Abstract Book Index

	Page
1. Welcome Address	**2**
2. General Information	**3**
2.1. Congress Organisation	3
2.2. Useful Conference Information	4
2.3. Useful Information about London	6
2.4. Plans of ExCel Centre	7
2.5. Floor plan for GI NURSES 2009 Conference	8
2.6. Official Conference Openings and Welcome Receptions	9
2.7. GI NURSES 2009 Free Paper & Poster Prize	10
3. GI NURSES 2009 - Programme Overview	**11**
4. GI NURSES 2009 – Detailed Programme	**14**
4.1. GI NURSES Workshops on 21 November 2009	14
4.2. GI NURSES Scientific Programme on 22 November 2009	22
4.3. GI NURSES Scientific Programme on 23 November 2009	30
4.4. Postgraduate Teaching Programme	31
4.5. ESGE/OMED Learning Area	32
5. Abstracts	**33**
5.1. GI NURSES Scientific Programme on 22-23 November 2009	33
5.2. GI NURSES Poster Round I and II on 21 November 2009	50
6. GI NURSES Faculty	**68**
7. GI NURSES Free Paper and Poster Authors	**71**
8. Sponsors	**73**
9. Announcement for next ESGENA Conference	**75**

GI Nurses 2009 ESGENA/SIGNEA London

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

in conjunction with

At ExCel Centre in London, UK from November 21 – 23, 2009

Welcome Address

Dear Colleagues,

In 2009, the medical organisations, the United European Gastroenterology Federation (UEGF) and the World Gastroenterology Organisation (WGO), together with the World Organisation of Digestive Endoscopy (OMED) and the British Society of Gastroenterology (BSG), are jointly organising **"Gastro 2009"** in London, from November 21 – 25, 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)**" organise a joint meeting on 21-23 November 2009, hosted by the "Endoscopy Associates Group of the British Society of Gastroenterology (BSG-EAG)". The meeting is called "GI Nurses 2009". The meeting will take place at the ExCel Centre in the east of London.

It is with great pleasure that we welcome you to a comprehensive three day conference with state-of-the-art lectures, free papers & posters, lunch sessions, several workshops with hands-on-training and live transmissions. Interesting topics of 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 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, we will be offering hands-on training using bio simulators for nurses on Saturday and Sunday. These workshops will be organised in close cooperation with ESGE and OMED. Nurses will also have access to the post graduate course of Gastro 2009" on Saturday and Sunday and the live demonstrations, which are planned from Monday to Wednesday.

The conference will officially open with the GI NURSES 2009 Welcome Reception on Saturday evening. In the past, this has been a most enjoyable, informal evening with the opportunity to meet colleagues and friends from all over Europe and overseas. This evening will be organised by the BSG-EAG as hosts of the conference.

On Sunday, the scientific programme, which includes two free paper sessions and a nurses' poster session, will offer mainly nursing-oriented lectures in two parallel halls. In addition, 4 parallel lunch sessions will have a more practical focus. On Monday morning, the Plenary Session bring together all the delegates and we will award the prizes for the best free paper and the best poster. We will conclude with invitations to the next conferences.

The trade exhibition will open on Monday at lunchtime, and there should be enough time to browse the stands if the medical scientific programme does not tempt you back into the lecture halls.

We welcome you again to GI Nurses 2009 in November 2009 in London, UK and wish you an interesting amd successful conference.

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

2. General Information

2.1. Congress Organisation

Scientific Secretariat of GI NURSES 2009 and ESGENA Contact

Ulrike Beilenhoff (ESGENA-President)
c/o Medconnect GmbH
Brunnsteinstr. 10
81541 Munich, Germany
Tel: +49 731 950 3945
Email: UK-Beilenhoff@t-online.de

SIGNEA Secretariat

Society of International Gastroenterological Nurses and Endoscopy Associates (SIGNEA)
Norah Connelly (SIGNEA President)
Caroline Bernero (SIGNEA Executive Director)
PO Box 267, Mount Prospect, IL 60056, USA
Tel: +1-(0)847-297 5088; Fax: +1-(0)847-445 0800
Email: signeahq@aol.com

BSG- EAG contact person:

Pauline Hutson (Chair of BSG-EAG)
Sheffield Teaching Hospitals NHS Trust
Gastroenterology
Herries Road, S5 7AU Sheffield, England, UK
Tel: 0044 114 2715776
Email: pauline.hutson@sth.nhs.uk

Steering Committee for GI NURSES 2009

- ESGENA
  Ulrike Beilenhoff (co-chair), Germany
  Michael Ortmann, Switzerland
  Stanka Popovic, Slovenia
  Sylvia Lahey, The Netherlands
- SIGNEA
  Norah Connelly (co-chair), USA
  Cindy Hamilton, Canada
  Raewyn Paviour, New Zealand
- BSG-EAG
  Pauline Hudson, UK

Programme Committee for GI NURSES 2009

- ESGENA
  Christiane Neumann (co-chair), UK
  Jayne Tillett, UK
  Mette Olesen, Denmark
  Jadranka Brljak , Croatia
- SIGNEA
  Gail DeCosta (co-chair), USA
  Di Jones, Australia
  Suzana Müller, Brasil
  Herdis Astradsdottir, Iceland
- BSG-EAG
  Irene Dunkley, UK
  Diane Campbell, UK

2.2. Useful Conference Information

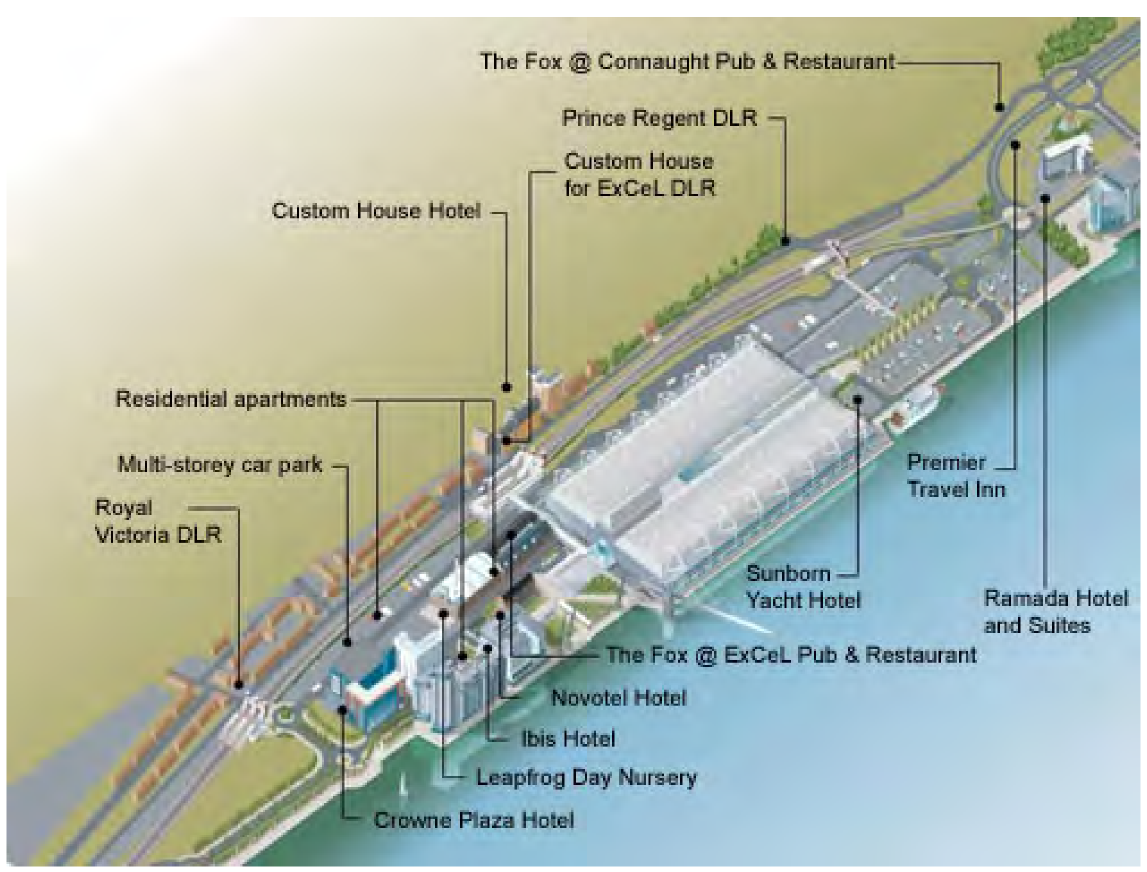
Attendance Certificates	Attendance Certificates will be given to delegates who hand in a **completed evaluation form** at end of the sessions on Sunday afternoon at the ESGENA information desk in front of hall Hall S 6/7 or on Monday morning at the GASTRO 2009 registration desks. Evaluation forms are inserts of the GI NURSES conference bags.
Banks and ATM's	At ExCeL London you will find Barclays and HSBC ATMs situated in the Boulevard on level 1 and on level 0, where all bankcards are accepted; two HSBC machines are at the west end of the Boulevard, and one at the east end of the Boulevard. The nearest banks are located at Canary Wharf, which is a short train ride away from ExCeL London.
Cloakroom	The main cloakroom is located centrally in the Boulevard on Level 0 (below the level of the session halls). The cloakroom is free of charge for GASTRO 2009 participants. There is a lift adjacent to Hall N7/8 to access Level 0. Normal operating hours are 30 minutes before the event opens until 30 minutes after the event closes.
Coffee & Lunch	Coffee and Lunches will be served for all GI NURSES registered participants from Saturday to Monday in the catering areas.
Conference Language	The official language of the GI NURSES conference is English. No simultaneous translation will be provided.
Emergency and First Aid	ExCeL London will deal with any emergencies within the venue. There are many emergency phones within and around the venue (the number is pre-programmed). If you need to call from another phone, the contact numbers are: • In the case of an emergency: +44-(0)20-7069 4444 • For general security inquiries: +44-(0)20-7069 444 The First Aid Room is located on Level 0 below the Boulevard. If you require first aid, please contact the medical treatment room at +44-(0)20-7069 5556.
ESGENA Annual General Meeting	ESGENA Annual General Meeting will be held on Sunday, November 22, 2009 from 18.00-19.00 hours. Access for ESGENA-members only.
ESGENA Payments	Membership payments (up to Euro 50) will be accepted in cash (Euro) at the ESGENA membership desk on Saturday afternoon and Sunday only
Exhibition	GI NURSES registered participants have access to the trade exhibition Monday, November 23, 2009 09:00 - 17:00 Tuesday, November 24, 2009 09:00 - 17:00 Wednesday, November 25, 2009 09:00 - 16:00
GASTRO 2009 Core Programme	Nurses are welcome to attend the medical lectures of the GASTRO 2009 core programme at no extra charge.
GI NURSES Hands-on-Training	Hands-on-Training on bio simulators will be offered on Saturday and Sunday in the ESGE/OMED Learning Area (Hall N13). See Workshops 9, 14-17 in the GI NURSES detailed programme. Please note that there are only a limited number of tickets available in order to ensure small training groups at each station. Tickets for nurses will be available at the ESGENA information desk - on a first-come-first-served basis.
GI NURSES Lunch Sessions	3 parallel Lunch Sessions on Sunday, November 22, 2009, will offer hands-on-training on new techniques and development and key points of reprocessing. Combined state-of-the-art-lectures and hands-on-training will update on Upper GI and Small bowel diseases. Please note that there are only a limited number of tickets available in order to ensure small training groups at each station. Tickets for nurses will be available at the ESGENA information desk - on a first-come-first-served basis.

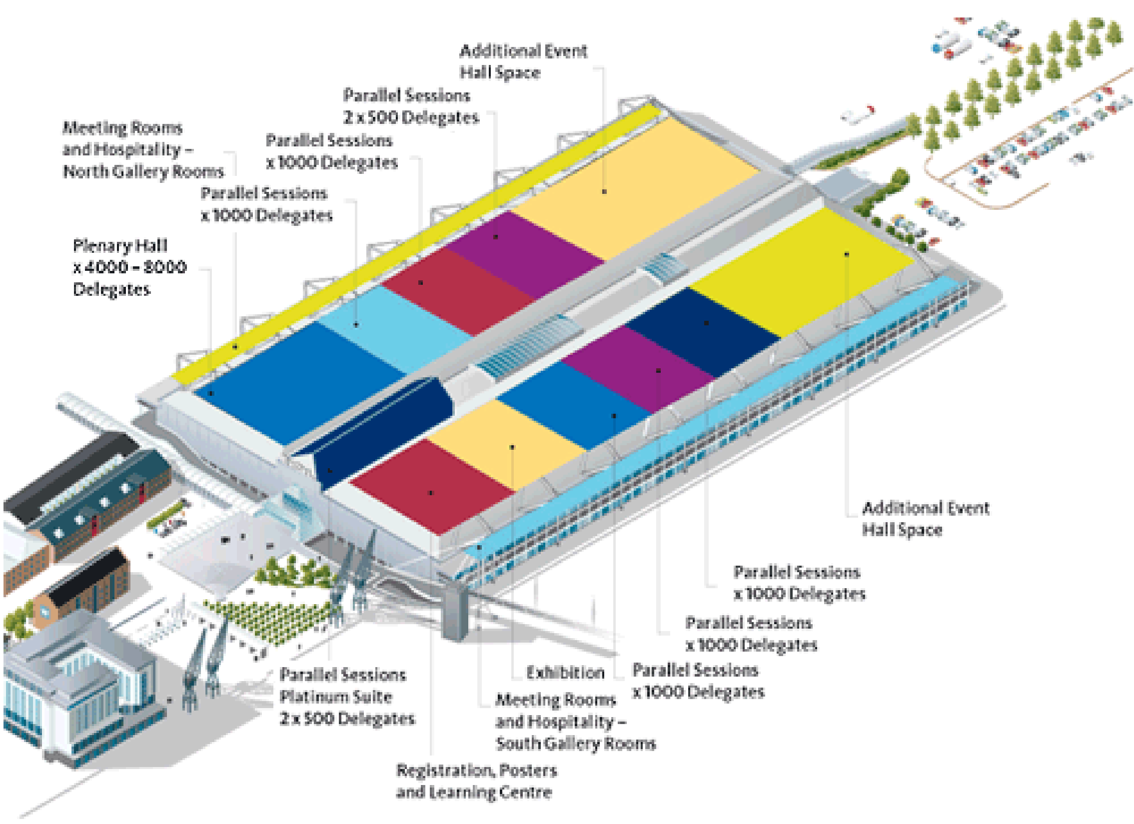
GI NURSES Poster Sessions	GI NURSES posters will be displayed in Hall 10. They should be mounted on the assigned board on Saturday 12.00 hours and removed before Sunday 16:00 of the same day. GI NURSES will have two poster sessions on Sunday November 22, 2009 • From 10.00-11.00 hours and • From 13.00-14.00 hours • in Hall 10
GI NURSES Welcome Reception	GI NURSES participants are invited to attend the GI NURSES-Welcome Reception • on Saturday, November 21, 2009 • at Platinum Suite, at ExCel Centre The GI NURSES badges are needed as ticket for the GI NURSES Welcome Reception.
Internet Points & Wireless LAN	Several terminals and wireless LAN areas will allow easy access to the internet on-site: • Platinum Suite/Level 1: Internet Points • Platinum Suite/Level 2: Wireless LAN Area • Industry Exhibition/Hall N4/5/6: Internet Points and Wireless LAN Area
Membership Desks of • **ESGENA,** • **SIGNEA and** • **BSG-EAG**	The membership desks will be situated in front of Hall S 6/7 on Saturday from 11.0-17:00 hours and on Sunday from 08:30-15:30 hours.
Programme Changes	The organizers cannot assume liability for any changes to the programme, due to external or unforeseen circumstances.
Public Transport	All registered GI Nurses and accompanying persons are entitled to use transport for London's (TFL) Central London Transport system during the 3 days of the congress. This travel card (called Oyster card) will be available for collection at the Oyster Card Counter in the registration area of ExCeL . To ensure you get charged the lowest fares you MUST ALWAYS TOUCH IN AND OUT on the yellow reader located at each station entry and exit. The reader at ExCeL is situated at the top of the stairs/ramp from the platforms, at the beginning of the main walkway to the congress centre. Please note, Oyster cards are not valid on the Heathrow or Gatwick Express trains, or overland trains and outside of zones 1 – 3. Visit London is organising special rates for travel from airports to the city/ExCeL which will be featured on the GASTRO 2009 website under Housing & Travel. In the interests of sustainable event management we would be grateful if you could RETURN THE OYSTER CARD ON YOUR FINAL DAY to one of the collection boxes at the congress centre.
SIGNEA Business Meeting	SIGNEA Business Meeting will be held on Saturday, November 21, 2009, from 12.30-13.30 hours in Hall S 6/7. Access for SIGNEA-members only.
Speakers Preview Centre (SPC)	Speakers are requested to check and hand in their presentation at the Speakers Preview Centre on the Green **Level the day before or at least three hours prior to their lecture**. **SPC Opening Hours:** **Friday, November 20, 2009** 14:00 h 18:00 h **Saturday, November 21, 2009** 07:00 h 18:00 h **Sunday, November 22, 2009** 07:00 h 18:00 h **Monday, November 23, 2009** 07:00 h 18:00 h **Tuesday, November 24, 2009** 07:00 h 18:00 h **Wednesday, November 25, 2009** 07:00 h 16:00 h At the SPC speakers will be able to check and rehearse their PowerPoint presentation.
Tickets for GI NURSES Workshop, lunch sessions and Hands-on-Training	Tickets for **GI NURSES workshops, lunch sessions and Hands-on-Training** on Saturday and Sunday will be available at the ESGENA desk in front of Hall S 6/7 Saturday from 10.00-17:00 hours and on Sunday from 08:30-15:30 hours. Please book early as tickets are issued on a "first come" basis.

2.3. Useful Information about London

Bank and ATM	Banks are open between 09:30 and 16:30 h on weekdays. Some of the principal banks offer extended opening hours even on Saturdays. ATM's (Automated Teller Machines) can be found everywhere in London, including at the congress venue - ExCeL London.
City of London	London - and England - has something for everyone. Whether you wish to party, or to explore for your roots, whether you are history buff or a theatre go-er, a shopper or a country walker, whether gregarious or introspective, this destination will rise up to your expectation! London offers superb museums and galleries, a truly eclectic range of theatre and cinema presentations, beautiful parks and horticultural wonderlands, and the timelessness of the busy River Thames. Come on and find out what's going in London by checking out: www.visitlondon.com.
Climate	Whatever the season, the British weather is liable to change from day to day, so if you are wondering what to pack, a good idea is to bring layers, a waterproof coat or jacket and an umbrella. The usual temperature in autumn is between 7 and 14 degrees.
Currency	The United Kingdom's monetary system is based on the pound sterling (British Pound). Credit cards are widely accepted.
Electricity	Electricity in the United Kingdom is 240-volt current, AC. Converters may be borrowed by contacting the hotel reception. If you see a special 110-volt razor socket in your bathroom, do not use it for anything other than a razor.
Shopping	Shopping hours vary from shop to shop, but in general, stores are open from Monday to Saturday between 09:00 and 18:00. Late-night shopping is available either Wednesdays or Thursdays, depending on the district. Some stores are now open for up to five to six hours on Sundays.
Sightseeing in London	**Half- and Full-Day Tours** Take advantage of being in one of the most historical cities in Europe, and discover the many "faces" of London. Make your choice and experience its immense richness and diversity. An interesting sightseeing programme was created specifically for GASTRO 2009 and GI NURSES 2009. It is exclusively offered to its participants. Great attention has been paid to its design, with careful selection of the right content for the given time. The programme showcases the different "faces" and "flavours" of the City of London and its surroundings. With the following unique selections we have tried to cater for all personal interests. Choose your favoured programme(s) and prepare to be captivated. • All tours will be conducted in English. • All half- and full-day tours will start and end in the City of London – at the Hilton Metropole (further address details will be provided after confirmation of bookings). • Meeting point for departure: GASTRO 2009 Tours desk in the lobby of the Hilton Metropole. • A minimum participation of 20 guests is required to operate each tour!
Telephone	Country code: +44. Outgoing international code: 00.
Time Zone	London's time zone is Greenwich Mean Time (GMT) and is 5 hours ahead of the US - Eastern Standard time and 1 hour behind most countries of mainland Europe.

2.4. Floor Plan of ExCel Centre





2.5. Floor Plan for GI NURSES Conference

NORTH GALLERY MEETING ROOMS

Registration

Exhibition

ESGE/OMED Learning Area
– GI NURSES hands-on-Training
N13

ENTRANCE WEST

PLATINUM SUITE

CATERING

GI NURSES CONFERENCE
S 4/5

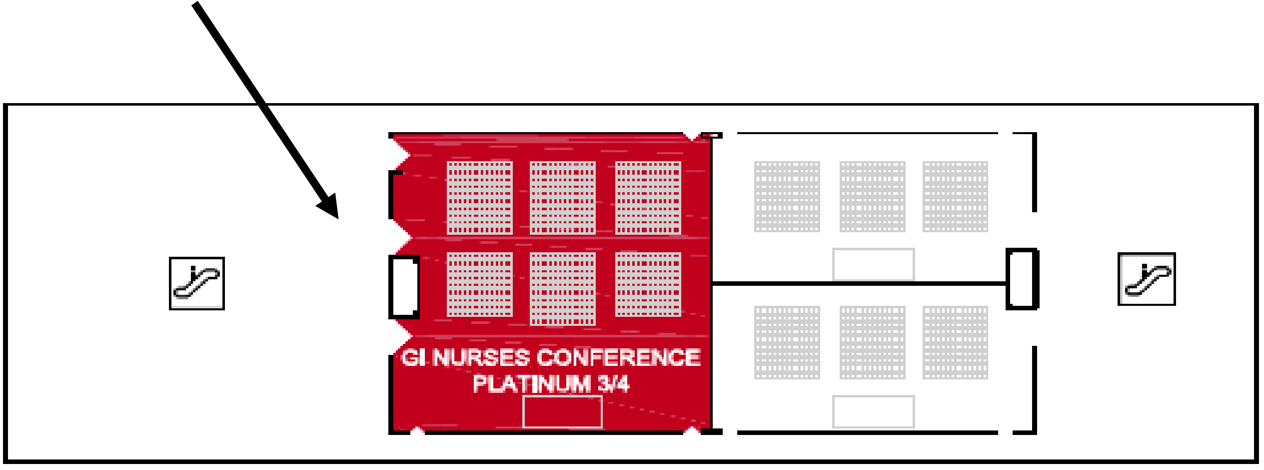
GI NURSES CONFERENCE
S 6/7

GI NURSES CONFERENCE
S 8/9

Poster Exhibition

SOUTH GALLERY MEETING ROOMS

GI NURSES
Lecture halls



2.6. Official Conference Openings & Welcome Receptions

GI NURSES Welcome Reception

The **Endoscopy Associates Group of the British Society of Gastroenterology (BSG-EAG)**
invites the GI NURSES conference participants

to the
Official Welcome Reception & Opening of GI Nurses 2009
On 21 November 2009
from 17.30-19.30
at Platinum Suite of Excel Centre (at level 3)

You are invited to a most enjoyable, informal evening with the opportunity to meet colleagues and friends from all over Europe and overseas.

Attendance at the Welcome Reception is included in the registration Ticket: Access only with badges of GI NURSES 2009

Welcome Ceremony of Gastro 2009

You are cordially invited
to join the amazing Welcome Reception
on Sunday, November 22, 2009,
at the ExCeL Centre.

The ceremony will be followed by a spectacular entertainment programme and will offer the opportunity to meet with colleagues from all over the world.

2.7. GI NURSES Free Paper & Poster Prize

Best Free Paper Prize is sponsored by

Accepted Abstracts receive *Free Registration* at the GI NURSES Conference

PRIZES to be won:

Best Free Paper – Oral Presentation wins
Free Registration and 2 nights' Free Accommodation at the next ESGENA Conference

Best Free Paper – Poster Presentation wins
a Digital Camera

The best Free Paper and best Poster will be announced at the GI NURSES Plenary Session on Monday, November 23, 2009

For details how to submit an abstract for the next ESGENA conference
please see ESGENA Conference Announcements
on www.ESGENA.org

3. GI NURSES 2009 - Programme Overview

Entrance Tickets to restricted Workshops are available from the ESGENA Information Desk

SATURDAY, November 21, 2009					
Lecture Halls	**Platinum 3/4**	**S 4/5**	**S 6/7**	**S 8/9**	**N 13 ESGE / OMED Learning Area**
Gastro 2009 – PG Training Programme	11.00-12.30 **Workshop 1** Sierra Scientific Instruments: See it all in one colourful Shot: The Beauty of practical High Resolution Manometry	11.00-12.30 **Workshop 2** Managing Endoscopy in the UK	11.00-12.30 **Workshop 3** CBC Group: Easy to use Endoscope Channel Cleaning with High Performance	11.00-12.30 **Workshop 4** Pentax: Automating Operational Efficiencies to drive Quality Patient Care	
Lunch Break 12.30-13.30					
SIGNEA Business Meeting at 12:30 in Hall 6/7 (members only)					
Gastro 2009 – PG Training Programme	13.30-15.00 **Workshop 5** Current Issues around Bowel Preparation	13.30-15.00 **Workshop 6** Boston Europe Endoscopic Clipping: Changing Algorithms, Changing Outcomes	13.30-15.00 **Workshop 7** Olympus Europe: Endoscope Drying and Storage: Current State of the Art and future Challenges	13.30-15.00 **Workshop 8** Given Imaging: New Developments in Capsule Endoscopy – Reading by Nurses and Endoscopy Assistants	13.30-15.00 **Workshop 9** Hands-on-training on bio simulators: Upper GI Bleeding ERCP Colonoscopy Entrance by ticket only
Coffee Break 15:00-15:30					
Gastro 2009– PG Training Programme	15.45-17.00 **Workshop 10** ABBOTT The pivotal Role of the gastroenterology Nurse in Managing Crohn's Disease: from biological Therapy to enabling cross-speciality Care	15.30-17.00 **Workshop 11** Custom Ultrasonic: The Risk of Transmission of Bio Film, Clostridium difficile and other epidemiologically important infectious Agents during GI Endoscopy	15.30-17.00 **Workshop 12** Olympus America: Bench Marking and best Practices, utilizing a global Prospective	15.30-17.00 **Workshop 13** Given Imaging Bravo ph Monitoring	15.30-17.00 **Workshop 14** Hands-on-training on bio simulators Upper GI Bleeding ERCP Colonoscopy Entrance by ticket only
	17.30-19.30 **GI NURSES 2009 Welcome Reception** Platinum Suite, ExCel Centre				

SUNDAY November 22, 2009				
Hall S 6/7	**Hall S 8/9**	**Hall S 4/5**	**Hall S 10**	**N 13 ESGE / OMED Learning Area**
08.30-10.00 **Session 1** Free Paper Session	08.30-10.00 **Session 2** Nutrition	----		----
10:00 – 11.00 Coffee	10:00 – 11.00 Coffee	10:00 – 11.00 Coffee	10:00 – 11.00 **Poster Round I**	-----
11.00-12.30 **Session 3** Free Paper Session	11.00-12.30 **Session 4** Lower GI	----	----	11.00-12.30 **Workshop 15** Hands-on-Training on Bio Simulators ERCP Short Wire System Cook Entrance by ticket only
12.30-14.30 Lunch	12.30-14.30 Lunch	----	13.00-14.00 **Poster Round II** & Lunch	----
13.00-14.30 **Lunch Session 1** New Techniques & Developments Entrance by ticket only	13.00-14.30 **Lunch Session 2** Key Points of Endoscopes Reprocessing Entrance by ticket only	13.00-14.30 **Lunch Session 3** Upper GI and Small Bowel Endoscopy Entrance by ticket only	----	
14.30-16.00 **Session 5** Ethics	14.30-16.00 **Session 6** GI Diseases	----	----	13.30-15.00 **Workshop 16** Hands-on-Training on Bio Simulators: ERCP Short Wire System Olympus Entrance by ticket only
16.00-16.30 Coffee	16.00-16.30 Coffee	16.00-16.30 Coffee	----	----
16.30-18.00 **Session 7** IBD	16.30-18.00 **Session 8** Staff Welfare & Management	----	----	15.30-17.00 **Workshop 17** Hands-on-Training on Bio Simulators: ERCP Short Wire System Boston upper GI Bleeding Entrance by ticket only
18:00-19.00 ESGENA General Assembly (members only)				

MONDAY November 23, 2009
HALL S 8/9
8:30-10:30 **New Techniques and Developments in Endoscopy** Presentation by Major Sponsors **Scientific Lectures** **Marsha Dreyer Memorial Lecture** Advancements in Endoscopic Treatment of Pancreatic Disease – Yesterday and Today **Best Free Paper and Best Poster Award** **Invitation to next conferences**
10:30 – 11:00 *Coffee*
Visit of Exhibition ESGE/OMED Learning Area Gastro 2009 Sessions
12:30-14:00 *Lunch*
Visit of Exhibition ESGE/OMED Learning Area Gastro 2009 Sessions Gastro 2009 Live Demonstrations
15.30-16.00 *Coffee*
Visit of Exhibition ESGE/OMED Learning Area Gastro 2009 Sessions Gastro 2009 Live Demonstrations

4. GI NURSES 2009 – Detailed Programme

4.1. GI NURSES Workshops on 21 November 2009

Workshop 1: See it all in one colourful Shot: The Beauty of practical High Resolution Manometry

This workshop is organised by **Sierra Scientific Instruments**

11.00-12.30 Hall Platinum 3/4
Chairs: Debbie den Boer, Rebecca Chandler, USA

Aim: This learning activity is designed for nurses, technicians and other healthcare professionals who perform esophageal motility and want to build a foundation which will enable the user to perform accurate High-Resolution Manometry (HRM) with the ManoScan 360™ system and establish an effective, organized motility lab.

Objectives upon completion of the workshop: The participant should be able to:

- Describe the basic anatomy of the upper gastrointestinal tract
- Recognize the swallowing process which will be assessed during the ManoScan study.
- Be aware of the role of respiration on the abdominal and thoracic cavity pressure in aiding the ManoScan catheter positioning.
- Comprehend the basic study analysis with the ManoView Analysis program.
- Briefly review sample ManoScan images for normal and abnormal function
- Describe the nursing process related to motility procedures.

Workshop 2: Managing Endoscopy in the UK

This workshop is organised by the **BSG-EAG**

11.00-12.30 Hall S 4/5
Chairs: Alison Ball, Bethan Davies, Susan Dreyer, Wendy Edwards, Linda Hodgson, Andrea Nicholls, Libby Thomson, UK

Since the advent of the National Bowel Cancer Screening Programme in the UK, all endoscopy units have been subjected to a rigorous quality assurance visit from the Joint Advisory Group (JAG). This has stimulated a number of initiatives to improve training and education for endoscopy staff. The Endoscopy Team Leadership Programme is a recent project, which has been generated in order to address the learning needs of the Endoscopy Lead.

Aims

- To define the difference between a manager and a leader
- To consider how the leadership role impacts on goal achievement
- To discuss common challenges within the endoscopy environment and how these can be addressed

Objectives

- To be able to deliver plans for an effective and high quality service
- To be able to challenge inappropriate behaviour through competence and confidence
- To be able to provide evidence of a motivated, high quality team

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Workshop 3: Easy to use Endoscope Channel Cleaning with high Performance

This work shop is organized by **CBC Group, Tokyo, Japan**

11:00 – 12:30 Hall S 6/7
Chair: Monica Cimbro, Italy

Aims & Objectives
This workshop will present a new method to mechanically clean endoscope channels by using the channel cleaner ball brush system. Efficient Channel brushing and cleaning is a pre requisite to ensure a sufficient disinfection. The quality of cleaning and brushing an endoscope is depending on the skill of the worker. This new method of channel brushing/cleaning minimizes this variability. It is easy to handle and provides reproducible efficient results. Tests performed and presented during this session show the good efficacy in lowering the residual protein and bacteria.

Content
11:00 - 11:30 Evaluation of the cleaning efficacy of a brushing procedure of endoscope channels using the ball brush; in vitro trials
Marlene Richard, France

11:30 - 12:00 Clinical experience using the channel cleaner ball brush method
Maria Vittoria, Italy

12:00 - 12:30 Presentation of cleaning efficacy in the combination of ball brush and washer disinfector

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Workshop 4: Automating Operational Efficiencies to drive Quality Patient Care

This workshop is organised by **PENTAX Medical Company America**

11.00-12.30 Hall S 8/9
Chair: Dariele Burchfield, USA

Aims & Objectives
At the conclusion of this presentation, the participants will be able to:

- Describe a structured performance improvement methodology
- Understand the definition of benchmarking and how it can impact and drive performance improvement
- Verbalize key data collection points to measure operational efficiencies as it relates to patient throughput, resource utilization, patient satisfaction, and quality indicators
- Understand tools available to automate the data collection process
- Discuss importance of buy in from administration, physician, and nursing staff
- Verbalize take away strategies for performance improvement

Workshop 5: Current Issues around Bowel Preparation

This workshop is organised by **BSG-EAG**

13.30-15.00 Hall Platinum 3/4
Chair: Pauline Hutson, UK

Within the UK a recent report highlighted the dangers of administering bowel preparation in certain patients. Recommendations to improve current practice were subsequently given within the report, which has had a direct impact on the administration and supply of bowel preparation. Gastroenterology and Endoscopy services have therefore had to review their services and new guidelines have been written by the British Society of Gastroenterology in order to help units to comply with these changes.

Aims

- To consider how recent guidelines relating to bowel preparation has impacted on the Gastroenterology and Endoscopy services in the UK and what lessons can be learnt by other countries
- To review areas of good practice, which relate to the supply and administration of bowel preparation
- To discuss the differences in bowel preparations

Objectives

- To be able to understand the reason for the recent National Patient Safety Agency report in the UK.
- To be able to challenge current practice where necessary and implement change if required.
- To have an understanding of the recent British Society of Gastroenterology guidelines and to be able to justify new practice.

Presentations:

Clinical Implications of Bowel Prep
Mike Geraint, UK

New Guidance for Bowel Prep: The Practicalities and Problems
Pauline Hutson , UK

Evaluation and Audit of Bowel Preparation: Results of Study
Alison Ball , UK

Workshop 6: Endoscopic Clipping - Changing Algorithms, Changing Outcomes

This workshop is organised by **Boston Europe**

13.30-15.00 Hall 4/5
Chair: Francisco Ou, France

Content:

13.30-13.50 The Physician's view
13.50-14.10 The Nurse's view
14.10-14.20 Q&A
14.20-15.00 Resolution Clip™ Hands-on

Workshop 7: Endoscope Drying and Storage -Current State of the Art and future Challenges

This workshop is organised by **Olympus Medical Systems Europe GmbH, Hamburg, Germany**

13:30-15:00 Hall S 6/7
Chair: Reinhard Blum, Germany

Aims & Objectives
Reliable and effective reprocessing of endoscopes has been a major focus for many years. Many recommendations and new European norms have been published on this subject. However, the importance of proper endoscope drying and especially the storage of ready to use endoscopes were of minor interest in the past. This situation has started to change. In the frame of quality assurance, the documentation and traceability of endoscopes even during drying and storage is playing a more and more important role. This workshop is intended to

- show current practice
- bring examples about microbiological risks in case of inadequate storage
- present current guidelines and regulations
- summarise typical and important product features
- inform about documentation and traceability measures

Speakers: Lionel Pineau, France; Ulrike Beilenhoff, Germany and Jayne Tillett, UK

Workshop 8: New Developments in Capsule Endoscopy – Reading by Nurses and Endoscopy Assistants

This workshop is organised by **Given Imaging GmbH, German**

13.30-15.00 Hall S 8/9
Chair: Owen Epstein, UK

Content

- How nurses and endoscopy assistants can do the reading of capsule endoscopy videos (educational background, indications, facilities and procedure of reading, follow-up, legal issues)
- How can medical doctors benefit from pre-reading done by nurses
- How will the final report be compiled

Presentations:
Indications, Contraindications, Clinical Application of Capsuleendoscopy
Owen Epstein, UK

Workflow for CE, Scheduling of CE Reading – Difficulties – Solution
Owen Epstein, UK

Pre-Reading by Nurse – When, How, Tips & Tricks for Reading
Linda Jackson, UK

Final Diagnosis Report
Owen Epstein, UK

Workshop 9: Hands-on-Training on Bio Simulators

13.30-15.00 Hall N13: ESGE/OMED Learning Area
Chairs: Michael Ortmann, Eric Pflimlin, Switzerland

Hands-on training on bio simulators (pig models) under the supervision of highly experienced tutors:
Participants will have the opportunity to perform endoscopic techniques on the following topics:

- OGD with Injection techniques, Ligation, Clipping, APC
- Colonoscopy with Polypectomy, EMR and APC
- ERCP with stone extraction and stenting

As participation will be limited, registration will be treated on a first-come-first-served basis.
Ticket will be available onsite only – at the ESGENA membership desk

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Workshop 10: The pivotal Role of the Gastroenterology Nurse in Managing Crohn's disease: From biological Therapy to enabling cross-speciality Care

This workshop is organised by **Abbott Laboratories, Abbott Park, Chicago, Illinois**

15.45-17.00 Hall Platinum 3/4

A multidisciplinary approach is fundamental to best practice in the management of Crohn's disease. From diagnosis onwards, the gastroenterology nurse plays a critical role as the patient's advocate, and is uniquely placed to coordinate a responsive service that meets the patient's changing needs. In this interactive workshop, IBD nurses and other members of the healthcare team will illustrate various aspects of one patient's journey, up to and including the use of anti-TNF therapy.

Aims:

In this workshop, gastroenterology nurses will gain a practical insight into achieving best practice in individualized clinical management, including care for patients receiving anti-TNF therapy. It will also provide an opportunity to discuss and reflect on their pivotal role in the collaborative approach to the management of Crohn's disease.

Content:

- Rationale for treatment history, including decision to prescribe an anti-TNF
- Provision of information and support, ongoing since diagnosis
- Coordination of cross-speciality care throughout the treatment journey
- Anti-TNF therapy: screening, administration, and monitoring
- The patient's interpretation of their disease, and its impact on their life
- Their counselling need at different stages of their disease
- Tailoring of dietary recommendations with and for this patient

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Workshop 11: The Risk of Bio films and Transmission of Clostridium difficile and other epidemiologically important infectious Agents during GI Endoscopy

This workshop is organised by **Custom Ultrasonic**

15.30-17.00 Hall S 4/5
Chair: Lawrence F Muscarella, USA

Aims:
A focus on biofilms, multidrug-resistant organisms (MDROs), and reprocessing breaches in GI endoscopy.

Objectives

- Discuss the properties of biofilms, how they form, and some of the different surfaces on which they may form.
- Investigate whether GI endoscopy is a risk factor for the transmission of biofilms.
- Review the epidemiology of C. difficile, MDROs, including MRSA and VRE, and other "epidemiologically important" microorganisms."
- Investigate whether GI endoscopy is a risk factor for the transmission of C. difficile and MDROs.
- Discuss Standard Precautions; the three primary modes of disease transmission; and Transmission-based Precautions, including Contact Precautions, which may be necessary to prevent transmission of C. difficile and MDROs.
- Outline strategies to prevent the transmission of biofilms, C. difficile, and MDROs during GI endoscopy.
- Answer the audience's questions

Workshop 12: Bench Marking and best Practices, utilizing a global Prospective

This workshop is organised by **Olympus America**

15.30-17.00 Hall S 6/7
Chair: Nancy Vacante, USA

Description:
It has been said that healthcare facilities are often data-rich and information-poor. Today's GI facility is no exception. A quality Benchmarking program can help convert data into useful information and improve the business and quality of care of any GI unit. This presentation will summarize the features of an effective benchmarking service applicable to any country as well as highlight the key 2009 U.S. findings compared to other initiatives in Canada and Japan. Session attendees will identify which key findings can be applied to their practice setting in an effort to determine their own best practice goals.

Objectives

- Identify quality benchmarking service features
- Identify key U.S. BM findings and relate to various GI practice settings

Content:

- Quality Bench Marking service features
- What's available in U.S. versus other countries
- Bench Markings versus Best Practices
- Highlight 2009 Bench Marking results
- Factors to consider for own practice setting application

Workshop 13: Bravo™ pH Monitoring

This workshop is organised by **Given Imaging GmbH**

15.30-17.0 Hall S 8/9
Chair: Rami Sweis, UK

Ambulatory reflux studies provide a definitive diagnosis in patients with symptoms that may be related to gastro-oesophageal reflux. Standard pH monitoring is performed by placement of a naso-oesophageal catheter with a pH electrode 5 cm above the lower esophageal sphincter. However this can be limited by local discomfort and social embarrassment both of which can result in a modified diet and lifestyle which may not be representative of normal daily life and thus reduce reflux provoking activities. Furthermore results of 24hr catheter based pH monitoring are compromised by the high day to day variability of acid exposure in patients with reflux symptoms. This reduces diagnostic accuracy and the ability of pH studies to guide effective clinical management.

Bravo™ is a new technique which involves placement of a capsule directly onto the mucosa of the lower oesophagus. This transmits information regarding acid reflux events to a wireless receiver and can associate symptoms with reflux events over a prolonged period of time (48 -96hours). Prior to its placement the capsule requires careful preparation and calibration. On its return the information recorded needs to be downloaded and accurately analysed by an experienced physiologist. Furthermore, in most centres capsules are placed endoscopically and require the assistance of a trained healthcare specialist. Therefore Bravo™ wireless pH monitoring is a coordinated endeavour between experienced doctors, physiologists and healthcare professionals.

Aims & Objectives
The seminar will begin with an introduction to the principles and practice of modern reflux studies and the benefits of prolonged ambulatory pH monitoring. It will then be followed by brief presentations about the preparation, insertion and downloading of the data. The seminar will then develop into an interactive discussion about reading and interpreting Bravo™ pH-studies using case-presentations.

Participants
The seminar will be of interest for nurses, physiologists and physicians caring for patients with reflux disease and, in particular, for physicians and staff performing, reading and interpreting reflux studies.

Presentations

15.30-15.45 Historical background to development of Bravo™
Terry Wong, UK

15.45-16.00 Improvement in patient tolerability and diagnostic yield using 48 and 96 hour Bravo™ studies
Rami Sweis, UK

16.00-16.10 Bravo™ preparation/calibration and introduction to the patient
Jayne Fong, UK

16.10-16.20 Endoscopic deployment of Bravo™ capsule, challenges and possible complications
Dean Borrows and Rami Sweis, UK

16.20-16.30 Downloading the data from receiver and diary card
Jayne Fong, UK

16.30-16.50 Reading and interpreting Bravo-pH studies with interactive case discussions
Rami Sweis and team, UK

16.50-17.00 Summary and final questions to the panel
Terry Wong, UK

Workshop 14: Hands-on-Training on Bio Simulators

15.30 – 17.00 N 13: ESGE/OMED Learning Area
Chairs: Michael Ortmann, Eric Pflimlin, Switzerland

Hands-on training on bio simulators (pig models) under the supervision of highly experienced tutors. Participants will have the opportunity to perform endoscopic techniques on the following topics:

- OGD with Injection techniques, Ligation, Clipping, APC
- Colonoscopy with Polypectomy, EMR and APC
- ERCP with stone extraction and stenting

As participation will be limited, registration will be treated on a first-come-first-served basis.
Ticket will be available onsite only – at the ESGENA membership desk

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17.30-19.30
Welcome Reception
GI NURSES 2009
Platinum Suite, ExCeL Centre

4.2. GI NURSES Scientific Programme on 22 November 2009

SESSION 1: Free Paper Session

08:30-10:00 Hall S 6/7
Chairs: Diane Campbell, UK; Di Jones, Australia; Linda Hodgson, UK

08.30-08.35	Welcome Ulrike Beilenhoff, Germany	
08.35-8.50	Nursing and technical Perceptions of the usefulness Applicability, Enjoyment and Realism of Simulation-based Training in the Pediatric GI Endoscopy Unit Meghan Fredette, Lisa Heard, Jenifer Lightdale, USA	L-1
08.50-09.05	First Norwegian Computer based Nursing Care Plan for Patients undergoing Gastrointestinal Endoscopy Bjørg Kjos, Kristin Woldstad, Norway	L-2
09.05-09.20	The Development of a Nurse led Hepatitis C Treatment Service Joanne Spicer, UK	L-3
09.20-09.35	Nursing Patients with Hepatitis Encephalopathy – evidence-based clinical Guidelines Lea Ladegaard, Denmark	L-4
09.35-09.50	Is the Use of intravenous Opioids essential to control Pain during Colonoscopy? The Patient's Perception: A critical Review Pauline Hutson, UK	L-5
09.50-10.00	Drying and Storage of Endoscopes– Survey in European Countries Ulrike Beilenhoff, Germany	L-6

SESSION 2: Nutrition

08.30-10.00 Hall S 8/9
Chairs: Stanka Popovic, Slovenia; Debbie den Boer, USA; Bethan Davies, UK

08.30-08.40	Welcome Norah Connelly, USA	
08.40-09.05	Managing Anorexia: A Psychiatrist's Perspective Rebecca Cashmore, UK	L-7
09.05-09.30	Establishing Hookworms in Coeliac Disease—A novel Approach for an increasingly common Disease James Daveson, Australia	L-8
09.30-09.55	Burried Bumper – Treatment without Surgery Ben Witteman, The Netherlands	L-9

Poster Round I (Management, Patient Care & Hygiene)

10.00-11.00 Hall S 10
Chairs: Jayne Tillett, UK; Herdis Astradsdottir, Iceland; Mandy Collins, UK

1. Endoscopy Pre-Assessment: Service Provision & Patient Satisfaction
   Julie Bowen, Geri Beech, Jo Corrigan, UK.

2. Cross City Emergency Out of Hours On-Call Service: The Endoscopy Nurse`s Experience
   Rachel Rawnsley, Jo Corrigan , UK

3. P.I.N.S - Patient Safety and Involvement Networks - who is involved?
   Pat Bottrill, UK

4. Computerization of the digestive Service, the medical Pharmacologist Prescription and the Nurse´s Registry Chart
   Natalia Bartolomé(1); Victoria Balauder(1); Noemí Aguirre(1); Margarita Bastida (1); Mª Jesús VIlar(2), Spain

5. Development of a Quality Assurance System and improved Quality in the Gastroenterology Institute
   Sigal Shafran-Tikvah, Nurit Porat, Goldin Eran, Israel

6. Do psychological Factors explain Symptoms in Patients with self-reported Food Hypersensitivity?
   Lind R, Berstad A, Kristine Lillestøl, Arslan Lied G,Norway

7. The Awareness and Preparedness Level of the Patients for Endoscopic Gastrointestinal Tract Procedures in Latvia
   Valentina Lapina, Ina Mezina-Mamajeva, Polina Domburga, Latvia

8. Patient's Perception of Gastroscopy compared to professional's Perception.
   Díaz Rodríguez, DR. Granados Martín, M., Spain

9. Description of Factors that influence in Upper Gastrointestinal Endoscopy Toleration
   Granados Martín, M., Díaz Rodríguez, DR., Spain

10. Needless Fasting: Can Fasting be avoided?
    E.Mathus-Vliegen, M. Kloppenburg-Flieringa, S. Simson, G. Veenboer , P. Fockens, The Netherlands

11. Teaching Cleaning and Disinfection Procedures to medical Students – new Role to Nurses
    Linden, Ane Isabel, Muller,Suzana. Brazil

12. Multidrug-resistant Organisms and the Implications for Endoscopy Units
    Linden, Ane Isabel, Brazil.

13. Efficacy of manual Cleaning of gastrointestinal Endoscopes with the Ball Brush Method
    Mattiola R, Chiarioni L, Coppolino M, Lamanna L , Locoro S, Puddu D, Ferrari A, Garripoli A. Italy

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SESSION 3: Free Paper Session

11.00-12.30 Hall S 6/7
Chairs: Diane Campbell, UK; Di Jones, Australia; Linda Hodgson, UK

11.00-11.15 What is the Experience of Patients with Barrett´s columnar-lined Oesophagus undergoing Endoscopic Disease Surveillance? L-10
Helen Griffiths, UK

11.15-11.30 Gastric, small intestinal and colonic Findings in a specialist Nurse Led Capsule Endoscopy Service L-11
Linda Jackson, Owen Epstein, UK

11.30-11.45 Lean Patients are at increased Risk for Failure to complete small intestinal Transit of Capsule Endoscopy L-12
Rachel Shley, Dorit Skinezes; Israel

11.45-12.00 Diabetic Colon Preparation Study L-13
Ann Hayes, Martha Buffum, Joyce Hughes, USA

12.00-12.15 High Prevalence of Fatigue in Patients with Inflammatory Bowel Disease: Results of a case-control Study L-14
Maria van Vugt- van Pinxteren, Tessa Römkens, Fokko Nagengast, Martijn van Oijen, Dirk de Jong, The Netherlands

12.15-12.30 A hermeneutic Study of Patients' Experiences and Sacrifices Living with Irritable Bowel Syndrome L-15
Marit Rønnevig, Per Olav Vandvik, Ingegerd Bergbom, Norway

SESSION 4: Lower Gastrointestinal Tract

11.00-12.30 Hall S 8/9
Chairs: Mette Olesen, Denmark; Raewyn Paviour, New Zealand; Karen Linton, UK

11.00-11.30 Bowel Preparation – A Review L-16
Owen Epstein, UK

11.30-12.00 Colo-rectal Cancer Screening worldwide L-17
Jerome Waye, USA

12.00-12.30 Norovirus – the highest Incidence of all Gastroenteritis´ L-18
Friedrich von Rheinbaben, Germany

Workshop 15: Hands-on-Training on Bio Simulators

11.00-12.30 N 13 / ESGE/OMED Learning Centre on level 1
Chairs: Björn Fehrke, Eric Pflimlin, Switzerland

Hands-on training on bio simulators (pig models) under the supervision of highly experienced tutors. Participants will have the opportunity to perform endoscopic techniques on the following topics:

- ERCP short wire system of COOK

As numbers are limited, registration will be treated on a first-come-first-served basis.
Ticket will be available– at the ESGENA membership desk

Poster Round II (Treatment and Patient Care)

13.00-14.00 Hall S 10
Chairs: Jayne Tillett, UK; Herdis Astradsdottir, Iceland; Mandy Collins, UK

14. Percutaneus Endoscopy Gastrostomy (PEG) in a new Hospital
Dania Rocío Díaz-Rodríguez; M José Gómez-Guerra; Marta Valbuena-González; Aurora de Pedro-Esteban; Alberto Ibáñez-Pinto; Juan Jesús Pérez-Poveda; Esteban Hernández-Surman; Purificación Pardo del Río, Milagros Ochoa Carmena, Spain.

15. Capsule Agile Patency© in suspected intestinal Stricture Patients: Role of Nursing Staff in Slection and Follow-Up of Patients.
Ibáñez Zafón IA; Alonso MC; Muñoz Galitó J; Dedeu Cuscó JM; Cañas-Ventura A; Delgado-Aros S; Andreu García M; Bory Ros F and Gonzalez Suárez B., Spain

16. Clinical Impact of Utilization of correct Accessories in the EUS – guided Drainage of pancreatic Pseudocysts
Daniela Burtea, Monica Molete, Mihaela Caliță, Romania

17. Patient Satisfaction with Endosonography Services
Sally-Hannah Brown, Sharon Nicholson, Abdul Razack and Sam Khulusi.UK

18. The Difference a Nurse makes: Hepatitis B Research in Aotearoa New Zealand
Kathryn Adams; Jennifer Masters, New Zealand

19. Treatment of Patients with acute liver Failure without gastric Tube reduces Mortality.
Iben Asmussen, Yvonne Boegh, Steen Vadstrup., Denmark.

20. Establishment of the Nursing Consultation for specific Control and Monitoring of Patients with Portal Hypertension on Drug Treatment for Prophylaxis of gastrointestinal Bleeding
Pablo Leis, AI; Gonzalo Domínguez, E; Chorro, V;Gallardo, C.; González, MC.;Pinilla, MC.;Plaza, AI, Spain

21. Impact of different oral Agents for Bowel Preparation
Palle Bager, Lotte Hansen and Helle Nielsen, Denmark

22. A prospective single-blinded randomized Trial of Polyethelene Glycol-electrolyte Solution vs. Sodium Phosphate as a Bowel Preparation for Colonoscopy in Lynch Syndrome Gene Carriers
Maria van Vugt-van Pinxteren, Mariëtte van Kouwen, Martijn van Oijen, Fokko Nagengast, The Netherlands

23. 4-Litre Kleanprep© versus 2-Litre Moviprep©: Assessement by Physician, Patient and laboratory Values
Elisabeth Mathus-Vliegen, Karin van der Vliet, Marjon de Pater, Paul Fockens, The Netherlands

24. What is preferable for Cleansing: Soffodex or PEG?A Comparison of two Methods of colonic Cleansing prior to Colonoscopy
Sigal Shafran-Tikva, Dov Wengrove[1], Natalia Belenko, Eran Golden, Israel

25. Adverse Side-Effects during the Sdministration of Infliximab: A Study of 1271 Infusions in 88 Patients
Paulo P. Nogueira, Rafael Oliveira, Sara Travassos, Miguel Silva, Patricia Gonzalez, Daniela Roque, Cristina Carvalho, Portugal

26. The Relationship between Health Locus of Control and Health related Quality of Life in Patients with Inflammatory Bowel Disease
Sheila Mair, Hairmyres Hospital, East Kilbride, UK

27. Application of Biological Treatment to Patients with IBD in the Czech Republic
Eliska Konecna, Czech. Republic

28. Enrollment in IBD Clinical Research: The Patient's Point of View
Matteo Martinato, Roberta Caccaro, Antonino Caruso, Perla Bertomoro, Lydia Oliva, Giacomo Carlo Sturniolo, Renata D'Incà, Italy

29. Knowledge of Disease in Patients with recent Diagnosis of Inflammatory Bowel Disease
Matteo Martinato, Michele Ferrante, Giacomo Carlo Sturniolo, Renata D'Incà, Italy

30. E-Mail Service for Communication between IBD Patients and Healthcare Personnel: A Study on Feasibility and Expectations
Matteo Martinato, Roberta Caccaro, Antonino Caruso, Perla Bertomoro, Tiziana Slongo, Francesca Lamboglia, Lydia Oliva, Giacomo Carlo Sturniolo, Renata D'Incà, Italy

31. Quality Improvement of Education for Patients Post Colonoscopy at Outpatient Services, NKC Institute of Gastroenterology and Hepatology
Siriporn Ratanalert, Wanpen Pinyopatsakul, Sopa Boonviriya, Varaporn Senapitakkul, Sulee Saengnil, Ruankwan Pongprayoon, Thailand.

Lunch Session 1: New Techniques and Developments

13.00-14.30 Hall S 6/7
Chairs: Marjon de Pater, The Netherlands, Cindy Hamilton, Canada; Pauline Hutson, UK, Michael Ortmann, Switzerland, Theresa Vos, USA; Susan Dreyer, UK

Content
This lunch session is focused on various endoscopic developments. Hands-on-training will be offered for the following endoscopic techniques:

- Devices and Techniques for Haemostasis and ESD (Olympus Europe)
- Clipmaster³ (medwork medical products and services GmbH)
- New single use Lithotriptor System (medwork medical products and services GmbH)
- Feel the difference - Olympus short guidewire system (Olympus Europe)
- Advanced Dilation and EUS Solutions (Cook® Medical)
- Gastro Pack™ – the smallest Endoscopy unit (Karl Storz GmbH & Co.KG)

As numbers are limited, registration will be treated on a first-come-first-served basis.
Ticket will be available– at the ESGENA membership desk

Lunch Session 2: Key Points of Endoscope-Reprocessing

13.00-14.30 Hall S 8/9
Chairs: Ulrike Beilenhoff, Germany; Siriporn Ratanalert, Thailand; Libby Thompson, UK

Content
Cleaning, drying and storage of endoscopes are key points of the reprocessing cycle. New developments on endoscope cleaning and storage will be presented:

- Initial Cleaning and safe Transportation of your Endoscopes (Medical Innovations)
- Endoscopy Bed Side Care Kit (Peskett solutions)
- Cleaning Balls (CBC)
- Trouble Shooting & manual Reprocessing of Endoscopes (Fujinon Europe)
- Drying Cabinets (Lancer UK)
- Training and Education on Decontamination (Lancer UK):

As numbers are limited, registration will be treated on a first-come-first-served basis.
Ticket will be available– at the ESGENA membership desk

Lunch Session 3: Upper GI and Small Bowel Endoscopy

13.00-14.30 Hall S 4/5
Chairs: Gail DeCosta, USA; Alison Ball, UK; Wendy Edwards, UK; Sylvia Lahey, NL

Content
This session will cover two main aspects of upper GI Endoscopy. There will be formal presentations followed by

- Gaining best results for Upper Gastro-intestinal endoscopy: Managing challenges in providing effective symptom relief in patients awaiting endoscopy, and in subsequent management of scoped patients (Reckitt Benckiser Group)
- Fujinon's Double Balloon Endoscopy™ System
- "NaviAid™ BGE – The next generation of small bowel endoscopy from Pentax
- Double balloon Endoscopy of Olympus with the use of single-balloons
- Including Hands-on-training

As numbers are limited, registration will be treated on a first-come-first-served basis.
Ticket will be available– at the ESGENA membership desk

Workshop 16: Hands-on-Training on Bio Simulators

13.30-15.30 ESGE/OMED Learning Centre on level 1
Chairs: Björn Fehrke, Eric Pflimlin, Switzerland

Hands-on training on bio simulators (pig models) under the supervision of high experienced tutors. Participants will have the opportunity to perform endoscopic techniques on the following topics:

- OGD with therapeutic procedures
- ERCP short wire system of Olympus Europe

As numbers are limited, registration will be treated on a first-come-first-served basis.
Ticket will be available– at the ESGENA membership desk

SESSION 5: Ethics

14.30-16.00 Hall S 6/7
Chairs: Christiane Neumann, UK; Theresa Vos, USA; Alison Ball, UK

14.30-15.00 National Variations of what is perceived to be ethical in Patient Care — L-19
Timothy James, UK

15.00-15.30 How to ensure our Patients are well informed — L-20
Raewyn Paviour, New Zealand

15.30-16.00 Patient Choice – should we do what Patients want? — L-21
Christiane Neumann, UK

SESSION 6: GI Diseases

14.30-16.00 Hall S 7/8
Chairs: Christine Petersen, The Netherlands; Suzana Muller, Brazil; Suzan Dreyer, UK

14.30-15.00 World View of Hepatitis B & C — L-22
Ken O' Riordan, USA

15.00-15.30 Complimentary Medicine – Is there a Place in Gastroenterology — L-23
Irene Dunkley, UK

15.30-16.00 Emergency within Gastroenterology — L-24
Mark Feeney, UK

Workshop 17: Hands-on-Training on Bio Simulators

15.30-17.00 Hall N 13: ESGE/OMED Learning Area
Chairs: Björn Fehrke, Eric Pflimlin, Switzerland

Hands-on training on bio simulators (pig models) under the supervision of high experienced tutors. Participants will have the opportunity to perform endoscopic techniques on ERCP short wire system from Boston Scientific.
As numbers are limited, registration will be treated on a first-come-first-served basis.
Ticket will be available– at the ESGENA membership desk

SESSION 7: Inflammatory Bowel Disease (IBD)

16.30-18.00 Hall S 6/7
Chairs: Pilar Perez-Rojo, Spain; Gail De Costa, USA; Wendy Edwards, UK

16.30-17.00 IBD – An International Overview — L-25
Matthew Lewis, UK

17.00-17.30 Alternative Treatments of Crohn's Disease — L-26
A.B. Hawthorne, UK

17.30-18.00 Nursing Management of IBD Patients — L-27
Marika Huovinen, Finland

SESSION 8: Staff Welfare & Management

16.30-18.00 Hall S 7/8
Chairs: Michael Ortmann, Switzerland; Rebecca Chandler, USA; Stephen Collins, UK

16.30-16.50	Global Rating Scores (GRS) as an Instrument for Quality Assurance Roland Valori, UK	L-28
16.50-17.10	Accreditation of Endoscopy Units Debbie Johnson, UK	L-29
17.10-17.30	A national Training Programme for Management of Sedation in GI Endoscopy Ulrike Beilenhoff, Germany	L-30
17.30-17.50	Creating a healthy Work Environment by using intelligent Light Jesper Durup, Denmark	L-31

4.3. GI NURSES Scientific Programme on 23 November 2009

SESSION 9: New Techniques and Developments in Endoscopy

08.30-10.30 Hall S 8/9
Chairs: Ulrike Beilenhoff, Germany; Norah Connelly, USA; Pauline Hutson, UK

08.30-09.30 **Presentations from the Major Sponsors Industry**

08.30-08.40 Advanced Imaging, revealing the hidden Colours of Disease (Pentax)
Greg Calder, USA

08.40-08.50 News from Olympus
Rüdiger Tamm, Germany

08.50-09.00 New Technologies in Endoscopy
Fritz Haller, Cook Medical – Endoscopy

09.00-09.10 Boston Scientific: The Innovation Journey
Francisco Ou, France

09.10-09.20 Endoscope Channel Validation (Custom Ultrasonics, Inc)
Frank Weber, USA

09.20-09.30 **New Technologies in the Detection and Characterization of colorectal Neoplasias** L-32
Arthur Hoffmann, Germany

09.30-09.50 **Double Balloon Endoscopy – How many Balloons and Prevention of Complications** L-33
Andrea May, Germany

09.50-10.20 **Marsha Dreyer Memorial Lecture:** Advancements in Endoscopic Treatment of Pancreatic Disease - Yesterday and Today L-34
Theresa Vos, USA

10:20-10:25 **Best Free Paper and Best Poster Award (sponsored by PENTAX)**
Ulrike Beilenhoff, Germany; Norah Connelly, USA

10:25-10:30 Invitation to the next ESGENA Conference 2010 in Barcelona
Pilar Perez-Rojo, Spain
Invitation to the next SIGNEA Conference
Norah Connelly, USA

4.4. Postgraduate Teaching Programme of GASTRO 2009 on 21-22 November 2009

This year it will be the third time that the congress offers an integrated two-day Postgraduate Teaching Programme from November 21–22, 2009 which has the flexibility for the delegates to participate in both of the plenary sessions and four specialist postgraduate courses in Endoscopy, Hepatology, General Gastroenterology and Gastrointestinal Surgery according to their needs and wishes.

GI NURSES participants have free access to the Postgraduate Teaching Programme from November 21–22, 2009

Postgraduate Teaching Programme

SATURDAY **09:00 – 10:30**	PLENARY SESSION 1 Management of IBD			
11.00-17.00	PARALLEL SESSION 1 Quality endoscopy in 2009	PARALLEL SESSION 2 Fibrogenic diseases of the liver and the pancreas: The science and the management	PARALLEL SESSION 3 GORD: Challenges and opportunities	PARALLEL SESSION 4 Surgery
Sunday **08.30-13.00**	PARALLEL SESSION 5 Quality endoscopy in 2009	PARALLEL SESSION 6 Hepatology world update	PARALLEL SESSION 7 IBS: Challenges and opportunities	PARALLEL SESSION 8 Surgery
14:00 – 16:00	PLENARY SESSION 2 New advances in the management of Upper GI Bleeding			

4.5. Endoscopy at Gastro 2009

ESGE/OMED Learning Area

The doors of the ESGE /OMED Learning Area are open to all GASTRO 2009 and GI NURSES 2009 delegates. The goal of the Learning Area activities is to serve endoscopic educational purposes and below is an overview of the main attractions. Several events are open on a walk-in basis, while others require registration.

- **Hands-On-Training on Biologic Models (in cooperation with ESGENA)**
  With access to state of the art endoscopic equipment and accessories and with personal doctor and nurse tutoring, participants will have the opportunity to perform techniques that are demonstrated and discussed in the endoscopic section of the Postgraduate Teaching Programme.
  Please check for availability for the nurses hands-on-training at the ESGENA Information Desk in front of Hall S 6/7.

- **DVD Learning Centre**
  The DVD Learning Centre offers all delegates the opportunity to visit 18 stations where the latest teaching material may be viewed on video screens with headphone sound transmission.

- **Lecture Theatre**
  Experts focus on topics of special interest before a small audience. Participants are invited to join in discussion following the presentation. In favour of a classroom atmosphere, the number of participants will be limited so interested delegates should ensure they arrive in good time.

Post Graduate Teaching Programme

On Saturday, 21-Sunday, 22 November, the congress offers a full two-day postgraduate programme incorporating gastroenterology, hepatology, endoscopy, surgery, imaging and other diagnostic modalities. GI NURSES participants have free access the Postgraduate Teaching Programme from November 21–22, 2009

ESGE/OMED Live Endoscopy from Centres of Excellence

From Monday, 23-Wednesday, 25 November, live demonstrations will be broadcast from international centres in Hyderabad, London and Rome. Recognised for their outstanding reputation in delivering international education in the field of digestive endoscopy, these three centres are listed as official OMED Centres of Excellence.
OMED honorary lectures will be held between live transmissions. These talks are delivered at each World Congress to commemorate Drs. Rudolf Schindler, Francois Moutier and Sadataka Tasaka.

GI NURSES participants have free access to the live transmissions on 23-25 November 2009.

Symposia

Interdisciplinary symposia will cover new approaches to diagnosis and treatment, and place major emphasis on innovative technical advances in the non-invasive management of gastrointestinal and hepatic disorders and basic science, including State-of-the-Art and Named Lectures. Lunch sessions will focus on the daily clinical practice of gastroenterology. Please note that these sessions are limited to a maximum of 30 participants. Registrations will be accepted on a “first-come, first-served” basis.

Working Party Reports

The goal of Working Party Reports is to present areas in need of a “new look” or where real guidance is required on classification, diagnostic criteria or therapeutic strategies.

Common Interest Groups

Common Interest Groups have the opportunity to meet at the congress outside the core programme.

5. Abstracts

5.1. GI NURSES Scientific Programme on 22-23 November 2009

SESSION 1: Free Paper Session

L-1

Nursing and Technician Perceptions of the Usefulness, Applicability, Enjoyment and Realism of Simulation-Based Training in the Pediatric GI Endoscopy Unit.

Meghan Fredette, BS, Lisa Heard, BSN, RN CGRN, Jenifer Lightdale, MD, MPH; Children's Hospital Boston; Boston, Massachusetts, USA

Introduction: Simulation-based training (SBT) involving high-fidelity scenarios provides health care teams with the opportunity to practice crisis resource management (CRM) skills in a safe environment without risk to patients. It is unknown whether this teaching modality can promote and maintain CRM skills in the GI endoscopy unit.
Aim: To survey GI endoscopy nurses and technicians involved in SBT to determine perception of SBT as a useful, enjoyable, applicable, and realistic tool.
Methods: All nursing and technical staff in the Gastrointestinal Procedure Unit (GPU) at Children's Hospital Boston were invited to participate in SBT program of endoscopic-based scenarios. Participants completed three surveys: 1) prior to; 2) immediately following; and 3) one-month following SBT. Survey questions obtained demographics data and assessed perceptions of the usefulness, enjoyment, applicability and realism of SBT using Likert scales of 1 to 5 (1-not, 5-very).
Results: 11/12 (92 %) nurses (10 female, median age 45 years) and 4/5 (80%) technicians (3 female, median age 38 years) participated. Prior to participation, nurses with > 5 years endoscopy experience rated their perceived enjoyment of SBT lower than their less experienced peers (mean Likert rating: 2.6 vs. 4.5 (p=0.005). However, when surveyed immediately after participation, both groups reported SBT to be highly useful (Mean ± SD, 4.8 ± 0.6), enjoyable (4.3 ± 0.8), applicable (4.4 ± 0.8) and realistic (4.4 ± 0.8), with no difference in ratings between groups. One-month after SBT, both nurses and technicians rated SBT as very helpful in their everyday practice (Mean 4.3 ± 0.8). 14/15 (93 %) participants indicated interest in participating in future SBT sessions.
Conclusion: SBT may serve as an enjoyable, applicable and realistic tool for nurses and technicians and enhance GI health care team performance during crisis events.
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Learning Outcomes:
Nurses and assistants will understand the role SBT plays in the GI/Endoscopy unit.
Nurses and assistants will describe the benefit of this modality and the use of CRM in their practice setting.

L- 2

First Norwegian Computer based Nursing Care Plan for Patients undergoing Gastrointestinal Endoscopy.

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Introduction: Annually, around 3000 gastrointestinal endoscopies are performed at our unit. Complex and therapeutic procedures require comprehensive nursing assessment and intervention. As the time is limited between the patients and the nurse, nursing documentation can be a challenge. Previous documentation was computer based but not in accordance to Norwegian laws and was strongly depending on the individual nurse experience and knowledge.
Aim: The aim was to develop an effective computer based tool for nursing documentation according to Norwegian laws, to patients undergoing gastrointestinal endoscopy.
Method: Project to improve the quality of nursing documentation in our unit in cooperation with the Unit of Informatics and Technology. We searched Medline, Cinahl, Embase, but found limited literature for nursing documentation for above – named patients. A nursing care plan was chosen as a structure for our documentation. Nursing diagnoses, patient results and interventions were based on consensus among best practice nurses knowledge and latest available literature.
Results: We have developed a computer based nursing care plan for inpatients undergoing upper endoscopy, as a part of the medical record. The nursing care plan is based on the Swedish documentation model, VIPS (Well–being, Integrity, Prevention and Safety), and individualized by standard choice lists and free text. The nursing care plan ensures high quality and advances continuity for the patients and improves the information to other units in the hospital. The nurses experience is that documentation is easier during the workday. A change in attitude and increased awareness has been observed among the nurses regarding nurse documentation.

Summary of results: The nursing documentation, as a computer based nursing care plan, is now a part of the medical record and has contributed to standardization of nursing communication.

Conclusion: Computer based standardized nursing care plan is a functional way to document nursing care in patients undergoing upper endoscopy. We aim to expand the project to include other endoscopic procedures, as well as out- patient care.

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Learning outcomes: We have seen the obvious value of including nurses in clinical practice early in the process, and to ensure appropriate funds for all phases of the project.

L-3

The Development of a Nurse Led Hepatitis C Treatment Service

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Introduction: It is estimated there are up to 500,000 people in the United Kingdom infected with Hepatitis C. (NICE August 2006) By 2005, there were 55,000 diagnosed cases and only 7000 of those had been treated with anti-viral therapy. (Health Protection Agency 2006) Hepatitis C is mainly transmitted via direct blood to blood contact, and many people do not realise they are infected, because it can take years or even decades for the symptoms to appear. Before the post was commissioned, Herefordshire residents had to commute to Birmingham for antiviral therapy, which was a 112 mile round trip

Aims/Objectives: To establish a local nurse led Hepatitis C treatment service providing education and information to both service users and healthcare professionals. The service will provide continuity for patients on their journey through the care treatment pathway, as well as avoiding expensive travel costs, time and the inconvenience of travelling out of area for treatment.

Method: Referrals are received from a variety of sources, and the patient is offered an appointment with the specialist nurse, for a full comprehensive assessment including appropriate blood tests and other diagnostic investigations. Health promotion advice and reduction of transmission routes are given at every opportunity. Depending on their genotype, treatment efficacy and duration are discussed at great length, including the management of side effects. If the patient wishes to commence treatment and there are no contra-indications a commencement date is arranged, and the patient meets the consultant at this point. Throughout treatment the patient is monitored closely by the nurse specialist, and weekly meetings are arranged with the lead consultant to discuss patient's progress.

Results: I have been in post for five months and the service is in its infancy. Feedback from both patients and other clinicians has been very positive. We anticipate to treat up to 20 patients in our first year, with 15 new referrals made to the service since January.

Conclusion: Expanding practice in accordance with the NMC Code Of Professional Conduct (2002), the clinical nurse specialist can be instrumental in providing continuity of care and expertise in the management of Hepatitis C infection.

Learning Outcomes: Patients can be monitored and treated safely by an appropriately trained, competent nurse "freeing up" doctors outpatients slots.

Many patients diagnosed with Hepatitis C often experience isolation and stigma, and many factors influence access to care. The development of a local service ensures that residents living in a rural area have equal access to the same specialist care and treatment, as those living in larger cities or towns.

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L-4

Nursing Patients with Hepatic Encephalopathy evidence-based clinical Guidelines

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Introduction: Hepatic Encephalopathy (HE) is a well-recognized clinical complication of chronic liver disease. On most occasions, HE appears due to a superimposed precipitating factor (gastrointestinal bleeding, infections, renal and electrolyte disturbances, constipation, etc.) and it is estimated that about 30% of patients with cirrhosis die in HE (1). The recognition of symptoms and signs by the personnel caring for those patients is essential for the early detection of this condition and for the prognosis and the clinical course of these patients.

Although a wealth of research is available regarding the basic tenets on nutrition, effects of medications, mobilization, etc, nurses do not always utilize the latest research results. It can lead to a limited quality of care basing practice on intuition and/or experience.

Aims: The purpose of the study was to compile evidence-based guidelines, which can be used in the process of improving and strengthening the basis for decision making in relation to patients with HE. Furthermore to reduce inappropriate practice by

improving nursing skills and documentations within this field.

Materials and Methods: We performed a systematic literature review concerning collecting, grading, critically evaluating and summarizing the research according the area.

The systematic literature review was retrieved in PubMed (MEDLINE), Cinahl, SweMed, EMBASE, different Internet sites and by hand searching list of references.Methodological quality of the studies was critically evaluated using checklists comprising questions with regard to quality and design (2).

Result: No materials on nursing guidelines regarding HE was found. However, material based upon evidence emerging from controlled clinical trials or case-control studies was added to our scientifically based knowledge about hepatic nursing and led to the development of evidence-based clinical guidelines for nursing of patients with HE. This tool has become an important part of the daily nursing and has improved the efficiency of the choice between the different opportunities available in the care and treatment of HE. During treatment and care the nurse can more readily predict any approaching needs of the patient and thereby better the prognosis and the clinical course of these patients and avoid a relapse in prone patients.

Conclusion: Nursing guideline for patients with HE based on collections of evidence-based practical information assist clinical decision-making. It allows nurses to develop treatment plan and greatly improve the odds of achieving positive clinical outcomes. It will be necessary to make a periodic update to conform to future research development.

References:

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L- 5

Is the Use of intravenous Opioids essential to control Pain during Colonoscopy? The Patient's Perception: A critical Review

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Introduction: Within the Western World colorectal cancer is a leading cause of death and in the United Kingdom 30,000 affected people are reported each year, (Office for National Statistics 2002). Colonoscopy is considered to be the gold standard procedure for bowel cancer screening due to the ability to detect polyps, which can be excised during the procedure thus reducing the potential to develop into more significant lesions, (Bowles et al 2004). Unfortunately colonoscopy is an uncomfortable investigation and a combination of a benzodiazepine and an opioid is a regime commonly used within the UK and other countries to alleviate procedural discomfort. However the synergism between these two drugs increases the risk of a cardio-respiratory event (British Society of Gastroenterology 2003).

Aim of the Study: To consider the necessity for using an opioid during colonoscopy investigation and whether omission reduces patient satisfaction and perception of pain

Method: A critical review of the literature was the chosen method of research, which would ultimately provide a collection of data from primary studies. A comprehensive search process was employed and sixteen studies were reviewed in depth using a piloted quality appraisal tool. A mix of non-randomised and randomised controlled trials were included within the review and results focused on the patient's perception of pain and cardio-respiratory side-effects. A standard data extraction sheet for quality assessment included but was not limited to methods of randomisation, comparability of baseline characteristics and intention to treat analysis. The studies within the reviews were scored and ranked as 8.0 – 10.00 very good, 7.0 – 7.9 good, 5.0 – 6.9 acceptable and less than 5.00 as poor.

Results: Cardio-respiratory side-effects were considered in studies where sedation was administered but excluded in those studies where conscious sedation was not used. No reference was made to cardio-respiratory events throughout the sedation-free studies, suggesting that these risks are minimal when conscious sedation is omitted. However there were fundamental considerations which cannot be disregarded despite the positive aspect of these findings. Results from the studies using a combination of drugs demonstrated variable degrees of oxygen saturation although there was an increase in patient satisfaction and tolerance of procedure with a reduction in pain. The experience of the endoscopist, therapeutic intervention and the anxiety level of the patient were key variables within the chosen studies.

Summary: Whilst the results of the studies demonstrated a reduction in cardio-respiratory risks in the unsedated patient, satisfaction and tolerance of colonoscopy was compromised in some patients.

Conclusions: Overall findings suggest that commencing a procedure without the routine use of an opioid with an option to use should the patient's response dictate maybe a more acceptable and certainly safer option.

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Learning Outcomes

- To understand the risks of conscious sedation during colonoscopy
- To increase knowledge of alternative medication regimes for colonoscopy in selected patients

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L- 6

Drying and Storage of Endoscopes– Survey in European Countries

Beilenhoff Ulrike, Germany

In the last years drying and storage cabinets have been introduced into the market, but their use could be established in a few countries only. Discussions during conferences showed many uncertainties among nurses and a great variety in national recommendations. Few studies are available about shelf life of reprocessed endoscopes (1-3). The updated ESGE-ESGENA-Guideline gives common recommendations concerning drying and storage of endoscopes and the use of drying and storage cabinets (4).

Aims: The aims of the survey were to compare data from different European countries and to identify trends.

Method: A questionnaire was developed focused on national practice, not on specific departments. The questionnaire was sent to all ESGE and ESGENA membership countries (44 countries).

Results: 27 responded (61.4 %). In 16 countries national guidelines provide special recommendations on drying and storage of endoscopes. In case of manual reprocessing 9 countries recommend to use compressed filtered air if endoscopes have to dried manually. 9 countries (33.3 %) recommend the use of automated washer disinfectors including drying cycles. Only 6 guidelines emphasised the responsibility on the staff to check the drying quality.

Flushing with 70-90% alcohol or isopropyl alcohol is established in 7 countries (25,9%) in order to increase the drying quality or to increase the shelf life of endoscopes (e.g. in Denmark).

A variety of recommendations exist for the storage of endoscopes: 12 countries (44.4%) recommend a vertical storage, often in combination with ventilated cupboards. It is widely accepted that valves and distal cups should not be connected during storage. The use of drying cabinets is mentioned in national guidelines of Finland, France, NL, Portugal, Sudan, UK and Ukraine. But only in Finland, UK and the NL drying cabinets are widely established.

In some countries the shelf life for reprocessed endoscopes are defined: In the UK endoscopes can be used for up to 3 hours before a repeated reprocessing, in NL 4 hours, in Slovenia 6 hours, in the Czech Republic, France and Portugal 12 hours, in Israel and Italy 14 hours. In Denmark the endoscope can be used for up to 72 hours if an alcohol flushing is performed. In the UK the shelf life can also be increased to 72 hours if endoscopes are dried and stored in drying cabinets. In Finland the shelf life is 7 days. Quality management for drying cabinets is only recommended in NL and the UK.

Summary & Conclusion: The survey showed that many national variations were apparent. The shelf life of endoscopes and the storage of endoscopes showed the greatest differences. Quality assurance programmes for drying cabinets have to be established. A European statement might help to reduce the uncertainties.

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

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SESSION 2: Nutrition

L-7

Managing Anorexia: A Psychiatrist's Perspective

Rebecca Cashmore, UK

Although still a relatively rare disorder, Anorexia Nervosa has the highest mortality rate of any psychiatric illness. Myths that it is a “slimmer disease” typically affecting high achieving young women, models and celebrities belies the truth that it affects a wide range of individuals for whom it can have devastating effects.

For some there will be recovery and return to a life simply postponed for the time of illness; for others anorexia will be life long condition, a lifestyle of its own.

The main treatment is a combination of psychological and physical interventions. Therapy aims to disentangle food and eating from emotional regulation and interpersonal dilemmas and nutritional advice supports safe weight restoration.

For a few severe cases more invasive interventions will be required, which may include naso-gastric and PEG feeding. These interventions are not easy “quick fix” options. Although they may prove helpful adjuncts to treatment, they may also have the potential to be counter- therapeutic and traumatising. These procedures raise ethical dilemmas for both patients and clinicians which need consideration and understanding.

L-8

Establishing Hookworms in Coeliac Disease—a novel Approach for an increasingly common Disease

James Daveson, Australia

As with other autoimmune conditions, coeliac disease is increasing in incidence and prevalence. New studies are also emerging indicating that coeliac disease may mean more than just a troublesome approach to one's diet. Run in collaboration with several other sites nationally and

internationally, a randomized double-blinded placebo controlled trial has been conducted at the Princess Alexandra Hospital in Brisbane,Australia looking at a novel treatment for coeliac disease using the human hookworm, Necator americanus. This presentation will discuss the aetiology of coeliac disease and potential therapeutic treatments.

L-9

Endoscopic Treatment of the "Buried Bumper Syndrome"

BJM Witteman, NL

In patients suffering from clinical depletion, enteral nutrition is mandatory. Percutaneous Endoscopic Gastrostomy (PEG) has been demonstrated to be a safe and effective method for providing nutrition in selected situations where conventional nutrition intake is not adequately possible for a period of more than 3-4 weeks. However, this kind of nutritional therapy may lead to complications as the "Buried Bumper Syndrome" (BBS).

BBS is a long-term consequence of tight apposition of the external bolster of the PEG tube against the abdominal wall. The internal bolster slowly erodes into the gastric wall as tension is created on the PEG tube tract. This may lead to abdominal pain or failure to pass tube feeding. The diagnosis is usually made by endoscopy which will demonstrate the internal bumper buried within the gastric mucosa.

The treatment of BBS depends on the type of PEG tube used. If the internal bolster is collapsible the tube may be carefully removed by external extraction. For replacement of the PEG just pass a guide/pull wire through the PEG into the gastric cavity and after snaring out of the oral cavity. As the new pull-PEG is placed through the abdominal wall the old PEG is pushed out.

In case of a BBS with a rigid internal bolster it is best to perform an endoscopic ultrasound to be sure that the bolster is not buried into the muscular wall. In this case surgery is the treatment of choice. A submucosal rigid bolster has to be removed from the inside by pulling it with the endoscope. This can be done with the pull T technique or by attaching the pull wire by the use of a side hole. The pull wire is passed through the PEG tube opening in the gastric wall and is fixed to the outside of the PEG at 3 cm from the skin. After attaching the pull wire to the PEG tube it can be removed by fixing the pull wire through the endoscope en remove the endoscope carefully. This way the PEG bolster is pulled from under the mucosa into the gastric lumen en out of the oral cavity. By fixing a second pull wire to the PEG bolster one can use this pull wire to place a new PEG in the same handling.

Prevention of the BBS requires good nursing care and patient instruction. After the first week of placement the external bolster of the PEG should be left 1 -2 cm from the abdominal wall. To be sure the internal bolster is not buried under the mucosa the patient can push the PEG tube forward into the stoma and rotate it freely.

SESSION 3: Free Paper Session

L-10

What is the Experience of Patients with Barrett's Columnar-Lined Oesophagus undergoing Endoscopic Disease Surveillance?

Helen Griffiths, Hereford Hospitals NHS Trust, Hereford, United Kingdom

Objectives: Since the identification of Barrett's columnar lined oesophagus (CLO) in 1950[1] it has been recognised as a premalignant condition for the development of oesophageal adenocarcinoma. Improvements in the quality, safety and availability of endoscopy as a diagnostic tool have meant that Barrett's CLO is diagnosed on an increasing basis. However, our attempts to describe its natural history remain challenging and consequently opinion divided as to its treatment and management including the benefits of surveillance. So far those looking at the patient experience have used measurement tools that highlight the methodological limitations in applying quantifiable methods to studying patient experience and quality of life[2]. This study uses qualitative methods to elicit the challenges to patients living with a chronic condition with potentially life limiting progression to set a more patient focused agenda in the continued debate on the care and management of this group.
Method: Semi-structured taped interviews with 22 white Caucasian males aged 50-70 years identified as those at highest risk of malignant progression[2]. QSR NVIVO 7® was used to manage the transcribed data. Using content analysis and Mishel's reconceptualised model of uncertainty in chronic illness[3] themes were identified and refined leading to the development of a new 'Model of Uncertainty in Barrett's Surveillance'.
Results: Appraisal of uncertainty is important in patient's experience of living with Barrett's CLO. The impact of initial symptoms and ongoing symptom control, the endoscopic experience, understanding of Barrett's and cognitive capacity to manage information, the credibility of the health care profession and social structure providers such as family and friends were all key factors. These factors led to appraisal of uncertainty as either threat or opportunity. Threats included overall health issues, cancer perception and feeling vulnerable. From these mobilising strategies were often employed to move to a more positive view. Opportunities included having surveillance as a safety net and having control over their symptoms. From these buffering strategies were often employed to maintain that positive outlook. Employing these strategies allowed adaptation and an altered, but transient, view of life until further appraisal of uncertainty was required.
Conclusions: Uncertainty occurs when a person cannot adequately structure or categorise an illness related event because of lack of sufficient cues.

Which in this study have been shown to be largely due to inconsistent or inaccurate information leading to poor self-management and avoidable anxiety in some cases. Uncertainty is a neutral concept representing neither threat nor opportunity until it is appraised as such. This study shows that as nurses we can influence the appraisal of uncertainty to ensure a more positive patient experience and appropriate self-management strategies.

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L-11

Gastric small Intestinal and colonic Findings in a Specialist Nurse Led Capsule Endoscopy Service

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Introduction: The Video Capsule Endoscopy Service (VCES) at the Royal Free Hospital is a run by an accredited Specialist Nurse supported by a Consultant Gastroenterologist. Currently, the VCES performs sixteen patency and small bowel capsule procedures a week. All patients referred to the VCES are referred by either a Specialist Gastroenterologist or Gastroenterology Nurse Specialist following appropriate workup. The video capsule endoscopy (VCE) trained nurse undertakes the primary read and reports abnormal findings. All studies are subjected to appropriate review by the specialist gastroenterologist.

Aims & Methods: To assess the prevalence of gastric, small intestinal and colonic abnormalities reported by the Nurse Specialist in consecutive patients referred for VCE.

Results: 129 consecutive VCE examinations were reported by the Specialist Nurse. Indications included assessment of Crohns disease (42%), iron deficiency anaemia (34%) and abdominal pain (12%).

All had previously undergone upper and lower endoscopy examination in accordance with National Institute for Clinical Excellence (2004) and British Society of Gastroenterology (2007) guidance. There was a single non diagnostic study in a patient who had failed to fast and one episode of capsule retention.

VCE was normal in 33%. Imaging identified oesophageal or stomach pathology in 20 patients (16%), none of which had been identified on prior upper endoscopy. Small bowel pathology was identified in 53% and in five patients, previously unidentified colonic pathology was detected. More than a single class of abnormality was reported in 24% of patients.

Conclusion: The prevalence and spectrum of abnormal studies in this Specialist Nurse led VCES was similar to that expected in a Gastroenterologist run service. The nurse also recognized foregut mucosal and colonic pathology not previously reported on upper and lower bowel endoscopy. It is likely that with increasing demand for WCE, accredited nurse specialists will play an increasing role in reading and reporting. The case series also highlights the often unexpected detection of oesophageal, gastric and colonic pathology.

Reference(S):

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- Wireless Capsule Endoscopy for investigation of the small bowel. National Institute for Clinical Excellence. 2004

Learning Outcomes:

1) Due to the rapid growth of VCE, Specialist Nurses are likely to lead the development of VCES. The case series shows that specialist trained nurses are highly competent in reading and reporting WCE
2) Pathology not found in upper endoscopy and colonoscopy can be discovered on VCE

L-12

Lean Patients are at increased Risk for Failure to complete small intestinal Transit of Capsule Endoscopy

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Background: Swallowable video capsule endoscopes (VCE) are increasingly used in the diagnosis of small bowel pathology. However, in a non-negligible number of capsule studies, the battery-life ends before the capsule reaches the large bowel thereby resulting in a non-complete examination of the small intestine

Aim: The aim of this study was to investigate if obesity is associated with failure to image the entire small bowel by capsule endoscopy.

Methods: Retrospective chart review of all patients who underwent VCE in a tertiary medical center between 1st January 2008 to 31st December 2008. All patients underwent the procedure after midnight fast, and after ingesting 3 liters of PEG lavage solution the night before.

Patients' BMI was computed, divided to quartiles, and correlated with the passage of capsule to the cecum or its lack of. Other demographic and clinical factors were also investigated.

Results: 130 patients were included (63 females). The capsule failed to reach the cecum in 7 out of these 130 patients (5.3%). Six out of the 7 failed procedures occurred in patients from the lowest BMI quartile (OR 23, CI 2.6-202, p=0.002). There was no correlation between procedure failure and the age or sex of the patients, nor the indication for the procedure.

Conclusion: Lean patients with low BMI are at significantly increased risk for failure of complete

imaging of the small intestine by capsule endoscopy.

Learning outcomes:

1. The rate of incomplete small bowel examination by VCE may be lower than previously reported and is 5% of procedures.
2. Lean patients are more prone to have an incomplete VCE examination

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L-13

DIABETIC COLON PREPARATION STUDY

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Study Aims: To evaluate if there is a difference in bowel preparation for colonoscopy between diabetic patients who receive an experimental colon preparation and diabetic patients who receive a standard colon preparation. Those in the experimental group used a 10 oz Magnesium (Mg) citrate two days prior to colonoscopy and 10 oz Mg citrate and 4 liters Polyethylene Glycol (PEG) the day prior to colonoscopy. Those in the standard group used 10 oz Mg citrate and 4 liters PEG the day prior to colonoscopy. Both groups had a clear liquid diet the day prior to colonoscopy.

Background/Significance: Adequacy of bowel preparation is critical for good bowel visualization. However, diabetic patients are prone to slowed gastric emptying (Cluose and Lustman, 1989), slowed colonic transit (Maleki et al., 1998), and slowed colon evacuation. Inadequate bowel preparations may lead to sub-optimal colonoscopic examinations resulting in overlooked pathology or repeated examinations. Repeated colonoscopy exposes the patient to potential cardiac and respiratory risks, as the procedure is performed using moderate sedation. Further, the endoscopy itself may cause perforation and bleeding. Avoiding repeated colonoscopies thus maximizes patient safety and organizational efficiency.

Methods: Using a double blind experimental design, 198 diabetic patients scheduled for a colonoscopy were randomly assigned to either the experimental group (N=106) or the standard group (N = 92) using a table of random numbers. All patients received verbal and written instructions on the preparation by the nurse.

On the day of the procedure the admitting nurse completed the demographics questionnaire. During the procedure the nurse and endoscopist, who were blinded to which preparation the patient received, completed the colon preparation evaluation.

Findings: There was a significant difference between those diabetic patients who used the experimental preparation and those who used the standard preparation. Patients in the experimental group had significantly cleaner colons than those who used the standard preparation. The experimental group resulted in 70% good colon preparations, compared to 54% in the standard group (chi-square = 5.14, p = 0.02).

There was not a significant difference in demographics between the experimental group and the standard group. (Mean age 62 years; Men 190; women 8; insulin dependent 53; non insulin dependent 145.)

Conclusion and Implications: These findings indicate that diabetic patients who use 10 oz Mg citrate two days prior to procedure followed by 10 oz Mg citrate and 4 liters PEG the day prior to procedure will have a cleaner colon than those patients who use the standard preparation. As a result of this study, the Gastroenterology Interventional and Diagnostic Center informs all diabetic patients scheduled for colonoscopy to use this diabetic colon preparation. Other gastroenterology units may confidently implement this preparation for diabetic patients. Furthermore, this safe and inexpensive intervention may be used for patients scheduled for colonoscopy who have constipation or have a history of prior poor colon preparations.

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L-14

High Prevalence of Fatigue in Patients with Inflammatory Bowel Disease: Results of a Case-Control Study.

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Introduction: Many patients with Inflammatory Bowel Disease (IBD) complain about severe fatigue even if their disease is in remission. Therefore we performed a study to examine the prevalence and severity of fatigue and to define possible determinants of fatigue.

Aim: In a three month period we conducted a case-control study in consecutive patients at our outpatient clinic. Patients with confirmed Crohn's Disease (CD) and Ulcerative Colitis (UC) were studied. Lynch syndrome gene carriers (Lynch) served as a control group.

Method used: Demographic variables, clinical history and laboratory results were obtained from the medical records. In IBD patients severity of disease was assessed by the Harvey Bradshaw Index. Severity of fatigue was scored using the revised Piper Fatigue Scale (PFS), a validated questionnaire consisting of 22 numerically (0-10) scaled items, that measures four dimensions of subjective fatigue: (1) behavioral/severity; (2) affective meaning; (3)sensory and (4) cognitive/mood. Mean PFS (overall and dimensions) scores were compared between the three groups. Within the IBD patient group we looked for possible determinants of fatigue, by comparing demographic

and clinical variables between patients with a high (≥4) and low (<4) PFS score.
Results: A total of 300 patients were included of whom 222 (117 CD; 55 UC; 50 Lynch) returned the questionnaires. Six patients (3CD, 2UC, 1Lynch) were excluded because of missing data in the PFS. The remaining 216 patients (82M/134F) were included in the statistical analysis. Demographic variables were not different between groups. Mean age was 44.4±13.1 years.
Summary of results: IBD patients scored significantly higher on the PFS, throughout all four dimensions, than the control group, with a mean (SD) PFS score of 4.8 (2.1) for CD and 4.2 (2.3) for UC versus 2.0 (2.0) for the control group, respectively (P<0.01). . Within IBD patients, gender distribution, age, anemia or high CRP did not alter PFS scores. Only the Harvey Bradshaw index was positively correlated with the overall PFS score (r=0.37, p<0.01), and throughout all four dimensions.
Conclusions: In conclusion we found a high prevalence (in all dimensions) of fatigue in patients with IBD. This prevalence was significantly higher compared to the control group, for both CD and UC patients. Within the IBD group, only the Harvey Bradshaw Index correlated with the Piper Fatigue Scale.
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Learning outcomes:
- Fatigue in patients with IBD is a real problem.
- High prevalence of fatigue even with a low disease activity.

L-15

A Hermeneutic Study of Patients' Experiences and Sacrifices Living with Irritable Bowel Syndrome

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Introduction: Irritable bowel syndrome (IBS) is characterized by abdominal pain, diarrhoea, constipation, distension and bloating (Drossman et al. 2000) and affects patients through reduced quality of life (Lee et al. 2008). Patients may experience negative attitudes from healthcare personnel and they can feel helpless and frustrated trying to control symptoms. The care of these patients must be developed to meet their needs, in order to restore or maintain their experience of health. Few reports describe patients' experiences living with IBS.

Aim: The aim of this presentation is to describe the experiences of "not being in control" and "living with sacrifices" while living with IBS.
Method: The research was carried out in the county of Vest-Oppland, Norway at one healthcare centre or at the participants' home. A hermeneutic approach was used and an interpretative analysis was performed from open-ended interviews with 13 patients currently diagnosed with irritable bowel syndrome. The interviews were conducted during 2005 -2006.
Findings: "Not being in control" and "making sacrifices" were two themes identified in the data. The first theme describes e.g. how diarrhoeas could come suddenly with only minutes from the onset of their need to having to reach a toilet. The second theme describes different situations they had to avoid in order to make sure that they did not need to go to the toilet during a meeting. Such avoidances could be not eating before the meeting. Further details of the findings and discussion are described in "Patients' experiences of living with irritable bowel syndrome" an in press article in Journal of Advanced Nursing (Rønnevig et al. 2009).
Summary: Patients living with IBS experience not to have control over their bowel needs, and they have to make sacrifices in order to have more control.
Conclusion: The experience of "not being in control" made the patients suffer, feel constrained and dependent. Healthcare personnel should allow patients to talk about their suffering, but also assist patients to get access to nursing care and medical treatment which can alleviate their discomforts.
Learning outcomes: To have knowledge about patients experiences of threats of "not being in control" and how they make sacrifices trying to increase the feeling of control.
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SESSION 4: LOWER GI TRAKT

L-16

Bowel Preparation – A Review

Owen Epstein, UK

Colon cleansing preparations can be broadly classified into three groups. Firstly, the stimulant laxatives such as senna, sodium picosulphate and bisacodyl which directly stimulate peristalsis and also add water content. Secondly, there are pure osmotic laxatives, such as sodium sulphate, magnesium citrate and mannitol. These increase colonic water content by creating the osmotic

conditions which stimulates the efflux of fluid across the bowel wall. The third class of laxative, polyethylene glycol (PEG) is an iso-osmotic electrolyte solution; as there is little electrolyte exchange across the bowel mucosa, the PEG-laced fluid is immobilized in the gut lumen, and is washed through the colon by peristalsis, clearing the colon contents by a "tsunami" effect. In clinical practice a wide range of bowel preparations are used and individual choice rather than evidence has dictated the choice of regimen. This is illustrated by a survey of 68 UK hospitals, where the most widely used regimens were sodium picosulphate + magnesium citrate (36.8%), polyethylene glycol + electrolytes (20.7%) and sodium phosphate (15.6%).
Although sodium picosulphate + magnesium citrate are widely used in the UK, studies indicate that these colon preparations produce less satisfactory outcome than PEG or sodium sulphate, both of which appear to have equal cleansing quality. There is no uniformity in the methods used for assessing the quality of bowel preparations and a common standard would be very useful.
In the absence of clear differences in efficacy, tolerability and side effects are likely to be the main arbiters of choice between bowel preparations. Comparisons between sodium phosphate and PEG indicate that 4 litre PEG is less well tolerated because of fluid volume. However, the introduction of a new 2 litre vitamin C + PEG-based preparation has addressed this. Side effects with sodium phosphate include electrolyte abnormalities, renal failure, nephrocalcinosis and rare reports of death. PEG-based preparations are associated with fewer and less serious complications and is the preparation of choice in renal failure.

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L- 17

Colo-rectal Cancer Screening worldwide

Jerome Waye, USA

Colorectal cancer is the fourth most common cause of death from cancer throughout the world. Each year over a million cases are diagnosed and there are about 500,000 deaths each year throughout the world. In North America and Western Europe, colorectal cancer is the second leading cause of cancer (1). The biology of colorectal cancer (CRCa) provides the opportunity for both early detection and prevention since most cancers evolve slowly from pre-malignant adenomas whose removal can effectively prevent colon cancer. There are multiple tests for screening, some of which primarily detect colon cancer, and others that may also detect high risk adenomas or (adenomas over 1cm in size, those with high grade dysplasia, or with villous components). The use of screening tests will prevent many colorectal cancers and mortality from this disease would be reduced.

A. Non-invasive tests which are intended to detect early cancer

1.Detection of blood or DNA in stool
These tests positively identify an individual at high risk, and colonoscopy is recommended for all positive testing. Unfortunately, these tests do not identify most patients with advanced neoplasia.
2. Guaiac-based testing for blood in the stool (fecal occult blood testing – FOBT)
This test has been found to be positive in about 50% of patients with cancer (2). However, with high risk adenomas, the FOBT is positive in only approximately 1/5th of these patients. A more sensitive guaiac-based FOBT (Hemoccult Sensa) has a sensitivity for cancer of approximately 64% and 40% for advanced adenomas (3).
3. Fecal Immunochemical Test
Detects the globin portion of human hemoglobin, and is much more specific than the FOBT. This test can detect about 2/3rd of patients who have cancer (4).
4. Stool DNA
For this test, stool is sent to a specialized laboratory and a positive test is found in about half of the patients with cancer and 1/5th of patients who have high risk adenomas (without invasive cancer) (5).

B. Tests which detect both adenomas and cancer

1. Flexible sigmoidoscopy
Sigmoidoscopy is associated with a 60-80% reduction mortality from colon cancer in the portion of the colon visualized by this examination (6,7). However, this does not reduce the likelihood of cancers beyond the reach of the sigmoidoscope.
2. Flexible sigmoidoscopy combined with FOBT
This combination has been reported to detect 3/4th of patients with advanced neoplasia.
3. Computer Tomographic Colononography (CTC)
There is a consensus to not report polyps less than 6mm in size. This technology can detect both polyps and early cancer. All polyps over 10mm in size should be referred for colonoscopy. Polyps in the range of 6-9mm may have a 2-7% risk of high grade dysplasia and up to 1% risk of invasive cancer (8).
4. Colonoscopy: There is a greater than 95% probability of finding cancer of the colon. There is a high probability of detecting high risk adenomas.

When screening for colon cancer is viewed on a global basis (9) the colorectal cancer incidence ranges from 50-60 per 100,000 in developed countries whereas in developing countries, the rate is considerably lower, ranging from 6-8 per 100,000 populations. The average incidence of colon cancer per 100,000 population in Japan is about 80, in France 60, United States 50, Hong Kong 40, whereas the incidence in Thailand is approximately 9, Egypt 4, India 3, Zimbabwe 2 (10). In many developing countries, the major cause for death is communicable diseases, and not caner. In developed countries the mortality from cancer in adults is approximately 25% of all deaths and only 5% of deaths are from communicable diseases. As an example, in the African population, the mortality from all cancers is approximately 5% whereas that from communicable disease ranges up to 65% of all deaths in patients less than 70 years old.

The current status of screening in the European Union is that currently 60 million persons are screened annually, 3.2 million Europeans are diagnosed with cancer on an annual basis, and 32% of cancer deaths in women is due to cervical or colon cancer where 11% of cancer deaths in men are from colon cancer. Currently, 22 of 27 EU states screen for breast cancer whereas only 12 of the 27 screen for colon cancer (11).
In Greece, the current status is that in persons age 50-70, 54% of women have mammography, 40% of men have a PSA, only 20% of men have a digital rectal examination, and 10% have had fecal occult blood tests, whereas only 8% of women have been screened with a fecal occult blood test in the past three years(12).
In Ontario, Canada, only 17% of persons interviewed had decided to do a fecal occult blood test. (13). The Canadian guidelines are to screen all patients between 50-74 years old for colorectal cancer, however, fecal occult blood screening in the past year was only performed in 8% of the population, endoscopy screening in the past five years was performed in 9% of the population, and 70% of the population was not compliant with guidelines (14).

Conclusion: In developing countries, the incidence of colorectal cancer is relatively high and accounts for a significant proportion of deaths from cancer. Although screening in this population is advised, many patients do not avail themselves of a screening opportunity. In developing countries, where the cancer death rate compared to death rate from other causes is relatively low, population screening does not appear to be a worthwhile use of health care resources. In developed countries, it is important to increase the knowledge of the target populations to the availability and efficacy of screening tests for the prevention of colon cancer.

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L-18

Norovirus – the highest Incidence of all Gastroenteritis´

Friedrich von Rheinbaben, Germany
Not submitted

SESSION 5: ETHICS

L-19

National Variations of what is perceived to be ethical in Patient Care

Timothy James, UK
Not submitted

L-20

Informed Consent – How do we ensure Patients are well informed?

Raewyn Paviour, New Zealand

This presentation examines the following question: "How do we ensure patients are well informed"?
The starting point is an overview of a well documented historical health challenge in New Zealand forty years ago. Research on women with cervical abnormalities was conducted without participating patients consent and which ultimately gave rise to New Zealand's significant health law changes and major ethical review of health research. This unorthodox study became known as the "Unfortunate Experiment" at National Women's Hospital in Auckland. The resulting Commission of Inquiry conducted by Judge Silvia Cartwright had profound effects on the delivery of healthcare in New Zealand. It is inevitable that events surrounding this major inquiry have continued to be reviewed and debated over the last four decades. However since the Cartwright Report was released in 1988 and new legislation enforced, informed consent in both treatment and research is now a term that has become widely used throughout New Zealand.
An overview and discussion of the major health laws will demonstrate significant changes in health professionals practice in New Zealand and show the positive impact on patients statutory rights to make

informed choice and give informed consent. The purpose and elements of informed choice and informed consent will be explored and outlined based on the Code of Health and Disability Services Consumers' Rights which were introduced in 1996 and further endorsed consumers rights and providers duties.

The Ten Rights include:

- Right to be Treated with Respect
- Right to Freedom from Discrimination, Coercion, Harassment and Exploitation
- Right to Dignity and Independence
- Right to Services of an Appropriate Standard
- Right to Effective Communication
- Right to be Fully Informed
- Right to Make an Informed Choice and Give Informed Consent
- Right to Support
- Rights in Respect of Teaching or Research
- Right to Complain

A recent case study will demonstrate the legal obligations under New Zealand legislation to ensure that informed consent is obtained legally and ethically and patients rights have not been breached. Exploration of this case will show how a legal challenge can be mounted against the hospital, the doctor and the nurses and the subsequent legal process and outcome. Finally this presentation is aimed at raising awareness of health professionals legal and ethical obligations and provides an opportunity for the audience to consider their own current practice and review how patients are given information, choices and appropriate advise and documentation that fully supports informed consent.

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L–21

Should we do what Patients want?

Christiane S. Neumann, UK

Introduction: The recent increase in emphasising peoples' rights particularly in the Western World has resulted in a consumer type model of medicine, with the patient as consumer with choices, and the health care professional as provider of a service.

Aim: To introduce the audience to the complexity of respecting patient's autonomy without compromising the autonomy of the Health Care professional or that of other people, using unreasonable portions of available resources.

From Refusing Treatment to Demanding Treatment:

The principle of patients' autonomy to refuse treatment is well established and usually accepted by practitioners, even if their training emphasises interventions they believe is of benefit, as for example, blood transfusions in Jehovah's witness'.

Gillian advocates that the principle of respect for autonomy should be understood as primus inter pares (the most important among otherwise equals) of the 'four principles' of medical ethics. Western Society supports this with a society that is focused on the individual's rights rather than the greater good for society. Consequently more and more patients are demanding respect for their autonomy and wishes regarding treatment, or refusal of treatment, with the argument that they have rights to have control over their own bodies and to make decisions about their medical treatment

In contrast, the medical practitioner also has rights, and some demands by the patient infringe on the practitioner's own autonomy - in this case his or her professional autonomy, especially if the requests confer no clinical benefit or may even cause harm, as in the case of assisted suicide. Some limits to autonomy have been defined in case law, in that doctors may not be forced to provide interventions which the doctor thinks is unnecessary, inappropriate or even harmful.

Other limits to autonomy have been defined by health care providers and the state that cannot afford to fund expensive interventions with limited benefit or costly benefit for just a few, in line with the ethical principle of justice.

Summary: Patients' autonomy may be limited by clinical indication, by the doctor's own professional autonomy, as well as externally imposed limits such as cost, local availability of technology and expertise. Ultimately, as technological possibilities outpace our medical and financial resources, autonomy may be forced to give way to economics.

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SESSION 6: GI DISEASES

L-22

World View of Hepatitis B & C

Ken O' Riordan, USA

Hepatitis B and C represent continuing major worldwide health problems. Significant advances have been made in the last decade with respect to the treatment of these infections.
Over 12 million people have been infected with the hepatitis B virus in the US and this number rises to 2 billion people infected worldwide. 400 million people worldwide have chronic hepatitis B infection resulting in 1 million deaths annually. In the US, one million people are chronically infected with hepatitis B resulting in 5,000 deaths annually. There are multiple risk factors including intravenous drug use, multiple sexual partners, MSM as well as working in the health care field. Many patients have no risk factors. The incidence of hepatitis B varies in different areas of the world with areas of high endemicity characterized by infection at a younger age and a higher frequency of chronic infection.
Hepatitis B is more commonly symptomatic when contracted in adulthood. Patients may have a viral prodrome, which can be complicated by jaundice. Most patients infected initially in adulthood will clear the virus with the development of a protective surface or core antibody. However, this occurs less frequently in children. Multiple blood tests are available to diagnose and monitor hepatitis B. Measurement of hepatitis B viral loads by PCR aids greatly in identifying potential candidates for anti-viral therapy. Ultrasound of the liver and liver biopsy may be needed in some cases. Chronic hepatitis B may result in cirrhosis, portal hypertension and hepatocellular carcinoma. It is the leading etiology of hepatoma worldwide.
Various different therapeutic options are now available for patients who have evidence of ongoing active viral replication characterized by elevated liver enzymes and the presence of HBV-DNA in the serum. These medications include interferon, lamivudine, adefovir, entecavir, telbivudine and tenofovir. With the introduction of hepatitis B vaccination, there has been a significant decrease in the number of new cases worldwide.
Hepatitis C infection is still in search of a vaccine. Its incidence and prevalence have stabilized in the US over the last several years and the CDC now estimates that there are 2,800 new infections per year. However, 12,ooo people still die annually in the US from hepatitis C. Approximately 2% of the US population has been infected at some stage with an estimated 4 million people infected with chronic hepatitis C.
Unlike hepatitis B, most patients with acute hepatitis C infection go on to develop chronic HCV infection. 20%-40% of acutely infected patients may spontaneously clear the virus. Development of the hepatitis C antibody denotes exposure to the virus and does not confer immunity. Risk factors for hepatitis C are similar to those for hepatitis B mentioned above.
Most patients are discovered on routine lab evaluation or at the time of blood donation. The most common initial complaint is fatigue. However, patients may present with complications of cirrhosis including jaundice, ascites, variceal bleeding, encephalopathy or hepatocellular carcinoma. Up to 30% of patients may have normal liver enzyme levels and this is not necessarily associated with a more benign prognosis. Typically, 20%-30% of patients with chronic hepatitis C will progress over a 20-30 year period to cirrhosis and its potential complications. Predicting disease progression involves estimation of time since exposure, liver enzyme levels and often liver ultrasound and frequently liver biopsy. Newer blood tests, US and MRI have the ability to detect fibrosis and may replace liver biopsy in the future. Measurement of hepatitis C viral loads by PCR confirms active infection. Viral load is not directly associated with disease progression and functions primarily as a guide to the success of anti-viral therapy. Hepatitis C genotype (1-6) measurements help predict the duration of anti-viral therapy.
Patients with significant inflammation and fibrosis are thought to benefit the most from anti-viral therapy. The current standard of anti-viral therapy is pegylated interferon given SQ once weekly with daily oral ribavirin. The sustained virological response rate (SVR) after completing a 6-12 month treatment course varies from 40%-80% depending on various factors including baseline viral loads and genotype. Potential side effects have to be closely monitored during therapy. The future of hepatitis C therapy includes the addition of protease and polymerase inhibitors to the present drug regimens with a presumptive improvement in overall response rates. We are presently awaiting the release of these new compounds.

L- 23

Complimentary Medicine – Is there a Place in Gastroenterology

Irene Dunkley, UK

It is not my intention within this lecture to give answers but rather to initiate thought and discussion regarding our attitude towards complementary therapies and how they influence our patient care.
Complimentary therapies have been undertaken throughout ancient times in various forms, there has been evidence of their value in alleviating symptoms for many centuries, some of these 'therapies' seem bizarre to us today but some remain valid, yet there is a reluctance for conventional medicine to accept complementary therapy which is often viewed with suspicion.
The integration of complementary and conventional medicine is variable and is determined by our and our patient's beliefs, values and cultures. These influences determine the care our patients receive.

The reasons why one complementary therapy is more acceptable may depend on the country one lives in and how available and accepted these therapies are within the differing healthcare arenas. I will explore the differences in how access to complimentary therapies varies between countries and the cultural beliefs associated with them.

So what type of complementary therapies might be helpful in Gastroenterology and is there any evidence? I will give some examples of the complementary therapies available in the United Kingdom (UK) for gastrointestinal problems, and how they are accessed within the national and private healthcare setting.

Providers of complementary therapies in the UK vary in their training and regulation; often registration is voluntary and can be little more than a fee that provides a certificate to demonstrate affiliation. The implications for registered nurses who undertake complementary therapy as part of a patients treatment are answerable to their regulating body, in the UK this is the Nursing and Midwifery Council, to which the public can ask for individual nurses to be held accountable for their actions or omissions. Nurses must decide whether the training they have had makes them competent to undertake these therapies, however the registration of non-nurse complementary therapists remain largely unmonitored by a professional body.

Finally I will offer my views for the need of a national register of complementary therapists who treat patient's symptoms. This national body should have the same powers to monitor the practices of individual therapists to safeguard potentially vulnerable individuals.

L-24

Emergencies within Gastroenterology

Mark Feeney, UK

This session will cover

1. Diagnosis
2. Resuscitation
3. Therapy
   - Endoscopic
   - Drug
   - Radiological interventions
4. Communication and Legal issues

The talk will be illustrated with a number of case histories

SESSION 7: IBD

L-25

IBD – An international overview

Matthew Lewis, UK

Introduction: IBD affects people in many different parts of the world, with certain manifestations varying depending on the geographic location and ethnicity of the patient. Migration of ethnic groups between countries has resulted in exposure to different risk factors which might partly explain these observations.

Diagnosis: Tuberculosis, which is prevalent in certain populations, can sometimes mimic intestinal Crohn's disease. Methods for distinguishing these conditions will be presented.

Clinical and Pharmaceutical Trials: Major IBD trials in recent years have recruited patients from units in many countries. We will discuss the findings of some of these multi-centre international trials and consider the effect that they have had in changing our clinical practices.

Genetic Effects on Therapeutic Response and Complications: The effect of certain treatments varies with different populations. Sometimes this can lead to enhanced benefit, but at other times this can result in increased susceptibility to complications. Treatments may need to be tailored to suit the particular genetic or environmental circumstances of individual patients.

Guidelines: Now that the evidence for the benefit (or otherwise) of many therapies has been more clearly established, it is considered helpful to standardise our practice according to clinical guidelines. In UK, USA and Europe guidelines have been produced to encourage evidence-based medicine in the management of IBD. Recently, guidelines have also been published by the World Gastroenterology Organisation. We will review some of the recommendations of these guidelines and compare different approaches.

Conclusion: IBD is an international condition, affecting people in countries across the world. Treatment regimes have been established on the basis of multicentre, international trials and the information acquired from these studies has been used to draft standardised multinational guidelines. Individualised treatment also may be required.

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- ACG Guidelines: http://www.acg.gi.org/physicians/clinicalupdates.asp#guidelines

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L-26

Alternative Treatments of Crohn´s Disease

AB Hawthorne, UK

Not submitted

L-27

Nursing Management of IBD-patients

Marika Huovinen, Finland

We run in the hospital a patient counselling project called Asterit. The project began in year 2006 and will last until year 2009. Our goal is to improve the counselling skills of the nursing staff.

According to literature review for example; Patients are more unsatisfied with insufficient counselling and routines of counselling. (Poskiparta 1994, Mattila 1998, Timonen & Sihvonen 1998, Cares 2000, Goss 2002, Kettunen ym.2002, Stenman & Toljamo 2002, Carter 2003, Clark 2003, Neale 2003, Ward 2003, Kyngäs ym. 2004, Richards 2004, Boaro 2005, Kääriäinen ym. 2007, Kääriäinen & Kyngäs 2005a, Kääriäinen & Kyngäs 2005b, Vivar ym. 2005, Heikkinen ym. 2006, Kääriäinen ym. 2006, Casey 2007).

Patients' and nurses' opinions regarding adequate and patient centred counselling are divergent (Cillers ym. 2000, Kääriäinen 2007). Counselling may be inadequately applied to individual patient's phase of life when talking about problems related to the illness, reasoning the instructions, telling about problems that may occur when having a medication, diet, mental strength, sexuality and social benefits (Mattila 1998, Timonen & Sihvonen 1998, Kuivalainen 2004, Kyngäs ym. 2004, Kääriäinen ym. 2005a, Hendersson 2006).

The first appointment after confirmed diagnosis of IBD is with the IBD specialized nurse in our department. During a counselling session I discuss with the patient about IBD generally. We discuss about the latent- and active periods of IBD and how the patient itself can affect bowel's wellbeing. We talk about way of life, sufficient need of sleep, importance of physical exercises and diet.

We also have a talk about how IBD can affect work, studying, pregnancy and breastfeeding. Getting a serious chronic disease is always a crisis. I ask the patients how they are getting along with this new disease. Patients may feel many kinds of feelings; sadness, fear, hate, shock, helplessness, bitterness, disbelief.

IBD specialized nurse's appointment activity at this form started in our outpatient clinic in autumn 2006. We have not done any research regarding this type of counselling given by nurse, but my opinion is that patients have been quite satisfied. They can have appointment quicker with the nurse than with the doctor. They can tell their problems individually and the whole appointment is based on patient's needs. Every appointment is different due to the different individual patient needs.

I belief that this kind of model will prove to be the most cost-effective activity and of course in the patient's best interest!

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SESSION 8:
STAFF WELFARE & MANAGEMENT

L- 28

Global Rating Scores (GRS) as an instrument for quality assurance

Roland Valori, UK

In England >90% of endoscopic activity, all endoscopist training and all complex endoscopy is done in 216 endoscopy units in large acute hospitals. Since 2005 these units have been self assessing the quality of patient care using the Endoscopy Global Rating Scale (GRS). The GRS provides a framework for service improvement and is used to quality assure services.

The GRS is a web-based self assessment tool that assesses 12 aspects (items) of the patient experience within two domains: clinical quality and quality of the patient experience (www.grs.nhs.uk). Each item is scored in levels D to A where level A is the best quality. Each level is underpinned with 1-4 measures that services have to achieve to reach that level. A measure is a process, policy or standard. Services have to indicate whether they have achieved each, measure (or not) on the web-

based tool. The web-based tool automatically scores the GRS. Level B is currently the required standard.
Endoscopy units have been required to complete the GRS twice a year since April 2005. In 2006 a peer review accreditation process of endoscopy units, based on the GRS, began roll out. This process involves an assessment of the environment, policies and processes, staffing levels and competencies, and validation of the self reported GRS scores (www.thejag.org.uk).
Nine bi-annual censuses of the GRS have been completed with compliance rates in excess of 97% for the last six censuses. There has been a steady improvement in GRS scores and >80% of units are scoring level B or better for all but one item (appropriateness). To date 154 of 216 endoscopy units (75%) have undergone formal peer-review and validation of self report GRS scores. 107 of these have been accredited and 47 have been deferred pending submission of further evidence. The improvements in quality have been achieved during a period of massive reduction in patients waiting more than 6 weeks for their procedure from >250,000 in 2004, to <2,000 in October 2008.
The endoscopy service in England values the GRS to support service improvement. The GRS underpins accreditation, providing a framework on which to base the assessment process. The combination of the GRS and peer review accreditation has lead to a substantial improvement in the quality of care of patients having an endoscopy in England, during a period of massive reduction in waiting times.

L-29

Accreditation in endoscopy Units: the UK experience

Debbie Johnston, UK

Institutions: 1. National Endoscopy Team, Leicester, United Kingdom. 2. The JAG, London, United Kingdom.
Abstract Body: Since 2005 endoscopy units in the UK (n216) have been self assessing the quality of patient care using the Endoscopy Global Rating Scale (GRS). The GRS provides a framework for service improvement and lies at the heart of the accreditation process for endoscopy units in the UK. This peer-review accreditation process of all 216 acute hospital units began roll out in 2006. This abstract describes the accreditation process and its impact on the English endoscopy service.
Methods: In 2006 a peer review accreditation process of endoscopy units, based on the GRS, began roll out. This process involves an assessment of the environment, policies and processes, staffing levels and competencies, and validation of the self reported GRS scores (**www.thejag.org.uk**).
Level B or better for each item is currently the standard required for all endoscopy services.
Results: The Joint Advisory Group in Gastroenterology (the JAG) keeps a database of all endoscopy units in the UK including all NHS acute providers, community endoscopy units, independent sector treatment centres and private hospitals. From this a rolling programme of accreditation of all endoscopy units has been established. The initial accreditation focus was primarily in England but this has changed in the last year with the JAG supporting all the other regions to get ready for accreditation. In England Currently 73% of acute units have undergone formal peer-review and validation of self report GRS scores. 108 of these have been accredited and 51 have been deferred pending submission of further evidence. The accreditation process has led to huge improvements in quality and safety in the service. Training and workforce standards have also greatly improved. All of this has been achieved during a period of massive reduction in patients waiting more than 6 weeks for their procedure from >250,000 in 2004, to <2,000 in October 2008.
Conclusion: The combination of the GRS and peer review accreditation has lead to a substantial improvement in the quality of care of patients having an endoscopy in England during a period of massive reduction in waiting times. These results indicate that the endoscopy service values the GRS and the accreditation process and the GRS.

L-30

A national Training Programme for Management of Sedation in GI Endoscopy

Ulrike Beilenhoff, Germany

Introduction: For over 10 years, aside from the standard medication with Benzodiazepines often in combination with an opioid, short-acting hypnotic Propofol is increasingly being used in Germany. With the German S3-guideline „Sedation in gastrointestinal endoscopy“ (1) precise recommendations exist for the structure and process quality for safe sedation, the qualifications for medical and nursing staff, the sedation tasks and the delegation to nurses under the supervision of a medical practitioner. The guideline allows delegation of sedation to qualified nurses under certain conditions. It underlines also the necessity of suitably trained and competent staff”
Aim: Based on this guideline, the German Society of Endoscopy Nurses (DEGEA) developed a national core curriculum for the training in sedation and emergency management for nurses (2). The aim of the curriculum is to acquire and expand knowledge, competence, and skills in preparation, implementation, and follow-up of sedation during endoscopic interventions.
Target group: The curriculum is aimed at the experienced nurse working in endoscopy. The curriculum can be implemented as a separate course, as in-house training at large institutions, or as a module of the specialist education of endoscopy nurses.
Content of courses: The course consists of 16 hours theory and 8 hours practice. Course books cover the theoretical part which includes pharmacology, structural and personnel requirements, pre-, intra- and post-endoscopy management, complication management and legal aspects. Knowledge is assessed by examination. The practical training on human patient simulators

includes basic and advanced cardiac life support and training on different sedation concepts. An intensive reflection of practice in small groups ensures effective reflection of previous practice, improvements and reinforcement of experience. After the course an internship of 3 days supports the practical implementation. Further training and assessment of competencies in the own department are recommended before delegation of sedation can take place. **Learning outcomes and competencies** are focused on basics of pharmacology, pharmacokinetics, different sedation concepts, pre-, intra- and post-endoscopy patient care concerning sedation, monitoring, recovery, discharge criteria and management of complications.
Official recognition: Courses can be recognized officially by the German Society of Gastroenterology (DGVS) and the German Society of Endoscopy Nurses (DEGEA). Structure, content, facilities and the teaching body of courses are criteria for the recognition.
Results: The Core Curriculum was published in February 2009 (2). Between February and October 2009, 55 courses in 14 institutes were officially recognized. 407 nurses passed the courses. A survey among the course participants was performed by DEGEA with a reply rate of 36.7%. The survey compared the working situation before and 3 months after completing the courses. Improvements could be found in 85.1% of participants, covering the complete equipment as well as the organization of the sedation and recovery.
Conclusion: The national Core curriculum provides a structured frame for a professional and balanced 3 days course to train nurses in sedation and emergency management. First evaluations showed improvements in the participants departments. Nurses are aware of their knowledge, skills and limitations.

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2. Beilenhoff et al. DEGEA-Curriculum Sedation and Emergency Management in Endoscopy. Endo-Praxis 2009; 1; 32-35. English version on www.degea.de

Learning outcomes: Participants should be

- Aware of the nurses role in sedation and monitoring, their options and limitations
- aware of additional options to train nurses in sedation and emergency management

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L-31

Intelligent Light – an option to increase the working condition in endoscopy

Jesper Durup, Denmark.

It is a well-established fact that the lightning in connection with the activities in endoscopy rooms and operating rooms is insufficient for several staff groups.
Lightning is often configured to cover the needs of single staff groups (e.g. surgeons), leaving other staff (e.g. nurses) with inappropriate lightning that complicates their work and increases the risk of mistakes.
A lightning that could continuously adapt itself to the needs of each staff, and that in addition could be modified according to the different activities, would solve this problem. Also, as an added bonus, appropriate lightning would further create a suitable atmosphere for both patient and staff.
Based on this issue, the Odense University Hospital (OUH) Department of Surgery has developed a lightning comprising a series of lightning fixtures that may be all changed in both colour and intensity. The fixtures are connected to a user-friendly touch-interface that allows the users to change the lightning in the room according to individual needs.
We call it *ergonomic lightning*.
In this presentation the theory and background for using coloured light are described and examples are given in pictures and video.

SESSION 9: NEW TECHNIQUES AND DEVELOPMENTS IN ENDOSCOPY

L- 32

New Technologies in the Detection and Characterization of colorectal Neoplasias

Arthur Hoffmann, Germany

Introduction: Colonoscopy is the accepted gold standard for identifying colorectal neoplasia. Aim of the current study was to prospectively compare high definition colonoscopy with i-Scan functionality (electronic staining) versus standard video colonoscopy. Primary endpoint was the detection of patients having at least one adenoma or colon cancer.
Methods: Patients with screening colonoscopy, post polypectomy surveillance or positive occult blood test were included. Patients were randomized in a 1:1 ratio to undergo high definition colonoscopy in conjunction with i-Scan surface enhancement (Pentax, Japan 90i series) or standard video colonoscopy (Pentax, EC-3870FZK). Identified colorectal lesions were judged according to type, location and size. Lesions were characterized in the high definition group by using further i-scan functionality (p- and v-mode) to analyse pattern and vessel architecture. Histology was predicted and biopsies or resections were performed on all identified lesions.
Results: High definition colonoscopy identified in 200 patients significant more patients having colorectal neoplasias (38%) compared to standard resolution endoscopy (13%). Significant more neoplastic lesions and more flat adenomas could be identified using high definition endoscopy with surface enhancement. Final histology could be predicted with high accuracy (98.6%).

Conclusions: High definition colonoscopy is superior in detecting patients with colorectal neoplasia compared to standard video colonoscopy based on this prospective, randomized controlled trial.

L- 33

Small Bowel Endoscopy: how many balloons?

Andrea May, Germany

Until recently, large parts of the small bowel were not accessible with non-surgical endoscopic techniques. In this scenario, the advent of video capsule endoscopy and double balloon enteroscopy represented a major breakthrough. Although capsule endoscopy is a save method that may provide imaging of the entire small bowel major drawbacks are that biopsy sampling and endoscopic treatment can not be performed; moreover, in many cases interpretation of non-specific findings remain a concern.
Initially, a double balloon enteroscopy (DBE) system was developed by Yamamoto and collegues in 2001. This system has rapidly gained an established role in small bowel investigation and therapy and is widely applied in clinical practice. Importantly, besides small bowel endoscopy the DBE technique can be applied for additional indications, e.g. for difficult colonoscopies or for gaining access to the pancreatic and biliary tract in patients with surgically modified gastrointestinal tract. Recently, another balloon-assisted enteroscopy device with only one balloon at the tip of the overtube was introduced as single balloon enteroscopy (SBE) system and an enteroscopy system without balloon was presented as spiral enteroscopy.
Double balloon enteroscopy (DBE): The double-balloon enteroscopy system (Fujinon, Inc., Saitama, Japan) consists of a high-resolution video endoscope with a working length of 200 cm and a flexible overtube. Latex balloons are attached at the tip of the enteroscope and the overtube, and are inflated and deflated with air from a pressure-controlled pump system. The principle of the DBE technique is based on alternating "push-and-pull" maneuvers, with the inflated latex balloons anchoring the endoscope within the small bowel. For small bowel enteroscopy two different DBE enteroscopes are available. The EN-450P5 has a working channel of 2.2 mm, an outer diameter of 8.5 mm and an overtube with an outer diameter of 12.2 mm. The EN-450T5 has a working channel of 2.8 mm and an outer diameter of 9.4 mm and an overtube diameter of 13.2 mm.
Multiple studies have demonstrated the high diagnostic value of this method with approximately 60 – 80% of relevant pathological findings combined with an acceptable low complication rate (< 1% for diagnostic DBE). Pancreatitis after oral DBE seem to be the most important complication. The major indication is the mid gastointestinal bleeding (MGI), that means that the bleeding source is located in the small bowel. Other conceivable indications (still under evaluation) are Crohns`s disease, polyposis syndromes and in refractory celiac disease or malabsorption symptoms as well as difficult ileocolonoscopy or ERCP after stomach resection and Roux-Y reconstruction or endoscopy after bariatric surgery. The high diagnostic yield of small bowel DBE goes along with a high therapeutic yield, that means the findings of DBE influences therapeutic strategies substantially. Based on the published data an endoscopic therapy (e.g. argon plasma coagulation, dilation, polypectomy) can be performed in 40-55% of the patients for treatment of small bowel lesions with a total complication rate of approximately 3 %.
Single balloon enteroscopy (SBE): Recently, a single balloon enteroscope system has been proposed for small bowel enteroscopy (Olympus, Tokyo Japan). The prototype (XSIF-Q160Y) consists of a high resolution enteroscope with a working length of 200 cm. The device is equipped with a 2.8 mm accessory channel, and a transparent overtube with a latex-free balloon attached on its distal part. In contrast to the DBE device there is no balloon attached at the enteroscope, and therefore stable position of the device has to be maintained by hooking the distal tip of the enteroscope into the small bowel wall. The DBE device can also be used for single balloon examinations by detaching the balloon from the enteroscope tip. After the positive results of the single balloon technique using the DBE device in difficult colonoscopy, question arises, whether this technique can be applied also to the more complex situation of the small bowel. The first results with the SBE are quite positive, but both, the diagnostic yield and the rate of complete enteroscopy are lower compared with the results published for the DBE technique. There is only one prospective, randomized, multicenter study comparing diagnostic push-and-pull enteroscopy in double or single balloon technique in patients with small bowel disorders with clear results. The complete enteroscopy rate was three times higher with DBE than with SBE technique (66% versus 22%, $p < 0.0001$). The overall diagnostic yield was significantly higher ($P = 0.025$) in the DBE group at 72%, compared with 48% in the SBE group.
Therefore, DBE must be considered as the standard method for diagnostic and therapeutic endoscopy of the deep small bowel avoiding intraoperative enteroscopy or laparotomy for therapy.

Spiral enteroscopy: Whereas, the DBE and SBE are working with the push-and-pull technique, the spiral enteroscopy follows a complete new idea of enteroscopy technique. This special overtube is shorter (118cm) and larger (16mm) than the overtube used with SBE and DBE. It has a raised hollow spiral on the distal 21 cm of the overtube. Both slim available enteroscope types of Fujinon (EN-450T5) and Olympus (SIF-Q180) can be used. Clockwise rotation of the overtube pleats the small bowel onto the overtube. The rapidness of the insertion, which can be confirmed by own experiences, is impressive and seem to be the main advantage of this new technique. Main disadvantage is the very low rate of complete enteroscopies of <1% due difficulties with the anal approach. This new technique is promising, but the ideal patients or conditions still needed to be defined. Therefore, further and especially comparing studies with the other available small bowel

endoscopy techniques have to be done to evaluate the position of this new spiral enteroscopy.

L- 34

Marsha Dreyer Memorial Lecture: Advancements in Endoscopic Treatment of Pancreatic Disease - Yesterday and Today

Theresa Vos, USA

Advancements in the endoscopic treatment of pancreatic disease has posed both challenge and opportunity for those dedicated to its study. Literature reveals a variance of opinion when adopting the best endoscopic treatment based on research and clinical trials. Although ERCP has served in its capacity as both a diagnostic and therapeutic tool over the last twenty years, advancements in adjunctive therapy have paved the way when addressing the role of endoscopy and pancreatic disease. Advancements in two areas of study will be presented for discussion: The role of intraductal pancreatic endoscopy in the treatment of calcifications in chronic pancreatitis; and the use of prophylactic pancreatic duct stent placement during high-risk ERCP procedures as a means of decreasing risk for post-ERCP pancreatitis. Both topics will be addressed through a review of the literature and video presentations.

Key words: Pancreatic endoscopy, ERCP, Chronic Pancreatitis, Calcifications, Post-ERCP pancreatitis, Stenting

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5.2. GI NURSES Poster Round I and II on 21 November 2009

No. 1

Endoscopy Pre-Assessment: Service Provision & Patient Satisfaction

Julie Bowen (ANP),Geri Beech Staff Nurse, Jo Corrigan Senior Sister, ULTH NHS Trust, Leeds, UK

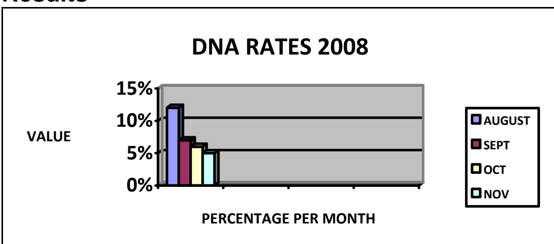
Introduction: Endoscopy is constantly striving to meet demands placed upon the service from local, regional and national standards, along with implementation of new initiatives such as The Bowel Cancer Screening Programme (NHS 2007). Ensuring capacity is utilised to meet this increasing demand is a constant pressure for the endoscopy team. Research has shown (Tibble et al 2000 Ludlow et al 2005) that pre-assessment can improve patient attendance for endoscopic procedures by enhancing the information provided. This enhanced information would enable the patients to make a much better informed decision, and help alleviate any pre-conceived apprehensions and anxieties.

Background: Endoscopy services in Leeds operate across three sites and consist of four departments; three departments are based on the acute sites, the fourth at a peripheral site.

The Endoscopy services in Leeds had an increasing “Did Not Attend” (DNA) rate for out-patient procedures. This combined with other issues such as, inadequate bowel preparation, inadequate patient information, and no consistent administration processes, often resulted in lost capacity and under-utilisation of lists. As a result changes in service delivery were required. Pre-assessment Clinics for patients undergoing all Endoscopic Procedures were introduced in August 2008 at the Leeds General Infirmary.

Aim: To provide an accessible Nurse Led Pre-assessment service to all out-patients referred for endoscopic procedures, and to streamline the admission process on the day of the patient`s procedure.

Objective: By providing a pre-assessment service the patients were afforded the opportunity to discuss their forthcoming procedures, bowel preparation, consent processes and medical conditions. Patients would be provided with a date and time of appointment and all the relevant written information prior to leaving the clinic.
Method: Key stakeholders and Project Leads identified at team meeting. Proposal and service delivery improvements raised at Endoscopy users meetings. Documentation and bowel preparations protocols amended and approved. Audit tool for data collection of DNA rates and patient satisfaction developed and approved. The service was profiled at out-patients clinics and surgical meetings. Implementation and data collection commenced August 2008
Results



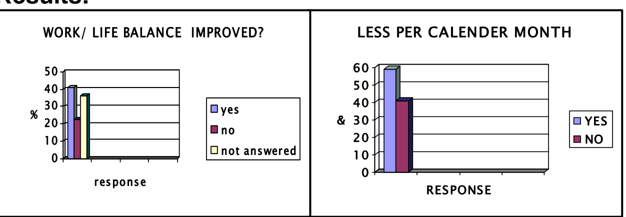
Patient satisfaction questionnaire returned a response rate of 16 %.These results indicated that 89% of patients were satisfied with the service and no improvements could be made. 55% of patients attending the clinic appeared very satisfied with the information and support provided by the nurses and rated this support as excellent. A reduction of DNA rates by 7% over a 12 week period
Conclusion: Provision of Pre-assessment clinics, for Endoscopic procedures, shows that patients are satisfied. This service also reduces DNA rates for procedures and optimises the capacity available within the demanding endoscopy service.

No. 2

Cross City Emergency Out Of Hours On-Call Service: The Endoscopy Nurse`s Experience

Rachel Rawnsley, Sister, Jo Corrigan Senior Sister
LTHT NHS Trust Leeds UK

Introduction: Endoscopy services in Leeds are provided across three sites and consist of four departments; three departments are based on the acute sites, the fourth at a peripheral site providing a diagnostic endoscopy service. The two larger acute sites (Leeds General Infirmary and ST James Hospital) provided an out of hours on call service for over 20 years. This was staffed by two nurses from their respective endoscopy units.
In early 2008 the decision was taken to amalgamate the Endoscopy nursing teams from across the three sites to provide a "Cross City On Call –Service".
Rationale: The rationale behind the decision was due to reconfiguration, poor recruitment and retention issues within the trust and also recent government initiatives (European Working Time Directives DOH 2007, Hospitals at Night DOH 2007).The trust's financial position also influenced the decision. Disruption to operational aspects of all departments in maintaining service delivery and patient safety was affected, when two nurses were called out. This resulted in departments being under-staffed. Nurses participating in providing the service averaged twelve on call periods per month, resulting in sub-optimal achievement of work/life balance.
Aim: To provide a collaborative, efficient and safe out of hours On Call service, delivered experienced and competent Endoscopy nurses, (JAG 2009)To standardise practise, policies and procedures across the service, and ensure patient safety.
Objectives: To introduce Cross City On-Call using a structured approach, over a six month period, following consultation with medical and senior nursing staff. To conduct a staff audit after the introduction of Cross City On-Call. To determine staff perceptions, involvement and the planning and implementation of the new service and the impact on work/life balance.
Method:
Month one: introduction of a one night per week
Month two: two nights per week
Month three: three nights per week.
Month four: four nights per week,
Month five: five nights per week. All staff actively participating.
Month six saw the expansion to seven nights per week and weekend cover.
Results:



Staff audit response rate of 73%
Results showed that 60 % of staff had a reduction in the number of on call periods Work life balance was achieved by those who responded. Results also indicated that staff were involved in the planning and implementation process. Problems highlighted from the audit included: contactability of nursing colleagues, availability of portering services.
Conclusion: The Cross City On-Call Service is a successful, fully operational, significant element of the endoscopy services across the Leeds Trust. It is recognised as being beneficial to patients, nursing staff and service delivery.

No. 3

P.I.N.S PATIENT SAFETY AND INVOLVEMENT NETWORKS - WHO IS INVOLVED?

Pat Bottrill MBE FRCN Public Patients Voice 25 Carolyn Crescent Whitley Bay NE26 3ED, UK

The Hospital should do the sick no harm (Florence Nightingale) but it does. 1 in 10 service users will be harmed by their treatment (DoH 2000) (1) may be significantly more as underreporting is suspected due to patient's reluctance and fear of reprisal.
High Quality Care for All (Darzi 2008)(2) defined quality as having three dimensions; ensuring care is

safe, effective and provides patients with the most positive experience possible.
Patient and Public Involvement is at the forefront of NHS Policy, and in relation to Patient Safety, several initiatives are underway. The National Patient Safety Agency, and Association for Victims of Medical Accidents (AvMA) have formed a unique partnership, with the establishment of National Patient Safety Champions, working across regional networks, sharing their experience and stories. The network has strong links with the WHO World Alliance Patients for Patients Safety Initiative.
Quality Accounts are to be published by all providers, creating more transparency and accountability with which to drive Quality improvements. The patients experience and journey form key components of these accounts. .
Regionally there are two Patient Champions supported by AvMA as part of Patient Safety Action teams. In the North East of England the team has also developed links to patient, carer and public champions seeking to bring their voice to the fore in safety developments. As a Volunteer I participate in these groups and questioned how these initiatives are communicated to clinical staff? .
Strategies appear unclear; therefore in May I used a questionnaire at a National Nursing conference, and via a Regional gastroenterology network (n30) to establish the level of understanding of new Quality and Safety initiatives
Results show that front line staff have little knowledge about these issues. Only one response (endoscopy) reported a dedicated lead with regard to patient safety champions, who meet with a Link nurse responsible for liasing with other groups to discuss the wider safety agenda, and its relevance to unit performance.
Quality accounts information will be published, and on NHS Choices website, (3) thereby enabling prospective patients to compare outcomes and exercise some choice as to where they attend .In this event a poorer performing unit may suffer financially if patients move their allegiance.
Global Rating Scales, staffing levels and benchmarking all have their place in safety and quality measurement. but continuous monitoring of patient feedback to units, via a variety of methods, is also a vital tool to include in improving and demonstrating quality service delivery.
Units should identify a staff member to be responsible for capturing patient feedback and their experience, link and engage in wider groups to ensure their unit's quality and safety initiatives are reflected in Quality Accounts.

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No. 4

Computerization of the Digestive Service, the Medical Pharmacologist Prescription and the Nurse´s Registry Chart

Natalia Bartolomé(1); Victoria Balauder(1); Noemí Aguirre(1); Margarita Bastida (1); Mª Jesús VIlar(2).
(1) Digestive service nurses of the Hospital Del Mar, Barcelona, Spain.(2) Quality department nurse of the Hospital Del Mar, Barcelona (Spain).

Introduction: One of the aims in the quality plan of the Institut Municipal Assistencia Sanitaria (IMAS) was the computerization of the patient's medical history and to make easier to have access to pharmacological information.
Aim/Objective: The aim of this free paper is to present the efficacy of the computerized medical pharmacologist prescription in the Hospital del Mar-IMAS digestive service as a pilot unit and the adjustment and satisfaction of the nurses about this new tool.
Metodology: Multidisciplinary meetings (doctors, nurses, pharmaceutical and computer experts). Surveys of IMAS nurses to analyze their knowledge in medicines administration before and after the pharmacologist guide implementation. Survey of digestive service nurses about their satisfaction with the pilot experience. Description of the computerized medical prescription and the registry chart. Issues record.
Results: Making helps as a pharmacologic guide form linked to the record chart. The satisfaction degree of both the information about the preparation and administration of medicines increased around **15%** in the beginning of the pilot unit. The issues record indicates that a continued follow-up is required.
Conclusions: Both the implementation of the computerized record of the medical administration and the aid guide, has been very useful to increase the nurses knowledge about the medication. Moreover, it has helped to standardize criteria in the medicine preparation and administration.
The use of applied technology has been a challenge and an encouragement for the pilot service nurses. At the same time we think it will increase the security health of our patients.

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Keywords
Computerised nurses registry chart, pharmacology guide.

No. 5

What is preferable for Cleansing: Soffodex or PEG? A Comparison of two Methods of Colonic Cleansing prior to Colonoscopy

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Background: Colonic cleansing prior to colonoscopy examination is critical to the success of the examination. The significance of successful cleansing is mostly expressed in the ability to clearly see the wall of the colon, allowing for identification of small polyps and their removal. There are still no commercially available products which both completely cleanse the colon and are pleasant for the patient to take.(1,2) The most commonly used products in Israel are Soffodex and PEG.

Goals: To compare patient tolerance and preparation effectiveness for two different methods.

Methods: A non-randomized sample of ambulatory patients who received guidelines from the Gastroenterology Institute in preparation for the examination and used one of the two preparations: Soffodex or PEG. The patients completed a questionnaire which included details on side effects and demographics. The examiners were two senior gastroenterologists, completed a questionnaire after each examination, which included details on the effectiveness of the preparation for the examination and the type of medical intervention. The physicians had no knowledge as to the type of preparation used by each patient prior to the examination.

Findings: Initial findings were based on a sample of 178 patients of which 34% (60) were in the Soffodex group with an average age of 56.9 $\pm$ 12.5 and 66% (108) were in the PEG group with an average age of 60.95 $\pm$ 13.4.With the exception of age there were no significant demographic differences between the two groups (p=0.051). The quality of colonic cleansing in both groups was the same across different parts of the colon with a significant difference found in the area of the caecum in favor of the Soffodex (p< 0.006). No significant difference was found in the number of interventions between the two groups. In terms of patient tolerance no significant differences were found between the two groups.

Summary: In light of the fact that no significant difference was found in terms of patient tolerance, it is possible that in the absence of contraindications, the selection of colonic cleansing preparation may be subject to patient preference. Regarding the effectiveness of the preparation, no significant difference was found in various areas of the colon with the exception of the caecum, where Soffodex was more effective.

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No. 6

Do psychological Factors explain Symptoms in Patients with self-reported Food Hypersensitivity?

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Objective: Anxiety and negative response expectations are assumed to be causally related to unexplained extra-intestinal somatic symptoms in patients with functional gastrointestinal disorders (1; 2). In this study, we aimed to study this relationship in patients with self-reported food hypersensitivity and abdominal complaints.

Methods: Patients (n=52) (mean age 37 years, 79% women) remitted because of abdominal complaints self-attributed to food hypersensitivity filled in questionnaires for subjective health complaints (SHC), general anxiety (HADS-A), gastrointestinal disease-specific anxiety, the Visceral Sensitivity Index (VSI), expected reponses to food ingestion (ERFI), and abdominal symptoms (IBS-SQ). The association between psychological factors and somatic symptoms was studied by multiple regression analysis.

Results: Generally, the patients scored high on IBS-SQ and SHC. Thirty-three patients (63%) reported 12 or more health complaints on SHC during the last month, mainly from abdominal and musculoskeletal systems. Sixteen patients (32%) had HADS-A score ≥ 8, i.e. possible anxiety (3). Psychological factors (general and disease-specific anxiety, and negative response expectations to food ingestion) explained 5% of the variance in abdominal complaints and 3.2% of the variance in extra-intestinal complaints (tiredness, anxiety, sleep problems, allergy, headache, neck- and low back pain).

Conclusion: Contrary to what often is assumed, psychological factors could not explain the high scores on abdominal and extra-intestinal complaints in patients with self-reported food hypersensitivity.

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Learning outcomes:

Anxiety, depression, food hypersensitivity and extra-intestinal complaints are associated with functional gastrointestinal disorders. However, psychological factors explained neither food hypersensitivity nor extra-intestinal complaints in patients with self-reported food hypersensitivity.

No. 7

The Awareness and preparedness Level of the Patients for Endoscopic Gastrointestinal Tract Procedures in Latvia

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Objectives: The purpose of this study was to identify the patients' level of preparedness and awareness about the gastrointestinal endoscopic procedures in Latvia. Well-timed patient information and preparation for examination contributes to the quality of the endoscopic examination and provides personnel and patient collaboration. There has been no previous research performed in Latvia assessing the awareness of the patients about the procedure.
Methods: Both qualitative and quantitative research methodology was utilised in this study. The qualitative research data consisted of an in-depth review of 54 scientific literature sources on the subject matter. The quantitative research data was gathered with the aid of a questionnaire. 100 questionnaires were completed by the patients awaiting gastrointestinal endoscopic procedure. The response rate was 100 %.
Results: The results of the questionnaire revealed a high level of unawareness and unsatisfactory preparedness for the endoscopic procedure. 10% of the respondents were not aware at all of the type of procedure they were going to go through. Whilst 68% of the respondents received information about the procedure from the medical staff, the rest of the respondents obtained it from other sources (friends, relatives or mass media). The sufficiency of the received information about the procedure was described: 41% have stated that it was satisfactory, whereas 27% stated that it was almost sufficient and 12% found it insufficient. Using statistical analysis it was confirmed that "very scared" of the procedure are those patients, who have not received sufficient information, confirming the insufficient information as a "fear" producing factor.
Conclusions: The currently provided information to the patients prior to endoscopic procedures is insufficient resulting in greater stress both to the patient and medical staff as well as increasing the cost and decreasing the effectiveness of the procedure.

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Learning outcomes:

1. It was confirmed that very scared of the endoscopy are those patients, who have not received sufficient information, confirming the insufficient information as a fear producing factor.
2. Improve the awareness and preparedness of the patient to endoscopic procedure by correct and clear information.

No. 8

Patient's Perception of Gastroscopy compared to professional's Perception.

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Introduction: Upper Gastrointestinal Endoscopy (UGE) is a performed diagnostic and therapeutic procedure of the oesophagus, stomach and duodenum. It is viewed by the medical community as routine medical practice, but is often seen by the patient as invasive.The aim of this study is to compare the experiences lived by the patients undergoing UGE and what the professionals think the patients feel like.
Methods: A cross-sectional study 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 Likert questionnaire, the day after the gastroscopy.
Results: 202 patients were included in this study, 43'6% were males and 56'4% females. The average of age was 44'6% years old (D.S. 15'1). Employment status: 59'4% were active, 23'8% were housewives, 8'9% pensionists. Educational level: 49'5% had received primary education, 33'2% secondary education, 6'9% were university graduate, 10'4% no formal studies. Concerning the procedure the results were: 65'3% Primary Health Care Unit; 25'3% Digestive Unit, from which more than a half were CAR (High Resolution Surgery), and from another Hospital Unit. When the patients and the nurses were asked for the UGE tolerance, the results coincided in 49'5% of the cases of bad experience, and 76'2% of the cases of good experience. However, when the patient had a bad experience, the nurse said in 50'5% of the cases where patients reported a bad experience the answer disagreed. As for Nurses assistants, they agreed with patients who reported bad experiences in 46'4% of the cases and in 65'7% of the cases when patients reported a good experience. The ratio between patients and doctors was 53'6% agreement in cases of bad experience and 64'8% in cases of good experience. In all of the comparisons was $p \le 0'05$.
Conclusions: Patients studied reported an experience that varied from very bad to bad, indifferent to good and not even the professionals who attended these patients can explain this properly. Each professional had a personal opinion about patient's experience but in some cases this did not correspond to what the patient felt. There were significant differences $p \le 0'05$ between the tolerance felt by the patient and what the professionals thought. Nurses' perception was more accurate when patient tolerance was good. On the other hand, it was less accurate when the patient had a bad experience.

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No. 9

Description of factors that influence in Upper Gastrointestinal Endoscopy toleration.

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Introduction: The term of toleration of Upper Gastrointestinal Endoscopy describes the patient's ability to undergo the technique with no harm. This is subjective information and can be influenced by the patient's real experience and the UGE process. The aim of this study is to assess the patient's toleration to the gastroscopy and to explain associated factors.

Methods: A cross-sectional design was used, applying an output questionnaire.

The data were collected in a data base specifically designed for this study and were analyzed by SPSS 10.0.

202 outpatients attending for gastroscopy, over 16 years of age, mentally alert and able to communicate freely, were asked to participate in a Likert phone questionnaire, the day after the gastroscopy.

Results: 228 patients were enrolled but 26 did not complete the questionnaire and were discounted from the study. The average age was 44'6 ± 15 and the majority of patients were women, 56'4% (114). The experience was declared as regular or bad by 48% of patients, and good by 52%. Regarding the factors that influence the toleration, 17% of the patients waited more than 30 minutes to undergo the UGE. 99% where treated with topic anesthesic. The UGE lasted 4'33'' (SD 2'). 67'7% of the patients reported that it was their first UGE. A multivariate study has been developed in which age, waiting time and biopsies are associated factors (p<0'05) to toleration.

Discussion: UGE is a procedure that is commonly used to valuate digestive pathology. It is not harmful but it is annoying and risky. The higher is the patient's tolerance, shorter is the duration and better the patient's well-being. However, the toleration appears to be associated to age, waiting time and biopsies. There are some factors of the process that can be modified to increase patient tolerance and satisfaction.

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No. 10

Needless Fasting: Can Fasting be avoided?

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Introduction In hospitals 25-40% of subjects suffer from malnourishment. In the Netherlands, this has resulted in an initiative to screen patients and in a consultation of underfed patients by the dietician within 24 hours of admission. All to prevent extra complication due to malnourishment. An extra step can be taken by nurses to prevent unnecessary fasting.

Aim To investigate whether a light breakfast 3 hours before the endoscopy interferes with safety and practicability of the procedure.

Methods All consecutive patients admitted to our ward and necessitating an endoscopy, except for an ERCP, were included. Exclusion criteria consisted of an active upper digestive bleeding, dysphagia and upper gastrointestinal motility disturbances. Endoscopies were always scheduled in the afternoon and patients were allowed to consume a light breakfast (Dutch rusks with jam, tea with sugar without milk) up to 3 hours before the provisional endoscopy appointment. Patients, who could not participate in the study, had the usual fasting since midnight. During the endoscopy, problems associated with the meal such as aspiration, impaired visibility etc. were recorded. Also, the administration of sedative agents was noted. Patients recorded their opinions and well-being on a form.

Results 125 patients were included, 74 were allowed to participate in the study, 51 had a contraindication. The 74 patients had to undergo an endoscopie: a gastroscopy(38), a colonoscopy(29), or both procedures(7). These 74 patients were fasting for 5.2 hours since their breakfast, whereas according to the operative protocol they should have been fasting for 13.8 hours. Of these 74 patients 45 patients (60.8%) received intravenous sedation. No aspiration occurred and in 3 patients (4.1%) remnants of food interfered with a proper judgement but after extensive rinsing did not require a new examination. The 51 patients who could not participate were scheduled for gastroscopy(28), colonoscopy(17) or both procedures(6). They fasted for 13.3 hours. Of these 51 patients 37 (72.5%) received intravenous sedation during the procedure. In retrospect, 14 (18.9%) of the 74 patients were included incorrectly as they suffered from haematemesis in 7, dysphagia in 5 and motility disturbances in 2. Notwithstanding this, the endoscopy was uneventful. On the other hand, 34 of the 51 patients (66.7%) might have been included. Patients highly appreciated the small breakfast.

Summary A reduction in the duration of fasting of 8.6 hours could be achieved without the danger of aspiration and with interference with the visibility in only 4.1%.

Conclusion It is feasible and safe to provide patients with a light breakfast until 3 hours before the endoscopic examination.

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Learning outcomes:

Nurses can reduce malnutrition by avoiding unnecessary fasting

Nurses can relieve the suffering from diagnostic interventions by small interventions such as allowing people to eat, provided this is feasible and safe.

No. 11

TEACHING CLEANING AND DISINFECTION PROCEDURES TO MEDICAL STUDENTS – NEW ROLE TO NURSES

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In order to prevent the spread of infections associated with the use of endoscopes, properly cleaning and disinfection must be assured. Usually the nursing team is responsible in cleaning scopes. However, in some health care facilities in Brazil, doctors are responsible for this task, as well as training their assistants in disinfection procedures.
The **purpose** of this study is to present the Residents Training Program promoted by the endoscopy registered nurses in the “Hospital de Clínicas de Porto Alegre” – Brazil.
The Hospital where this program was developed is a tertiary-level reference teaching hospital, and it is currently engaged in developing clinical quality safety.
The subjects that we approach in this program are: endoscope’s inner structure, functioning and maintenance, handling techniques to prevent damages, cleaning and disinfection process based on International standards and Brazilian guidelines, adequacy of caring the endoscopic accessories, and hands on training of cleaning and disinfection process. The classes start in the beginning of the year when a new group of medical interns is arriving. Every class spends 3 hours, including practicing. Classes are offered to different specialties as gastroenterology, pneumology and proctology.
As a **result** of our program, we realize that medical personnel consistently adhere to the good practices of cleaning and disinfection, protecting the endoscope against damage. Besides, the results of physicians satisfaction level after the course were high, and they realized the importance of all endoscopy team taking care of the endoscopes assuredly. Nurses should develop and maintain programs that provide quality care to patients, and the residents training program is an effective way to achieve these goals.
Learning Outcomes It is a nursing responsibility the process of cleaning and disinfection of endoscopes. Nevertheless, it is necessary to involve medical staff in this process, in order to ensure safety. Doctors should be involved in all aspects of an endoscopy, including the Disinfection procedure

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No. 12

Multidrug-Resistant Organisms and the Implications for Endoscopy Units

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An increase in methicillin-resistant *Staphylococcus aureus* (MRSA), Vancomycin-resistant *Staphylococcus aureus* (VRSA), Acinetobacter baumanii infections and Multidrug-resistant Tuberculosis has been observed in Brazil, as well as in many countries. Multidrug-resistant organisms(MDRO) have important infection control implications, and its transmission is frequently reported in acute care facilities. However, all healthcare settings, including endoscopy units, are affected by the emergence of antimicrobial resistant organisms.
Aim The goal of this study was to minimize the risks of transmission of multidrug- resistant organisms in Endoscopy units, by assuring that appropriate preventing strategies are fully implemented in this health care setting.
Method At first, we observed the infection control practices in the Endoscopy unit in a tertiary-level reference teaching hospital, done by all health care personnel, during a work day. After that, we investigated problems concerning environmental sources in infection control, such as poor ventilation, lack of protective equipment, and so on. Finally, we did a comprehensive review of the scientific literature about MDRO, with the purpose of comparing specialists key recommendations to our routine.
Results The results demonstrated that continued compliance with infection control guidelines is not a reality at all times. Even though there is scientific evidence to suggest that multidrug-resistant organisms are carried from one worker to another via the hands and contaminated materials and equipments, some essential measures aren’t been followed by our staff, nurses and doctors. To prevent further spread of multidrug-resistant would require systematic measures, from correct hands hygiene and use of alcohol-based hand washing products, to isolation of infected patients. We realized that important measures, such as enhanced environmental and instruments cleaning were performed on a regular basis. On the other hand, simple aspects of the routine have been forgotten. Sometimes, the best results are in the simplicity.
Based on this study, we composed some pamphlets and posters with important topics regarding infection control measures, in order to get the personnel attention as well as to start a campaign that continually educates endoscopy unit healthcare providers.
Learning Outcomes The basic infection control measures in general have the greatest impact on preventing spreading of multidrug resistant organisms. Endoscopy units are at great risk of infections associated to multidrug-resistant organisms, and personnel education can make a difference.

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cause of health care–associated blood stream infections. Clin Infect Dis. 2006;42:647–56. PubMed DOI
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No. 13

Efficacy of manual Cleaning of Gastrointestinal Endoscopes with the Ball Brush Method

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Introduction Manual cleaning represents the most important and critical step in the reprocessing of flexible endoscopes. Its efficacy can vary between operators and can negatively affect the outcome of the reprocessing if it is not adequately performed. Therefore the standardization of this step is more than desirable. The Channel Cleaner® is a new disposable device for the cleaning of endoscope channels consisting of small balls made of a special polymer; the balls are sucked into the channels and rapidly perform the brushing.
Aim To investigate in the practical experience if a manual cleaning procedure including ball brushing with the Channel Cleaner® is as effective as manual cleaning with conventional brushes.
Method After endoscopic procedures 80 gastroscopes and 80 colonoscopes were randomly selected and assigned equally to the treatment with the Channel Cleaner® ball brushes (ball diameter 2.8 mm for gastroscopes and 3.2 mm for colonoscopes) or with conventional brushes of proper size according to the type of endoscope. The Channel Cleaner® is made of a cartridge containing three balls: after filling with a detergent solution a cup where the cartridge is fixed, by pressing the suction button the balls are sucked in a sequence into the channels from the tip of the endoscope to the suction outlet. For each group manual cleaning was performed according to our internal protocol which follows the recommendations of international guidelines on cleaning and disinfection in digestive endoscopy. Endoscope suction channels were sampled before and after manual cleaning by flushing with sterile saline. The recovered solutions were plated and incubated at 37°C for 48 hours to get the total microbial count expressed as CFU/ml; $\log_{10}$ values were used to calculate the reduction between the initial and the final load which was considered an indicator of the manual cleaning efficacy.
Results The results obtained in the study are summarized in the following table:
The comparison of the variation before and after cleaning did not show any statistical difference between the treatments ($p > 0.05$).
Conclusions: manual cleaning using the Channel Cleaner® ball brushes resulted as effective as manual cleaning with conventional brushes. Moreover the total time for manual cleaning is remarkably shortened by using the ball brush method. Our data shows that when manual cleaning is performed following the recommendation of the guidelines, the bacterial load on the instrument can be greatly reduced by this step.

Instrument	Treatment	N	N. aerobic microrganisms– Log_{10} values Mean ± SD		
			Before cleaning	After cleaning	Variation
Colonoscope	Channel Cleaner	40	7.12 ± 1.12	0.22 ± 0.95	-6.89 ± 1.14
	Conventional brush	40	6.72 ± 1.21	0.01 ± 0.68	-6.71 ± 1.33
Gastroscope	Channel Cleaner	40	3.30 ± 1.64	-0.27 ± 0.13	-3.58 ± 1.67
	Conventional brush	40	3.80 ± 2.07	-0.14 ± 0.38	-3.94 ± 2.19

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No. 14

Percutaneus Endoscopy Gastrostomy (Peg) in a new Hospital

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Introduction: Dysphagia of any origin, represents an inpediment for oral feeding. Percutaneus endoscopy gastrostomy (PEG) has changed the management of these patients and is an alternative for enteral feeding in the long time. Indications for PEG are in expansion because of its simplicity, low cost, low morbility and mortality. The present study was performed in the Endoscopy and Gastroenterology Unit of the Henares Hospital, Madrid which was open in February 2008.
Aims: To describe our experience in performing PEG and evaluate it's indications and complications.
Methods: Retrospective work between February 2008 and April 2009. Data of 17 consecutive patients were collected. PEG was performed according Ponsky-Gauderer Pull technique. All patient were sedated by the endoscopist. All patients and/or their main care providers were trained by the nursery team in order to take care of the stoma. They also received recommendations in a document that was designed by the nurses themselves. Demographic data, morbidity, indications and complications were collected. Data were analyzed using an Excel application.
Results: Data about 8 men and 9 women were collected. Average age was 71,5 years (range 47-

91). Mains indications were dementia in 10 (58,8%), other neurologic disorder in 3 (17,6%) and cancer in 3 (17,6%). The service of origin were Internal Medicine 11 (64,7%), gastroenterology 2 (11,76%) and other services: neumology, oncology, neurology and geriatrics, 1 (5,8%).
There were no acute complications related with the technique. Late complications were: 1) stoma infection in one case (it did not require PEG replacement); 2) periestomal debit that was resolved with a replacement of new tube with bigger caliber; 3) accidental extraction with partial fistula closing during follow-up.
During follow-up there were 3 deaths, none related to the endoscopic procedure. Causes of death were: 1) progression of cancer in one case, 2)severe bronchial repetition and 3) urinary sepsis. Seven patients had replacement of the initial PEG during follow-up.

Conclusions:

1. The main indication in our series was dysphagia caused by dementia.
2. The PEG has many advantages over other feeding techniques. Complications are mild and similar in frequency to other series described in the literature.
3. We perceive that the degree of patient satisfaction and / or primary caregivers is high because the PEG tube allowed autonomy in the management of patients.
4. The endoscopy team made up of doctors, nurses and nursing assistants give information and educate patients and / or primary caregivers on the following items: 1) care on the stoma and feeding tube; 2) alimentary recommendations; and 3) detection and management of complications. The information was given using a document developed in the Endoscopy Unit.

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No. 15

Capsule Agile Patency© in suspected intestinal Stricture Patients: Role of Nursing Staff in Selection and Follow-Up of Patients.

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Introduction: Pillcam capsule endoscopy is considered the gold standard in the study of small bowel. The main complication is capsule retention. Therefore we might prevent it using the Agile Patency Capsule (APC) before. The Patency capsule is a new non-endoscopic, non-invasive dissolvable capsule which has the objective of screening the patency of gastrointestinal tract. In our endoscopy unit, the nursing staff is the responsible for evaluation of APC indication in patients fulfilling the standard accepted criteria.

Objective: To demonstrate utility of APC in decreasing risk of pillcam capsule retention, following standard criteria controlled by nursing staff.

Patients and methods: All patients referred for pillcam capsule in our hospital from April 2007 to September 2008.

Results: We included 200 patients referred for pillcam capsule endoscopy. A full interview by our nursing staff before administration and a consequent follow-up after APC ingestion to evaluate small bowel patency was performed. Seventy-one patients were candidate to APC. Indications were: Inflammatory bowel disease (n=30), abdominal pain (n=23), previously known radiological stricture (n=9), previous treatment with NSAID (n=6), previous abdominal surgery (n=2) and intestinal polyps (n=1).
Ten of seventy-one APC administered (14%) were expulsed with delay and deformed: pillcam capsule was contraindicated. Four of these patients had abdominal pain and intestinal pseudo obstruction solved spontaneously in forty hours.
Only 1/129 (0.7%) patients considered no candidate to APC suffered a pillcam retention, requiring abdominal surgery.
In our unit the retention rate of pillcam capsule was 0.5% (1/190 patients). Without Agile Patency Capsule retention rate would be higher (5.5 %; 11/200 patients).

Conclusions: Agile Patency Capsule is useful to prevent capsule retention in patients with suspected small bowel strictures and nursing staff monitoring is highly necessary and desired.

No. 16

Clinical Impact of Utilization of correct Accessories in the EUS – Guided Drainage of pancreatic Pseudocysts

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Background Endoscopic ultrasound (EUS) is currently used in major gastroenterology centres throughout the world. Interventional EUS procedures acquired new advances, limiting surgical interventions for pancreatic pseudocysts. The nurse may be asked to assist the endoscopist, handling the scope and the accessories, sustaining in this way the correct diagnosis and the therapeutic abilities of the doctor. The endoscopy nurse has to be trained in scope handling, but also to understand the possible complications due to endoscopy in order to initiate the proper interventions under the supervision of the endoscopist.

Aim EUS procedures are minimal invasive and they are associated with significant reduced complications as compared with surgical interventions. The accessories are diverse, a special training and great experience are needed for

the endoscopy nurse in order to use them correctly. The perfect synchronisation of the manoeuvres performed by endoscopist and the nurse during the drainage procedure is compulsory.
The aim of our study was to establish the most appropriate and safe method for pancreatic pseudocysts drainage and to demonstrate the important role of the endoscopy nurse in correct handling of the accessories, as well as in the prompt recognition of complications (bleeding, perforation, etc.).
Patients and method The study was performed in the Gastroenterology and Hepatology Research Centre Craiova during a 5 years period (2004-2008) and included 40 patients transferred from surgical clinics with the diagnosis of pancreatic pseudocyst. Two different methods of drainage have been used in chronological order: drainage with the Giovannini system was used initially, and drainage with a 19 G EUS needle associated to a guidewire, a cannula and a balloon dilatation (6 or 8 mm) afterwards. Both were done under EUS guidance in real-time and were followed by placement of stents.
Results From the 40 patients subjected to EUS-guided drainage, the 19G EUS needle was used as method of initial access in 26 patients, while the Giovannini needle-wire was used on the rest of 14 people. The drainage was successful in 24 out of 26 patients in the first group (technical success of 92.3%) without any complications. The drainage was also possible in 12 out of 14 patients drained with the Giovannini system (technical success of 85.7%), but there were complications in three cases: two upper gastrointestinal bleedings and a gallbladder perforation, all of them requiring surgical intervention. All complications were recognised early based on the careful follow-up of the nursing team.
Conclusion Our study demonstrated that the use of the 19 G needle in association with a guide wire, a cannula and/or a dilatation balloon remains the most efficient drainage method of pancreatic pseudocysts, with lower complications and higher technical success rate. Moreover, the qualified nurses are needed to perform EUS procedures in optimal conditions, but also for the early recognition of possible complications through careful follow-up of the patients after the procedure.

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No. 17

Patient Satisfaction with Endosonography Services

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Introduction: Little data is available on patient satisfaction with dedicated endosonography (EUS) services.
objective: To assess in a prospective study the level of satisfaction with different aspects of the EUS experience, and identify any deficiencies in the service.
Method: All patients attending for EUS in one calendar month were given a questionnaire, covering: Patient Information, Consent, Experience during Procedure, Privacy and Dignity, Aftercare and Follow-up. They were asked to complete the anonymised form at home and return it using a postage-paid envelope.
Results: 34/41(83%) questionnaires were returned completed. 24(70%) patients received an EUS information leaflet, and of the others, 7(20%) had had their appointment booked at short notice, and all of these patients had the procedure explained by telephone. 2(6%) patients failed to receive a leaflet, and one did not answer the question. 96% of those receiving information leaflets confirmed that the process was explained completely by it. 97% of patients were satisfied with verbal explanation of the procedure, and 100% had had any residual concerns answered on the day of procedure.
97% of patients were completely satisfied with the consent process. 67% of patients experienced no delay on the day of the procedure, while the rest noted some delays. 26(76%) patients experienced only slight or no discomfort during the procedure, a further 5(15%) reported moderate discomfort, and only 2(6%) reported episodes of severe discomfort, one patient failed to answer this question. However, 97% of all patients said that they would have an EUS again if required.
Verbal aftercare instructions were received by 97% and contact phone numbers by 90% of patients. There were no residual side effects reported, and all 34 patients were satisfied with politeness of staff, environment, privacy and dignity and cleanliness of the Unit.
Conclusion: All EUS procedures in our Unit are carried out in under 2weeks. Patients can be booked with a few days notice and so may not receive an Information Leaflet. To compensate for this, they are telephoned, the procedure is explained in detail and they are given the contact details of a dedicated EUS nurse. Adequate time is spent on the day of procedure answering any further questions.
Pre-planning precise EUS appointment times is difficult because of the variable complexity of case, resulting in some delays. As a result of this study we now have a greater mix of procedures within EUS lists. Initial re-evaluation suggests that this is effective at reducing delays.
The majority of patients were comfortable and while a small group found the procedure uncomfortable, an issue which we are addressing at present,

virtually all patients reported that they would have an EUS again if necessary. The data on privacy and dignity and the personal conduct of staff is highly satisfactory.

Learning outcomes (1)Adequate written and verbal information about highly specialised endoscopic procedure that patients who are unlikely to be familiar with is valuable. (2)Improving specialised endoscopic services is aided by Patient Satisfaction Surveys targeted specifically at that patient group.

No. 18

The Difference a Nurse makes: Hepatitis B Research in Aotearoa New Zealand

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Objective: To determine: (1) Whether our current informed consent process for Hepatitis B screening is responsive to New Zealand Maori and; (2) How can tikanga Maori (Maori customs and values) inform the screening/research process?

Introduction: A fundamental principle underpinning the New Zealand Health Strategy is acknowledging the special relationship between Maori and the Crown under the Treaty of Waitangi, New Zealand's founding document. Maori are the tangata whenua (indigenous people) of New Zealand and present disproportionately negatively in the majority of health and wellbeing statistics. One out of every 100 New Zealand Europeans is a potential Hepatitis B carrier, but among Maori adults the rate is as high as one in seven.

Disappointingly poor recruitment into screening programmes by young Maori could be the result of research teams failing to develop projects in a culturally appropriate way and in a way that is responsive to Maori. In 1996 the Nursing Council of New Zealand introduced cultural safety as a competency requirement for nursing registration, as "the ability to apply the principles of the Treaty of Waitangi/Te Tiriti o Waitangi to nursing practice".

As a Treaty partner and a priority population requiring appropriate health intervention for Hepatitis B, Maori involvement in this aspect of health research is critical.

Methods: This qualitative research study drew primary data from interviews with treatment-naive Maori patients with Hepatitis B who had been invited to participate in a Phase III international clinical trial comparing the efficacy and safety of a new nucleoside analogue antiviral agent with the current standard of care, adefovir. Results were analysed thematically.

Results: 75% of patients declined to participate due to cultural reasons**.** Maori participation in the clinical trial was enhanced when nurses practised principles of cultural safety by respecting the principles of tikanga Maori. Knowing that tikanga Maori is integral to our nursing research process gave participants confidence and trust in order to provide informed consent. Participants were more likely to remain in the study when they perceived their future care and treatment was important and would continue to be available to them. Patients who declined consent or did not follow the trial requirements felt that their tikanga Maori values were marginalised.

Conclusions: The major conclusion of this study was that the current informed consent process is limited in its responsiveness to Maori. However, when nurses ensure that the process is appropriate and acceptable to Maori; this contributes to Maori health development by addressing an important health outcome – the screening and treatment of Hepatitis B.

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Learning Outcomes: Through critical questioning, demonstrate knowledge of: (1) the meaning and importance of culturally safe nursing practice and; (2) the importance of the nurse's role within the research team.

No. 19

Treatment of Patients with acute Liver Failure without Gastric Tube Reduces Mortality

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The treatment of patients with acute liver failure includes in most regimes a gastric tube for aspiration of gastric content and installation of hypertonic glucose solution and lactulosis.

Due to disturbance of the coagulation system, thrombocytopenia and portal hypertension, these patients often have gastro-intestinal bleeding. We have therefore during the last 2,5 years treated our patients with a tubeless regime consisting of i.v. glucose 10 %, followed by parenteral nutrition given in a peripheral vein. Lactulosis was administered orally or as clysma. The patients were furthermore treated with antibiotics i.v. if they showed signs of infection.

Of 63 patients with acute alcoholic liver failure treated in this period, only 3 patients developed gastrointestinal bleeding, which needed acute transfusion and surgical assistance. Small bleeding episodes from mouth and rectum were treated with fresh plasma 1-2 portions per day. All patients received vitamin K intravenously for 2 days followed by oral vitamin K. Of the 63 patients 5 were submitted multiple times with acute liver failure (3-25 times). The total mortality from acute liver failure was 27 % in our patients.

Previous studies have shown that upper gastro-intestinal bleeding was seen in 34-64 % of the patients with severe liver failure (1) Mortality in these patients was increased 2,5 times compared with patients without bleeding (1).

In our opinion, treatment of acute liver failure without the use of a gastric tube is a step forward in order to decrease the mortality as shown here by

the very low bleeding frequency in patients treated without gastric tube and the relative low mortality in our group of patients.

In order to increase the quality of treatment further in these patients we have planned to start the treatment with hypertonic glucose in a peripheral vein as soon as possible. If possible starting at home, the glucose infusion administered by paramedics (day 0) and on day 1 to start parenteral nutrition in a peripheral vein if the patient was still in coma (degree 3-4). If the patient was improving (degree 2 or less), intensive oral therapy with protein enriched nutrition was used in stead of parenteral nutrition.

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No. 20

Establishment of the Nursing Consultation for specific Control and Monitoring of Patiens with Portal Hypertension on Drug Treatment for Prophylaxis of Gastrointestinal Bleeding.

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Objectives: :To evaluate the effectiveness of the introduction of the nursing consultation assessing adherence to monitoring, compliance and hemorrhagic recurrence during treatment(tto).

Patients and methods: This descriptive study discusses the monitoring of 47 patients(pac) from March 2006 to August 2008 that came for Nursing tto.B-blocker medication (propranolol or nadolol) for primary and secondary prophylaxis of upper gastrointestinal bleeding by portal hypertension, sent from consultation and / or Hospitalization Service Gastroenterology. Target: primary prophylaxis in cirrhotic patients with esophageal varices pac. who have never bled, and secondary prophylaxis pac. with previous episodes of bleeding varices with or without endoscopic tto. Medical protocol is followed:SUMIAL (propanolol) tablets of 10 and 40 mg. SOLGOL (nadolol), 40 mg tablets. Should be administered at the maximum tolerated dose to achieve lower heart rate (FC.) by 25% over the baseline, provided that this does not fall of 55 bpm or systolic blood pressure (TAS.) of 90 mmHg. Initial dose:SUMIAL 10-20 mg every 12 hours. Increasing doses of 10 mg weekly (alternating morning and evening) as tolerance and control of TA and FC. Nadolol: Start with 20 mg in the morning and 20 mgs weekly increase to the maximum tolerated dose. Be increased to the next dose if the pac no symptoms due to medication (tiredness, dizziness, shortness of breath ...) and if FC>55-60 bpm, and the TAS 90. Called to review a Nursing Consultation weekly while rising dose and after reaching the maximum tolerated dose for a month.

Results: We conducted 362 consultations in 47 pac Nursing: 18 (39.3%) left the track leaving to go to regular review (4 (22.22%) showed hemorrhagic recurrence: 3 of them with major bleeding and required urgent placement of transjugular intrahepatic portosystemic shunts and the remaining 14 had no episodes of bleeding while attending the scheduled review, 18 of them are alcoholics pac 16 and also left the active follow-up medical consultation). Three were pac died. Two pac not attended the first visit (1 of them rebleeding). Pac 24. (51%) continued to review and found optimal dose, of which 1 (4.16%) showed hemorrhagic recurrence by taking medication concurrently with tto. and clarified ligation esophageal varices.

Conclusions: There is a high dropout rate probably due to revisions to the long tto. Significance of nursing consultation to increase adherence to tto, increasing the dose gradually increasing tolerance to the medication and increases the effectiveness of primary prophylaxis. The pac. attending scheduled revisions have a lower percentage of relapse haemorrhagic (22.22% vs 4.16%).

No. 21

Impact of Different oral Agents for Bowel Preparation

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Introduction: Adequate bowel preparation prior to elective colonoscopy is essential for successful examination. Patients' express how bowel preparation feels far more unpleasant that the colonoscopy itself. The most common agents used are Oral Sodium Phosphate Solution (OSPO) and Polyethylene Glycol (PEG). Studies comparing these agents show a variety of outcomes, but overall concludes that no agent is superior regarding cleansing the gut (1,2). What agent to use in a clinical setting? What are the patients' preferences?

Aim: To identify the best bowel preparation in combination with the patients' compliance, side effects, preferences' and productivity in clinical settings. The agents compared were OSPO taken the day before examination and PEG taken either as a single dose the day before examination or as a split dose taken the day before- and on the day of examination.

Method: 140 patients from 2 gastroenterological department and 1 surgical department undergoing elective colonoscopy completed questionnaires regarding compliance, side effects, preferences and productivity. Patients received bowel preparation agents as the departments practice. Quality of bowel preparation was evaluated by a trained endoscopist.

Results: 83% had a very good or good bowel preparation (80% for OSPO vs. 87% for PEG). The patient assessment of overall wellbeing showed no differences' between the groups. Compliance >90% for >85% of the patients. Approximately 50% reported signs of dehydration (no differences

between the agents taken). The frequency of vomiting was higher for those treated with PEG than OSPO (22% vs. 10%). Approximately 50% of the patients' reported > 50% productivity on the day before examination, 33% had to take the day off (no differences between the agents taken).
The mean length of fasting prior to colonoscopy was 24 hours (2-48).
Conclusion: In conclusion this study highlights the importance of using an agent acceptable for the patient, as bowel preparation and wellbeing seems equal between the agents studied. Further more the results indicate how fasting (more than bowel preparation) might lead to take a day off prior to colonoscopy.
Learning outcomes?
Choose a bowel preparation agent acceptable for the patient. Minimize the fasting period prior to colonoscopy.

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No. 22

A prospective single-blinded randomized Trial of Polyethelene Glycol-Electrolyte Solution Vs. Sodium Phosphate as a Bowel Preparation for Colonoscopy in Lynch Syndrome Gene Carriers.

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Introduction: Lynch syndrome gene carriers undergo regular surveillance colonoscopies. Polyethylene glycol-electrolyte solution (PEG) is routinely prescribed for bowel cleansing but often poorly tolerated by these patients. Sodium phosphate (NaP) may be an effective alternative.
Aim: To randomly compare the effects of bowel preparation on colonic cleansing and patient's acceptance.
Methods: During a one year inclusion period Lynch syndrome patients, who previously underwent a colonoscopy were invited to participate. Patients were randomly assigned to either PEG or NaP and asked to fill in a questionnaire about preparation tolerability and future preferences prior to and one week after the preparation for colonoscopy. The endoscopist (blinded for the preparation) filled out a report about the colon cleansing.
Results: A total of 125 carriers were included in the study. Nine (7%) were excluded because of missing data. The remaining 116 patients (M/F 58/58, mean age 50 ±30 yrs) were included in the statistical analysis. Of those, 53 used PEG and 63 NaP. Baseline characteristics did not differ between groups. Of the patients using PEG, 13% found the preparation almost intolerable, in contrast to 8% of those using NaP (p=0.005). Future preparation preferences were 18% for PEG, 51% for NaP, 27% did not have a preference (of 4% no data). The colonoscopy was poorly tolerated in 28% of individuals using PEG and in 25% of the NaP participants (p=0.963). The endoscopist reported a good to excellent clean colon in 83% of the patients on PEG and in71% of those on NaP (p=0.096). The proportion of colonoscopies with introduction into the cecum within 25 min did not differ between groups: 68% PEG and 72% NaP (p=0.645).
Summary of results: PEG and NaP both are effective as preparation for colon cleansing. However, only in among 20%-25% of the colonoscopies an excellent clean colon was found. Patients prefer NaP as future preparation.
Conclusion: Lynch syndrome carriers tolerated NaP better and preferred this formula for bowel preparation. Colon cleansing was suboptimal by both treatments with a tendency towards a cleaner colon with PEG.
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Learning outcomes: Preference of patients is important. Colon cleansing can be improved.

No. 23

4-Litre Kleanprep© versus 2-Litre Moviprep©: Assessement by Physician, Patient and Laboratory Values

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Introduction: A well-prepared colon is a prerequisite for adequate colonoscopy. The intake of 4 litres of PEG fluids is burdensome for patients. A small-volume sodium phosphate preparation appeared to be unsatisfying in our hands because of poor bowel cleansing and substantial changes in blood chemistry. Moviprep© combines the effects of a small-volume 2- litre PEG solution with 20 g of ascorbic acid.
Aim: To investigate bowel cleansing effect, patient's satisfaction and impact of high doses ascorbic acid by using Moviprep in comparison with Kleanprep.
Method: Consecutive out-patients were randomised to receive Kleanprep or Moviprep in a single-blinded prospective study. Patients with a PEG-allergy, previous bowel surgery, or inability to ingest the solution were excluded. A nurse explained the bowel cleansing and colonoscopy. A blood sample was taken for chemistry and haematology. On the day of the colonoscopy a second blood sample was taken. The patients filled out a questionnaire on tolerance, side effects and ease of intake.

Physicians blinded for the intake scored each part of the colon as to the cleanness and filled out the Ottawa score.

Results:110 patients entered the study and were randomised to receive Kleanprep(n=51) or Moviprep(n=59). Endoscopists rated the preparation with Kleanprep significant better for the transverse colon, for the remainder of the colon and the Ottawa score there was no difference between Kleanprep and Moviprep. In 3 Kleanprep cases and in 6 Moviprep cases the colonoscopy had to be repeated because of insufficient cleansing(NS). Patients were able to comply with the intake of 4 litres in 79.2% and of 2 litres in 98.2%. Patients on Moviprep were able to drink 5 glasses more of extra fluid compared to those on Kleanprep. Patients randomised to Kleanprep suffered more from bloating and anal irritation, they found it hard to comply with the intake and did not appreciate the taste. Only 25% of Kleanprep users, but 75% of Moviprep users preferred to have the same solution the next time. In the laboratory, the change in pre- and post-intake values was significant for bicarbonate after the intake of Moviprep.

Summary: Kleanprep preparation resulted in a slightly higher endoscopic score, the patients clearly preferred Moviprep. The high dose of ascorbic acid had a limited effect on laboratory values.

Conclusion : Moviprep is a safe and small-volume cleansing agent, preferred by patients and in cleansing almost equal to the large-volume Kleanprep solution.

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Learning outcomes

By their investigational protocol nurses helped in the choice of the cleansing preparation.

A small-volume cleansing agent is preferred by patients and increases the compliance.

No. 24

What is preferable for Cleansing: Soffodex Or Peg ? A Comparison of two Methods of Colonic Cleansing prior to Colonoscopy

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Background: Colonic cleansing prior to colonoscopy examination is critical to the success of the examination. The significance of successful cleansing is mostly expressed in the ability to clearly see the wall of the colon, allowing for identification of small polyps and their removal. There are still no commercially available products which both completely cleanse the colon and are pleasant for the patient to take.(1,2) The most commonly used products in Israel are Soffodex and PEG.

Goals: To compare patient tolerance and preparation effectiveness for two different methods.

Methods: A non-randomized sample of ambulatory patients who received guidelines from the Gastroenterology Institute in preparation for the examination and used one of the two preparations: Soffodex or PEG. The patients completed a questionnaire which included details on side effects and demographics. The examiners were two senior gastroenterologists, completed a questionnaire after each examination, which included details on the effectiveness of the preparation for the examination and the type of medical intervention. The physicians had no knowledge as to the type of preparation used by each patient prior to the examination.

Findings: Initial findings were based on a sample of 178 patients of which 34% (60) were in the Soffodex group with an average age of 56.9 $\pm$ 12.5 and 66% (108) were in the PEG group with an average age of 60.95 $\pm$ 13.4.With the exception of age there were no significant demographic differences between the two groups (p=0.051). The quality of colonic cleansing in both groups was the same across different parts of the colon with a significant difference found in the area of the caecum in favor of the Soffodex (p< 0.006). No significant difference was found in the number of interventions between the two groups. In terms of patient tolerance no significant differences were found between the two groups.

Summary: In light of the fact that no significant difference was found in terms of patient tolerance, it is possible that in the absence of contraindications, the selection of colonic cleansing preparation may be subject to patient preference. Regarding the effectiveness of the preparation, no significant difference was found in various areas of the colon with the exception of the caecum, where Soffodex was more effective.

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No. 25

Adverse Side-Effects during the Administration of Infliximab. A Study of 1271 Infusions in 88 Patients

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Introduction: Infliximab is a monoclonal antibody used in the treatment of several autoimmune diseases. It blocks the effects of tumor necrosis factor alpha (TNF alpha), reducing the signs and

symptoms of inflammation. Infliximab is administered by intravenous infusion. Specifically, infliximab is used for treating the inflammation of Crohn's disease (1,2).

Objective: The aim of this study was to evaluate the adverse side-effects during the infusion of Infliximab (for) the treatment of Intestinal Inflammatory Disease (IID).

Methods: Observational study of 88 patients (49 female) with IID treated with Infliximab, between February 2000 and March 2009. Ages ranged between 18 and 76, with an average of 37.5. The effects were classified as weak (headache, flushing, diaphoresis, dizziness, rash, nausea), moderate (hyperthermia, rash, palpitations, chest pain, low or high blood pressure) and severe (dyspnoea with coughing, stridor, myalgias, arthralgia, swelling of face, lips or extremities).

Results: 1271 infusions were performed, with an average of 14.4 infusions per patient. Infliximab was administered intravenously. For IID the dose used was 5 mg/kg, followed by additional doses of 5 mg/kg two and six week after the first dose. Thereafter, the maintenance dose was 5 mg/kg every eight weeks. 73 patients were treated for Crohn's disease, 14 for ulcerative colitis and 1 with atypical colitis.

Infliximab is approved for use in patients with moderately to severely active Crohn's disease, who have had an inadequate response to conventional therapy: IID cortico - resistant (n=16), IID cortico - dependent (n=42), IID Immunosuppressors (n=71). 49 adverse side effects were observed, of which 6 were considered severe, where the administration of Infliximad was discontinued. All the adverse side effects were successfully treated, with no resuscitation techniques used.

Conclusions: The therapeutic use of Infliximab in the treatment of IID was safe in all cases. The occurrence of adverse side effects during the infusion, although rare, were potentially dangerous and should be administered under rigorous nursing surveillance.

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No. 26

The Relationship between Health Locus of Control and Health related Quality of Life in Patients with Inflammatory Bowel Disease

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As a chronic disease with a relapsing and remitting course inflammatory bowel disease (IBD) affects the quality of life of sufferers to varying degrees. Treatment is aimed at relieving symptoms and increasingly towards improving the health related quality of life. While it remains a personal evaluation of health, it is generally accepted that disease activity, medical therapy and its side-effects, social support, coping strategies and level of education have all been shown to influence quality of life. (Janke et al, 2005, van der Eijk et al, 2004).

The traditional patient information model involves explaining the risks of a behaviour in terms of the undesirable effect on health. The patient is then expected to choose the appropriate lifestyle changes to improve their health. An understanding of locus of control theory helps to explain why this approach alone is unlikely to benefit all patients. Health locus of control is the degree to which an individual believes they have control over their health. It has been suggested that those who have internal locus of control are more likely to comply with health recommendations. Health related behaviours may in turn have an effect on quality of life. The aim of this study was to investigate whether a relationship exists between health locus of control and health related quality of life in patients with IBD.

A quantative, correlational study was carried out. Data for this study was collected by means of questionnaires, the Inflammatory Bowel Disease Questionnaire and the Form C of the Multidimensional Health locus of control scale.

Participants were recruited from a database of 212 patients attending the outpatient clinics of two consultant gastroenterologists held in one district general hospital.

ResultsThe findings of this study show that there is a statistically significant although weak correlation between health related quality of life and health locus of control. This correlation suggests that a high internal locus of control score is associated with a higher total quality of life score.

ConclusionsIn practice the findings of this study should increase awareness of the factors that contribute to quality of life in patients with IBD. An understanding of these influences, including that of locus of control, should allow nurses to further develop nursing interventions appropriate to the individual and which contribute to quality of life until such times as a cure is found.

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No. 27

Application of Biological Treatment to Patients with IBD in the Czech Republic

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Introduction: In the Czech Republic, there are centres for biological treatment (CBT) for gastroenterology, rheumatology and dermatology. For gastroenterology - ie. treatment of Inflamatory bowel diseases (IBD) - biological treatment (BT) includes infliximab and adalimumab. Since 2006,

there are 26 CBTs in the Czech Republic with more than 1000 patients. More than 150 patients with IBD have been treated of BT at the University Hospital in Olomouc.

Set of Patients and Methodology: 32 patients with IBD underwent BT before the establishment of CBT and continue to undergo BT to date. We have examinated these patients' satisfaction with application of BT before and after the CBT establishment using a questionnaire survey. The questionnaire featured 9 questions and patient's satisfaction was graded at the scale 0-5. doctors care, nurses care, monitoring of adverse effects, providing information on BT, support from auxiliary staff, waiting time, informed consent, recommendations and overall satisfaction. The quantitative differences were evaluated by CHI quadrate test and qualitative differences by Student T-test.

Results: Statistically non-significant difference (p=0.88) before and after the establishment of CBT was only found in evaluation of the level of doctor's care. In all other monitored items showed statistically significant difference – nurses care (p<0.05), monitoring of adverse effects (p<0.05), providing information on BT (p<0.05), support from auxiliary staff (p<0.05), waiting time (p<0.05), informed consent (p<0.05), recommendation and overall satisfaction (p<0.05).

Conclusion: Establishing CBT for IBD patients in majority of cases significantly improved the standard of medical care for IBD patients.

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Learning outcomes:

1. The application of biological therapy for IBD patients is more safe and comfortable in centres for biological treatment.
2. The IBD patients assess especially better nurses care and waiting time.

No. 28

Enrollment in IBD Clinical Research: The Patient's Point of View

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Introduction Clinical trials are crucial in health research; recruitment is a relevant point which can be influenced by several factors such as patient's choice, type of protocol, healthcare personnel's behaviour or motivation.

Aim Aim of the study was to explore the causes that may reduce enrollment in clinical research.

Method Data on recruitment in research protocols were collected at a tertiary referral centre through a paper card over a 12 month period; eligible patients were screened by the research nurse and each trial listed on the card was completed during the visit. Both participation and non-participation were written down on the card together with the reasons for the refusal.

Results 614 consecutive patients were proposed to participate in one or more clinical trials for a total of 1613 proposals, with an average of 2.6 proposals per patient.The proposals resulted in 802 recruitments, 579 screening failures and 232 refusals. The main reasons for refusing enrollment were: the distance between home and the research centre (N = 44), no time (N=18), job commitments (N=9) and fear related to the procedures listed in the studies (blood draws, endoscopy) (N=5); only 2 patients motivated the refusal acknowledging that the proposed study would not cause any direct personal benefit; one patient, who had been previously enrolled in another trial without reporting significant benefit, refused three further proposals not trusting clinical research anymore; in 151 cases, the patient declared no interest. The percentage of patients who refuse participation in clinical research, classified on the type of proposed study, is described in Table 1. The most refused type of study regarded investigations on genetics and diagnostic procedures (OR 8.6 p <0.0000), while questionnaires and observational studies were accepted significantly more frequently (OR 0.09 p <0.0000).

Type of Study	Pro-osal	Enrol-ent	Patient´s refusals	Screening failure
Questionnaire	692	466 (67.3%)	25 (11.9%)	201 (29.0%)
Clinical trail	210	25 (11.9%)	13 (6.2%)	172 (81.%)
Genetic & Diagnosis	711	311 (43.7%)	194 (27.2%)	206 (28.9%)

Conclusion The patients' refusal to participate in clinical research often remains without explanation. Improving information on the study protocol and the possible benefits of clinical research could improve patient's enrolment rate.

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Learning Outcomes

Patients refuse to participate in clinical research without a clear explanation.

Improving information on clinical research could be a strategy to improve enrolment rate.

No. 29

Knowledge of Disease in Patients with Recent Diagnosis of Inflammatory Bowel Disease

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Introduction Inflammatory bowel diseases (IBD) negatively impact on daily activities and the quality of the patient's life (HRQOL) of patients.

Information about the disease may improve HRQOL, reduce anxiety and depression, improve adherence to treatment, reduce health related costs and improve outcomes.

Aim To identify the characteristics of the population exposed to the risk of having little knowledge about IBD and to assess which patients would benefit from educational programs.

Method All IBD patients followed at a tertiary referral centre with a diagnosis lasting less than 18 months, with no major surgery (ileostomy, ileo-anal pouch) or concurrent other chronic diseases were investigated by means of the Crohn's and Colitis Knowledge (CCKNOW) Score, a valid index of high internal consistency and a good level of reliability that assesses disease-related knowledge of IBD patients in four knowledge areas regarding IBD management, including general understanding, treatment, diet, and complications.

Quality of life was investigated by the Short Inflammatory Bowel Disease Quality of Life (S-IBDQ); disease activity was assessed by the MTWSI (Modified Truelove and Witts Severity Index) for ulcerative colitis (UC) and the Harvey Bradshaw Index for Crohn's disease (CD).

Results 49 out of 79 patients signed informed consent, filled both questionnaires and had their disease activity index assessed. Knowledge regarding diagnostic tests, symptoms and general knowledge about IBD, was correct in above 50% of the patients; medical treatment, disease aetiology, bowel anatomy and extra intestinal manifestations were correctly answered by 25- 30% of the patients, while medical therapy side effects were correct in 15%; areas related to fertility and pregnancy and surgery received correct answers in 4%. Knowledge correlated with education level (Spearman's rho=0.405; p=0.01) and age (Spearman's rho=0.307; p=0.05); quality of life, disease activity, sex, type of disease (UC or CD), time spent after the first diagnosis and number of contacts with health personnel did not influence the patients' knowledge.

Conclusion Educational interventions should involve old patients and those with low education and focus particularly on type of medical therapy and its side effects and on surgical complications.

Information provided during specialist consultations or hospitalization appears not effective on patient's knowledge and therefore ad hoc patient education interventions should be realized soon after diagnosis.

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Learning Outcomes

Old patients and those with low education are at risk of being poorly informed on IBD. The standard care doesn't improve patients' information; the nurse should assume a new role in the IBD team, assessing and improving patients' information on IBD.

No. 30

E-Mail Service for Communication Between IBD Patients and Healthcare Personnel: A Study on Feasibility and Expectations

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Introduction Nurse lead telephone help-lines have been successfully tested for improving quality of life and reducing healthcare costs, in the UK and North America. The use of new communication technologies such as e-mail has theoretical advantages compared with telephone or fax as it is more rapidly available, economical, easy to use, and available 24 hours a day; it also allows the patient to reduce the risk of forgetting to provide important information or ask relevant questions to the team and to keep a copy of the message providing memory of the information provided by the healthcare personnel.

Aim The aim of this study was to assess the feasibility of an e-mail communication system between patients and healthcare personnel (doctors and nurses), studying the availability of technological resources among patients, the actual use of e-mail and the possible impact (expected) on Health Related Quality of Life (HRQoL). Free reply to information on the disease, management of therapy, treatment of symptoms and instructions to examination procedures was offered within 24 h.

Method A feasibility survey was obtained with a multiple choice questionnaire which was administered during the outpatient follow-up visit; privacy was guaranteed and data were collected anonymously.

Results 376 questionnaires were collected. 82% of interviewed patients have an e-mail service available, 64% with personal address. 57% use e-mail every day or almost every day, 76% at least once a week. Only 37% of patients use e-mail to communicate with public or private services. 85% of patients thought that the availability of an electronic service could improve their quality of life. Frequency of use of e-mail, possession of a computer and an

e-mail address, the ability to use other people's resources to read e-mails are related to the age of subject. A positive impact on quality of life is expected using this project.

Conclusion An e-mail based communication system between patients and healthcare personnel is feasible and appreciated by patients. Its use could improve the patients' HRQoL.

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Learning Outcomes E-mail is a feasible communication system between IBD patients and healthcare personnel. An e-mail communication system would be appreciated by patients and could improve their HRQoL.

No. 31

Quality Improvement of Education for Patients Post Colonoscopy at Outpatient Services, NKC Institute of Gastroenterology and Hepatology

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Introduction Colonoscopy is a diagnostic and therapeutic procedure for abnormalities of large bowel. Nowadays, this procedure can widely be done as an ambulatory colonoscopy service. A challenge for endoscopy nurses working around this service is how to inform all essential information for patients within such limited time, and how to be sure that they will be able to manage with self care at home after the procedure. The aims of this study were to assess patients' knowledge and understanding about colonoscopy, and to identify any important symptoms and signs that took place after the procedure in these patients.

Method NKC institute provides specific instructions for any colonoscopy procedures. In this study, endoscopy nurses gained permission from the patients to gather data related to their knowledge and understanding about the colonoscopy procedure at the outpatient services. The endoscopy nurses verbally informed patients to ensure that they understood well about the procedures. Prior to receiving a colonoscopy procedure, patients were asked to complete a questionnaire about their personal data as well as knowledge and understanding about the colonoscopy procedure. They were also asked about how to manage with any complications that might have occurred post procedures. Then, the day after having the procedure the patients were interviewed through a telephone to identify any complications that had had occurred with them and how they managed with such complications. Inclusion criteria of the sample were patients aged over 17 years who were mentally alert and able to communicate well, both verbal and written.

Result During 17 February 2009 to 17 April 2009, 107 patients voluntarily joined the study. The findings revealed that 100 patients (93.4%) understood well about the information given by endoscopy nurses, and 98.1% reported that they would seek medical treatment if bleeding per rectum or fever occurred post procedures. Only 89.7% of the patients were willing to go to a hospital if abdominal pain occurred. This correlated significantly to their levels of understanding ($p < 0.05$). Phone interviews indicated that very small number of patients had mild gas cramp (3.7%) and small rectal bleeding (0.9%). No severe abdominal pain was identified in any patients. All patients experiencing these signs and symptoms indicated that they called the hospital to seek help with medical assistance.

Conclusion Patients' knowledge and understanding about the colonoscopy procedure is necessary to increase patient safety and comfort. Endoscopy nurses have a vital role to ensure effective communication with patients, especially at the outpatient services where time and spaces are limited. From the findings, further improvement is recommended to increase patients' understandings of the colonoscopy procedures and to maximize their abilities to self care at home. This could be done by adding more education about details of serious symptoms and signs after colonoscopy that need appropriate medical interventions, such as characteristics of abdominal pain.

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Special thanks for support of the Hands-on-Training Centre goes to:	**www.endo-trainer.de**

9. Announcement for next ESGENA Conference

14th ESGENA Conference

In conjunction with the

Spanish Society of Endoscopy Nurses and Associates (AEEED)

Spanish Society of Gastroenterology Hepatology and Endsocopy Nurses (AEEPD)

18th UEGW

23. - 25. October 2010

Centre Convencions Internacional Barcelona, Spain

See **Call for Abstracts** on Page 75

Further Information

www.esgena.org and www.uegf.org

www.aeeed.com and www.aeepd.com

Call for Abstracts for 14th ESGENA Conference

on 23-25 October 2010 in Barcelona, Spain

ESGENA invites colleagues from Europe and from all over the world to present their experience, studies and projects at the 14th ESGENA Conference in October 2010 in Barcelona, Spain. Participants wishing to submit abstracts can do so **only in electronic format** by sending a **MS Word document** with their abstract by e-mail to: Ulrike Beilenhoff, ESGENA President (Email: **UK-Beilenhoff@t-online.de)**

Deadline for submitting abstracts: 30th May 2010

General Information on Abstract Submission
Participants are invited to submit original scientific abstracts for oral or poster presentation.
Authors have to conform to the following guidelines for abstract submission. **Those not conforming to the guidelines will not be considered for reviewing.**

- Abstracts must be submitted in English and must be presented in English.
- 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 presenting author by June 30, 2010.
- Detailed information, guidelines and recommendations for oral or poster presentation, as well as day, time and room will be sent in due time to duly registered presenting authors.
- The presenting author of an accepted free paper or poster will receive a free registration to the conference GI NURES 2009.
- Accepted abstracts will be published in the Abstract Book of GI NURSES 2009, in the ESGENA NEWS, the SIGNEA Newsletter and on the websites of ESGENA and SIGNEA.

The abstract should be typed as follows:

- Use 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 12-point font.
- A brief title, which clearly states the nature of the investigation, with the entire title in capital letters
- Abbreviations should, if possible, be avoided in the title, but may be used in the text if they are defined on the first usage
- The authors´ names (full first name, surname) and the institution (hospital, university, organization, city and country, e-mail and fax number) where the research was carried out, with the name of the presenting author underlined
- Type in the top section of the abstract the title of the paper in capital letters
- Use single line spacing
- Include tables if necessary
- The abstract should be as informative as possible
- **The abstract should have a logical, scientific structure (introduction, mains & objectives, method, results, conclusion, summary, References, Learning outcomes for audience)**
- Statements such as „results will be discussed " or „data /information will be presented " cannot be accepted
- Please ensure that your abstracts do not contain any spelling, grammar or scientific errors, as it will be reproduced exactly as submitted
- The abstract should have a **nursing relevant content** and should **add to existing knowledge**.
- The abstract should have a minimum of **2 relevant References**
- The abstract should state **2 things the delegates could learn** from your presentation

Call for Abstracts For 14th ESGENA Conference

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

ABSTRACT SECTIONS	**Checked**
TITLE, which clearly states the nature of the investigation,	
AUTHORS´ names (full first name, surname), please underli	
PRESENTING AUTHOR (the name of the presenting author is 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)	
REFERENCES (minimum 2)	
LEARNING OUTCOMES (2 things you would like the reader to learn from your presentation)	
FORMATTING etc	
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*	
Presenting author underlined	
Single Line Spaced	
Abstracts must be submitted in English and checked for spelling errors	
Use 12 point Font e.g. Arial, Times Roman,etc.	
500 words – max. one A4 page	
The abstract should have a NURSING RELEVANT CONTENT and should add to existing knowledge.	