Nurses Week at Montfort Hospital, Ottawa, Canada

Submitted by: Rachel Thibault Walsh RN, BScN, CGN(C) & Nancy Campbell RN, CGN(C)

This year for Nurses week I and a coworker Rachel Thibault Walsh decided to do a presentation on Colorectal Cancer Screening at our hospital. Fuelled by the recent diagnosis of a colleague with colon cancer we decided that we wanted to raise awareness of this treatable and preventable disease. We signed up for a kiosk and presented our power point presentation endlessly for more than two hours as hospital staff wandered from kiosk to kiosk. We even demonstrated how a polypectomy was done! We had the CAG poster for colorectal Screening Guidelines on display and had handouts of this poster for people to take home. If any of you would like a CAG Colorectal Screening poster for your unit please contact your CSGNA Director or Chapter President. We had an excellent turnout and the interest level in our presentation was very high. The following is our presentation. If we only save one life it will be worth it!

COLORECTAL CANCER
IMPORTANCE OF SCREENING

May 2005

Colorectal cancer is:
◆ Third type of cancer most frequently diagnosed
◆ Second cause of death from cancer in Canada

STATISTICS:
(CANADA, 2005)
◆ Estimates for 2005:
  ◆ 19,600 persons will be diagnosed with colorectal cancer
  ◆ 8,400 persons will die

EACH WEEK:
◆ 377 Canadians will be diagnosed with colorectal cancer
◆ 162 Canadians will die

PROBABILITY OF BEING DIAGNOSED WITH COLORECTAL CANCER
◆ Men: 1 out of 14
◆ Women: 1 out of 16

PROBABILITY OF DYING FROM COLORECTAL CANCER
◆ Men: 1 out of 28
◆ Women 1 out of 31

Risks associated with colorectal cancer
◆ age (higher after age 50)
◆ Presence of polyps
◆ Family history of colorectal cancer
◆ Inflammatory GI disease
◆ Nutrition
◆ Obesity
◆ Lack of physical activity
◆ Alcohol abuse
◆ Smoking

SIGNS AND SYMPTOMS THAT MAY OR MAY NOT INDICATE COLORECTAL CANCER
◆ Blood in stools
◆ Change in bowel habits without apparent cause
◆ Thinner stools
◆ Urge to defecate but stools are small
◆ Feeling of incomplete evacuation
◆ Frequent pain due to gas
◆ Diffuse pain radiating to back
◆ Anemia
◆ Unexplained weight loss
◆ Fatigue
◆ Nausea, vomiting, indigestion

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COLORECTAL CANCER MAY OCCUR EVEN IN THE ABSENCE OF SYMPTOMS

PREVENTION
◆ Colorectal screening
◆ Diet rich in fruits, vegetables and whole grains
◆ Daily physical activity
◆ Maintain healthy weight
◆ No smoking
◆ Limit alcohol

SCREENING TESTS
◆ Fecal Occult Blood
◆ Barium Enema
◆ Flexible Sigmoidoscopy
◆ Colonoscopy

THE SOONER COLORECTAL CANCER IS DISCOVERED THE BETTER THE CHANCE FOR SUCCESS OF TREATMENT
◆ The cure rate in patients diagnosed after symptoms is 50%
◆ Conversely the cure rate rises to 80% if the diagnosis is made and treatment is begun at an early stage

CANADIAN GUIDELINES FOR COLORECTAL SCREENING
◆ 50 years and over with average risk:
  ◆ Fecal occult blood every 2 years with follow up if positive
  ◆ Flexible sigmoidoscopy every 5 years
  ◆ Colonoscopy every 10 years
  ◆ Barium enema with double contrast every 5 years

NEED FOR PERSONALIZED SURVEILLANCE PLAN FOR HIGH RISK CLIENTS:
◆ First degree parent with colorectal cancer
◆ Personal history of previous colorectal cancer
◆ Inflammatory bowel disease
◆ Benign colon polyps

WHAT CAN WE DO?
◆ Awareness to inform population to prevent colorectal cancer and reduce risks
◆ Colorectal screening program with available resources for its application

Colon Cancer

Polyps
WHY?
Colon Cancer is
Preventable
Treatable
And Curable!

REFERENCES:
Canadian Association of Gastroenterology and
The Canadian Digestive Health Foundation:
Guidelines On Colorectal Cancer
Screening, Leddin, Desmond et al. (2004)  
Can J Gastroenterol 18(2) 93-98 February.

Society Gastroenterology Nurses & Associates-
Colorectal Cancer Awareness Month
www.sgna.org/legislative/CRCA.cfm

American Society Colon & Rectal Surgeons
Colorectal Cancer http://fascrs.org/
displaycommon.cfm?an=1&subarticlenbr=7

American Society Colon & Rectal Surgeons
Screening & Surveillance for Colorectal Cancer
http://fascrs.org/
displaycommon.cfm?an=1&subarticlenbr=7

CAG Colorectal Cancer Screening Guidelines-
2005 (poster)

Canadian Cancer Society (Colorectal Cancer
Stats) updated: April 12, 2005 http://
www.cancer.ca/ccs/internet/standard/
0,3182,3172_14447_langID-en,00.html
The World Congress of Gastroenterology is just around the corner. We have been planning and discussing this for several years and now it is finally becoming a reality. It has been a pleasure working with SINGEA to develop the nurses program for the WCOG. By the way, there is still time to register! We had 33 very interesting abstracts submitted and four were chosen to be presented orally. We will have live endoscopy Monday and Tuesday-September 12th and 13th. There will be opening ceremonies on Sunday evening, Nurses Welcome on Monday evening and Canada Night on Tuesday evening. The combination of an interesting current program with nightly entertainment will provide a wonderful venue for networking and learning, as well as having fun! We are looking forward to seeing you there! CSGNA is also hosting the Foundation courses for people who have decided to write the GI Certification exam next year, or for those who are contemplating it. It is also an excellent review for any GI nurse. Sign up information is in this issue of The Guiding Light and also on our website@www.csgna.com. In addition to our program, we are fortunate this year to have Leslie Ann Patry from the Canadian Nurses Association as a guest speaker at this event. She is going to speak on study groups-how to organize them & their benefits. This will be on Sunday September 11th from 11-3PM. CSGNA will be hosting its annual Chapter dinner on Sunday evening. This is an invitation only dinner for chapter executive. This year we have some chapters who will share their success in arranging education sessions to meet the required 4 hours of education per year. This may be your only time to participate in a World Congress so make certain that you are not caught listening to your coworkers detailing all their fun at the WCOG. Plan to be a part of those escapades!

By now those of you who attained your CGN(C) will have been informed. Congratulations! Wear your pin proudly and join the group of Certified Canadian GI nurses!

We were pleased to be able to announce that there were 33 new scholarships offered this year in addition to our CSGNA ones. That equates to an additional 66 eyes at the WCOG!

There are still some CSGNA education sessions taking place in June across Canada. Have a safe and happy summer and I look forward to seeing you in Montreal in September.

Respectfully Yours,  
Nancy Campbell RN, CGN(C)  
President CSGNA
Nancy Campbell and I had the pleasure of representing CSGNA at this excellent course. Although content varies from year to year, the format remains consistent. A summary of the program and events follows. For those CSGNA members who have not had the opportunity to attend an annual US meeting, I would encourage you to do so at least once. I have no doubt that after having been to one you will want to go again. I recognize that employers are looking carefully at travel for education, particularly if it is out of the country. However, the SGNA rotates their sites from west to east as does CSGNA. Next year’s SGNA course is in San Antonio, TX, May 19-24, 2006.

The Friday and Saturday are optional days at each course with a variety of sessions offered. This year sessions covered hands-on ERCP, advanced principles in sedation/analgesia, caring for children in the GI Unit, the nurse manager’s guide to the reprocessing competency, and learning to name only a few. A certification preparation course is always offered on the Friday with the CBNGA certification exam writing on Saturday from 0800-1200. The House of Delegates meeting is held on Friday and Nancy and I attended as guests and had the privilege of being recognized from Canada at this meeting. We also had the distinct pleasure of being invited to lunch with Cathy Dykes, Nancy Deniro, president-elect, and Mary Beth Hepp, executive director of SGNA. Late Saturday afternoon vendor programs started. These additional offerings are separate from the regular course but usually involve awarding of contact hours for continuing competency requirements. Vendor programs run throughout the course. Dr. Michelle Alfa from St. Boniface Hospital, Winnipeg, was vendor-sponsored. Her talk focused on evaluating cleaning efficacy on scope reprocessing. Saturday night a gala dinner sponsored by Wilson Cook for all US certified nurses was held. A standup comic entertained.

The main course program starts on Sunday at 1200hrs and is finished Wednesday at 1200hrs. The opening ceremonies were impressive with Cirque du soleil-like rope climbers performing. Cathy Dykes, the outgoing president, addressed attendees and recognized the national board. Award winners were acknowledged as well as all foreign attendees.

Sessions were varied and included Botox therapy, strategies to address increased demand for colonoscopy, mentoring in the GI unit, the role of non-physician endoscopists to name only a few. The days were packed with education, the evenings with social events. This being my third US conference, I’m always pleased to see that our Canadian practice compares with the best GI nursing practice in the US. However, I believe we often do more with less, particularly when it comes to staffing in endoscopy.

If there was one topic which stimulated discussion and emotion it was the use of Propofol, particularly nurse administered Propofol. Several sessions were devoted to this topic. Twenty-three states currently have legislation about the administration of this drug. Those who use it rave about its short acting properties and patients sing its praises. We met nurses from doctors’ offices where endoscopy is performed. Many of them give Propofol! We heard not only from nurses who administer the drug but also from a nurse/lawyer from New York State who discussed lawsuits pending in situations where the patient was not appropriately monitored. It will be interesting to see how our practice with this drug will evolve.

We thank the SGNA volunteers who put on an excellent conference!

Respectfully submitted,
Debbie Taggart RN, BN, CGRN, CGN(C)
President-Elect

Deb Taggart, Pres. Elect CSGNA; Margie Lanza, President, Ohio SGNA; and Nancy Campbell, President, CSGNA
REPORT FROM EDUCATION DIRECTOR

SCHOLARSHIPS:

CAG scholarships: This year we are very fortunate that CAG has chosen to fund 2 nurses one as a Research nurse and the other as an Endoscopy nurse to attend the World Congress in September 2005. This is done only this year because there are no CDDW conference being held this year. The lucky winners are Linda Feltham and Rachelle Thibeault-Walsh.

Carsen has generously offered 30 scholarships of $500.00. 12 will be awarded to Central and Western Canada and 6 for the Eastern Canada. The successful recipients will be notified in June.

SciCan has generously offered a scholarship of $1,500.00. They have asked that each Chapter submit a name of a colleague who is outstanding in his/her work. In June they will pick a name to select the successful applicant.

CSGNA scholarship: We have received 29 applications and we will be offering 12 scholarships. We encourage the ones that did not win the scholarship to reapply for the following year. This year is an exceptional year because it is a World Congress so we received many requests. Each year is different so everyone is eligible to reapply if unsuccessful the first time.

Certification: At the time of printing of this report we are unable to obtain numbers of nurses who have written the certification exam for 2005. The only thing I can tell you is that CNA was very proud of the number of registrants for the Gastroenterology exam. Congratulations to the ones who registered and committed to writing the exam. We are very proud of such a fine group of nurses.

Our goals for the year to come:
• Develop a study module for ERCP
• Develop a manual for studying for certification
• Revise the orientation manual and have it ready for distribution at the Fall conference
• Take an active role in obtaining contact hours for the World Congress
• Revise the orientation manual on reprocessing flexible endoscopes to ensure most recent guidelines are up to date.
• Present at the annual conference a new program for the ones who want to write the certification exam in which we will offer a mock exam, tips on how to prepare for this exam and we will select different topics not discussed during the main conference so that a larger group of people wanting additional learning opportunities can attend as well.

Michele Paquette CGRN; CGN(C)

Included below are the recipients for the Carsen Scholarships. Congratulations to all of the recipients:

WEST
L. McGeough
E. Matthews
D. Dunford
D. Ryan
M. Dorais
L. Buchanan
J. McCalla
M. Wild
D. Bourgeois Burton
G. Lazarian
C. Schultz
I. Ohly

CANADA CENTER
K. Rhodes
E. Binger
K. Williams
J. Macnab
J. Hoover
M. Lafrance
N. Januszewski
E. Nyentap
D. Joncas
A. Child
E. Hill
J. McKechnie
K. Bonner
M. Zimmerman

EAST
L. Feltham
L. McGee
E. Coady
L. Nash

DIRECTOR PRACTICE REPORT

The position statements published in this issue have been revised. We are working on completing Personal Protective Equipment and Jewellery and False nails; updating Charting and Conscious Sedation Guidelines.

There have been numerous questions that have been sent in and have led us to new challenges and future plans to expand our horizons. Please continue to send comments and questions to any one of us on the executive.

Congratulations to those who wrote the exam in April! I look forward to seeing all of you in September in Montréal. My email address is bstefanac@smgh.ca.

Sincerely Branka Stefanac

CANADA EAST REPORT

As the summer approaches we here on the east coast anxiously await its arrival. For many of us it has been a cold or soggy spring. Chapters are winding down for the summer. Some have held or are holding their final education session or meeting.

ADVERTISING

The CSGNA Newsletter “The Guiding Light” welcomes requests for advertisements pertaining to employment. A nominal fee will be assessed based on size.

For more information contact the editor.
lesliejoy@sasktel.net
Newfoundland Chapter

On June 11th, 2005 the NFLD chapter held a great education day. Topics presented by physicians included medical and surgical management of IBD, and a great discussion on Hepatitis C. The nursing component to the day included a talk given on Celiac Disease, Infection Control and reprocessing in the endoscopy setting, and a session on “New Bugs” coming our way. Approximately 30 attended. Feedback on the day was positive.

New Brunswick/PEI Chapter

The NB/PEI chapters have a new executive. Welcome on board Patricia McPhee as president and Kelly Conway as secretary. We appreciate them stepping in and keeping the chapter alive. They plan to hold a chapter meeting during their attendance at the meeting in Lunenburg.

Nova Scotia Chapter

The NS chapter is hosting the nursing component at this year’s Atlantic GI Meeting being held in Lunenburg, NS, June 23rd-25th, 2005. Thirty-two members are registered with a number coming from out of province. They would like to say thanks to the Atlantic Society of Gastroenterologists for once again including nursing into their program. Past meetings have proven to be of great educational value.

Wishing you all a safe and fun filled summer. See you in Montreal!

Respectfully Submitted by Joan Rumsey RN, CGN(C)

DIRECTOR OF CANADA CENTRE REPORT

Spring is here and it is time to dust off the cobwebs and wake up from the cold and dark winter days. The second Gastroenterology Certification Exam was written in April – good luck to all those who participated.

I had the opportunity to interact with the presidents of each Chapter of Canada Centre and discuss different ideas which could keep our members abreast of all the new developments that are occurring.

The Credit Valley Hospital is organizing a GI education evening on May 3, 2005 for the Golden Horseshoe Chapter on Gastric Variceal Gruing and GI Complications of Liver Disease. 87 participants have registered. The event is sponsored by Boston Scientific, Steris, Pentax and Cook. Next session will be hosted in Hamilton in November and the topic will be on Crohns Disease and Remicade.

The Central Ontario Chapter held an educational session on April 26, 2005 on Hepatitis “C” with regards to current treatment and findings in an endoscopic setting. The event was hosted by Roche Pharmaceutical.

On April 5, 2005 the Greater Toronto Chapter hosted an educational evening “Hidden Hernia: Diverticulosis and Diverticulitis” sponsored by Boston Scientific. It was a great meeting. On June 14th the chapter will present its last educational session before the summer on “Survivor: A Therapeutic Approach” and “Nurse Led Flexible Sigmoidoscopy – 2 year Pilot Project.”

The South Western Ontario Chapter has organized an educational seminar for May 30, 2005 on “ERCP: Indications and Possible complications.”

The London Area Chapter held an educational session March 29, 2005 on “Endoscope Ultrasound”, the event was well attended. A new executive was also elect: President – Melanie Lankin, secretary – Dale Glover and the treasurer – Rosa Crecca. In June another session will be held and a pharmacist will present “Drugs that are commonly used in Endo”.

The Ottawa Chapter will host on June 22, 2005 an educational session on “Remicade: From Joint to Gut” which will be presented by a rheumatologist and the Remicade nurse coordinator.

On April 26, 2005 the Montreal Chapter organized an educational session on “Nosocomial Infection: Review and Update” sponsored by Boston Scientific. The event was a success. As Montreal will be the host city for the WCOG, they are looking into different ways of obtaining support from local businesses.

I want to wish everybody a nice summer and we will see you in September at the WCOG.

Regards,
Monique Travers RN, CGN(C),
Director of Canada Centre

CANADA WEST DIRECTOR REPORT

I report for the last time as Canada West Director, after a double term. I wish to express to everyone that the past four years has been a truly enriching experience for me, both professionally and personally. The C.N.A. Certification is a validation and acceptance into a greater world of Gastroenterology Nursing. Each Chapter of the West is proudly able to announce that they had members achieve Certification Status this year. Congratulations!

Being involved with the CSGNA at any level sets you up for achievement. Your Nursing Practice is more guided and adjunctively enhanced by

Please contact me about any comments you may have about this newsletter or any ideas for future issues.
Leslie Bearss, Newsletter Editor.
Email lesliejoy@sasktel.net

CSGNA MEMBERSHIP FEES ARE NOW $50.00 PAYABLE BY JUNE 1st.
being part of this group of specialized nurses. Patient Care becomes exemplary, almost naturally!

I will miss the regular communication from each of the 8 Chapters of the West. I will also miss the lively and driven discussions presented at the Executive Board meetings and being part of many commendable professional outcomes. It has been a wonderful time!

Welcome Joanne Glen into this position representing such a great group of dedicated GI Nurses!

Kamloops and Region Chapter
President Maryanne Dorais is proud to be sporting her new gold C.N.A pin. The Chapter has 12 members now and 3 will be attending the WCOG. They will be attending an Education session in Kelowna next week. Planning continues for their Education Day to be held in October.

Edmonton Chapter
Edmonton’s new Chapter President, Yvonne Verklan congratulates members Dianne Fuson and Corey Chuba who are now C.N.A Certified.

Eight members will be attending the WCOG in Montreal.

The chapter’s fall conference called “Celiac – A Closer Look” will be held on Saturday, October 29th at the Misericordia Hospital in Edmonton. Watch for posters and brochures, as well as the website “Upcoming Events” for more information.

Okanagan Chapter
Featured in this issue of the Guiding Light “What’s the Scope? Spotlight on the GI Unit,” Chapter President Bethany Rode is pleased to present The Okanagan Chapter.

Regina Chapter
The chapter raffled off two baskets to celebrate GI nurses day. A Chapter meeting on May 30 was held to begin planning for the ever-popular annual ‘GI Days’ Conference set for the fall. They are gearing up as well for the National CSGNA Conference – Regina 2006. Five nurses from the chapter are going to Montreal in September.

Manitoba Chapter
The Manitoba Chapter hosted their highly successful and informative Spring GI conference on April 23. 55 attended. Enlightening sessions included a talk by Dr. C. Andrew on Bariatric Surgery. Dr. Michelle Alfa spoke on Infection Control in the G.I. Unit. Sylvia Dolyanchuk represented an organization that takes discarded medical supplies to less fortunate areas of the world.

Dr. Vincent Taraska gave a good review of the practice of Bronchoscopy. Phyllis Reid-Jarvis RD spoke on nutrition and exercise and the importance of energizing in healthy ways.

Chapter Secretary Sue Drysdale and one other member attended the SGNNA Annual Course in Minneapolis. The next Manitoba Chapter meeting will be held in Brandon. A representative number of Manitoba nurses look forward to attending the World Congress.

Vancouver Island Chapter
Vancouver Island Chapter President Irene Ohly is happy to report that 3 members from Victoria are looking forward to Montreal in September. Others members from the Island are planning to attend as well.

Congratulations to Shirley McGee and Marilyn Doenel from Victoria who wrote the certification exam and received their C.N.A pins.

Calgary Chapter
President Evelyn Mathews reports that two more members are now using CGN(C) after their name!

During Nurses week, the Calgary Chapter recognized Doreen Reid and Sherry Pelensky from the Alberta Children’s Hospital, for their commitment to pediatric GI nursing and support of chapter activities. The GI nurses in the Calgary Health Region were treated by both Cook Canada and Boston Scientific during Nurses week. Pizza, fruit and desserts were enjoyed on each of these occasions.

An educational session “Overview of Enteral Stents” presented by Dr. Syd Bass and sponsored by Boston Scientific was held on June 9 at a popular Thai restaurant. Four members from the chapter are planning to attend the World Congress.

Vancouver Regional Chapter
The Vancouver Regional Chapter had a successful Education Day held on April 9 as President Adriana Martin reports. Almost 40 members attended and enjoyed the speakers and the events of the Day. The focus was on the Liver. Several members are registered to attend the WCOG. The Chapter now has 2 more C.G.N.(C)’s.

Respectfully Submitted by
Nala Murray RN, CGN(C)

PUBLIC RELATIONS DIRECTOR

REPORT

It is certainly an exciting year with the upcoming World Congress Meeting September 12, 2005 to September 14, 2005 in Montreal! This will be a wonderful opportunity to meet with fellow Gastroenterology Nurses from around the world and learn what’s new in GI! Please take the time to review the WCOG Nursing Program at www.csgna.com. Don’t forget the Foundations course that is being offered on Sunday September 11, 2005. This is designed to help prepare you for certification as well as refreshing your knowledge in GI. Registration forms for WCOG are available on-line.

The CSGNA website is a valuable tool to keep up to date with what’s happening around the country. We have recently received employment opportunities that have been posted on our website. Please remember to submit your local education events to belbeck@hhsc.ca for posting on the website.

Please forward any suggestions or ideas of what you would like to see on the CSGNA website to belbeck@hhsc.ca.

Jennifer Belbeck
Public Relations Director
DEAR COLLEAGUES

The financial report for the year 2004 was submitted and prepared by our accountant at Pricewaterhouse-Coopers LLP Chartered Accountants for our annual review.

The majority of our funds are kept in Term Deposits to earn as much interest as possible. These Term Deposits are guaranteed with no risk to our funds. We keep a minimum balance in both our operational and educational account to maximize our return. The term deposit are returned to the appropriate account as required.

The funds in our operational account come from:
- Membership dues
- National conference registration
- Exhibitor booths
- Support from our sponsors

The funds in our educational account come from:
- 25% profit each chapter submits after educational events
- Scholarships from our sponsors
- Market Place
- Silent Auction

Any questions or concerns regarding YOUR money please contact myself or any member of the Executive.

As my term is coming to an end I wish to thank everyone very much for the opportunity to serve on the board. It has truly been an educational experience for me both professionally and personally. I have met and worked with a wonderful group of nurses over the 11 years I was on the board. I think anyone who has the chance to be a board member should jump at the opportunity, I am sure you would never regret it.

Sincerely Edna Lang, CSGNA National Treasurer

MEMBERSHIP DIRECTORY REPORT

At present, we have 483 members. We have seen great growth in new membership, welcoming 128 new members since January of this year. Renewals are lower, perhaps because in other years, many members renewed their membership with registration to the Annual Conference. This opportunity is not available this year. Membership lapses automatically if payment is not received by the deadline. This is in keeping with our Bylaws (6.0, 6.1).

This year, our membership cards took on a new, colourful look. Chapter affiliation is now noted on the membership cards. If the Chapter noted on your card is not the Chapter you regularly attend, please let me know and I will make the change. If you attend a CSGNA meeting in another Chapter, please be sure to have your membership card with you, as Chapters have only their list of members.

Chapter Presidents will receive a membership list of their Chapter members as of July 1st. This is the list that will be used as we implement our new “Chapter of the Year” award this September. This exciting, new award will be introduced in Montreal during our annual conference.

We are always looking for ways to increase our membership. If you have any ideas, or have had success in attracting new people to our association, or another, please contact me so that these strategies may be shared with others.

As always, if you have any question regarding membership, please feel free to contact me anytime, by e-mail or phone.

Have a wonderful and safe summer. See everyone in Montreal.

Respectively submitted
Elaine Burgis
burgis@rogers.com

ROASTED CHERRY TOMATOES

This is a great recipe to use up all those cherry tomatoes ripening in the garden too quickly!

6-8 cups cherry tomatoes
olive oil
Kosher salt
ground black pepper

1. Preheat oven to 400 degrees F (200 degrees Celsius)
2. Toss the tomatoes with olive oil on an edged baking pan. Spread them out into one layer and sprinkle with salt and pepper. Roast for 15 to 20 minutes, until tomatoes are soft.
3. Transfer the tomatoes to a serving dish. Sprinkle with salt. Serve hot or at room temperature.
SYNOPSIS OF CSGNA BOARD OF DIRECTORS
OTTAWA APRIL 8-10, 2005

1. REVIEW/ADDITIONS/ADOPT THE AGENDA
   A motion was passed to adopt the agenda Usha/Branka

2. APPROVAL FOR THE NOVEMBER EMAIL MEETING
   Motion to accept minutes of the email meeting Michelle and Edna.

3. WGOC: Update on the agenda and the progress thus far was presented by Cindy Hamilton. Congress will give $65.00 per registration to SIGNEA; the remainder of the registration fee will be retained by the WGOC organisation committees. This has lead to limited financial resource. The money raised as a result of silent auction or 50/50 draw will be shared equally between SIGNEA and CSGNA.

4. REPORTS: CANADA EAST, WEST AND CENTRE: Local chapter educational events are planned for mid to late spring. These events will be acknowledged in each director’s report.

5. MEMBERSHIP: Currently there are 660 members. A motion was passed to add a new category of membership for non-active CSGNA members. This is open to previous active CSGNA member who are no longer practising Nurses. These members will pay 50% of the current membership rate and will receive a guiding light. A proposal was suggested to make membership compulsory with annual conference Registration. This will start in 2006 in Regina. Additional cost for non-member to attend the conference will be $75.00 which will include one year’s membership to the CSGNA.

6. NEWSLETTER: The new sponsor for the guiding light for the next 2 years is Carsen. In the future guidelines will be set for prospective sponsors of the guiding light to avoid any future disappointment. This may also necessitate a bidding process for the best offer. There is always a need for interesting articles for The Guiding Light.

7. EDUCATION: Michele Lesley Anne Patry C.N.A. is putting together a document for starting a study group. Hopefully this will be approved for the foundation 2005 which will be offered at the WGOC in Montreal. Lesley Anne will be at the foundation personally to present this information. Michelle is in the process of putting together a study guide for the GI certification.

8. CANADIAN STANDARD ASSOCIATION (CSA) REPORT: Nancy and Michelle attended the January CSA meeting and worked on the infection control document with Michelle Alfa. CSA would like the same person to attend the meeting. It was decided that Michelle would be the best person to attend this meeting. The next meeting is scheduled in Halifax, July 2005.

9. PUBLIC RELATIONS: These changes include advertising the market place to promote items such the orientation manual, study guide, reprocessing manual, and the standard of practise. At the current time we are not in a position to take orders on the website but an order form can be printed from the website which can be completed and faxed. Members need to be kept up-to-date with ongoing education event information and upcoming conferences. Other suggestions for the website were: a photo gallery of past annual conferences, a chat room for the members to discuss issues and posting surveys. A link to C.N.A will also be added on the website. This is excellent time to offer website support to other vendors. A number of changes are required on the website. The public relation portfolio needs to be revised to a vendor/sponsor role and maintenance of the website. The conference planning will be handed over to the president elect. A motion was passed to transfer the conference planning responsibility to the president elect.

10. MARKETPLACE: Joan reported that the 50/50 draw at the annual conference generated $500. This was an easy fundraising and did not cost a lot of time or money. If we are to have it again this year we will need extra people to help. There are 50 luggage tags remaining from last year. A motion was passed to purchase 200 more luggage tags and give them to each registrant at the 2005 SIGNEA/CSGNA conference at the WCOG.

11. PRACTICE DIRECTOR: The final version of the infection control guideline was presented and this document will be posted on the website. Personal protective equipment (PPE) guideline is almost ready to be placed on the website. Jewellery, false nails need to be formatted and will be ready soon. Future guidelines that will be developed in the upcoming year will be using the same scope for upper and lower endoscopic procedure and enteroscopy using the paediatric colonoscope.
12. **TREASURER:** Edna presented the annual report concerns about the deficit for World Congress were addressed and discussed.

13. **BYLAWS** Deb is reviewing the bylaws and there seems to be number of discrepancies in the wording. She will edit these and will forward the changes to the board members. A question was raised last year from a member at large regarding re-electing past presidents. In the event that this may occur the past president can run as president elect. Deb will look at other organizations and review their bylaws to see if this is possible.

14. **VENDOR MEETING:** The purpose of the meeting was to present CSGNA vision and mission at the national level and to get feedback from the Vendors on how to attain this vision. Our goal is to increase the scholarships funds which will allow nurses from across Canada to attend the annual conference, provide education support and support GI certification. In return this will increase quality of care we provide for the patients. Currently there are 12 CSGNA Scholarships @ $500 we hope to increase this to 12 scholarships @ $1,000. How can CSGNA increase the Scholarships?

15. **GUEST SPEAKER:** Gail Attara the executive director for CSIR is lobbying against the government medication rationing policy. Therapeutic substitution for Proton Pump Inhibitor (PPI) use is a policy brought in effect as of 2003 in British Columbia and will soon be moving across the country. This policy stipulates that all patients on stable dose of PPI be switched to designated brand name PPI and new patients be started on the designated brand name PPI. Patients are mandated to use this PPI for 8 weeks. If there is failure on this drug the physician must then apply for special authority to start or resume the old PPI. Gail wanted the CSGNA executive board members to be made aware of this policy and their society who also provides patient education brochure for patients with GI disorder.

Submitted By Usha Chauhan CSGNA Secretary

---

CHANGE OF NAME/ADDRESS

NAME: ____________________________

NEW ADDRESS: ______________________

CITY: ___________ PROVINCE: __________

POSTAL CODE: __________ PHONE: __________

FAX: __________ E-MAIL: __________

[Send change of name/address to the Membership Director]
Spotlight on the GI Unit,
Okanagan Chapter of the CSGNA

Kelowna is a gorgeous city located directly on Okanagan Lake in South Western British Columbia. The population including the surrounding area is approximately 120,000 people and Kelowna General Hospital (KGH) is the only Hospital service within the city.

We are a separate unit attached to the Ambulatory Care area of KGH. Since we perform many therapeutic GI procedures, the surrounding smaller city hospitals send patients to our unit. This extends our area of service to the Kootenay and Cariboo regions of the Province.

We have 6 Gastroenterologists and another scheduled to start in July. Three General Surgeons and three Thoracic Surgeons also do endoscopic procedures on our unit.

Our average numbers are 18-30 procedures per day for a total of 6500 or more, as of last year.

Our Unit is open Monday to Friday from 700-1800hrs.

One RN works on Sundays from 0800hrs to provide for a few inpatient procedures (usually a 4 hour shift)!

There are 8 Daycare beds in our unit for admission and recovery. We have an ‘overflow’ contingent in ‘Ambulatory Care’, (a few days per week), which increases our bed numbers to 12. We have 3 procedure rooms.

We are exclusively, a G.I. Endoscopy Unit. The largest percentage of the care we provide is to patients who are undergoing Colonoscopy and Gastroscopy procedures.

The Cancer Center is attached to our hospital so we also receive many referrals for PEG feeding tube placements to assist with nutrition during radiation and chemotherapy treatments.

We do between 3 and 5 ERCP’s each day in our Radiology Department. We take our portable cart and equipment over for each of these procedures.

We serve a large patient population with Liver Disease. Many require variceal banding, injecting or glueing. We also see many patients who require clipping or injecting to stop active bleeds.

2 of our RN’s have been trained to do Esophageal Motility tests they are done a few times per month.

We are 11 Registered Nurses and 1 clerk. 7 of us are Certified, either CGN(C) or CGRN and at least 1 more will be writing the CNA exam next spring. 1 of our RN’s is our Care Coordinator and is mainly responsible for assisting the Docs with ERCP’s as well as ordering supplies and just generally keeping everyone on task. Each of us is responsible for the manual reprocessing of scopes post-procedure and our clerk assists with loading and unloading the Automatic Endoscopic Reprocessors(AER) machines as well as maintaining our unit office.

Such a great group! Everyone works really well together and it feels like an ‘extended family’. One of our biggest challenges is having enough time to get all the work done that is needed and wait lists are ever growing!

Respectfully Submitted by
Bethany Rode, President,
Okanagan Chapter of CSGNA

SCHOLARSHIP REQUESTS SHOULD BE SENT TO THE EDUCATION DIRECTOR BEFORE THE DEADLINE ON APPLICATION FORMS.

GUIDELINES FOR SUBMISSION to “THE GUIDING LIGHT”
• white paper with dimensions of 81/2 x 11 inches
• double space
• typewritten
• margin of 1 inch
• submission must be in the possession of the newsletter editor 6 weeks prior to the next issue
• keep a copy of submission for your record
• All submissions to the newsletter “The Guiding Light” will not be returned.

C.S.G.N.A. DISCLAIMER
The Canadian Society of Gastroenterology Nurses and Associates is proud to present The Guiding Light newsletter as an educational tool for use in developing/promoting your own policies and procedures and protocols.

The Canadian Society of Gastroenterology Nurses and Associates does not assume any responsibility for the practices or recommendations of any individual, or for the practices and policies of any Gastroenterology Unit or endoscopy unit.
The Guiding Light, July 2005

The Okanagan Chapter
CSGNA CHAPTER EXECUTIVE LIST

BRITISH COLUMBIA
Vancouver Island Chapter
President: Irene Ohly
Victoria General Hospital,
Endoscopy Unit
#1 Hospital Way,
Victoria, BC V8Z 6RZ
250-727-4234 (W)
250-727-4317 (Fax)
Email: iohly@shaw.ca
Secretary: Shirley McGee
Treasurer: Donna Gramigna

Vancouver Regional Chapter
President: Adrianna Martin
Lions Gate Hospital,
Endoscopy Suite 231
East 15th Street,
North Vancouver, BC V7L 2L7
604-988-3131 ext. 4341 (W)
604-980-8003 (Fax)
Email: aem46@shaw.ca
Secretary: Monica Brennan
Treasurer: Nonie Hodgson

Okanagan Chapter
President: Bethany Rode
Kelowna General Hospital
Gastroenterology Unit
2268 Pandosy Street,
Kelowna, BC V1Y 1T2
250-868-8465
Email: behl@shaw.ca
Secretary: Jean Tingstad
Treasurer: Debra Hodgson

Kamloops and Region Chapter
President: Maryanne Dorais
Ambulatory Care Unit
Royal Island Hospital
311 Columbia,
Kamloops, BC V2C 2T1
Email: maryamedorais@shaw.ca
Secretary: Sandra Henderson
Treasurer: Lori Taylor

ALBERTA
Calgary Chapter
President: Evelyn Matthews
112 Penny Lane,
Stillwater Lake, NS B3Z 1P5
902-473-4006 (W)
Email: evelynmcmullen@ns.sympatico.ca
Secretary: Suzanne Winter
Treasurer: Lisa McGee

Edmonton Chapter
President: Yvonne Verklan
Misericordia Community Hospital
Endoscopy Unit
16940-87 Avenue,
Edmonton, AB T5R 4H5
Email: yvolver@gmail.com
Secretary: Anna Bang
Treasurer: Marla Wilson

SASKATCHEWAN
Regina Chapter
President: Linda Buchanan
G.I. Unit, Pasqua Hospital
4101 Dewdney Avenue,
Regina, SK S4T 1A5
306-766-2441 (W)
Email: l.buchanan@sasktel.net
Secretary: Dianne Ryan
Treasurer: Susan Latrace

MANITOBA
Manitoba Chapter
President: Jennette McCalla
Grace Hospital, Endoscopy Unit,
2nd Floor, 300 Booth Drive,
Winnipeg, MN R2Y 3M7
204-837-8311 ext 2120 (W)
Email: jennettemc@shaw.ca
Secretary: Susan Drysdale
Treasurer: Donna Dunford

ONTARIO
Ottawa Chapter
President: Therese Carriere
Ottawa General Hospital
Riverside Campus
Ottawa, ON
Email: d.carriere@rogers.com
Secretary: Francine Nyventap
Treasurer: Micheline Lafrance

Golden Horseshoe Chapter
President: Joan McKechnie
304 Biehn Drive,
Kitchener, ON N2R1C6
519-748-2729
Email: c/o gibranka@rogers.com
Secretary: Suzanne Burgess
Treasurer: Margaret Hackert

Central Ontario Chapter
President: Jean Leigh
RR 1, Hillsdale, ON L0L 1V0
705-835-5389 ext. 6218 (W)
705-728-9802 (Fax)
Email: leighj@rvh.on.ca
Secretary: Linda Denis
Treasurer: Heidi Furman

South Western Ontario Chapter
President: Joan Staddon
Hotel Dieu Grace Hospital
1030 Ouellette Avenue,
Windsor, ON N9A 1E1
519-973-4411 Ext. 3241 (W)
519-255-2103 (Fax)
Email: joanstaddon@hotmail.com
Secretary: Janice Sutton
Treasurer: Theresa Berthiaume

Greater Toronto Chapter
President: Cathy Bidwell
St Michael’s Hospital
60 Bond Street,
Toronto, ON M5B 1W8
416-846-5001 Ext. 5601
Email: bidwellc@smh.toronto.on.ca
Secretary: Donna Jucora
Treasurer: Jacqueline Ho

London and Area Chapter
President: Melanie Larkin
London, ON
Email: mellanka@aol.com
Secretary: Dale Glovert
Treasurer: Rosa Crecca

QUEBEC
Montreal Chapter
President: Georgiana Walter
528 White Crescent,
Greenfield, QC J4V 1G1
514-843-1667 (W)
Email: gwalter47@hotmail.com
Secretary: Salima Yip Hoi
Treasurer: Lidia Sunak-Ferguson

NEW BRUNSWICK & PEI
New Brunswick & PEI
President: Pat McPhee
64 Lynden Drive,
Quispamsis, NB E2E 4J3
1-506-849-8276
Email: pmcp@nb.sympatico.ca
Secretary: Kelly Conway
Treasurer: Position Vacant

NOVA SCOTIA
Nova Scotia Chapter
President: Evelyn McMullen
19 Forde Drive,
St. John’s, NL A1A 4Y1
709-737-6431 (W)
Email: ellencoady@hotmail.com
Secretary: Tracey Walsh
Treasurer: June Peckham

NEWFOUNDLAND
Newfoundland Chapter
President: Ellen Coady
19 Forde Drive,
St. John’s, NL A1A 4Y1
709-737-6431 (W)
Email: ellencoady@hotmail.com
Secretary: Tracey Walsh
Treasurer: June Peckham
The Guiding Light, July 2005 Page Fifteen

The Big LeBowelski
by Ali MacDonald

Transverse

3. Word before job or plow
4. Passage of bloody stools
7. Candid camera?
11. To Sir With Love singer
12. Emergency exit?
15. "Sea!"
22. Gridlock?
21. Acid (protein)
22. Ready for customers
23. Parasympathetic innervation to right portion is derived from this nerve
24. Disease found in 16% of the population of developed nations
27. Explosive letters
28. Wastout
29. Break and enter?
30. Personal transport
31. Night time Jay
33. Promoting growth
34. Hereditary polyposis syndrome
35. Contrast barium enema
37. Delicious?
40. Entreaty
42. Going down?
44. Pub quiaff
49. Middle section
50. prvay
52. Word before deck or out

56. __________ colitis. (Acute inflammation of the bowel mucosa)
58. Spring month
59. Inflammation of the intestine
61. Left at the spleen?
63. Production workers?
64. Not capture
65. Abnormally distal colon
71. __________ polyposis coli
73. Glove
75. Syndrome with familial polyposis, osteomas, fibromas, and epithelial cysts
76. Pincers
77. Morning
78. Sustenance
80. Fibre source
82. 2006 National Conference location
84. Inflammation of the colon
87. Top RC
88. Diamond
89. Geeze formation
90. Unstable
91. Blood
92. "A mouse!"
93. Neonatal ulcerations of the GI tract

Descending

1. Cranky innards?
2. Bossy's comment
3. Catch and burn tool
5. Goal
6. Absence of myenteric ganglion cells in the distal colon
8. Regional enteritis
9. Enthusiasm
13. Chagas' Disease
14. Intractable 20 transverse
16. Needs Preparation?
17. Task
18. Can cause melanosia coli
19. Vascular dilations in the submucosa
26. __________ and behold
26. Evacuation maneuver?
27. Orange beverage
32. Yogi would like one
34. Afternoon
35. Former spouse
36. Chronic constipation resulting in involuntary leakage
39. Finish
41. Tide type
43. Second most common cancer
45. Angel's head gear
46. Going up?
47. Unwelcome guests?
50. End of the line?
51. Dishonorable discharge?
53. Aluminum wrap
54. GI Nursing org.
56. Bigfoot
57. What Scrooge would say if he was sheepish?
60. Produced by adaptation to tenia coli
62. Right at the liver?
65. Ileoceleval valve?
66. End of the descent?
67. Inert gas used in lasers
69. Large one is 90 to 150cm long
70. So be it
72. Ect
74. Paralytic _______ (obstruction of the intestine)
76. RDA is 25g per day
79. Some people are full of it
81. Ship wrecker
83. Mild explicative
85. Endure
86. ______ or not...
90. Metal container
We Need You To Get Involved With CSGNA!

We welcome all members to become involved with CSGNA. We have committees that need membership participation. Please contact the following executive for more information:

By-law committee – Deb Taggart – President Elect – debra.taggart@calgaryhealthregion.ca

Standards of Practice – Branka Stefanac – Practice Director – bstefanac@smgh.ca

Education – Michele Paquette – Education Director – michpaquette@rogers.com

Membership – Elaine Burgis – Membership Director – burgis@rogers.com

Conference Planning – Jennifer Belbeck – Public Relations – belbeck@hhse.ca

Newsletter – Leslie Bearss – Newsletter Editor – lesliejoy@sasktel.net

If you would like to become more involved at the local level, please contact your Chapter President or the National Director in your area:

Canada West – Nala Murray – nala_murray@telus.net

Canada Centre – Monique Travers – mtravers@rogers.com

Canada East – Joan Rumsey – hcc.rumj@hccsj.nf.ca

HOW TO REGISTER FOR MONTREAL 2005

Enclosed in this issue of the newsletter are registration forms for the World Congress 2005 to be held in Montreal September 10th to 14th. There is only one form for both Physician and Nursing Courses.

Instruction:
• PLEASE do not fax in registration as faxed forms will not be accepted
• Mail or email to the WCOG address on the form.

FOR CONFERENCE REGISTRATION

Fill in your demographic data for the first part of the form

GO TO SECTION C SIGNEA

Fill in section D

Added Social Programs are on the back of the registration form if interested.

FOR HOTEL REGISTRATION

• The Congress has blocked all hotels in the downtown Montreal area.
• PLEASE do not fax in registration as faxed forms will not be accepted
• Mail or email to the WCOG address on the form.

Fill in your demographic data for the first part of the form

Choose hotel by category and price listed on back of form

Space may be limited at chosen hotels so register early
### E. Social Program (continued)

<table>
<thead>
<tr>
<th>Event</th>
<th>Price</th>
<th>Code</th>
<th>Amount due</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening Ceremony &amp; Welcome Reception, September 11</td>
<td>$25</td>
<td>103</td>
<td></td>
</tr>
</tbody>
</table>

#### Spouses and Accompanying Persons

- **Accompanying Persons Program (Tours are offered from September 10 to 14 inclusively)**
  - Opening Ceremony & Welcome Reception, September 11
  - Old Montréal Walking Tour
  - Bateau Mouche Cruise (without lunch)
  - Biodome and Botanical Gardens & Biodome Tour
  - Bateau Mouche Cruise (including lunch)
  - Folk Luncheon at Cabane à Sucre
  - Discover Montréal
  - Bateau Mouche Cruise (without lunch)
  - Biodome and Botanical Gardens & Biodome Tour

**Select one of the following:**

- Bateau Mouche Cruise (without lunch) $175 050
- Biodome and Botanical Gardens & Biodome Tour $50 105

**Select one of the following:**

- Incl. Accompl. Pers. Fee

**Tickets for Spouses Not Taking Part in the Accompanying Persons Program**

- Opening Ceremony & Welcome Reception, September 11 $25 106
- Canada Night, September 13 $50 107

### Tours and Excursions (Individual Tickets for Congress Participants and Spouses not Taking Part in the Accompanying Persons Program)

<table>
<thead>
<tr>
<th>Tour</th>
<th>Price</th>
<th>Code</th>
<th>Amount due</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discover Montréal</td>
<td>$30</td>
<td>120</td>
<td></td>
</tr>
<tr>
<td>Old Montréal Walking Tour</td>
<td>$14</td>
<td>123</td>
<td></td>
</tr>
<tr>
<td>Biodome and Botanical Gardens &amp; Biodome Tour</td>
<td>$40</td>
<td>124</td>
<td></td>
</tr>
<tr>
<td>Bateau Mouche Cruise (without lunch)</td>
<td>$39</td>
<td>125</td>
<td></td>
</tr>
<tr>
<td>Bateau Mouche Cruise (including lunch)</td>
<td>$68</td>
<td>126</td>
<td></td>
</tr>
<tr>
<td>Folk Luncheon at Cabane à Sucre</td>
<td>$65</td>
<td>127</td>
<td></td>
</tr>
<tr>
<td>Cooking Class</td>
<td>$160</td>
<td>128</td>
<td></td>
</tr>
<tr>
<td>Laurentian Day Trip</td>
<td>$89</td>
<td>129</td>
<td></td>
</tr>
<tr>
<td>Québec City Day Trip</td>
<td>$82</td>
<td>130</td>
<td></td>
</tr>
<tr>
<td>Ottawa, National Capital Day Trip</td>
<td>$105</td>
<td>131</td>
<td></td>
</tr>
</tbody>
</table>

### Payment

Payment must be made in USD. Please state your name and address clearly on cheques and money orders.

The total amount due (as calculated):

- Credit card (recommended method of payment)
  - Type of Card: □ AMEX □ VISA □ Mastercard □ Diners Club
  - Card Number
  - Expiry date (m / y) [mm / yy]
  - CVC code (last 3 digits on the back of the card), except Amex

Cardholder’s name

Cardholder signature

- Remitted by enclosed cheque payable to CONGRES HOLLAND BV, P.O. Box 302, 1000 AH Amsterdam, The Netherlands (Personal or company cheques cannot be accepted). Include your family name and mention “Registration fee”. Bank fees must be included.
- Remitted by bank transfer to ABN AMRO Bank, Vrijestraat 68 & 78, Amsterdam, The Netherlands, Account number: 54.16.32.167 BIC: ABNANL2A, IBAN: NL97ABNA0541632167. Include your family name and mention “Registration fee”. Bank fees must be included.

### Cancellations and Refunds

Notification of cancellation of registration, social program, tour reservations must be submitted before July 15, 2005 in writing to the WCOG 2005 Secretariat. For cancellations received before July 15, 2005, a refund will be issued after the congress, less the following administration fees: Registration $75 USD; Social Program and Tours $20 USD.

For cancellations received after July 15, 2005, no refunds will be granted.

Signature

Date (d / d) (m / m) (y / year)

*By signing this form I accept the cancellation policies.*
HOTEL RESERVATION FORM

World Congress of Gastroenterology 2005, September 10-14, Montréal, Canada

Please return this form to:
WCG 2005 Secretariat
P.O. Box 302, 1000 AH Amsterdam
The Netherlands

Tel.: +31 20 50 40 204
E-mail: wccg2005reg@congres.nl
Faxed forms will not be accepted

Please return this form to:
WCG 2005 Secretariat
P.O. Box 302, 1000 AH Amsterdam
The Netherlands

Tel.: +31 20 50 40 204
E-mail: wccg2005reg@congres.nl
Faxed forms will not be accepted

FILL IN ONE COPY PER REGISTRANT. PLEASE TYPE OR PRINT CLEARLY AND PROVIDE INFORMATION AS YOU WISH IT TO APPEAR ON YOUR BADGE.

Title
prof. dr. mr. ms

Family name

First name

Company/Organisation

Department

Address

City

State

Postal Code

Country

Phone (country-area-local)

Fax (country-area-local)

E-mail

DEADLINE FOR RESERVATIONS: JULY 15, 2005

See reverse for hotel listing, map and prices.

Preferred hotel: 1. Code: [ ] 2. Code: [ ] 3. Code: [ ]

Date of arrival
09/20/2005
Date of departure
09/20/2005

Number of nights

One bed

Two beds

Non-smoking

Wheelchair accessible

Early arrival

Late departure

The WCG 2005 Secretariat reserves the right to book you into another hotel should the desired category be fully booked.

Rooms will only be booked after receipt of a credit card guarantee. Rooms will be booked on a first-come-first-served basis and based on availability.

Mandatory Guarantee

Credit card: (recommended method of guarantee)

Type of Card:

AMEX

VISA

Mastercard

Diners Club

(Card must be valid at the time of WCG 2005)

Card Number

Expiry date

CVC code (last 3 digits on the back of the card), Except Amex

Cardholder’s name

Cardholder signature

In case you do not have a credit card, a deposit of $300 USD is required. The deposit can be paid by one of the following options:

Remitted by enclosed check payable to CONGREX HOLLAND BV, P.O. Box 302, 1000 AH Amsterdam, The Netherlands (Personal or company cheques cannot be accepted). Include your family name and mention “Hotel Deposit”. Bank fees must be included.

Check no.

Remitted by bank transfer to ABN AMRO Bank, Vijzelstraat 68 & 78, Amsterdam, The Netherlands, Account number: 54.16.32.167 BIC: ABNANL2A, IBAN: NL97ABNA0541632167. Include your family name and mention “Hotel Deposit”. Bank fees must be included.

Cancellations and Refunds

Notification of cancellation of hotel reservation must be submitted before July 15, 2005 in writing to the WCG 2005 Secretariat. For cancellations received before July 15, 2005, a refund will be issued after the congress less a $50 USD administration fee. For cancellations received after July 15, 2005 no refunds will be granted.

Signature

Date

By signing this form I accept the cancellation policies.
<table>
<thead>
<tr>
<th>CATEGORY A</th>
<th>Legend</th>
<th>Rate starting from</th>
<th>Code</th>
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<tbody>
<tr>
<td>Inter-Continental</td>
<td>1</td>
<td>242 $</td>
<td>2001</td>
</tr>
<tr>
<td>Omni Mont-Royal</td>
<td>2</td>
<td>209 $</td>
<td>2001</td>
</tr>
<tr>
<td>Le Saint-Sulpice</td>
<td>3</td>
<td>210 $</td>
<td>2002</td>
</tr>
<tr>
<td>Loews Hôtel Vogue</td>
<td>4</td>
<td>265 $</td>
<td>2003</td>
</tr>
<tr>
<td>Sofitel Montréal</td>
<td>5</td>
<td>200 $</td>
<td>2004</td>
</tr>
<tr>
<td>The Ritz-Carlton</td>
<td>6</td>
<td>242 $</td>
<td>2005</td>
</tr>
<tr>
<td>W Hotel</td>
<td>7</td>
<td>228 $</td>
<td>2006</td>
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<table>
<thead>
<tr>
<th>CATEGORY B</th>
<th>Legend</th>
<th>Rate starting from</th>
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<tbody>
<tr>
<td>Auberge du Vieux-Fort</td>
<td>8</td>
<td>195 $</td>
<td>2007</td>
</tr>
<tr>
<td>Delta Centre-Ville</td>
<td>9</td>
<td>126 $</td>
<td>2008</td>
</tr>
<tr>
<td>Delta Montréal</td>
<td>10</td>
<td>181 $</td>
<td>2009</td>
</tr>
<tr>
<td>Fairmont The Queen Elizabeth</td>
<td>11</td>
<td>188 $</td>
<td>2010</td>
</tr>
<tr>
<td>Hilton Bonaventure</td>
<td>12</td>
<td>178 $</td>
<td>2011</td>
</tr>
<tr>
<td>Le Germain</td>
<td>13</td>
<td>196 $</td>
<td>2012</td>
</tr>
<tr>
<td>Hotel Nelligan</td>
<td>14</td>
<td>189 $</td>
<td>2013</td>
</tr>
<tr>
<td>Place d’Armes</td>
<td>15</td>
<td>207 $</td>
<td>2014</td>
</tr>
<tr>
<td>Wyndham Montréal</td>
<td>16</td>
<td>165 $</td>
<td>2015</td>
</tr>
<tr>
<td>XIXe Siècle</td>
<td>17</td>
<td>137 $</td>
<td>2016</td>
</tr>
<tr>
<td>Marriott Château Champlain</td>
<td>18</td>
<td>189 $</td>
<td>2017</td>
</tr>
<tr>
<td>Sheraton Centre</td>
<td>19</td>
<td>182 $</td>
<td>2018</td>
</tr>
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<table>
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<tr>
<th>CATEGORY C</th>
<th>Legend</th>
<th>Rate starting from</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Château Versailles</td>
<td>20</td>
<td>133 $</td>
<td>2019</td>
</tr>
<tr>
<td>Clarion Hotel &amp; Suites Downtown</td>
<td>21</td>
<td>140 $</td>
<td>2020</td>
</tr>
<tr>
<td>Courtyard Marriott</td>
<td>22</td>
<td>118 $</td>
<td>2021</td>
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<table>
<thead>
<tr>
<th>CATEGORY D</th>
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</thead>
<tbody>
<tr>
<td>Best Western Hôtel Europa Downtown</td>
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<td>55 $</td>
<td>2031</td>
</tr>
<tr>
<td>Best Western Ville-Marie Hôtel &amp; Suites</td>
<td>33</td>
<td>104 $</td>
<td>2032</td>
</tr>
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<tr>
<td>7:30-8:00</td>
<td>Registration</td>
<td>Management of UGI Bleeding</td>
<td>Panel Discussion: Managing Patient Comfort; The Sedation Spectrum: Moderator: Agnes Gaber, Conscious Sedation - Lori McNeough, Nurse administered Propofol, A “Hot” topic of Debate: Jo M. Harbaugh, No sedation-enteroscopy the safest way - Sarah Hamden</td>
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<tr>
<td>8:00-8:15</td>
<td>Welcome and Opening Remarks</td>
<td>Video Session</td>
<td>Opening Remarks - announcements</td>
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<tr>
<td>8:15-9:15</td>
<td>Key Note Address: Nursing in the 21st Century</td>
<td>Video Session</td>
<td>Meet The Authors</td>
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<td>9:15-10:45</td>
<td>Video Session</td>
<td>Refreshment Break and View Exhibits</td>
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<td>10:45-11:15</td>
<td>Refreshment Break and View Exhibits</td>
<td>Advances in Hepatology</td>
<td>Concurrent Sessions</td>
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<td>11:15-12:15</td>
<td>Infection Control Issues in Gastrointestinal Endoscopy: “What's New up the Wazoo?”</td>
<td>Lunch and View Exhibits</td>
<td>Developing an Educational Poster</td>
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<td>12:15-13:30</td>
<td>Lunch and View Exhibits</td>
<td>Disposable or Reusable? Device Selection in Today's Endoscopic Suite</td>
<td>Concurrent Sessions</td>
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<tr>
<td>13:30-14:30</td>
<td>Panel Discussion: Professional Development in GE Nursing</td>
<td>SIGENA Business Meeting</td>
<td>Endoscopic Ultrasound: Expanding the Scope for Diagnoses</td>
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<td>13:30-14:00</td>
<td>Panel Discussion: Professional Development in GE Nursing</td>
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<td>Refreshment Break and View Exhibits</td>
<td>Functional Testing in the GI Lab: Scoping Out What the Scope Can’t See</td>
<td>IBS – Is it all about gas?</td>
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<td>15:00-15:45</td>
<td>Refreshment Break and View Exhibits</td>
<td>Overcoming Financial Constraints While Meeting Safety Requirements in Caring for Patients with TB</td>
<td>Endoscopy in Evolution: To Infinity and Beyond</td>
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<td>15:45-16:15</td>
<td>GI Pharmacology and New Technologies</td>
<td>Corporate Vendor Panel</td>
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<td>16:00-17:00</td>
<td>Nurse’s Feet, the Ins and Outs of Foot Pain and How to Treat it</td>
<td>Corporate Vendor Panel</td>
<td>Closing Ceremony</td>
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<td>16:45-17:00</td>
<td>Free Paper Presentation</td>
<td>Corporate Vendor Panel</td>
<td>Distribution of Contact Hours</td>
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<td>17:00-17:30</td>
<td>Free Paper Presentation</td>
<td>Corporate Vendor Panel</td>
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For additional questions, contact SIGENA at signeahq@AOL.com
Infection Control
– Recommended Guidelines in the Endoscopy Setting

RECOMMENDATIONS FOR SAFETY OF PERSONNEL

Safety is of the utmost importance and should be in the forefront of each employee’s mind. Consistent practice must be maintained to prevent the spread of disease and to protect from the dangers of the chemicals used in the cleaning and high level disinfection of endoscopes. Universal precautions shall be practiced at all times. Personnel shall be immunized against Hepatitis B.

• Health care workers who have respiratory problems (i.e. asthma) should be assessed by Occupational Health prior to working with chemical germicides. Personal protective equipment (eye protection, face shield or a moisture resistant surgical mask that will not trap vapours, gloves, eye protection, and impervious gown) shall be worn.

• Moisture resistant gowns shall be worn to prevent contamination of personnel due to splashes of blood or other body fluids or injury due to chemical disinfectant/sterilant contact. The gown shall be changed between procedures.

• Protective apparel (gown and mask) shall be removed when leaving the procedure room and the cleaning room.

• Gloves shall be worn for handling and cleaning of dirty equipment as well as for any potential contact with blood or body fluids. Chemical resistant gloves (nitrile) are recommended when handling disinfectant solutions.

• All needles and sharps shall be appropriately disposed of in puncture resistant containers at their point of use. Do not recap needles.

• Fingernails should be kept short to prevent the puncturing of gloves. False nails (including gel nails) should not be worn because they harbor microorganisms and may puncture gloves. Jewelry should not be worn on the hands because it harbors microorganisms and may puncture gloves.

• Meticulous hand washing should be done between patient contact, after glove removal and when entering or leaving the Endoscopy area. If hands and other skin surfaces are contaminated with blood or body fluids, wash immediately.

• Health care workers who have exudative lesions or weeping dermatitis shall refrain from all direct patient care and from handling patient care equipment until the condition resolves.

BACKGROUND

Attention shall be given to the implementation of infection control standards. Contaminated endoscopes and accessories are potential sources of infection for both patients and personnel. Strict guidelines are needed to standardize the cleaning/disinfecting/sterilization processes. These guidelines are intended to assist institutions and Endoscopy units in developing their own policies for their specific needs.

RECOMMENDATIONS FOR ENDOSCOPES

Refer to the manufacturer’s instructions for cleaning and disinfecting each particular endoscope: Scrupulous cleaning and disinfection after each patient use shall be completed to prevent the spread of infection. Only trained personnel shall perform this procedure.

INSPECTION

At all stages of handling there should be inspection of the endoscope for damage.

Leakage testing of the endoscope should be done each time before the cleaning process starts.

Ensure immersion cap is placed on all videoscopes.

If damage is detected or bubbling occurs, ensure the pressure is maintained through the leakage tester and proceed to carry out a thorough external cleaning and cleaning of the internal channels. Follow your service provider’s instructions concerning disinfection of a damaged fiberscope. However, with proper maintenance of internal pressure, manual disinfection of the scope in many cases can be achieved. Send to the repair service immediately. If the scope cannot be cleaned prior to transport, ensure that it is clearly labeled ‘contaminated’.

CLEANING

Meticulous manual cleaning is the most important step in the cleaning process. It is imperative that all channels, removable parts and all immersible parts of the endoscope be cleaned.

The rationale for cleaning of the scope at the bedside is to minimize transmission of infectious material during transfer of scope from procedure room to scope reprocessing area.

Wipe the outer surface with enzymatic solution soaked lint free cloth immediately after removal of the endoscope from the patient. Light source must be turned off, but suction remains on – the nurse places distal end of the scope and suction enzymatic solution through the biopsy/suction channel for 30 seconds, and then removes the distal tip from the enzymatic solution and suction air for 10 seconds.

Now the assisting personnel turns light source on; the nurse removes water
button and replaces with air/water channel cleaning adapter valve; she places distal tip into clean water for 30 seconds and watches for bubbles, then removes distal end out of water, depress air/water valve and watches for water squirting from distal end (from water bottle) for 10 seconds. She transports the scope to the cleaning area.

- If unable to initiate the manual cleaning process immediately, the endoscope may be flushed and then soaked with enzymatic solution (follow manufacturer’s recommendations – biofilm is present 2 hours after scope submersed in enzymatic solution) according to Dr Alpha’s latest study.
- Leak test the scope following the manufacturer’s instructions. Fully immerse the scope in a solution with an enzymatic cleaner to prevent the drying of secretions. Brush all channels to remove the organic material and decrease the number of organisms present. Ensure that access to the air/water/biopsy channel is attained, as these channels are very difficult to clean. Ensure the outer surface of the scope is thoroughly cleaned. Use of a soft bristle toothbrush to clean the lens end is acceptable.
- All channels must be brushed and irrigated to remove particulate matter. A channel irrigator shall be used to facilitate complete cleaning of all channels.
- Rinse all the channels and the endoscope thoroughly with water following the cleaning process to remove the residual of the enzymatic agent.
- Remove all excess water from the channels by injecting air via the all channel irrigator to decrease the possibility of dilution of the disinfectant solution.
- Clean all non-immersible parts with a hospital recommended surface disinfectant.
- Non-immersible endoscopes should be replaced because they are very difficult to clean and disinfect.

### STERILIZATION AND DISINFECTON

When deciding whether to sterilize or disinfect the endoscope, it is important to refer to the following classifications:

1. Critical devices are those that enter sterile tissue: the vascular system or body space (i.e. biopsy forceps, polyp snares and surgical instruments).
2. Semi-critical devices (i.e. laryngoscopes, endoscopes) come into contact with mucous membranes or non-intact skin during use and should at least receive high level disinfection (defined as the inactivation of all micro-organisms with the exception of bacterial endospores).
3. Non-critical devices (i.e. blood pressure cuffs, bedpans) come into contact with intact skin. Endoscopes that come into contact with mucous membranes are classified as semi-critical items.

Endoscopes that enter sterile body cavities are classified as critical items.

- High level disinfection of the endoscope internally and externally must be performed after scrupulous mechanical cleaning has been completed. All processes will be rendered ineffective if any organic material or moisture is present on or in the endoscope.
- Chemical agents registered with Canada Health and Welfare, sterilant/ disinfectants are appropriate for high level disinfections. To ensure efficacy, the manufacturer’s instructions regarding use of disinfectant must be adhered to.
- All internal and external surfaces and channels must be in contact with the disinfecting agent for not less than 20 minutes.
- Disinfectant agents must be chosen carefully and must be used according to the manufacturer’s instructions including monitoring chemical concentrations. Effective use-life is more dependent on frequency of use rather than on a pre-

- Ethylene Oxide (ETO) gas sterilization requires an extended time to complete the sterilizing and aeration process. This may not always be practical and has been replaced with the sterrad method in some institutions.
- Sterrad Sterilization Systems offer rapid cycles for rapid returns. Sterrad Sterilization Systems offer the most productive solution for low-temperature sterilization needs. Engineered using gas plasma technology, Sterrad Sterilization Systems sterilize instruments and medical devices safely and effectively.
- The Peroxide Acid based automated system sterilizes immersible instruments and rinses them with sterile water. Contact of all external and internal surfaces with the sterilant must occur. Check with the manufacturer’s instructions regarding the cleaning of the elevator channel of the duodenoscope.
- Hydrogen Peroxide (H2O2) is acceptable for endoscopic reprocessing although it can damage the external surfaces of the insertion tube and corrodes copper, zinc and brass. Hydrogen peroxide gas plasma sterilization is a low-temperature, low-moisture sterilization process that is rapid enough to provide high throughput. There are no toxic residuals; therefore, no aeration is required. The primary by-products of the process are water vapour and oxygen. As a consequence, the cycle time for processing can be relatively short. Several new improvements in hydrogen peroxide gas plasma sterilization technology have reduced cycle time from 74 minutes to 55 minutes, allowing more instruments to be processed. The hydrogen peroxide gas plasma sterilization system can safely and effectively sterilize most surgical instruments, except for powders, liquids, devices with narrow lumens, linens, and other cellulosic materials.
RINSING

To remove all traces of the disinfectant, adequate rinsing must follow the disinfection process. Any residual chemical can cause toxic effects in a patient if it is transmitted during the next endoscopic procedure.

After each reprocessing cycle, each and every scope must be irrigated with 70% alcohol rinse; followed by drying with compressed air:

- All the channels must be purged with air
- Bacteria such as Pseudomonas aeruginosa have been identified in both tap and filtered water and may multiply in a moist environment
- Avoid using excessively high air pressure. High-pressured air can cause damage to the internal channels of the flexible endoscope.
- All channels, including any accessory channels, are flushed with alcohol until the alcohol can be seen exiting the opposite end of each channel
- 70% isopropyl alcohol is used to aid in drying of the interior channel surfaces
- Alcohol must be properly stored in a closed container between uses. If alcohol is exposed to air, it rapidly evaporates, and if below recommended percentage level, cannot be relied upon to assist with the drying process
- Alcohol flushes should be used even when sterile water is used for rinsing

- All the channels must be purged with air again following the alcohol flush
- Alcohol mixes with the remaining water on the channel surfaces and acts to encourage evaporation of the residual water as air flows through the channel
- Remove all channel adapters

Dry the outside of the endoscope with a soft, clean and lint-free cloth
- Thoroughly rinse and dry all removable parts. Do not attach removable parts (valves, etc.) to the endoscope during storage.
- Storage of endoscopes with the removable parts detached lowers the risk of trapping liquid inside the instrument and facilitates continued drying of the channels and channel openings.

STORAGE OF SCOPES,
CASE-TO-CASE, DAY TO DAY:

Endoscopes should be stored hanging vertically in a well-ventilated area, or placed in aerating cupboards commercially sold for the purpose of preventing recontamination and damage. Scopes should never be coiled and stored in their cases.

Endoscopes should be hung vertically with the distal tip honing freely in a well-ventilated, dust-free area.

- A storage area with good ventilation will encourage continued air drying of the surfaces and avoid undue moisture build-up
- Wipe down the storage cupboard with disinfectant solution weekly.

DOCUMENTATION

Results of disinfectant solution testing should be documented. Institutional policy may require documentation of disinfection cycles. Documentation in accordance with institutional policy to ensure tracking of patients, scopes numbers and reprocessing machine must be done to ensure and provide adequate tracking and follow-up should there be an epidemic.

CULTURING

Culturing requires very precise techniques done in close consultation with an infection control department. Institutional policy may dictate when and how culturing of scopes should be carried out. Biological testing of the reprocessing equipment shall be carried out as per institutional policy and manufacturer’s recommendations.

SPECIAL CONSIDERATIONS

Sterilization or high level disinfection should be used as directed by institutional policy. Diagnosed or suspected infection, including Hepatitis B, VRE, MRSA or HIV is not a contraindication for endoscopy. It is not recommended to have instruments dedicated for use with infected patients.

RECOMMENDATIONS FOR ACCESSORIES

Non-disposable accessories require meticulous manual cleaning and disinfection or sterilization after each use according to manufacturer’s guidelines and as directed by institutional policy.

Cleaning Brushes should be disposable or thoroughly cleaned and receive high-level disinfections after each use.

BIOPSY FORCEPS

Meticulous manual cleaning of reusable forceps with a brush and an enzymatic agent is required as soon as possible after the procedure.

Ultrasonic cleaning is recommended to remove debris that hand cleaning cannot.

Biopsy forceps break the mucosal barrier. Therefore, they are classified as critical instruments and require sterilization.

The only method that will effectively penetrate the metal coils of the spring-like structure and any residual organic material is steam under pressure. Chemical sterilization does not completely penetrate the coils and therefore is not effective.

WATER BOTTLE

According to manufacturer’s instructions, sterilize or high level disinfect the water bottle and its connecting tubing at least daily.

For endoscopic irrigation, fill the bottle with sterile water.

Each ERCP procedure requires a fresh sterile bottle with sterile water. Pseudomonas aeruginosa colonization of equipment has been associated with patient infection following ERCP.

The Guiding Light, July 2005
OTHER ACCESSORIES
Clean all reusable accessories meticulously with an enzymatic agent followed by rinsing thoroughly with water. Use the ultrasonic cleaner prior to steam autoclave.
Consult the manufacturer if steam sterilization is not applicable.
Injection needles should be discarded in the sharp container after each use.
Discard suction tubing after each procedure.
MEDICAL EQUIPMENT
Keep all non-critical equipment (i.e. teaching heads, light sources, cameras) visibly clean with soap and water or recommended institutional disinfectant.
If significantly soiled, use an intermediate disinfectant after cleaning.
RECOMMENDATIONS FOR ENVIRONMENT
GENERAL CLEANING
For general wipe-down of equipment such as procedure carts, stretchers, sinks, etc. after each use, an EPA registered housekeeping product is recommended.
SPILLS
In keeping with Universal Precautions:
• Use gloves; blot spills of blood or body fluid with disposable towels.
• Wipe the area with clean, disposable towels soaked in a freshly prepared household bleach (1:10) dilution or an EPA registered tuberculocidal ‘hospital disinfectant’ and allow to dry.
Disinfectant spills should be handled by consulting the solution MSDS (Material Safety Data Sheet) WHMIS Guidelines.
WASTE
Minimal handling of all medical waste should be encouraged.
The storage and disposal of waste should be handled according to institutional policy and provincial and federal guidelines.
PROCESSING AREA
Patient care areas should be separate from cleaning/disinfection areas.
Clean and dirty areas should be separate with proper plumbing and drains. Adequate storage space should be provided.
The use of covered containers and proper ventilation to remove toxic vapors is essential.
Periodic air quality monitoring of glutaraldehyde levels should be performed.
AUTOMATED WASHERS/DISINFECTANTS
Endoscopy unit cleaning/disinfecting process may be standardized by the use of scope washer/disinfectants. This equipment may be useful in circulating germicides, containing vapors and decreasing exposure of personnel to contaminated equipment and disinfectants.
Meticulous manual cleaning must precede the use of any automated system as previously described.
Clean all non-immersible parts of the endoscope with hospital recommended surface disinfectant.
THE FOLLOWING CAPABILITIES MUST BE PRESENT IN ANY WASHER/DISINFECTANT:
• Enzymatic and/or disinfectant should be circulated through all channels at equal pressure without trapping air.
• Washing and disinfecting cycles should be followed by thorough rinsing cycles followed by forced air to remove the used solution.
• Disinfectant should not be diluted with wash or rinse water.
• Routine disinfection of the washer/disinfectant according to the manufacturer’s recommendations and institutional policy must be done.
OTHER CONSIDERATIONS:
• A channel irrigator may miss a blockage of one channel.
• When used to disinfect duodenoscopes, ensure that the channel for the elevator is cleaned and disinfected as part of the processing cycle or it may require manual processing.
• A forced air-drying cycle or air-drying should be completed by hand after the final rinse.
• All endoscope channels must be flushed with 70% alcohol and dried with air after each reprocessing cycle.
• Colonization of bacteria may be caused by residual water remaining in the water hoses and reservoirs. This could lead to contamination during subsequent instrument processing.
CLEANING DISINFECTION AND STERILIZATION PROCEDURES
Endoscope Withdrawal
Precleaning at bedside
Leakage testing
Manual cleaning
Enzymatic Rinse Air
High level Disinfection Air
Sterilization
Rinse & Air
Alcohol flush
Forced air
Storing the endoscope
TERMINOLOGY

Clean – Visibly free from debris
Endoscope – Flexible – Flexible fiberoptic or video endoscope used in the examination of the hollow viscera (i.e., colonoscope, gastroscope, duodenoscope, sigmoidoscope, bronchoscope).

High-Level Disinfectant – A liquid chemical germicide which is capable of destroying all microbial life including high numbers of bacterial endospores but is used under conditions where it achieves the destruction of all vegetative bacteria, viruses and fungi but not necessarily all bacterial endospores.

Patient – Ready Endoscope – An endoscope rendered clean after being subjected to a validated cleaning procedure subjected minimally to a high level disinfection process and rinsed so that it does not contain residual chemicals in amounts that can be harmful to humans.

Alcohol – 70% isopropyl or ethyl alcohol
Air – Airflow provided by a pump or compressor.
Detergent – Low-sudsing enzymatic formulations recommended by the manufacturer of the endoscope.
Water – Clean potable water or potable water that has been filtered by the manufacturer of the endoscope.

DISCLAIMER:
The Canadian Society of Gastroenterology Nurses and Associates assumes no responsibility for the practices or recommendations of any member or other practitioner or for the policies and practices of any Endoscopy unit.

BIBLIOGRAPHY

On Friday May 13th [GI Nurses Day] we had a Great day in Kelowna. We all wore pink corsages, beautifully made by Chris Schultz, which stated it was GI Nurses Day. There were LOTS of goodies that everyone brought in to share, so we certainly celebrated by eating!

We took the time to plan our next Chapter education evening for June 21st. It will be sponsored by Janssen Ortho. Our own Dr Shane Agnew will be speaking and the evening will be open to our local Chapters and interested hospital staff. It was a very special, fun day had by all!

On Friday May 13th the Regina Chapter of The CSGNA celebrated GI Nurses Day! We held a come and go tea in the afternoon and had our visitors tour the unit. We also raffled off another beautiful basket. This year it was a kitchen basket. We raised over $1200.00.

Everyone had a wonderful time!

It was a great success.

We are all planning and looking forward to next year’s celebration!

Sincerely Linda Buchanan
President of the Regina Chapter of the CSGNA
FUTURE CSGNA CONFERENCES
WORLD CONGRESS MONTREAL 2005
REGINA 2006
HALIFAX 2007
VANCOUVER 2008
TORONTO 2009
METHEMOGLOBINEMIA

Submitted By: Helga Sisson RN CGN(C)

Recently, while assisting with an ERCP, our patient became cyanotic, tachycardic and her oxygen saturation dropped and was unresponsive to oxygen administration. She was diagnosed with Methemoglobinemia, a potential complication of benzocaine-containing substances. In writing this article, I hope to bring more awareness about this rare but potentially life-threatening condition.

DEFINITION AND BACKGROUND:

Methemoglobinemia refers to the presence of an elevated circulating fraction of methemoglobin within erythrocytes\(^1\). Methemoglobin is an altered state of hemoglobin where the iron compound of hemoglobin is oxidized from ferrous iron to ferric iron. This compound is unable to transport oxygen and carbon dioxide, leading to tissue hypoxemia and in severe cases, death\(^1\). Methemoglobin is normally present in blood at <1% to 2%. It is continuously formed in erythrocytes and is readily reduced back to its ferrous state by intracellular enzyme systems\(^1\). Methemoglobinemia can arise from genetic or congenital sources (enzyme deficiencies or alterations in hemoglobin molecule), dietary causes (ingestion of well water contaminated with nitrates) or more commonly, the ingestion of toxins or medications\(^1\). Acquired methemoglobinemia occurs when the rate of methemoglobin formation exceeds the rate of its reduction. Acquired methemoglobinemia is most often caused by ingestion or skin exposure to an oxidizing agent. Common agents include acetaminophen, aminophenols, aniline compounds, benzocaine, dapsone, EMLA-cream, flutamide, GI nitrate production secondary to infection, lidocaine, metoclopramide, nitrates, nitric oxide, nitroprusside compounds, phenacetin, prilocaine, primaquine, pyridine, sulfonamides\(^4\). Individuals can also acquire this condition from self-medication with readily available over-the-counter products advertised as toothache and baby-teething gels, sting relief formulas, pain relief sprays, hemorrhoidal creams and vaginal and rectal suppositories. These preparations contain benzocaine in concentrations varying from 5% to 20%\(^2,5\).

SIGNS AND SYMPTOMS

• Onset is usually within 20 - 60 minutes of drug administration.
• Signs and symptoms of methemoglobinemia generally correlate to the amount of methemoglobin present\(^2,8\).

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<tr>
<th>CONCENTRATIONS</th>
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<tr>
<td>3-15%</td>
<td>slight discoloration (pale, grey, blue) of skin</td>
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<tr>
<td>15-20%</td>
<td>cyanosis</td>
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<tr>
<td>25-50%</td>
<td>headache, dyspnea, light-headedness, weakness, confusion, palpitations, chest pain</td>
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<tr>
<td>50-70%</td>
<td>altered mental status, delirium</td>
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<tr>
<td>&gt; 70%</td>
<td>death has been reported and may be due to arrhythmia, circulatory failure or neurologic compromise</td>
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DIAGNOSIS

Methemoglobinemia should be suspected in patients who appear cyanotic and have a low pulse oximetry reading that does not improve with oxygen therapy, yet have no apparent respiratory or cardiovascular problems to explain the low O2 saturation\(^1\). Arterial blood is described as dark red, chocolate or brownish to blue in color\(^6\). Arterial blood gases will show a normal PaO2 concentration. Pulse oximetry may show SpO2 of about 85%, despite a much lower actual arterial saturation\(^9\).

Co-oximetry is a spectrometer, but unlike a pulse oximetry, measures light absorbance at 4 different wavelengths. Co-oximetry is found to be an accurate method of measuring methemoglobin\(^8\). It is the diagnostic test of choice because it provides the concentration of methemoglobin and oxyhemoglobin\(^2\).
TREATMENT

With acquired methemoglobinemia, the offending agent should be discontinued. General supportive measures are appropriate if methemoglobin levels are < 30%. Most cases will resolve within 24-36 hours (2). In severe cases, the treatment of choice is Methylene Blue (6,5). It is given intravenously in a dose of 1 - 2 mg/Kg injected into a vein over a period of 5 minutes. A second dose may be given after 1 hour, if needed (6). A blood transfusion may be necessary for patients who are in shock (6).

SUMMARY

Methemoglobinemia is a rare, but potentially fatal complication that can occur with the use of benzocaine-containing compounds. Nurses and physicians who work in endoscopy or other areas that use topical benzocaine preparations should be familiar with this condition. Prompt recognition, diagnosis and treatment are necessary to prevent further complications.

REFERENCES


BROCCOLI SALAD

1-bunch broccoli florets (use 2 if the bunches are small)
1/2 cup golden raisins
3/4 cup salted sunflower seeds
1/2 cup red onion, chopped fine
1-cup mayonnaise
2 tbsp. white sugar
1 tbsp. white vinegar

1. Wash and drain broccoli. Add raisins, onion and sunflower seeds to broccoli.
2. Blend together mayonnaise, sugar and vinegar. Add dressing to broccoli mixture.
3. Ideal to make at least 1 day ahead, and lasts for several days in the refrigerator.
4. May substitute half cauliflower, half broccoli.

HIGH FIBER MUFFINS

3 cups All Bran
3 cups water

Mix together and soak for 5 minutes.
Add 1 package of Betty Crocker Cookie Mix
{Chocolate Chunk or Oatmeal Cookie Mix is the best} and 2 teaspoons of Baking Soda. Mix well
Drop into lined muffin tins.
Bake at 350 degrees for 15 to 18 minutes.

This recipe makes 18 small muffins or 12 large muffins.

P.S. If you are on Weight Watchers a small muffin is only 1 point and a large muffin is 2 points!
FOUNDATIONS: GI CERTIFICATION PREP COURSE

CSGNA is pleased to once again offer you the preparation course for the Canadian Gastroenterology Certification exam. It will take place in conjunction with the World Congress in Montreal, Quebec. It will be at the Courtyard Marriott Hotel (410 Sherbrooke St West) on Sunday, September 11th, 2005 from 11am-3pm in the Des Chatelets Room. Leslie Ann Patry from the Canadian Nurse Association will be a guest speaker talking about study groups. She will discuss the benefit of a study group and how to form one. We also are going to include a mock exam to give you an idea of exam format and questions. The fee is $50.00 Canadian payable to Edna Lang CSGNA Treasurer @ 27 Nicholson Dr., Lakeside, Nova Scotia, B3T 1B3. Phone #1-902-876-2521 (H) 1-902-473-4008 (Fax) 1-902-473-4406 (B) or ednalang@hotmail.com or Edna.Lang@cdha.nshealth.ca Please indicate on your cheque that you are registering for Foundations. Contact person regarding the program is Michele Paquette – Education Chair CSGNA 1-613-737-8384(W) or michpaquette@rogers.com. You are encouraged to register as soon as possible as space is limited. This course is an excellent review of anatomy & physiology. It also gives you an idea of the exam format. This would also be an excellent course to attend if you felt you might benefit from a review in GI. If you are planning to write the 2006 GI Certification exam or wanting to explore the possibility of writing, this course is a must!

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Make certain to include your payment.

CSGNA Foundations 2005

The Edmonton Chapter of the CSGNA is planning a one day conference on October 29th, 2005 at Misericordia Hospital, Edmonton, Alberta from 9:00am to 3:00 pm. Our conference is titled Celiac Disease a Closer Look. Please contact the Edmonton Chapter President Yvonne Verklan at yvohven@gmail.com or Anna Tsang at tsangana@telus.net for more information.

On Friday October the 28th the Regina Chapter of The CSGNA will be holding its annual GI DAYS! We will be sending out our brochures in September. If you are interested in attending you can also contact me at lesliejoy@sasktel.net or our Chapter President Linda Buchanan at l.buchanan@sasktel.net. We look forward to seeing you there.

Sincerely, Leslie Bearss
Newsletter Editor “The Guiding light”
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SO YOU THINK YOU KNOW EVERYTHING?

A dime has 118 ridges around the edge.
A cat has 32 muscles in each ear
A crocodile cannot stick out its tongue.
A dragonfly has a life span of 24 hours.
A goldfish has a memory span of three seconds.
A “jiffy” is an actual unit of time for 1/100th of a second.
A shark is the only fish that can blink with both eyes.
A snail can sleep for three years.
Al Capone’s business card said he was a used furniture dealer.
All 50 states are listed across the top of the Lincoln Memorial on the back of the $5 bill.
Almonds are a member of the peach family.
An ostrich’s eye is bigger than its brain.
Babies are born without kneecaps. They don’t appear until the child reaches 2 to 6 years of age.
Butterflies taste with their feet.
Cats have over one hundred vocal sounds. Dogs only have about 10.
“Dreamt” is the only English word that ends in the letters “mt”.
February 1865 is the only month in recorded history not to have a full moon.
In the last 4,000 years, no new animals have been domesticated.
If the population of China walked past you, in single file, the line would never end because of the rate of reproduction.
If you are an average American, in your whole life, you will spend an average of 6 months waiting at red lights.
It’s impossible to sneeze with your eyes open.
Leonardo Da Vinci invented the scissors.
Maine is the only state whose name is just one syllable.
No word in the English language rhymes with month, orange, silver, or purple.
On a Canadian two dollar bill, the flag flying over the Parliament building is an American flag.
Our eyes are always the same size from birth, but our nose and ears never stop growing.
Peanuts are one of the ingredients of dynamite.
Rubber bands last longer when refrigerated.
“Stewardesses” is the longest word typed with only the left hand and “lollipop” with your right.
The average person’s left hand does 56% of the typing.
The cruise liner, QE2, moves only six inches for each gallon of diesel that it burns.
The microwave was invented after a researcher walked by a radar tube and a chocolate bar melted in his pocket.
The sentence: “The quick brown fox jumps over the lazy dog” uses every letter of the alphabet.
The winter of 1932 was so cold that Niagara Falls froze completely solid.
The words ‘racecar,’ ‘kayak’ and ‘level’ are the same whether they are read left to right or right to left (palindromes).
There are 293 ways to make change for a dollar.
There are more chickens than people in the world.
There are only four words in the English language which end in “dous”: tremendous, horrendous, stupendous, and hazardous.
There are two words in the English language that have all five vowels in order: “abstemious” and “facetious.”
There’s no Betty Rubble in the Flintstones Chewables Vitamins. TYPEWRITER is the longest word that can be made using the letters only on one row of the keyboard.
Winston Churchill was born in a ladies’ room during a dance.
Women blink nearly twice as much as men.
Your stomach has to produce a new layer of mucus every two weeks; otherwise it will digest itself.

----------Now you know everything!!!

MEMBERSHIP RUNS FROM
JUNE 1ST TO MAY 31ST
ANNUALLY
LIFE WITHOUT WHEAT
...LIVING WITH CELIAC DISEASE

SUBMITTED BY: SANDY STONE, RN

Did you ever really stop to enjoy that slice of toast in the morning, that muffin at coffee break or that bowl of your favorite pasta at dinner? I didn’t until I was diagnosed with celiac disease. Some people may actually be asymptomatic because the portion of their small intestine that is not affected is able to absorb enough nutrients to prevent obvious symptoms. However these people are still at risk to develop complications that are associated with being celiac. Symptoms may occur singularly or in combination. These may be, but not limited to:

➢ Abdominal pain, bloating and gas
➢ Diarrhea or constipation (often both)
➢ Weight loss
➢ Nausea and vomiting
➢ Vitamin and mineral deficiencies
➢ Iron deficiency with or without anemia
➢ Depression
➢ Lactose intolerance
➢ Easy bruising
➢ Bone/joint pain
➢ Mouth ulcers
➢ Fatigue and weakness
➢ Skin Rash
➢ Anorexia

It is important that patients being screened for celiac disease to remain on a regular gluten diet until a confirmed diagnosis is achieved with positive small bowel biopsies. Screening involves assessment of the patient’s symptoms, physical examination, and laboratory tests. People suspected of having celiac disease may have elevated antigliadens, antireticulin, and endomyelial antibodies in the blood. The definitive exam is endoscopy with multiple biopsies of the distal duodenum to determine villous atrophy. These biopsies are repeated in approximately six months after strict adherence to a gluten-free diet. This will assess how the lining of the small bowel has responded to the gluten free diet. Some gastrointestinalists may perform a third set of biopsies following a gluten challenge to demonstrate a recurrence of the disease.

The only effective treatment for celiac disease is a life-long adherence to a strict gluten free diet. After starting a gluten free diet patients may show improvement in their symptoms within days and the damage to the small intestine will start to heal in a few months, although it could take up to 2 years in some patients (especially the elderly) for the villi to be fully functional. Vitamins, minerals and calcium supplements may be required depending on the patient. Strict compliance to a gluten free diet is the only absolute way to prevent any further small bowel damage and prevent further progression of the disease.

There are several other conditions that may occur because of untreated celiac disease such as osteoporosis, depression, anemia, lactose intolerance and certain types of cancer. The symptoms of these diseases will improve after the patient maintains a gluten free diet.

After years of G.I. problems I was diagnosed with celiac disease in June 2004. Having a past history of biliary colic in my early 20’s, I assumed the symptoms I was experiencing were related to this. The G.I. discomfort of bloating, abdominal pain, nausea, diarrhea and constipation had become a regular part of life. I will admit I didn’t readily seek medical attention for my symptoms because I would rather work with physicians rather than be their patient. That changed as my symptoms became worse and I was hospitalized in March 2004 with severe abdominal pain, and at this time I was treated for query enteritis. I returned to work in endoscopy but my symptoms persisted, in addition I developed pronounced anorexia with significant weight loss. It sure is difficult to hide G.I. problems from G.I. nurses and gastroenterologists, so I quickly found myself on the other end of the “scope”. During this very unexpected gastroscopy, gastric and small bowel
biopsies were taken and I was totally shocked when the small bowel biopsies suggested possible celiac disease. To confirm this diagnosis a second set of biopsies were required and of course that meant a second gastroscopy. Oh joy - because of my symptoms and a very strong family history of colon cancer, I found myself booked for a gastroscopy and colonoscopy. These procedures were not top on my list of things to do, but I do have a determined gastroenterologist. Again my second set of small bowel biopsies were positive for celiac. This time there was no turning back, so I started my lifelong commitment to a gluten free diet.

At first it was overwhelming. To be truthful, until I started work in the endoscopy unit my knowledge of celiac disease was limited to what I had learnt in nursing school over 20 years ago. Even after been diagnosed, all I really knew about a gluten free diet was that flour products had to be avoided. I was consulted to a dietician, but there was a three-month waiting list to be seen. Being the type who has to be in control of herself, I immediately made contact with the local chapter of the Canadian Celiac Association, talked to other celiac patients and a private dietician, in addition to spending endless hours doing research on the Internet.

My new diet doesn't only affect me; it also affects my family and friends. I am extremely lucky because I have a very strong support system in my family and friends. I immediately made contact with the local chapter of the Canadian Celiac Association, talked to other celiac patients and a private dietician, in addition to spending endless hours doing research on the Internet. My new diet doesn't only affect me; it also affects my family and friends. I am extremely lucky because I have a very strong support system in my family and friends. They took on the challenge to learn and become educated about celiac disease and what was involved in a gluten free diet. My coworkers have also been very supportive; whenever there is a social event including food, my dietary needs are always considered.

It quickly became a realization just how complicated maintaining a strict gluten free diet was going to be. It requires a completely new approach to eating. A gluten free diet is not just removing flour, wheat, barley and oats, it also necessary for you to be able to recognize products that have hidden gluten. Unfortunately products are not labeled as having gluten, so you need to know what additives have what derivatives. Products that are labeled wheat free are not necessarily gluten free. A major challenge as a celiac is to become proficient in reading labels on products. Food that contain hydrolyzed plant or vegetable protein {hpp/ hvp}, food starch, seasonings, dextrin, malt or flavorings and the label do not specifically state what type of protein or starch, etc. must be avoided because it may have hidden gluten. Everyday things such as Soya sauce, bullion cubes, beer, baking powder, salad dressings all have gluten in them. Hidden gluten could be in be in the most unlikely foods such as cold cuts, hard candies, jellybeans, many low fat products, and it is also in communion wafers. Many store and restaurant prepared foods may use wheat or wheat base products as a filler and thicken agents. Because manufactures may change product ingredients it is imperative that you read labels every time you buy products, you can never assume that the ingredients will remain the same. Not only do you have to be concerned about food products, but also many pharmaceutical products use gluten as binding agents, as well gluten can actually be in certain lipsticks and mouthwashes. Reading labels has become second nature to me (if I remember my glasses) and now I can quickly recognize what is or isn’t safe for me.

Another big concern for a celiac is avoiding foods that may have been cross-contaminated with gluten products. Even the smallest amount of ingested gluten can cause damage to the small intestine. A crumb of bread can do as much damage as a full slice of bread. This damage can occur even if you do not have any symptoms. Some celiac patients are very sensitive to even the smallest amount of accidentally ingested gluten and may become quite ill. To avoid cross-contamination at home it is wise to set up your kitchen to ensure you effectively maintain your diet. This involves having your own toaster, baking pans, butter, jam etc as well as labeling food as your own. Looking in my refrigerator you will find my products labeled with a big red “MOM”. As well I have set up my own cupboard to store my flours, baking powder, cereal, cookies etc. Again this just eliminates the chance of cross contamination. Another thing to be conscious of is if you are grilling or deep-frying that the grill or oil has not been used for gluten food such as breaded products.

There are limited gluten free product lines available, and they tend to be expensive. It is very encouraging that even in the short time that I have been a celiac, I have seen an increase in the amount of different types of products available. It is very wise to learn how to cook and bake gluten free. This may sound simple enough but there is a real knack to gluten free baking. Using rice and other different types of flour requires binding agents added such as zantham powder to replace naturally occurring gluten of regular flour. My husband, friends and I registered for a gluten free cooking class, but unfortunately because there were not enough of us, the course was cancelled. So I was on my own to teach myself. Luckily there are several cookbooks and resource books available. I will confess that I am still learning how to bake, but cooking I have mastered.

In today’s society going out to eat is a regular part of our lifestyle, but unfortunately that does not come easy for the celiac patient. The majority of the fast food restaurants provide very little options for a gluten free diet. Dining at a finer restaurant is usually safe if you call prior to going and speak with the chef, but of course this tends to be more expensive and is really not what your children considers running out for a quick burgers or pizza. Dining out also puts you in the spotlight because you find yourself explaining what gluten free diet entails and everyone is listening and watching and I find that very uncomfortable. After scrutinizing many menus, I have found...
a couple of restaurants that I know that there are a few food choices that I can safely eat, and that is where we go. Sadly this gives my family limited choice of restaurants. We have replaced our usual Friday night pizza with Wendy’s because their taco salad is safe for me. Actually it has become easier to stay home and cook something, then you are guaranteed it will be gluten free.

As a person who loves to eat and enjoys all types of ethnic foods, adapting to life as a celiac seemed to be a very daunting task initially. There is no magic pill; it required some mental toughness as I changed my long established and very much enjoyed eating habits. The positive attitude, understanding and patience of my family, friends and co-workers, and a concerned gastroenterologist have made the dietary transition easier. Living with celiac disease isn’t always easy, there are challenges to face each day. To live a full life as a celiac, self-management and self-control is a vital component. It means making safe and healthy choices all the time whether at home or away. However at the end of the day, the good health and well being that you experience far outweighs any inconvenience associated with following a gluten free diet.

REFERENCES:
POSITION STATEMENT
NURSE PERFORMED FLEXIBLE SIGMOIDOSCOPY

Position
The Canadian Society of Gastroenterology Nurses and Associates support the position that nurses trained and experienced in gastroenterology nursing and endoscopy be given the responsibility of performing Flexible Sigmoidoscopy for the purpose of colorectal cancer screening. Education and training should include but are not limited to anatomy physiology and pathophysiology of the colon, rectum and abdomen; indications, contraindications and alternatives; potential complications of screening flexible sigmoidoscopies and manipulation of endoscopes. Competency is demonstrated by successful performance of safe and effective procedures, recognition of normal anatomy and identification of pathology. This role is subject to approval of the Provincial Licensing Body The Physician, and the Employer.

Definition
Flexible sigmoidoscopy is the examination of the rectum and the colon from the anal verge to the splenic flexure using a flexible fiberoptic or video gastrointestinal scope.

Background
In response to the changes in the field of gastroenterology and endoscopy the traditional role of the gastroenterology nurse has changed. Colorectal cancer is the 2nd leading cause of cancer deaths in the US and Canada every year. Current research and practice publications illustrate the safety and accuracy of the performance of routine screening flexible sigmoidoscopies by trained registered nurses.

Disclaimer
The Canadian Society of Gastroenterology Nurses and Associates does not assume responsibility for the practices or recommendations of any member or other practitioner for the policy and practices of any Endoscopy Unit.

Bibliography
Adapted with permission of SGNA August 2000.
Performance of Flexible Sigmoidoscopy by Nurses for the Purpose of Colorectal Cancer screening.
Canadian Nurses Protective Society 1999. Legal Risks in Nursing.

JUST A REMINDER!!!
WE NEED DONATIONS FOR DOOR PRIZES AND THE SILENT AUCTION
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HOPE TO SEE YOU ALL THERE!!!
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Each year as a member on the planning committee for a regional conference (cumulative points) 1 Point
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REVISED September 2002
M. Paquette, Education Director
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