csgna
Canadian Society of Gastroenterology Nurses & Associates
Société canadienne des infirmières et infirmiers en gastroentérologie et travailleurs associés

Guiding LIGHT

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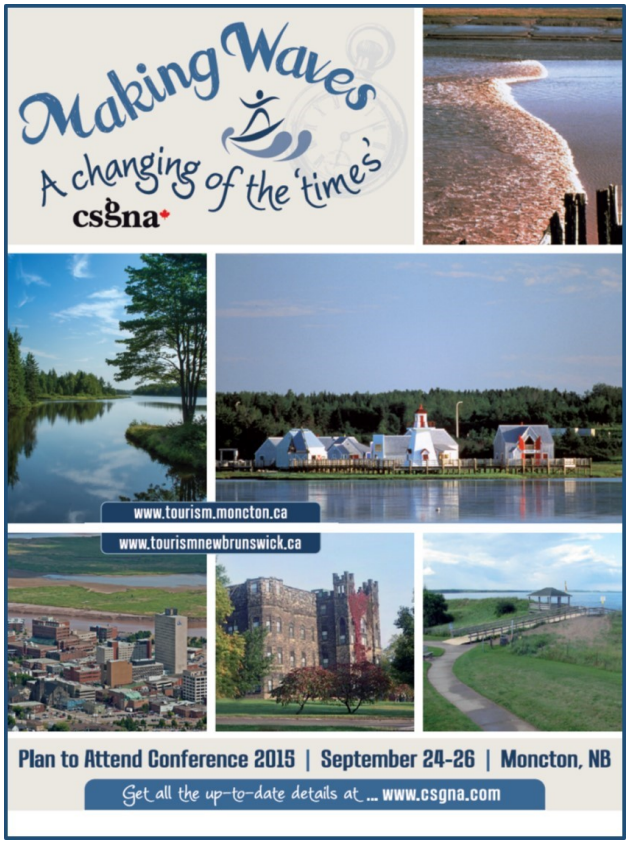

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President's Message

Year one of my term has flown by! I am very pleased with what we have accomplished this past year and look forward to the initiatives that will be launched in the coming year. We have also had some challenges, but I am certain that with the efforts of your dedicated Board of Directors, Chapter Executive and members we will find ways to meet those challenges head on and find positive solutions.

Registration is open for both the CSGNA 2015 conference in Moncton in September as well as the CANIBD Nursing meeting in November at the Mentoring in IBD program in Toronto. Members are provided with reduced rates for each meeting, so make plans to register early for these great educational events. If you haven't taken advantage of the number of educational grants available, check with your Chapter Executive regarding Chapter support to attend these conferences.

The board has been working tirelessly, under the direction of Dana Letto, to revise and develop practice guidelines that are pertinent to GI nursing. We know there are changes underway in many GI/Endoscopy units as a result of the fiscal climate in health care today. We hope that these guidelines will provide a foundation for adequate and safe staffing as well as further define the role, responsibilities and scope of nursing practice in each area. All of our revised and new guidelines are currently being translated in French under the direction of Mildred Clement.

GI Nursing Certification is still an ongoing goal for members of CSGNA. Connie Wescott and I have had conversations with CNA about the state of the CGN(C) program. Ultimately, we need a significant number of nurses to certify annually in order to sustain the designation. We have discussed several methods of improving the numbers and are considering our options. Our planned question writing year has been put on hold in order to further discuss how we can address the low numbers. Congratulations to those who have written and re-certified this year! We need to keep this validation of our GI knowledge and specialized nursing practice going for the future!

I am looking forward to the upcoming conference in Moncton. The Board has planned a new session for Chapter Executive this year. We hope that the topics addressed will assist the Executive in their leadership of the Chapters. The invitations will be sent in the next few weeks. I encourage Chapter Executive to attend this session, and if unable to, send an alternate from their Chapter. You never know when you spark a member's interest in Chapter Executive roles!

Have a great rest of the summer and see you in September!

Lisa Westin, RN, MN, CGN(C)

President CSGNA

Reports

President Elect Report

My role as President Elect continues to grow. At present I continue to work on correlating the roles of the National Board in the CSGNA's bylaws with the Guide to our roles and the timeline of duties.

I continue to work on gathering endoscopy sites across the nation, a guide to directors for the dissolution of a chapter, board of director roles and time lines and many other items.

Our new website launch is just around the corner so stay tuned.

Now is the time to sign up for the National Conference in Moncton NB. There's a lot of things to learn, people to meet and things to see, come and join us in Moncton!

If anyone has concerns, questions please feel free to contact your director, or any of the other directors and we will be more than happy to address anything you bring forward.

CSGNA is about you the member, let us hear from you!
Connie Wescott RN CGN©
President Elect

Public Relations Director

Public affairs....

We are proud to announce that we are presently working on

a bilangual Web site.

Nous sommes fier d'annoncer que notre site Web est en construction

bilangue.

Supportez ce projet en submetant un article (en français). Les histoires de votre département aussi sont bienvenue.

Mildred Clements

Public Relations Director

Canada East Report

All Chapters have completed their educational requirements for the year. Members are encouraged to renew their CSGNA memberships and take full advantage of all the educational grants available to them. The planning committee for the National Conference has been working extremely hard and has a great conference planned for September in Moncton, NB. Come and join us in Moncton for some great times in the Maritimes! Have a great summer and we hope to see you all in Moncton!

Paula Triantafillou,

Canada East Director

Canada West Director

The Canada West Chapters have enjoyed a successful year of educational events and activities. Thank you to our Local Executives for representing the needs and interests of their members and health care communities. Congratulations to all chapters for working cohesively together and for networking with Industry, to bring quality education to all who have an interest in GI nursing. CSGNA will continue to be successful because of you!
Yvonne Verklan, RN CGN(c)
Canada West Director, CSGNA

Regina Chapter

The Regina Chapter has been very busy lately! We had a journal club in March with a guest speaker on Hepatitis C and one in April on IBD tests and diagnoses. For GI Nurses' Day, the chapter set up an information booth at both of the Regina hospitals. The Pasqua Hospital had a booth set up outside of their unit with information on cholangioscopy while the Regina General Hospital had Crohn's and Colitis Canada set up with information at the main entrance. Both booths were very successful and got great feedback from staff and patients. The chapter is now busy planning for our annual GI Day conference which will take place on October 30th this year.
Jennifer Rodgers RN, BSN
Regina Chapter President

Reports

Canada West continued

Edmonton Chapter

The Edmonton Chapter had an evening dinner / presentation hosted by our Royal Alexandra Hospital chapter members on April 8th. "Stricture Management in Inflammatory Bowel Disease" was delivered as a two part presentation by Dr. Daniel Birch, Surgeon from the Royal Alexandra Hospital and by Dr. Brendan Halloran, Gastroenterologist from the University Hospital. We had 23 delegates attend. Our appreciation goes to Shane Morson, Boston Scientific and to Jaymes Purdon and Kevin Kwan, Abbvie for providing funds for our event! And thank you to Kathy Korner, chapter member for coordinating the evening.

We had a meeting on May 6th in which we reviewed our education year, and made plans for the upcoming year. Elections were held for two of our executive positions. Kathy Korner is Chapter Secretary and Kim Bernard is Chapter Treasurer each by acclamation. The election for President will be next year.

We planned to end before summer with a late June Chapter meeting, and begin in the fall with a COOK Canada evening education session on EUS from their 360 Series.

Hoping everyone had a happy and safe summer! We are looking forward to the upcoming National Conference in Moncton, NB. Congratulations on an excellent program!

Yvonne Verklan

Edmonton Chapter President

Calgary Chapter

All the Calgary Chapter sites continue to be busy; we have lots of research in the region and we continue to add new and innovative treatment options for our patients.

Thanks to National Office for supplying us with the beautiful banners.

Our chapter was able to provide a pizza lunch for each site to celebrate GI Nurses Day.

We had the Alberta Digestive Diseases Summit in Lake Louise on June 5 – 7. Several of our nurses attended, representing all the hospitals!

We are looking forward to the national conference in Moncton.

Our chapter is also collaborating with the zone GI Nurse Educators for a GI Education Day to be held early next year.

Bobbi Sheppy

Calgary Chapter President

Vancouver Island Chapter

Vancouver Island Chapter has had a busy and productive Spring. We hosted our annual Education Day in May with a great turnout from our members and also non-members. We learned about Chronic vs. Acute Pancreatitis (presented by Gastroenterologist, Dr. Andrew Singh) and about IBD vs IBS (presented by Gastroenterologist Dr. Justin Shah). We held our AGM and elected 2 new executives!! Shelley Dosso will be taking on the role of President and Alex Burrows will be our new Treasurer…Welcome to our new Executive and welcome to fresh new ideas!

Andrea White

Vancouver Island Chapter President

Alberta Southwest Chapter

The AB SW chapter is alive and well thanks to a great new influx of members with great ideas and lots of enthusiasm. We are back up to 10 members and have a couple of new LPNs on our roster. So wonderful to have their curiosity and insight into GI nursing. We are planning to use them to the full extent possible as we move forward.

We have an educational day booked for October 2, 2015 entitled "Great Big C" with inspiration from the band "Great Big Sea". We will be discussing GI cancer from mouth to anus and have 5 doctors and a social worker confirmed to speak for us. We are so excited to be back on track and looking forward to sharing GI knowledge with anyone who is willing to listen.

Our endoscopy unit and hospital are gaining a new Gastroenterologist this summer and he is bringing with him the skill of EUS. We are very excited to be taking on this new role and look forward to learning about this technique.

Wishing all our colleagues and friends a wonderful and restful summer.

Sincerely,

Barb Harbers BN,CGN(C)

President, AB SW Regional Chapter

Okanagan Chapter

We have been going through lots of change in Kelowna lately and are finally getting our Endoscopic Ultrasound going! We will be participating in training courses here starting June 18th and plan to be running first cases June 22nd! It has been YEARS in the works.

2015 Education Grant Recipients

Okanagan Chapter continued;

We are so pleased now to be able to offer this service to the Okanagan and Kootenay Regions

Dr Carla Nash will be heading the service and procedures will be done by her a few days per week within our endoscopy slate.

We have just been approached by Okanagan College to participate in creating an online (?) Endoscopy course! This is only the start of planning stages - but how exciting? It's a wonderful way to create interest in GI & Endoscopy Nursing. We are waiting to hear back from CSGNA for their support.

May 12th we had a dinner talk, sponsored by Abbvie. It was really great to have an IBD Nurse named Shauna Hill discuss with us methods of communicating better with IBD Patients. It was titled "From Prep Talk to Pep Talk". It was not only well presented but also very interesting. She practices in New Westminster and they seem to have a very busy clinic.

We had to cancel our last meeting and are rescheduling it to early July.

Bethany Rode
Okanagan Chapter President

ANNUAL MEMBERSHIP EDUCATIONAL GRANT

Stephanie Carr
Okangan

Linda Gandy
Golden Horseshoe

Mabel Chaytor
Newfoundland

Krista Combden
Newfoundland

Jody Hannah
Golden Horseshoe

Donna Joncas
GTA

Carina Kirk
Manitoba

Shelley Dosso
Vancouver Island

Wendy Schaufert
Calgary

Helga Sisson
GTA

Janet Young-Laurin
Central Ontario

NEW MEMBER EDUCATION GRANT

Bernice Sutton
Newfoundland

LPN/RPN, TECH EDUCATIONAL GRANT

Debi-Lyn Leippi - Central Alberta

SCICAN EDUCATION GRANTS

Denise Chiasson—Ottawa

Jodi Hannah
Golden Horseshoe

Rayleen Hogan - Newfoundland

Carina Kirk Manitoba

MICHELLE PAQUETTE CERTIFICATION AWARD

Carina Kirk - Manitoba

MICHELLE PAQUETTE RECERTIFICATION AWARD

Helga Sisson – GTA

CHAPTER OF THE YEAR

TBA at the 2015 National Conference

Synopsis CSGNA Face to Face Board Meeting
Feb 21-22, 2015

ATTENDANCE: All twelve Board members

REVIEW AND ADOPTION OF MINUTES AND AGENDA: Motions were passed to adopt minutes and agenda, as circulated prior to the meeting.

REGIONAL DIRECTOR REPORTS

Canada West A report was provided on chapter activities in the region. There have been attempts to actively engage members in the Vancouver area, in order to revitalize the Vancouver chapter. There has been industry support in this important endeavor. Members in the Prince George area have shown a keen interest in CSGNA activities.

Canada Center: A positive response from the members of the Ottawa chapter with participation in chapter education.

Canada East: The board voted to approve the name of the Quebec chapter, **CHAPTRE QUEBEC.** The Chaptre Quebec had their inaugural chapter education day, with a very successful turnout and event.

WEBSITE AND NEWSLETTER DIRECTOR REPORT The board voted to look into the economic feasibility of professional translation of English documents to French. A vote was also held, to get a quote for the professional translation of documents, standards and guidelines. The new webhost was confirmed and the website will be bilingual. This will include the key practice documents and standards as well as the chapter packages. There will be an interactive forum with some education modules and an option for a Go to meeting link. There will also be a COP section/page.

MONCTON CONFERENCE UPDATE: Conference planning is well underway with collaboration between the planner and the planning committee. There will be French translation at the plenary sessions and French only breakout session options, available for our Francophone members. Speakers are primarily from NB, PEI and NS. The conference budget was also reviewed. The early bird registration deadline is August 15th. Conference fees were reviewed and adjusted after a discussion and vote. Poster awards will be given and honorary members will be acknowledged. A Chapter executive mentoring event will be held at the conference.

IBD COMMUNITY OF PRACTICE An overview of the history of CANIBD group was given by CSGNA President Lisa Westin followed by Barb Currie one of its core members. 73% of its members voted to join with CSGNA as a community of practice (COP). The IBD group will develop their priorities to align with the strategic priorities of CSGNA. Being a COP within the CSGNA umbrella will facilitate an improvement in accessing IBD education of members across Canada. Information will also be in French which will maintain inclusion of our Francophone members. The plan is to have core members in each region with the eventual outcome of having IBD representation in each chapter.

Synopsis CSGNA Face to Face Board Meeting Feb 21-22, 2015 continued;

PRESIDENTS REPORT There will be a discussion with the CAG board for a possible joint conference with CAG and CSGNA. Lisa and Connie have provided input on selection of speakers for the ADDS conference.

EDUCATION DIRECTORS REPORT Nurses preparing for the certification exam will be able to access the prep guide and additional educational material that will be posted on the website, once the website update is completed. A call has been extended to recruit volunteer members to mentor members preparing for their exam.

PUBLIC RELATIONS DIRECTOR REPORT The Montreal and Quebec chapters have been officially posted on the Quebec Order of Nursing website. There will be some support provided for nurses on GI nursing day, with banners, buttons and posters to be sent to units by CSGNA.

TREASURERS REPORT A business plan is being developed with itemized expenses and a budget breakdown for all proposed activities.

PRESIDENT ELECT REPORT A list of GI units across Canada is being compiled as a reference for CSGNA to reach out to nurses in the field.

SECRETARY REPORT A social fund policy is being developed, in order that the board has a resource to use, in event that there are needs to acknowledge within the board group.

PRACTICE DIRECTOR REPORT The procedural sedation position statement is about to be finalized and approved and is expected to be posted on the website. A scope of practice document for RPN/LPN is in its development stage.

AWARDS & RESEARCH DIRECTOR REPORT The new deadline for submission of grant application is July 1st. Receipts for grant reimbursement must be submitted to the treasurer by 60 days after the event or the grant will be forfeited/revoked.

DOCUMENT REVIEW The mission, vision and value statement was approved by the board. The membership list access policy was reviewed. Chapter member list will be sent to each chapter President on a regular basis. The Grants and awards policy was reviewed and revised as needed. Standards of practice guidelines were reviewed and updated and will be translated to French. The RPN/LPN role delineation policy is being developed. Infection control guidelines continue to be a work in progress. A board teleconference meeting will be scheduled quarterly to review additional documents.

NEXT MEETING: Teleconference April 11th 2015.

Submitted by

Lorraine Majcen RN, BScN, CGN(C)

CSGNA Secretary

Introducing the new

CDHF IBD BRAT

IBD Treatment Options

Understanding Your Benefits and Risks

Helping patients understand the benefits and risks associated with IBD therapy options is challenging. Patients often focus on the risks of medications but forget to factor in the benefits -- and the risk of no therapy.

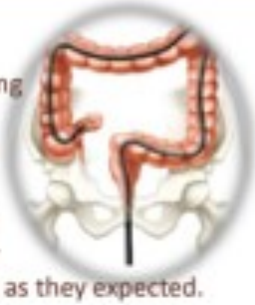
We know that patients who better understand their disease, are more adherent, healthier and enjoy a much better quality of life.

The Canadian Digestive Health Foundation (CDHF) has a solution to help you improve communication with IBD patients. We're proud to introduce a simple, interactive teaching aid – the new **CDHF IBD BRAT (Benefit Risk Assessment Tool)**.

The **IBD BRAT** is designed to help you explain IBD and the specific drug classes used to treat it. The **IBD BRAT** uses simple text and intuitive, eye-catching graphics to highlight relative common risk factors (infection, reaction, intolerance and cancer) as well as important benefits (reducing flares, complications and surgery and increasing healing and overall quality of life) associated with 5-ASAs, immunosuppressants, steroid and biologics.

Use the **CDHF IBD BRAT** to have informed, proactive, collaborative conversations with your patients. To order your IBD BRAT, please email Michelle@CDHF.ca.

NEW Bowel Prep Video



Too many people avoid life-saving colonoscopies because of the dreaded bowel prep. We know the benefits far outweigh the risks and that most people who have had a colonoscopy, openly assert that it isn't wasn't as bad as they expected.

Now you can invite your patients to spend a few minutes with Robbie, Anne and Laurie, ages 12 to 80 years. This enthusiastic trio, along with Dr. David Armstrong openly share their experiences, encouragement for and tips for a successful prep.
www.CDHF.ca/BowelPrep

JUST for KIDS! Solving the Mystery of Endoscopy

A fun, interactive, game to help ease anxiety and educate young patients undergoing endoscopy.

On-line. All the time. www.CDHF.ca

With over 1 Million hits per month, CDHF.ca is your 24/7 patient resource centre. Our site brings your pateints attractive, unbiased info on everything from gum to bum from health care professionals. Our free resources include educational disease and test guides, videos, personal stories and more.

UNDERSTAND. TAKE CONTROL. LIVE BETTER.

Canadian Digestive Health Foundation

Helping you help your patients feel their best.

Empowering Canadians to take control of their digestive health.
www.CDHF.ca

The CDHF is the foundation of the Canadian Association of Gastroenterology.

St. Clare's Mercy Hospital Endoscopy Unit Prepares for Colorectal Cancer Screening Program

Over the past two years Newfoundland and Labrador has been systematically ushering in the Colorectal Cancer Screening Program (CRCSP) throughout the province. People between 50-74 years of age who are of average risk and symptom free are invited to participate. Respondents are sent a FIT (Fecal Immunochemical Test) kit, which they complete at home and mail back for analysis. Response so far, has been excellent! With higher than expected positive FIT results of 15%, verses predicted rates of 8 to 10%, the program has demonstrated its value in this province.

The Eastern and most populated region of the province launched the program this summer and with every positive FIT test comes a colonoscopy with a timeline of 60 days. Coupled with current waitlists for procedures, it was recognized very early that we needed to prepare for the increased demand on our resources.

Eastern Health partnered with the Colorectal Screening Program and the Department of Health and Community Services to examine current demand and capacity and to develop a plan for the projected increase.

One of several initiatives identified to meet the anticipated demand, was to increase capacity within the current system. St. Clare's Mercy Hospital in St John's, was selected as the most appropriate site to be renovated, by adding a third procedure room to the Endoscopy unit. The additional procedure room would increase capacity for the added screening colonoscopies and help reduce the growing waitlist.

With the support of infrastructure, unit staff, physicians, administration and most importantly the patients and under the guidance of our project manager Mr. Scott Gow, our renovation began.

The result was a successful renovation in a fully functioning unit. No cancellations, slowdowns or delays were experienced throughout the renovation project.

External contractors were advised, educated and quickly made aware that patients have a right to dignity, confidentiality and respect throughout the renovation process. The staff happily worked around the demolition and renovation. They provided care to patients in a unit that was reduced in size by construction enclosures.

Patients were very interested to watch the complicated process of construction in a medical facility and ask questions. From time to time, the patients even offered the construction team suggestions

Everyone understood the reason for the project and the important role that each individual played in making it a success.

Stage 1: *Plan, plan and plan some more. Early meetings established the overall goals which were a) renovate the space b) minimize disruption c) include end users d) stay in budget.*

End users were informed about the project and invited to produce a "wish list". Drawings were drafted, then posted for staff and physicians input. They were then returned to the project manager who worked with the architects and engineers to rework and incorporate these ideas wherever possible. This process took several months and several drafts as they endeavored to include all the required elements and incorporate items from the wish list.

Stage 2: *Conversion of waiting room space to patient procedure preparation space that would accommodate three medical lounge chairs.*

This required rerouting of patients for registration, closure of half of the endoscopy waiting room and establishing an overflow waiting area.

Stage 3: *Relocating a nursing station and doorways to change the traffic pattern and allow for the addition of two recovery spaces, taking the 6 bed recovery room to 8 beds.*

We de-cluttered! Enclosures was erected, demolition occurred, medical gas lines were rerouted, laundry carts were relocated, lighting installed, flooring matched and HVAC filtered the air. It was noisy! A nursing station was rebuilt, computers moved and phone lines changed.

Stage 4: Construction of a new larger reprocessing area to meet current standards and increase reprocessing capacity by 33%.

To accomplish this, two offices and one restroom were combined and renovated. MDR (Medical Device Reprocessing) staff now enjoy new larger height adjustable ARC sinks that replaced old undersized sinks and an additional AER (automatic endoscope reprocessor) was installed to meet the increased volumes. This space was designed versus adapted, for high level disinfection of endoscopes.

Stage 5: *Renovation of the third procedure room.*

A room that was used for equipment and supply storage was selected for conversion into the third procedure room. While no major reconstruction was required, every unit needs storage! Now space had to be found to make up for this loss. Two offices adjacent to the unit were reallocated to endoscopy. One was to be the new endoscopy office/capsule endoscopy room and the other would be the storage for towers, equipment, X-Ray gowns and larger supplies.

Endoscopy also became part of a pilot project for a Pyxis System to manage materials and supplies. An in-unit hall space for this installation was identified early in the project planning stage and was included in the renovation plan. The Pyxis unit would house the smaller supplies and help manage our unit inventory. Larger items would be housed in the new store room with electronic "jitterbugs" that communicate with the larger Pyxis inventory control system.

Stage 6: *Redevelopment of the former reprocessing room into a shared physician dictation area and installation of an eye wash station.*

While a renovation never allows one to include absolutely everything, it was important to make space for another physician computer and to ensure that staff had the appropriate equipment to ensure their wellness and safety. The old "reprocessing room" was just big enough to meet these needs and its close proximity to the procedure rooms worked well.

As if this were not enough for one endoscopy unit, St. Clare's Endoscopy suite was also selected as the provincial site to host the CAG Skills Enhancement for Endoscopists Course. This required a procedure room technology installation with remote video/audio feeds. To date, three successful presentations have taken place and a forth is planned for October.

Our renovation concluded on July 17th and procedures were scheduled to 'test' the room. Over the remainder of that week, endoscopy staff selectively did procedures in "the new room" and minor bugs were worked out. By weeks end the room was officially deemed "ready to go"!

On July 23rd 2015, three years ***to the day****, that the screening program announced that they hoped to be province wide within 3 years, the Minister of Health and Community Services*,

The Honorable Steve Kent, accompanied by Eastern Health's CEO Mr. David Diamond, Mrs. Katherine Chubbs Vice President and Chief Nursing Officer and Dr Jerry McGrath Gastroenterologist and Medical Director for NL Colon Cancer Screening Program came together in the presence of many of the people who made it all possible, to officially announce the expansion of the screening program into the Eastern Region, making it province wide and exactly on target.

Of course we are planning a celebration and by this reading maybe we will have already had it!

What will we be celebrating?

The success of a plan well executed; The coming together of many people and disciplines to make the project a success; The culture of cooperation that surfaced during the renovation;

Every individual that worked, planned, advised, suggested and tolerated; Our patients that took the journey with us, or the future patients who will benefit. WE WILL CELEBRATE IT ALL!

Jeannie Harding
Endoscopy Manager
Eastern Health, NL

Share what's happening with your GI Team, GI Unit or CSGNA Chapter In The Spotlight

Foreign Body Ingestions and Food Impactions: A Case Study

Joan McKechnie, RN, CGN(C)

Accidental foreign body or large food bolus ingestion occurs mainly in children and the elderly or mentally impaired adults. The most common cause of esophageal obstruction in adults is a meat bolus impaction and the majority of foreign bodies in children are coins. Other causes include intentional ingestion in psychiatric patients or prison inmates and rarely foreign body impaction is a complication of pill ingestion.

Over 80 percent of ingested foreign bodies pass without the need for intervention. With intentional ingestions, endoscopic intervention is required in up to 76 percent of patients and 16 percent require surgery. Ulcer formation, lacerations, perforation, intestinal obstruction, aortoesophageal fistula formation, tracheoesophageal fistula formation and bacteremia are complications of foreign body ingestion or food impaction.

Structural or functional esophageal abnormalities that increase the risk of foreign body or food impaction in the esophagus include webs, rings, strictures, achalasia, diverticula, tumors and eosinophilic esophagitis.

The typical clinical presentation is acute onset of dysphagia or complete inability to swallow saliva. An inability to swallow oral secretions is important because it indicates a total obstruction. Other symptoms that occur include choking, refusal to eat, drooling, retrosternal fullness, regurgitation of undigested food, wheezing, blood stained saliva, respiratory distress and occasionally odynophagia. Odynophagia may indicate spasm but may also suggest a laceration or perforation. Some patients present with abdominal pain and distention.

Symptoms in patients with a perforation will depend on the site of the perforation. Perforation of the oropharynx or proximal esophagus may cause neck swelling, tenderness, erythema or crepitus. Perforation in the mid or distal esophagus may result in severe retrosternal chest and/or upper abdominal pain, tachypnea, dyspnea, cyanosis, fever and shock. Perforation of the stomach, small bowel or colon may present with signs of peritonitis such as abdominal pain, rebound, guarding, tachycardia, hypotension and fever.

Foreign bodies can be detected with plain radiographs, however some foreign bodies such as fish bones, wood, plastic, glass, thin metal objects and food impactions may not be seen. Patients with suspected foreign body ingestions and ongoing esophageal symptoms, require endoscopic evaluation even those with negative x-rays. Computed tomographic scanning may be helpful if plain x-rays are negative, especially in patients suspected of having ingested packets of narcotics or other drugs.

The management approach depends on the type of object ingested, the location of the object and the patient's clinical status. Conservative management is appropriate for the majority of patients since objects often pass uneventfully. Other patients will require endoscopic or surgical intervention.

Emergent endoscopy is indicated in patients with esophageal obstruction, disk batteries in the esophagus or sharp pointed objects in the esophagus.

Urgent endoscopy, within 24 hours, is indicated in patients with esophageal foreign objects that are not sharp pointed, esophageal food impaction without complete

obstruction, sharp pointed objects in the stomach or duodenum, objects >6 cm in length at or above the proximal duodenum and magnets within endoscopic reach. Non- urgent endoscopy is indicated in patients with coins in the esophagus, blunt objects in the stomach that are >2.5 cm in diameter, blunt objects that fail to pass the stomach within 3-4 weeks, blunt objects distal to the duodenum that remain in the same location for more than a week or disc batteries and cylindrical batteries that are in the stomach of patients without signs of GI injury.

Most foreign bodies that enter the stomach will pass in 4-6 days and conservative management is appropriate for most blunt objects in asymptomatic patients. Exceptions include disk batteries, magnets, objects longer than 6 cm and objects with a diameter >2.5 cm. Patients treated conservatively should have weekly radiographs to follow the progress of the object and they should be instructed to follow-up immediately if abdominal pain, nausea or vomiting develop. Patients should resume a normal diet and monitor their stools for evidence of the object.

Safe extraction of the object can usually be performed under moderate sedation. However, patients with objects that are difficult to remove, who have ingested multiple objects or those with significant psychiatric illness may require endotracheal intubation and general anaesthesia.

Devices that are commonly used for foreign body removal include rat-tooth and alligator forceps, polypectomy snares, baskets and nets. Coins are best retrieved with a rat-tooth forceps, snare or net. Round objects such as disk or button batteries are best captured using a net.

Overtubes may be used to protect the airway when removing objects that are difficult to grasp securely and to facilitate passage of the endoscope multiple times for piecemeal removal of a food bolus or to remove multiple objects. They should also be considered to prevent an object from accidently being dropped into the patient's airway. Overtubes are also used to protect the esophageal mucosa when removing sharp objects. Another option to protect the esophagus during removal of a sharp object from the stomach is a foreign body protector hood.

Drug packets ingested by drug traffickers in an attempt to conceal their possession should not be removed endoscopically because of the risk of rupture. The packets can often be seen on radiograph. Surgery is indicated for patients when the packages fail to progress and those with signs of intestinal obstruction or suspected rupture.

Push enteroscopy has been used as an alternative to surgery for the management of patients with foreign bodies in the small bowel.

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Recurrent esophageal foreign body impactions occur in 10 to 20 percent of cases.

Case Study

A 25 year old female came to hospital after swallowing three razor blades. She was accompanied by a social worker and a volunteer. She has a history of asthma and borderline personality disorder involving self harm and lacerations. The patient was assessed by the emergency physician. She denied chest pain, shortness of breath, throat pain, nausea or vomiting. Her vital signs were stable. The findings from the radiograph revealed foreign bodies in the form of three razor blades in the left flank presumably in the stomach. A gastroenterology consult was requested.

The patient has ingested razor blades several times in the past. She had been admitted to psychiatry but later discharged. The gastroenterologist was familiar with this patient and in fact removed two razor blades from her stomach three days before. He arranged for a gastroscopy to remove the razor blades.

IV Propofol was administered by the emergency physician. The patient received oxygen by nasal prongs. Her vital signs were monitored. An esophageal overtube over a gastroscope was advanced into the esophagus. The inner t.ube and the gastroscope were pulled out. The overtube cover was secured and the

gastoscope was then reinserted into the esophagus and stomach. A large amount of food was visualized. One of the razor blades was easily seen. It was retrieved with a rat tooth grasper. After suctioning and washing, the second razor blade was identified. It was finally removed after some time.

The third razor blade was very difficult to locate. The antrum and duodenum were visualized in detail but the blade could not be seen. It was seen in the fundus of the stomach hiding in between the food.

After suctioning and washing some more and removing large chunks of food, the third razor blade was retrieved as well. It took 45 minutes to retrieve all three razor blades from her stomach.

The patient tolerated the procedure well without any immediate postoperative complications. She was recovered as per our usual practice. The patient was later transferred to Psychiatry. She was medically cleared from GI.

Conclusion

The patient has a two year history of ingesting sharp objects. She has no fixed address and lives at shelters. The patient was discharged after a brief hospital stay in Psychiatry. The patient comes back at weekly to monthly intervals and in this instance after 3 days. The area GI physicians have discussed this case at length and are unsure how to proceed with her care.

Discussion

Have you had similar experiences in your unit? How do you think this patient should be best cared for?

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Medical Charts

George Triadafilopoulos, MD. Up-To-Date 2014, Ingested foreign bodies and food impactions in adults www.uptodate.com

Members are requested to submit articles for future Guiding Light publications.
Our next Guiding Light will be electronically delivered to members in November.
Please submit any articles or notices by October 1st.

A New Style of Nursing: Colon Cancer Screening Program

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I've thoroughly enjoyed nursing throughout my 30 plus year career. As we all know, there are many different types of nurses – some of us work in emergency, some with public health, others with obstetrics and so on. Most of my career has been spent providing hands on nursing in the areas of surgery and gastroenterology. That was until March 2011, when my career took a meaningful turn.

I applied for the position of follow-up nurse coordinator with the new Newfoundland and Labrador Colon Cancer Screening Program. This position was very different from the hands on nursing career to which I had been accustomed and thoroughly enjoyed. After being offered the position and consulting with family and trusted colleagues, I accepted the job and embarked on a new style of nursing.

Colon cancer is the second most commonly diagnosed cancer among men and women in Newfoundland and Labrador. But for me, there's a personal connection. Colon cancer screening is near and dear to my heart as I lost my father and other family members to this disease.

I viewed this new position as nurse coordinator as an opportunity for me to try to help, in some small way, to reduce the incidence of the disease in our province.

My new responsibilities included:

Informing colon cancer screening participants that their colon cancer screening test was positive and sharing test results with them; Completing detailed health assessments, networking with regional health authorities across the province and navigating patients through the colonoscopy process; Monitoring the results of colonoscopies and ensuring appropriate follow-up for patients.

I also work closely with the manager of the Newfoundland and Labrador Colon Cancer Screening Program and the program's Medical Director to provide education sessions on colon cancer screening for health care employees and the general public.

Even though I no longer have that "face to face" interaction with colon cancer screening program patients, the bond I develop with my patients is extremely important to me throughout the entire process.

My initial contact with patients is to inform them that they have a positive result to the Fecal Immunochemical Test (FIT) they've recently completed. The FIT test involves providing two stool samples for analysis. The test has no dietary or medication restrictions and is completed in the privacy of one's home and mailed backed to the lab at no cost to the client. Test results are sent to the client and their family doctors. Those with a negative test result are automatically re-screened in two years while those with a positive result are contacted by the screening program and guided through to colonoscopy.

The immediate reaction I hear from most patients to a positive test is fear that they have bowel cancer. In the majority of positive test results, this is not actually the case. It is important that I explain the test results in a caring and compassionate manner to alleviate their fears and concerns.

Reasons for a positive FIT result may vary from something minor such as hemorrhoids to something more concerning such as cancer. If polyps are detected during a colonoscopy, the Endoscopist will remove them during the procedure and send them for analysis.

Polyps start out as a small harmless growth on the inner wall of the colon which can bleed into the colon.

Not all polyps are precancerous; however some types of polyps, if not removed, may develop into cancer. Research has found that when colon polyps and cancer are found and treated early, there is a 90 percent cure rate

The way I see it – early detection and treatment is at the heart of the Newfoundland and Labrador Colon Cancer Screening Program.

During my initial discussion with the patient, I schedule an appointment to conduct a health assessment and consult with the program's Medical Director on any areas of concern. The health assessment provides a detailed review of the participant's past and present medical history. I provide patients with an explanation of the colonoscopy procedure including possible risks, outcomes and potential follow-up care required, as well as all the necessary information required to ensure an adequate bowel preparation and in turn ensuring a thorough and complete examination.

Following the assessment, I send a referral to one of the screening program's enrolled endoscopists who will review the assessment and schedule a colonoscopy. Patients are mailed a complete information package reviewing all the information that was given during the telephone assessment. My contact information is also provided and participants are encouraged to call me at any time.

t is through conversations such as these that I develop close relationships with my patients. I have frequent contact with these patients and feel privileged to become the person they rely on to address concerns, and answer their questions.

After the colonoscopy is completed, many of these patients call to inform me of their colonoscopy experience and to thank me for my guidance and support.

This new style of nursing is rewarding in so many ways. My level of job satisfaction continues to grow knowing that I have supported our patients through a sometimes frightening experience. It is also very satisfying to know that I am contributing towards the organizations effort to decrease bowel cancer throughout our province.

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- Submit all materials by email to the newsletter editor in word format.
- Submissions must be received by the first of the month preceding each issue i.e.: Feb1st for March issues, June 1st for July issues and Oct 1st for November issues.
- Include all references using APA referencing.

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Please contact me about any comments you may have about this newsletter or any ideas for future issues.

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