant advantages sedation during endoscopic procedures; propofol was more effective and safer than the combination of midazolam and meperidine for achieving and maintaining an adequate level of sedation during endoscopic procedures, with better titration of the level of sedation and shorter recovery times.

Aim: The two types of procedures were compared in order to measure recovery time, EUS procedural time, safety of administration by registered nurses, cost-benefit ratio, as well as endoscopist and patient satisfaction. Complications were assessed prospectively using a detailed protocol developed at the beginning of the study.

Patients and methods: The study was performed in the Research Center of Gastroenterology and Hepatology, with inclusion of 40 consecutive patients selected for EUS. Both propofol and midazolam were administered by registered nurses under the supervision of the endoscopist and / or anesthesiologist. The patients were divided in two groups (22 patients with propofol and 18 patients with midazolam).

Results: A total number of 40 patients were included, while the type of sedation was selected as a function of patient and doctor preference, after an informed consent was carefully discussed with the patient. The required exam was necessary in each case without any adverse reactions. The use of propofol was associated with a shorter recovery time (9.5 vs 17.3 minutes) and lower costs as compared with the midazolam group. Moreover, the EUS procedural time was reduced in the propofol group independent of the type of EUS (diagnostic or therapeutic). The overall patient satisfaction measured on a 10 point VAS (visual analog scale) was significantly higher both for the patients as well as for the endoscopists performing the EUS procedure.

Conclusion: The use of propofol sedation seems to represent a better option as compared with conventional midazolam sedation, although further studies are recommended in the future.

Propofol: patient's best friend during endoscopy

Lydia Singels EA, Henk Pelt EA, Department of Gastroenterologie, Academic Medical Center, Meibergdreef 9, 1100 DD Amsterdam, the Netherlands

Introduction: The introduction of propofol (P) for the sedation of patients undergoing colonoscopy gave hope to reduce the disadvantageous side effects of midazolam (M), which was used as standard sedation medication until 2005 in our institute. We prospectively evaluated two independent groups of 60 patients, one treated with M and the other treated with P, to detect possible advantages and disadvantages for the patient and for the endoscopic procedure.

Aim: To detect differences between the two different medications on patients comfort, endoscopic procedure and complications.

Method: Patients underwent the same bowel preparation in both groups. During examination specialised anaesthesia (SAE) and nurse employees were necessary in P group, whereas patients sedated with M received supportive care by an endoscopy nurse only. Endoscopies were performed by doctors in training supervised by senior specialist or by senior specialists directly. Patients in the M-treated group were monitored using a combined pulse and oxygen saturation machine (Dynamap) which was checked continuously by the endoscopy nurse. Patients in the P-treated group were monitored by the SAE. Depth of sedation was

measured by assessing consciousness and appropriate reactions to questions or stimuli, generating 5 levels of consciousness.

Results: Of all the various parameters we evaluated, the most important for daily practice were cecal intubation time, depth of sedation, patient discomfort and recovery time. Cecal intubation was achieved within 15 min in 70% of P treated patients and in 53% of M treated patients. In P treated patients, sedation was graded as deep sedation in 83%, with reactions only to direct contact. In M treated patients, sedation was graded as light sedation in 74%, with conversation being easily performed. Discomfort during the procedure, such as pain, vomiting or discomfort was reported by 7% of P treated patients and by 74% of M treated patients. Recovery time before dismissing the patient was shorter than 60 min in 78% in P treated patients. The majority of M treated patients (76%) stayed longer than 60 min on the recovery unit.

Conclusion: Our data suggest that colonoscopy using propofol sedation has advantages for both the patient and the endoscopist concerning patient discomfort and, possibly, time of the procedure.

Clinical efficacy of dexmedetomidine alone is less than propofol for conscious sedation during ERCP

Suzana Muller, MsS, RN, Silvia M. Borowics, Elaine A. F. Fortis, MD, PhD, Luciana C. Stefani, MD, Gabriela Soares, Ismael Maguilnik, MD, MSH, Helenice P. Breyer, MD, MSH, Maria Paz L. Hidalgo, MD, PhD, Wolnei Caumo, MD, PhD, Hospital de Clínicas de Porto Alegre, Universidade Federal do Rio Grande do Sul, Post Graduation Course in Gastroenterology Sciences, Porto Alegre, Brazil

Background: Propofol is an accepted method of sedation for an ERCP and generally achieves deep sedation rather than conscious sedation, and dexmedetomidine has sedative properties of equivalent efficacy.

Objective: To examine the hypothesis that dexmedetomidine is as effective as propofol combined with fentanyl for providing conscious sedation during an ERCP.

Design and setting: Randomized, blind, double-dummy clinical trial.

Patients: Twenty-six adults, American Society of Anesthesiologists status I to III, underwent an ERCP.

Interventions: Patients were randomized to receive either propofol (n 14) (target plasma concentration range 2-4 mg/mL) combined with fentanyl 1 mg/kg, or dexmedetomidine (n 12) 1 mg/kg for

10 minutes, followed by 0.2 to 0.5 mg/kg/min. Additional sedatives were used if adequate sedation was not achieved at the maximum dose allowed.

Main outcomes measurements: The sedation level was assessed by the Richmond alertness-sedation scale and the demand for additional sedatives. Furthermore, heart rate, blood pressure, oxygen saturation, and respiratory rate were continuously assessed.

Results: The relative risk (RR) was 2.71 (95% CI, 1.31-5.61) and the number of patients that needed to be treated (NNT) was 1.85 (95% CI, 1.19-4.21) to observe one additional patient with drowsiness 15 minutes after sedation in the dexmedetomidine group. Also, the RR was 9.42 (95% CI, 1.41-62.80), and the NNT was 1.42 (95% CI, 1.0-2.29) to require additional analgesic. However, there was also a greater reduction in blood pressure, a lower heart rate, and greater sedation after the procedure.

Conclusions: Dexmedetomidine alone was not as effective as propofol combined with fentanyl for providing conscious sedation during an ERCP. Furthermore, dexmedetomidine was associated with greater hemodynamic instability and a prolonged recovery.

Learning outcomes: Dexmedetomidine did not produce an effective sedation when compared with propofol combined with fentanyl in ERCP exams. Hemodynamic effects of dexmedetomidine may be useful in patients with high risk of respiratory depression.

Nursing care and instructions to outpatients discharge after endoscopy exams under sedation

Suzana Müller, PhD, RN; Ane Isabel Linden, Ms, RN, Hospital de Clínicas de Porto Alegre - RS- Brazil

Introduction: It is a standard practice to perform diagnostic and therapeutic endoscopic with the patient under moderate or deep sedation. The sedation can reduce the fear and the anxiety. Midazolam and/or meperidine are the choice drugs to induce sedation and minimize the anxiety and pain for endoscopy and/or colonoscopy procedures. Due its properties it may produce temporary dizziness and amnesia.

Objective: Nurse must be certain about the patients' conditions for discharge ensuring its security and well being. Some verbal instructions may be not be enough, making it necessary to reinforce the orientations by written form.

Methods: In Hospital de Clínicas de Porto Alegre (HCPA) the discharge informations are done by the nurse orally and by written form for the patient or for his companion, as necessary. The following instructions, among others, are: orientations about the diet, the need to have some rest a little more at home, do not drive or make any activity that requires attention. In addition, informations about the results and the new appointment with the physician are given. Also, orientations in case of emergencies are very important, such as bleeding, swallowing pain, chest pain, or blood vomiting. In such cases, is recommended to look for the emergency room of the HCPA. Also a phone number is given for doubts.

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Results: Patients and companions expressed better comprehension when received the written form orientations after verbal ones.

Conclusions: This procedure guarantees the patients' comprehension and helps to diminish its doubts and security beyond to give more security to the staff members.

Learning outcome: Informations after sedation should be reinforced by given in written form for patient or companion.

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Recommendations after an upper gastrointestinal endoscopy

Granados-Martín Mónica, Díaz-Rodríguez Dania-Rocío, Hospital de Fuenlabrada. Madrid. Spain.

monicagranados@yahoo.com

Introduction: Upper Gastrointestinal Endoscopy (UGE) is a diagnostic and therapeutic technique which consists of viewing the inside of the oesophagus, stomach and duodenum with a videoendoscope. The pharynx is sprayed with Lidocaine and the patient is placed in the left lateral decubitus position. The technique is usually uncomfortable, because the endoscope contacting with the pharynx and anaesthesia, both of which produce nausea, sialorrea and difficulty in swallowing. When the technique is finished, the patient may feel uncomfortable for several reasons. The patient may detect and minimize them. In our unit we have made some written recommendations about the post-operation nursing after the UGE, we explain it orally and then we give them to every patient. This is carried on by the nurse. The aim of this study is to determine the efficacy of this recommendations and the satisfaction level with the standard of nursing. The results will help us to maximize the quality of the nursing standard.

Methods: Cross-sectional study was carried out during 2004 in Digestive Endoscopy Unit in Hospital de Fuenlabrada. 202 outpatients attending for gastroscopy, over 16 years of age, mentally alert and able to communicate freely, were asked to participate in a phone questionnaire, type Likert, the day after the gastroscopy. Results: The average age was 44.6 ± 15 and the majority of patients

were women, 56.4% (114). Employment Status: 59% active (120); 24% (48) housewives, 9% (18) retired. Educational level: 49% (99) primary education, 33% (67) secondary education, 7% (14) professional degree, 10.4% (21) no studies. Concerning the information after the procedure, 83.2% are very satisfied, 14.4% satisfied, 1% medium and unsatisfied 2.5%. 99.5% understood the recommendations and 99% followed them. 60.9% declared having problems post-UGE, such as throat irritation, 17.8% stomachache. None went back to the Emergency Unit with these problems.

Discussion: Most of the patients had understood and followed up the recommendations, so they are useful. Taking into account that more than half the patients has no studies or only primary studies, they understood clearly the recommendations, and so the information was effective. The problems after the procedure were described in the recommendations paper, so the patients could anticipate it and they did not go to the Emergency Unit.

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Abstracts of ESGENA Poster Round II – Treatment and Patient Care

Minimal invasive endoscopic treatment for oesophageal stenosis

Krisztina Tari RN (1), Peter Lukovich MD (1), Szabolcs Farkas MD (2), Gabor Varadi MD (1), Peter Kupcsulik MD (1), ((1)Endoscopy, 1st Department of Surgery, (2)Department of Diagnostic Radiology and Oncotherapy, Semmelweis University, Budapest, Hungary, Email: tarikri@freemail.hu

Introduction: There are several diseases which cause nutritional disability by oesophageal stenosis (gr. IV. reflux disease, achalasia, oesophageal cancer, compression and dislocation of the oesophagus caused by lung tumour and its mediastinal lymph node metastasis, stricture of the anastomosis after oesophageal extirpation, stricture of the oesophagus caused by irradiation).

Aim and method: There are different methods for the palliative treatment of oesophageal stenosis: dilatation, laser therapy, conventional prosthesis implantation and self expandable stent implantation. Nutrition of those patients with inoperable oesophageal cancer can be solved by insertion of conventional Rüscher prosthesis. In the case of compression or dislocation of the oesophagus the most common method in palliation is the implantation of self expandable stent, which is more comfortable for the patients.

After dilatation of the stenotic part of the oesophagus by a Savary-Gilliard probe under fluoroscopy, endoscopic examination could be performed for those patients, for whom the insertion of the endoscope was impossible. These minimal invasive methods for palliation of nutritional disability are less stressful for the patients than surgery, but in many cases could be risky as well.

Results: Patients with oesophageal stenosis are usually in malnourished and cachectic condition, they often have cardiac or respiratory diseases, and in a lot of cases have oesophago-respiratory fistula. Due to the manipulation in the mouth, and the high risk of aspiration, during these interventions respiratory-failure can arise. In these cases suction of the airway, oxygen therapy, and even resuscitation could be needed under the examination.

Conclusions: Endoscopic assistants in our endoscopic outpatient department are supposed to do assist in these examinations, which require more preparation in the everyday practice.

Starting a new endoscopic technique: endoscopic retrograde cholangio-pancreaticography (ERCP)

Díaz-Rodríguez Dania-Rocío, Granados-Martín Mónica. Hospital de Fuenlabrada. Madrid, Spain

Introduction: Endoscopic retrograde cholangiopancreatography (ERCP) is a technique that combines the use of endoscopy and fluoroscopy to diagnose and treat certain problems of the biliary or pancreatic ductal systems. It is an x-ray examination of the bile ducts which is aided by a video endoscope. The nursing role during the technique is very important, as well as the knowledge of the specific materials, coordination with endoscopist and the continuous monitoring of the patient. In "Hospital de Fuenlabrada" (which opened recently), deep sedation by an anaesthesiologist is part of the protocol. The aim of this study is to describe the starting of this new activity and to evaluate the first results.

Methods: A cross-sectional study was carried out from March 2006 to August 2007. 75 patients attending for ERCP were included. The data was collected specifically designed for this study and was analyzed by SPSS 10.0. Sociodemographic data, therapeutics and complications were analyzed.

Results: The study was carried out on 75 patients, 57.1% (n=36) females. The average age is 58.4% years old (standard deviation: 20.24). Success in ERCP (cannulation of the proper duct) was 70.7% (n=53), biliar duct 72% and pancreatic duct 77.7%. Therapeutic most developed was: sphinterectomy 49.3%, Fogarty balloon 50.7%, Dormia basket 10.7%, biliar prothesis 16%, biliar duct dilatation 1.3%, lytotripsy 1.3%, pancreatic sphinterectomy 6.7%, pancreatic prothesis 6.7%. 86.7% had no complications after the procedure; of the 13.3% who had complications they are broken

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down as follows: 4% had pancreatitis, haemorrhagia 2.7%, cholangitis 6.7%, pulmonary tromboembolism 1.3% (these percentages refer to the 75 patients). Every patient had sedoanalgesy by an anaesthesiologist, and also the Pulse rate, O2 pulsioximetry, non-invasive blood pressure, oxygen by nasal cannula. Propofol, remifentanyl and midazolam were administered intravenously. Every patient spent at least 1 hour in "Day Hospital" till they were recovered from the medication.

Discussion: ERCP is a complex technique which requires coordination between Gastroenterologist, Anaesthesiologist, Rx technical and nurses. A work group is needed for ERCP effectiveness, specially cannulation and sphinterectomy. Sedation controlled by anaesthesiologist has given the best conditions during the technique. This is shown as time saving, better tolerance for the patient, high monitoring and better personnel satisfaction. As we develop every ERCP under sedation, a new study about patient's satisfaction with the technique is recommended.

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Influence of simeticone and metoclopramide administration for capsule endoscopy preparation: preliminary results

I.A. Ibáñez Zafón, B. González Suárez, J. Muñoz Galitó, X. Bessa, A. Castells, S. Delgado-Aros, B. Gras, L. Marquez, M. Andreu and F. Bory.
Endoscopy Unit. Hospital del Mar. Barcelona

Presence of intraluminal bubbles and impossibility to visualize entire small bowel are limitations in capsule endoscopy. It has been described that prokinetic and/or antiflatulent agents administration, would help to obtain better results.

Objectives: 1. To analyze the effect of metoclopramide administration on gastric and intestinal transit time. 2. To evaluate the quality of images after simeticone ingestion.

Patients and methods: We included 45 patients from March until October 2007. Patients were randomized, prospectively in 4 groups for the administration of metoclopramide (10 mg), simeticone (80 mg) or both previously to capsule ingestion: Group I (control, 14 patients), Group II (metoclopramide and simeticone, 8 patients), Group III (metoclopramide, 11 patients) and Group IV (simeticone, 12 patients). Presence of intestinal gas was classified in 4 grades (0-3), according to a scale recently described. We analyzed sepa-

rately proximal and distal small bowel segments.

Results: 45 patients (21 men and 24 women, Mean age: 56.4 +/- 18 years). Gastric transit time was 47.5 +/- 63.4 minutes in control group vs 20.9 +/- 12.05 minutes in patients taking metoclopramide ($p=0.1$). There were no significant differences in intestinal transit time. In proximal small bowel 87% of patients in group II had none or minima bubbles compared to 70% of patients in control group. Distally, 57% of patients in control group had a lot of gas avoiding to visualize mucous compared to 0% of patients in group II ($p=0.07$). No side effects were observed.

Conclusions: Our preliminary results in a small group of patients, suggests that prokinetic agents and simeticone ingestion before capsule administration can improve visualization and decrease the number of incomplete explorations.

Influence factors for nurse performed endoscopy

Chapman, Warren¹, Cooper Brian¹, Inman Chris². 1.City Hospital, Birmingham. Birmingham, B18 7QH, 2.Birmingham City University

A qualitative study was undertaken to examine influential factors to the development of the gastrointestinal nurse endoscopist (NE) role in the United Kingdom (UK). Demand for NEs increased in the UK due to the introduction of national colorectal cancer screening¹ and a greater burden of gastrointestinal disease². It was necessary to examine the experience of NEs to make recommendations to improve performance of the role and quality of patient care.

The study involved: (i) Reviewing existing literature examining NE roles (ii) Conducting face-to-face, one hour, semi-structured interviews with eight NEs. (iii) Inductive analysis of transcripts to identify themes and categories.

The literature review showed that nurse endoscopy could be carried out at the level of advanced or specialist practice if the competencies of advanced practice could be met. However, studies examining the role of NEs were limited. Therefore both literature on NE roles and advanced and specialist roles was examined to find facilitating and impeding factors to roles. It was concluded that, though there were a number of facilitating factors, including medical and nursing colleague support, patient interaction and networking; lack of role expectations, a lack of focus and excessive demand led to potential role overload and strain for nurses in advanced and specialist roles.

Data gained during the interviews was analysed qualitatively. The following categories emerged: 1. Role structure, 2. Collaboration, 3. Experience, and 4. Education and Training.

The main findings were: that patient services could be better provided from practitioners whose roles were structured around patient needs and not primarily focused on performing endoscopy; that degree level education and training were facilitating when accessed; and that NEs may be providing an inferior patient service due to being allotted lower quality equipment, less experienced nursing support and being given lower priority than medical endoscopists.

Recommendations included that nurses undertake endoscopy as part of gastroenterology advanced nurse practitioner role for which they are educated to degree level, with a preference for Master's level. Additionally, patients seeing NEs should receive equal treatment, in terms of equipment, staff and priority, to those seeing medical endoscopists.

References:

1. United Kingdom Parliament (2003). Hansard 3rd June 2003. www.publications.parliament.uk/pa/cm200203/cmhansrd/vo030603/text/30603w93.htm
2. University of Swansea (2006). Gastroenterology Services in the UK. The burden of disease, and the organisation and delivery of services for gastrointestinal and liver disorders: a review of the evidence. www.medicine.swan.ac.uk

Guideline for patients with chronic hepatitis C

Caballero, Iolanda (2), Giménez, MDolors (1), Márquez, MCarmen (1), Fontanet, Angels (3), Bernal, Rosso (2), Mangues, Pepita (4), Guixé, Queralt (5), Varoucha, Cristina (6), Ariño, JLuis (4), Salas, Ana (7), Taulé, Rosa (8), Feijoo, María (9), Vargas, Montserrat (10), (1)Hospital del Mar (Barcelona), (2) Hospital Terrassa, (3) Hospital Sant Pau (Barcelona), (4) CP Brians (Sant Esteve Sesrovires), (5) CP Modelo (Barcelona), (6) Centro Penitenciario (CP) Quatre Camins (La Roca del Vallès), (7) Hospital Germans Trias i Pujol (Badalona), (8) Hospital Sant Joan de Déu (Manresa), (9) Hospital Vall d'Hebron (Barcelona), (10) Hospital Juan XXIII (Tarragona)

Introduction: Patients with chronic hepatitis C who are candidates to antiviral therapy should receive adequate information about the disease and treatment in order to improve adherence

Aims: 1.To provide information regarding their illness and therapy to patients with chronic hepatitis C. 2.To recommend measures to mitigate possible adverse effects. 3)To Promote and improve their selfcare and the quality of life during therapy.

Methodology: Specific discussion groups will: 1) Unify criteria. 2) Define a target group of patients that may benefit of this guideline and 3) Develop and validate the guideline with the specialized Nursing Group in Hepatitis C.

Results: The guideline contains different sections: 1) Introduction, 2) Current situation, 3)Transmission mechanisms, 4) Prophylactic measures, 5) Treatment, 6) Side effects and 7)General Recommen-

datations on basic hygiene and diet.

Conclusions: The guideline will represent a useful tool to reinforce the information given to the patient by the health care workers and will promote patient adherence to treatment. The efficacy of the guideline will be evaluated in the future taking into account the results obtained with its implementation in the clinical practice.

References:

Solà R, Galeras JA, Montoliu S, et al. Poor response to hepatitis C virus (HCV) therapy in HIV – and HCV- coinfectet àtiens is not due to lower adherence to treatment. *AIDS es Huum Retrov.*2006; 22 (5):393-400. Sabaté P. Who adherence meeting report. Adherence to longterm therapies: policy for action. Organización mundial de la Salud, 2001.

Shehab TM, Sonnad SS, Lok AS. Management of hepatitis C patients by primary care physicians in the USA: results of a national survey. *J viral Hep.*2001;8(5):377-383.

Net information and web information

Palle Bager, Bodil Meyer and Gunhild Andersen; Department of Medicine V, Aarhus University Hospital, Denmark, Contact: Clinical Nurse Specialist, RN, MPH, Palle Bager: pbage@as.aaa.dk Head Nurse for the Outpatients Clinic, RN, Bodil Meyer: bmeye@as.aaa.dk NET-Nurse, RN, Gunhild Andersen: brand@as.aaa.dk; Fax: +45 89492860

Introduction: Neuroendocrine Tumors (NET) are rare tumors with an incidence rate for NET in the small intestine of 2.0-2.4 per 100.000 population per year. The true incidence seems higher as autopsy studies have reported incidence rates up to 8.4 per 100.000 inhabitants (1,2). Treatment is therefore centralized at 2 University Hospitals in Denmark. Approximately 140 patients from the western part of Denmark are treated at Aarhus University Hospital. Many patients have often been seen by several doctors with different specializations at local hospitals before a final diagnosis is established and treatment is initiated. Although the patients receive a large amount of information it is our impression that the patients often find it hard to obtain clear and specific information about the disease, and that patients' feel isolated. Only a few leaflets about NET treatment are available in Danish, and only sparse Web-information about the disease can be found in Danish. No National Patient Association (NPA) existed at the time of the investigation.

Aims: The primary aim of this investigation was to identify NET patients' need for information after establishment of the diagnosis. Furthermore, the needs for further Web-based information as well as the demands for a National Patients Association (NPA) were investigated.

Materials and methods: 39 NET-patients treated at Aarhus University Hospital completed questionnaires regarding: Socio-demographic data, diagnosis, NET related information, medication, Web-based information and the need for a NPA.

Results: Approximately 56% of the patients were men, mean age was 65 years, and > 90% were living together with a partner. 25% were still in a working position. 64% were diagnosed at a University Hospital. Less than half were given written information regarding NET. Approximately 85% received treatment for NET. 15% were not treated, mainly due to side effects or curative operations. Only a few patients expressed an interest in self-injection with Somatostatin analogues. Most patients appreciated the monthly contact with the hospital. A total of 68% had Web access and were active users of the Internet; 95% of patients >65 years had Web access. All Web users responded positively towards a Danish homepage for NET patients. A total of 72% would welcome an NPA and many wished to take active part in an NPA.

Conclusion: We identified a need for additional written and Web-based information in Danish regarding NET. Despite a relative high mean age, a large number of patients have Web access and are current users of the Internet. There was no major interest in self-injection with Somatostatin analogues. It seems that there was a need for an NPA and that patients were willing to commit themselves to this.

References:

Berge T., Linell F. Carcinoid tumors. Frequency in a defined population during a 12-year period. *Acta Pathol Microbio Scan [A]* 1976; 84: 322-30. Modlin I.M. Lye K.D. Kidd M.: A five decade analysis of 13,715 carcinoid tumors. *Cancer* 2003; 97: 934-959.

Functional status, health-related quality of life and symptom severity in patients with chronic intestinal pseudo-obstruction and enteric dysmotility

Marie Iwarzon^{1,2} RN., BNSc. PhD-student, and Greger Lindberg¹ M.D., PhD. ¹Department of Medicine, Division of Gastroenterology and Hepatology, Karolinska Institutet at Karolinska University Hospital, ²Department of Neurobiology, Care Sciences and Society, Division of Nursing, Karolinska Institutet Stockholm, Sweden Institute of gastroenterology, Sheba Medical Center, Ramat-Gan

Chronic intestinal pseudo-obstruction (CIP) and enteric dysmotility (ED) are rare, gastro-intestinal motility disorders that cause a lot of suffering. Both CIP and ED are characterized by severe gastrointestinal symptoms and measurable abnormalities of gut motor function. [1] The main difference between CIP and ED is that dilated bowel is present in CIP but not in ED. These diseases are life-long and there is no curative treatment. Most of the patients need treatment with analgesics and nutritional support and needs for medical and nursing care are extensive. [2] The prognosis is variable but in general it is poor. Little is known about perceived functional status and health related quality of life (HRQL) in patients with CIP and ED and data on patients' own perceptions of HRQL would be valuable as an 'outcome' variable for these patient groups in order to identify specific needs and to facilitate co-ordination of their care.

Objective: To investigate if patients with CIP differ from those with ED regarding self-reported measures of functional status, HRQL, and symptoms and to investigate whether symptom severity is correlated to perceptions of functional health and HRQL.

Methods: We used 3 validated questionnaires: the Sickness Impact Profile (SIP), the Swedish Health-related Quality of Life Questionnaire (SWED-QUAL) and the Gastrointestinal Symptom Rating Scale (GSRS).

Patients: We studied 28 patients (20 females) with CIP (median age 48, range 28-80 years), and 26 patients (22 females) with ED (median age 50, range 20-75 years).

Results: We found no significant difference in the overall, or the subscales of, GSRS between the two groups. Patients with CIP scored significantly worse on the SIP aggregated physical dimension (body care and movement, mobility) than did patients with ED ($p < 0.01$). Patients suffering from CIP reported a poorer general health (SWED-QUAL) compared to patients with ED (28.0 vs. 44.8, $p < 0.01$). Patients with CIP exhibited strong correlations between severity of abdominal pain and 9/12 subscales of SWED-QUAL and the SIP subscale "emotional behaviour and work". Likewise, the severity of indigestion correlated strongly with 8/12 subscales of SWED-QUAL and the SIP aggregated physical dimension and the subscale "eating and work" among patients with CIP. In patients with ED, strong correlations were only found for abdominal pain and constipation with 4/12 subscales of SWED-QUAL (satisfaction with physical health, positive affect, limitation due emotional health problems, general health) and the SIP subscales "body care and movement", "home management", and eating.

Conclusions: Patients suffering from CIP reported poorer functional health and general health, as compared to patients with ED. In particular, abdominal pain and indigestion were found to influence the perceived HRQL in patients with CIP but less so in patients with ED.

References:

1. Wingate D, Hongo M, Kellow J, et al. Disorders of gastrointestinal motility: towards a new classification. *J Gastroenterol Hepatol* 2002;17 Suppl: S1-14.
2. Iwarzon M, Gardulf A, Lindberg G. Health care use in patients with chronic intestinal dysmotility before and after introducing of a specialized day-care unit. *Clin Gastroenterol Hepatol* 2008 (in press).

Nursing quality and postoperative monitoring of patients undergoing surgery for perforated peptic ulcer in Denmark – results and perspectives

Ann-Sophie Nielsen, Ellen-Margrethe Jacobsen, Hanne Christiansen, Ulla Bachmann, Anne Nakano.
RN in the Danish National Indicator Group re perforated peptic ulcer

Objectives: To present and discuss national results from the 1. registration period of basic postoperative monitoring for patients undergoing surgery for perforated peptic ulcer. Basic postoperative monitoring are defined as registration and documentation of the following three indicators: 1) Daily weight (standard 90%), 2) Fluid balance (standard 90%) and 3) Blood pressure, pulse, temperature, oxygen level in blood (SAT) and level of consciousness twice a day (standard was decided after the first audit 2007). All parameters are to be registered for the first three postoperative days. It

is necessary that all 1-3 or 1-30 measurements are registered to fulfil the standard.

Methods: The Danish National Indicator Project (DNIP) has developed evidence based Indicators to follow the quality of treatment and care for patients suffering from perforated peptic ulcer.

Data for all indicators are registered in a national database. Participation is mandatory for all hospitals treating the above patients.

Results: From the 1st September 2006 to the 31 st August 2007 386 patients are registered in the DNIP database corresponding to a

completeness of registered patients at 98%. Completeness of data for the three specific indicators was 94, 95 and 95% respectively.

Table 1: Results: basic postoperative monitoring (the first three postoperative days)

	1) Daily weight	2) Daily fluid balance	3) Blood pressure, pulse, temperature, SAT and level of consciousness, 2 times a day
Achieved standard (%)	25%	76%	67%

Discussion: The completeness of registered patients and the completeness of data for the specific indicators demonstrates a large professional awareness. The desirable standards are far from fulfilled at the national level. A reason for lacking of fulfilment could be just one missing measurement. Patients are transferred post-operatively between intensive care units and intermediate wards with different procedures, levels of observation and documentation. This makes it difficult to find the relevant data afterwards, taken that all these data are registered. Daily weight measurement had, not surprisingly, the lowest fulfilment of the standard. Mortality for patients undergoing operation dropped from 31% to 24% in this period of registration. Whether it is due to the inten-

sive focus on basal postoperative monitoring, or random variation, future results will show. Results for DNIP are published once a year on sundhed.dk in order to support further quality development. Developing quality in nursing requires that nurses find this sort of data important. Practice will develop if knowledge about the importance of basal postoperative monitoring is spread within the field. Standards and national guidelines is a way to reach the desirable target. The goal is to identify more specific indicators for the benefit of these seriously ill patients.

References: www.NIP.dk, www.sundhed.dk

Common Mistakes in Abstract Submission

Christiane S. Neumann

Nurses often work very hard to produce an abstract of their work and may be disappointed when it does not get accepted for the ESGENA conference. There can be many reasons why an abstract is not accepted, and these notes summarize the most common problems.

Non-compliance with abstract submission guidelines. ESGENA gives clear guidelines on how abstracts should be written. The reason for this is to facilitate a structured, logical approach and to make judging fair. Non-compliance may result in the rejection of the abstract.

Poor English and/or spelling mistakes. ESGENA does not expect perfect English in the abstract, although the English must make sense. However, lots of spelling mistakes are inexcusable, as most computers have spell-checkers and there are also many online dictionaries available. Please make sure you check your spelling before submitting the abstract.

Inadequate or missing 'Introduction'/'Background'. The Introduction/Background section should state the reason for doing the research and the way in which it complements previously published works – cited under 'References'.

Unrealistic aims. The aim should be reflected in the methodology used and should be realistic. Are you able to measure the things you aim to measure?

Inappropriate methodology. The 'Methods' section describes what you did. Is it a study, an audit, or a case report (these use different methodologies)? Does the methodology measure what you want to measure? Is your measurement tool appropriate? Are you measuring all the items you mention in the aims? Are your patients randomized (if applicable)?

No actual results given. An important part of the abstract is the results. The abstract should therefore reflect your work already done and analysed, and a summary of the results needs to be given in the abstract. Statements such as 'results will be discussed' or 'data will be presented' cannot be accepted and will lead to rejection.

Inadequate summary/discussion/conclusion. The most interesting part of the abstract is the summary (what has been found out) and the conclusions and discussions – i.e., the impact on nurses' everyday work (how will the results influence nursing work or patient care; what is the essence of your work?). Under these headings, you should also consider the introduction and state whether

the results/findings have answered the original research question and achieved the aims.

Inconsistency between the introduction, aims, methods, results, discussion, summary and conclusion – each addressing a different issue. Often the background/introduction, aims, methods, results and discussion are conflicting. For example:

- The Introduction (which should give the reason for doing the piece of work) may say 'nurses find it difficult to cope with the workload'.
- The Aims may state that the investigation wants to see how many endoscopes are needed.
- The Methods may state that the number of doctors in the department at any one time is to be counted.
- In the Results section, it may state that nurses had to work lots of overtime.
- In the Discussion/Summary/Conclusions, it may say that the department did not have enough nurses or endoscopes to cope with the number of patients and doctors.

There is no direct link or logical progression in this example. Make sure that the information you give under each heading is consistent and follows on logically.

No nursing aspects mentioned. The ESGENA Conference is a nursing conference. The abstract should therefore be relevant to nursing. Some research may be mostly medical, but still of interest and relevance to nursing. To help you to persuade the judges that your piece of work is useful to nurses, you should list learning outcomes for nurses, as requested in the abstract guidelines. (How were nurses involved in your work, in what way are the results interesting for nurses, what can nurses learn from your work?)

No learning outcomes listed (24 of 32 abstracts had no learning outcomes this year). ESGENA asks that learning outcomes should be included, to help you focus on the relevance of your abstract to nursing. Not stating any expected learning outcomes may result in your abstract being rejected.

No references given (five of 32 abstracts this year). The work behind the abstract should be evidence-based. It can therefore be expected that a literature search will have been done to see whether similar or relevant research has been done previously and the way in which the submitted research complements or differs from what is already known. If no references are given, it would be assumed that little or no background reading has been done and that the research may not add anything to existing knowledge.

Advocating standards of care that are below the accepted minimum. Abstracts that advocate practice that is below the accepted minimum standards of care as published in the official guidelines cannot be accepted. ESGENA has a duty not to allow presentations that advocate potentially dangerous practice, or practice in contravention of published guidelines.

Deciding between oral and poster presentation. Abstracts may meet all the criteria listed above but still not be chosen for oral presentation. There may be several reasons for this. For example:

- The abstract may not be original, but only a repetition of something well known.
- The work may be only descriptive, without any evaluation.
- The subject may not be of general interest to a wide audience. This does not mean it is of less value, but it may only be of interest to a small number of delegates.

The ESGENA abstract judges can only take into account what has been written in the abstract. It is therefore essential that the abstract should be well written and in the format requested by ESGENA. Many nurses will not have done this type of work before and their inexperience may therefore result in rejection of the submitted abstract. ESGENA therefore advises that in this case you seek help – for example, from medical or nursing colleagues who have more experience in the way abstracts should be written.

Christiane S. Neumann
E-mail: neumann-esgena@fsmail.net

Announcements of National and European Conferences

Belgium

- 27th GEEW – Gastroenterology and Endotherapy European Workshop
22–24 June 2009, Brussels
Information: www.live-endoscopy.com

Bosnia and Herzegovina

- School of Gastrointestinal Endoscopy 2008
April 17–18 2009, Sarajevo
Information: www.gastrosa.ba

Germany

- Spring Conference of the German Society of Endoscopy Nurses and Associates (DEGEA) and 39th Conference of the German Society of Endoscopy and Imaging (DGE-BV)
19–21 March 2009, ArabellaSheraton Grand Hotel, Munich
Information: www.dge-bv.de, www.degea.de, www.cocs.de
Conference language: German
- Endoskopie 2009 / Euro EUS 2009
30 April – 2 May 2009, Berlin
Information: www.endoskopie-live-berlin.de,
www.euro-eus.com
- International Symposium on Complications in GI Endoscopy: How to Diagnose – How to Treat – and How to Prevent!
25–26 June 2009, Hanover
Information: www.esge.com and
www.gastro-henriettenstiftung.de

Luxembourg

- Annual Conference of the Luxembourg Association of Endoscopy Staff (Association Luxembourgeoise du Personnel en Endoscopie, ALPE)
28 March 2009
Information: Lorenz Rudkin, ALPE international contact,
E-mail: alpe@chl.lu

The Netherlands

- National Congress of the Dutch Society of Endoscopy Nurses and Assistants (SEVA)
19–20 March 2009, Congrescentrum “De Koningshof”, Veldhoven
Information: www.nvge-seva.nl
- Amsterdam Live Endoscopy 2009
14–15 December 2009, Amsterdam
Information: www.amsterdamendoscopy.com

Norway

- The XL Nordic Meeting of Gastroenterology (Scandinavian Association for Digestive Endoscopy)
3–6 June 2009, Stavanger
Conference language: Scandinavian languages

Spain

- 14th ESGENA Conference
23–27 October 2010, during the 18th UEGW, Centre Convencions Internacional, Barcelona
Information: www.uegf.org and www.esgena.org

United Kingdom

- Annual Conference of the British Society of Gastroenterology
23–26 March 2009,
Scottish Exhibition & Conference Centre, Glasgow
Internet: www.bsg.org.uk
- GI Nurses 2009 ESGENA / SIGNEA Conference
21–23 November 2009, London, during Gastro 2009, UEGW/WCOG
Information: www.gastro2009.org, www.esgena.org,
www.signea.org



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GI Nurses ESGENA/SIGNEA London



In conjunction with

GASTRO 2009

UEGW/WCOG, London



At ExCeL Centre in London, UK
21–23 November 2009

GI Nurses 2009, ESGENA/SIGNEA, London

Hosted by the Endoscopy Associates Group of the British Society of Gastroenterology (EAG-BSG)

Welcoming Address

Dear Colleagues,

The United European Gastroenterology Federation (UEGF) and the World Gastroenterology Organisation (WGO), together with the World Organization of Digestive Endoscopy (OMED) and the British Society of Gastroenterology (BSG), are jointly organizing the 'Gastro 2009' conference in London on 21–25 November 2009.

In conjunction with Gastro 2009, the European Society of Gastroenterology and Endoscopy Nurses and Associates (ESGENA) and the Society of International Gastroenterological Nurses and Endoscopy Associates (SIGNEA) are organizing a joint meeting on 21–23 November 2009, hosted by the Endoscopy Associates Group of the British Society of Gastroenterology (EAG-BSG). The meeting is called 'GI Nurses 2009' and it will take place at the ExCeL centre in the east of London.

It is a great pleasure for us to invite you to a comprehensive 3-day conference featuring state-of-the-art lectures, free papers and posters, lunch sessions, and several workshops with hands-on training and live transmissions. Interesting topics in gastroenterology and endoscopy will ensure a truly global context. We are hoping to provide a full and varied programme – to stimulate you into meeting and holding discussions with colleagues from all over the world. This format will encourage networking and communication between the delegates, both between individual nurses and national groups.

On the Saturday, there will be an opportunity to attend a choice of 12 workshops organized in four parallel rooms. The workshops will have a more practical focus and will be held in smaller groups

– up to 50 – to encourage discussion, questions, and exchanges of ideas. Following success at previous conferences, it is planned to offer hands-on training using biosimulators for nurses on the Saturday and Sunday. These workshops will be organized in close cooperation with ESGE and OMED. Nurses will also have access to the Gastro 2009 postgraduate course on Saturday and Sunday and to the live demonstrations that are planned from Monday to Wednesday.

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. In addition, four parallel lunch sessions will have a more practical focus. On the Monday morning, we will have the Plenary Session with lectures in just one hall to bring all the delegates together, and the meeting will close with the prize-giving for the best free paper and the best poster, followed by an invitation to the next conferences.

The trade exhibition will open at lunchtime on the 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.

We look forward to welcoming you to GI Nurses 2009 in November 2009 in London, UK.

Ulrike Beilenhoff, President, ESGENA
Norah Connelly, President, SIGNEA
Pauline Hutson, Chair of EAG-BSG

General Information on GI Nurses 2009

Scientific Secretariat:

Ulrike Beilenhoff (ESGENA President), c/o Medconnect GmbH,
Brünnsteinstrasse 10, 81541 Munich, Germany.
Tel.: +49 731 950 3945,
e-mail: UK-Beilenhoff@t-online.de.
See also www.esgena.org and www.signea.org
and www.gastro2009.org

SIGNEA Annual General Meeting:

The SIGNEA Annual General Meeting will be held on Saturday 21 November 2009. Access for ESGENA members only.

ESGENA Annual General Meeting:

The ESGENA Annual General Meeting will be held on Sunday 22 November 2009. Access for ESGENA members only.

Social events:

Saturday, November 21, 2009

- Evening: Welcome Reception & Opening of GI Nurses 2009
- The Endoscopy Associates Group of the British Society of Gastroenterology (BSG-EAG) will act as local organisers for the event.
- Attendance is included in the registration
- The welcome reception needs to be confirmed
- Please contact the websites of Gastro 2009, ESGENA and SIGNEA for further information

Sunday, November 22, 2009

- Evening: Welcome Reception & Opening of GASTRO 2009
- Attendance is included in registration fee of GI Nurses 2009

Scientific Programme for GI Nurses 2009

Conference structure

Saturday 21 November 2009

- All day: 12 workshops in four parallel sessions
- Afternoon: hands-on training on biosimulators
- All day: postgraduate teaching programme at Gastro 2009
- Lunch time: SIGNEA Annual General Assembly (access for SIGNEA members only)

Sunday 22 November 2009

- All day: GI NURSES 2009 scientific programme with free paper and poster sessions and four parallel lunch sessions
- Afternoon: hands-on training on biosimulators
- All day: postgraduate teaching programme at Gastro 2009
- Afternoon: ESGENA Annual General Assembly (access for ESGENA members only)

Monday 23 November 2009

- Morning: GI NURSES 2009 plenary sessions and scientific programme
- All day: technical exhibition and the ESGE/OMED Learning Area

Hands-on Training on Saturday and Sunday

- Hands-on training on biosimulators will be offered in collaboration with ESGE and OMED.
- Registration for nurses will be handled by ESGENA.
- Tickets for nurses will be available at the ESGENA information desk.
- Please note that only a limited number of tickets are available, in order to ensure small training groups at each station.

Poster Sessions at GI Nurses 2009

- Scientific posters will be displayed on Saturday 21 November and Sunday 22 November 2009.
- Two poster sessions will be held on the Sunday.

Lunch Sessions at GI Nurses 2009

- Lunch sessions will combine state-of-the-art lectures with hands-on training on different stations.
- On Sunday 22 November 2009, four parallel lunch sessions will be offered on hygiene, management of upper gastrointestinal bleeding, small-bowel diseases and ERCP.
- Tickets for nurses will be available at the ESGENA information desk.
- Please note that only a limited number of tickets are available, in order to ensure small training groups at each station.

Postgraduate Teaching Programme at Gastro 2009

- On the Saturday and Sunday, Gastro 2009 will be offering a full 2-day postgraduate programme incorporating gastroenterology, hepatology, endoscopy, surgery, imaging and other diagnostic modalities.
- On the Monday to Wednesday, live demonstrations will be transmitted from London, Hyderabad and Rome.

Scientific Deadline for GI Nurses 2009

- 30 May 2009: deadline for submitting abstracts

Programme

Saturday 21 November 2009

8.30–18.00	Gastro 2009 – PG Training Programme
11.00–12.30	<p>WORKSHOP 1 Sierry Scientific Instruments: High-Definition Esophageal Manometry</p> <p>WORKSHOP 2 Managing Endoscopy Service in the UK</p> <p>WORKSHOP 3 IBD</p> <p>WORKSHOP 4 COOK Medical Europe</p>
12.30 - 13.30	Lunch Break
13.30–15.00	<p>WORKSHOP 5 US Endoscopy: Varices and a Gastric Varix Gluing Protocol</p> <p>WORKSHOP 6 Vision Science: Transnasal Endoscopy</p> <p>WORKSHOP 7 OLYMPUS EUROPE: Hygiene & Infection Control</p> <p>WORKSHOP 8 GIVEN IMAGING: Capsule Endoscopy</p> <p>WORKSHOP 9 Hands-On Training on Biosimulators</p>
15.30–17.00	<p>WORKSHOP 10 OLYMPUS AMERICA: Benchmarking and Best Practices, Utilizing a Global Perspective</p> <p>WORKSHOP 11 TBC</p> <p>WORKSHOP 12 BOSTON EUROPE</p> <p>WORKSHOP 13 PEG</p> <p>WORKSHOP 14 Hands-On Training on Biosimulators</p>

SIGNEA Annual General Assembly (members only)

MEETING NOTICES

Programme

Sunday 22 November 2009

8.30–18.00	Gastro 2009 – PG Training Programme
08.30–10.00	SESSION 1 Free Paper Session SESSION 2 IBD
10.00–11.00	Coffee & Poster Round I
11.00–12.30	SESSION 3 Free Paper Session SESSION 4 Lower GI
12.30 - 14.30	Lunch & Poster Round II & 4 Parallel Lunch Sessions
14.30–16.00	SESSION 5 Ethics SESSION 6 GI Diseases
13.30–15.00	WORKSHOP 14 Hands-On Training on Biosimulators
16.00–16.30	Coffee
16.30–18.00	SESSION 7 Nutrition SESSION 8 Staff Welfare & Management
15.30–17.00	WORKSHOP 16 Hands-On Training on Biosimulators
18.00–19.00	ESGENA Annual General Assembly (members only)

Further details

Inflammatory bowel disease (IBD, Session 2):

- IBD – overview
- Alternative treatments for Crohn's disease
- Medical and nursing management of patients with IBD

Lower gastrointestinal tract (Session 4):

- Bowel preparation – a review
- CO₂ insufflation
- Colorectal cancer screening worldwide
- Norovirus – the highest incidence for gastroenteritis

Ethics (Session 5):

- National variations in what is perceived to be ethical in patient care
- How we do ensure our patients are well informed?
- Patient choice – should we do what patients want?

Gastrointestinal diseases (Session 6):

- World overview of hepatitis B/C
- Complementary medicine in gastroenterology
- Emergency room and gastroenterological emergencies

Nutrition (Session 7):

- Treatment of patients with eating disorders
- Coeliac disease and the consequences of non-treatment
- Percutaneous endoscopic gastrostomy (PEG)

Staff welfare and management (Session 8):

- Accreditation of endoscopy units
- Global rating scores (GRS) as an instrument for quality assurance
- A national training programme for management of sedation in gastrointestinal endoscopy
- Creating a healthy work environment

MEETING NOTICES

Programme

Monday 23 November 2009

08.30–10.30

NEW TECHNIQUES AND DEVELOPMENTS IN ENDOSCOPY

Presentation by major sponsors Double balloon endoscopy – how many balloons and prevention of complications
Marsha Dreyer Memorial Lecture

– ERCP –

Best Free Paper and Best Poster Awards Invitation to upcoming conferences

10.30–11.00

Coffee

Visits to exhibition

ESGE/OMED Learning Area

Gastro 2009 Sessions

12.30 - 14.00

Lunch

Visits to exhibition

ESGE/OMED Learning Area

Gastro 2009 Sessions

Gastro 2009 live demonstrations

15.30–16.00

Coffee

Visits to exhibition

ESGE/OMED Learning Area

Gastro 2009 Sessions

Gastro 2009 live demonstrations

Call for Abstracts for GI Nurses 2009 ESGENA/SIGNEA, London

Participants wishing to submit abstracts for the GI Nurses 2009 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 GI NURSES 2009 is 30 May 2009.

Participants wishing to submit abstracts for the GI Nurses 2009 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

General Information on Submitting Abstracts

Participants are invited to submit original scientific abstracts for oral or poster presentation. 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 Arial, 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 2009.
- 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 author presenting an accepted free paper will receive free registration for the GI Nurses 2009 conference.
- Accepted abstracts will be published in the Abstracts Book for the GI Nurses 2009 meeting, in *ESGENA News*, in the *SIGNEA Newsletter*, and on the web sites of ESGENA and SIGNEA.

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.
- 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.

MEETING NOTICES

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 that do not conform to the guidelines will not be considered for review.

ABSTRACT SECTIONS	Checked
TITLE , clearly stating the nature of the investigation	
AUTHORS' names (full first name, surname)	
PRESENTING AUTHOR (name of the presenting author underlined)	
INSTITUTION (hospital, university, organization, city and 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)	
LEARNING OUTCOMES (two things you would like the reader to learn from your presentation)	
REFERENCES (minimum of two)	
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 first usage	
Presenting 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., Arial, Times Roman	
500 words — max. one A4 page	
The abstract should have nursing-relevant content and should add to existing knowledge.	

Congress Registration

Registration and Registration Fees (Euros, including VAT)

Online registration for the GASTRO 2009 is possible at www.gastro2009.org.

Registration and payment	Up to 15 May (€)	Up to October 16 (€)	After October 16 (€)
Delegate	470	600	750
Fellow in training at Gastro 2009*	200	225	250
Accompanying person	90	90	90
Lunch sessions	55	55	55
Postgraduate teaching programme	250	250	250
Postgraduate teaching programme fellow in training*	100	100	100
GI Nurses 2009, ESGENA/ SIGNEA conference †	185	200	250

* Applicants must be under 35 years of age and a certificate from the Supervisor or Head of Department must be forwarded together with the registration.

† Copy of nurses' professional standing or similar identification is indispensable for proof of status (confirmation by employer, proof of education or registration as nurse).

The registration fee for GI Nurses 2009, ESGENA/SIGNEA conference includes:

- Admission to all GI NURSES 2009 scientific sessions and workshops
- Admission to the Welcoming Reception for GI Nurses 2009 on Saturday 21 November 2009
- Admission to the Opening Ceremony and Welcoming Reception of GI NURSES 2009 on Sunday 22 November 2009
- Admission to the Opening Ceremony and plenary and scientific sessions of GI NURSES 2009
- Admission to the poster exhibition and technical exhibition
- Admission to the ESGE/OMED Learning Area
- Admission to the Ultrasound Learning Centre
- Unlimited use of the public transport system, valid for 3 days
- Congress materials (delegate bag, final programme, GI Nurses 2009 abstract book, etc.)
- Coffee breaks and lunches (Saturday–Monday)

The registration fee for accompanying persons includes:

- Admission to the Opening Ceremony and Welcoming Reception on Sunday 22 November 2009
- Unlimited use of the public transport system, valid for 5 days

Organizer

- Gastro 2009 Secretariat, Hollandstrasse 14/Mezzanine, 1020 Vienna/Austria
Tel.: 0043-(0)1-212 36 91, Fax: +43-(0)1-212 36 91-29,
E-mail: secretariat@gastro2009.org

Congress Venue

- ExCeL London, One Western Gateway, Royal Victoria Dock, London E16 1XL
Tel.: +44-(0)20-7069 5000, Fax: +44-(0)20-7069 4747,
E-mail: info@excel-london.co.uk; www.excel-london.co.uk

Congress Language

The congress language is English. No simultaneous translation will be provided.

Travel Grants and International Scholarships

Travel grants and international scholarships will be available. For more details, see www.gastro2009.org.

Visa

The entry formalities for the United Kingdom vary depending on the participant's country of origin. All visitors entering the United Kingdom must possess a valid passport. For citizens from European Union member countries, a valid identity card is sufficient. Please check the current visa requirements.

Letter of Invitation

The GASTRO 2009 Secretariat will be pleased to send a formal letter of invitation to any individual requesting one. This does not imply a commitment from the Congress to provide any financial support. Letters of invitation may be requested from the congress office, E-mail: secretariat@gastro2009.org.

Travel Information

'Star Alliance' members have been appointed as the official airline network for Gastro 2009. For further information, see www.gastro2009.org.

Hotel Accommodation and Social/Cultural Programme

Destination Management & Consulting Europe (dm&c) is the officially appointed contract partner for Gastro 2009 in London and has reserved rooms in various hotels in different categories. An exciting programme accompanying persons will be available.

Participants are welcome to contact:

- Destination Management & Consulting Europe (dm&c)
Tel.: + 43-(0)1-409 56 31-0, Fax: + 43-(0)1-409 56 31-22,
E-mail: gastro2009@dm-and-c.at

Welcoming Reception for Gastro 2009

Participants are cordially invited to attend the welcoming reception on Sunday 22 November 2009 at the ExCeL Centre. The ceremony will be followed by a spectacular entertainment programme and will provide an opportunity to meet with colleagues from all over the world.

Order Form for Additional Copies

ESGENA offers additional Copies of *ESGENA NEWS* to ESGENA members and non-members.

Subscription Costs

For ESGENA Members	€ 15 per copy
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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:

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Bruennsteinstr. 10, 81541 Munich, Germany, Fax +49-(0)89-4141 9245

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.

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European Core Curriculum for Endoscopy Nurses

The ESGENA Education Working Group has developed a Core Curriculum for endoscopy nurses. In addition to theoretical information about the structure and content of modules, it also contains practical information about how to implement and structure national courses.

The Core Curriculum is available as a PDF on the ESGENA web site (www.esgena.org) and as a CD-Rom.

The CD-Rom can be ordered by sending this reply slip to:

ESGENA Secretariat

Medconnect GmbH, Bruennsteinstr. 10, 81541 Munich, Germany, Fax +49-(0)89-4141 9245

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