The Guiding Light

CANADIAN SOCIETY OF GASTROENTEROLOGY NURSES & ASSOCIATES

MARCH 2005 VOL. 14 #54

LET'S CELEBRATE GI NURSES DAY

EXPANDING THE SCOPE OF GI NURSING

FRIDAY MAY 13, 2005

It is that time of year to once again recognize the hard work and dedication of GI Nurses across the country. Friday May 13, 2005 has been designated as our annual day of recognition and we hope that all of you will participate in this celebration.

Gastroenterology Nursing is growing and becoming more specialized to encompass Endoscopy, Inpatient Care, GI Investigation, Clinical Research, Outpatient Care and Patient Education.

In April 2004, 94 nurses undertook the first Canadian Nurses Association GI Certification Exam. Congratulations to those who recognize the specialty of GI nursing and strive to inspire others to promote their unique role in nursing.

Let's take this opportunity to acknowledge each other's hard work and commitment, as well as educate our peers and patients about the variety of roles and responsibilities that we assume.

On Friday May 13, 2005, please take the time to showcase our expertise in the field of GI Nursing.

We would like to hear how you celebrated this day. Please forward stories and photos to lesliejoy@sasktel.net for the next Guiding Light.

INSIDE THIS ISSUE:

Let's Celebrate GI Nurses Day 1
Presidents' Messages 2
Reports 3
Infection Control: Disinfection of the Air Supply 7
Board Positions Available 8
Synopsis of CSGNA Email Meeting 9
Just How Boring is Endoscopic Ultrasound 10
Endoscopic Ultrasound at SPH 11
Announcing the SciCan Educational Scholarship 13
Ogilve's Syndrome 14
Personnel Protective Equipment 16
Education Meeting 18
Implementation of Routine Endoscope Sampling 27
Scope Reprocessing Challenges 29
What's the Scope? 31
Achlasia 32
The GI Professional Nursing Award 34

PRESIDENT'S MESSAGE

It would appear as though we are starting the New Year on a positive footing. Education sessions are happening across the country.

Our second GI Certification exam will be written April 2nd, 2005. This year at our certification prep course entitled" Foundations" we will be adding a mock exam. This will give you a feel for the exam question format. This course is a must if you are planning to write next year. By the way the exam date is April 1st, 2006 for those who may be interested. The" Foundations" course will be held in conjunction with the World congress in Montreal. Watch The Guiding Light for registration information.

Speaking of the World Congress, it still is not too late to register. This will be an awesome conference! Three whole days of GI learning combined with fun evenings at the nurse's reception and Canada Night. Don't miss out on the experience beginning with the Opening Ceremonies on September 11th and ending September14th, 2005.

In the ever important Infection Control Department we are looking at 4 issues. They are:

1. Staff wearing jewelry in the GI unit
2. Staff wearing fake nails in the GI unit
3. How long can a scope safely hang before it should be reprocessed?
4. Is it good practice to use one scope when doing a double procedure on a patient?

We are also trying to increase the number and dollar amount of our scholarships to enable more nurses to attend our national conferences.

I think that you will agree that CSGNA is truly working towards a common goal of improving practice in the GI setting!

Sincerely,
Nancy Campbell RN, CGN(C)
President CSGNA

The Road to President Elect

Since assuming this role in September, I've taken the opportunity to consider how I came to be here at this time in my life. In nursing, volunteer opportunities for personal growth and professional development abound. With mentoring from senior GI nurses, supportive management and involved physicians, and encouragement from national board members, I moved through the ranks. The support of my husband can't be underestimated. Larry saw how much I gained on a personal level from my involvement at the chapter level for 8 years and encouraged me to put my name forward for a national position which I did in September 2001. He did not live to see me as the Public Relations Director but I didn't participate in any activities in this role without thinking of him and often looking skyward, asking him if he could help me particularly with my computer skills!

The benefits I have gained from my CSGNA involvement are numerous. First as Calgary Chapter secretary and then as chapter president, I was able to attend national meetings with chapter financial support. One year I attended the SGNA conference with the CAG scholarship. Another year I was a CSGNA scholarship recipient. Over the years, my employer supported my involvement with funds for education and time off with pay in the form of educational days. In 1998 I received funds from the physicians at the Peter Lougheed Centre towards my writing the US certification exam. In 2004 the Calgary Health Region portfolio under which the GI Units fall, paid the full exam fee for each of the 10 or so successful Calgarians who wrote the Canadian certification exam. Since I joined the CSGNA in 1992, the only national conference I missed was in Ottawa in 1996. Have I been fortunate to have had this support and opportunity to meet dynamic, keen, GI experts from across North America while learning of the latest technology and best practice? Absolutely! Was it fun going to Halifax, St. John's, and Ottawa and extending my stay to turn it into a holiday? You bet! Can you be doing this for yourself, your patients, and your colleagues? Without a doubt. Have I ever asked myself, is the effort really worth it? Never.

As president elect I have things I'd like to see for our membership consistent with the vision of the national board. I want to see our website continue to improve in meeting our members' needs. I want to see more members writing the certification exam. I want members to feel their knowledge and practice are important and to feel comfortable in submitting an article to the Guiding Light. I want members to realize involvement with the CSGNA is invigorating and not draining. You will reap so much more than you sow.

I thank those who have helped me along the way to such a fulfilling GI nursing career.

Debbie Taggart, RN, BN, CGRN, CGN(C)

CANADA EAST REPORT

As I write this report we on the East Coast are about midway through our winter season. We anxiously await spring for the rebirth and rejeuvination it will bring.

Newfoundland Chapter

The chapter held two meetings. During our meeting in November discussion centered around the upcoming World Cngress meeting in Montreal. Number of members interested in attending and funding required were considered. Plans were made to register three members by the earlybird date with hopes of sending one to two more. Also discussed were potential changes in Branch Executive. Members were asked to consider offering themselves for an executive position. The second meeting took place in January. At this meeting two members offered themselves for positions. Patsy Gosse LPN will take over as President. Tracey Walsh RN as Secretary. June Peckham has agreed to stay on as Treasurer. I would like to take this opportunity to thank Ellen Coady outgoing President and Mabel Chaytor outgoing Secretary for all they have contributed to the chapter.

New Brunswick/PEI Chapter

No report submitted.

Nova Scotia Chapter

The NS Chapter held it's annual Education day on November 29th, 2004. Thirty one members attended. Topics included the argon plasma coagulator, the endo capsule, infection control and liver conditions. We heartily thank our sponsors and the endo unit at the Queen Elizabeth Science Centre for allowing the use of their area.

Plans are now underway for the East Coast Conference, which will be held in conjunction with the AAG's annual meeting. This year the venue will be held in Lunenburg Nova Scotia. Meeting will take place at the Lunenberg Arms. Accomodations will be throughout the beautiful town. Further details will be on the website as they become available.

This time last year many of us were busy preparing for the Certification exam. To those who are taking up the challenge this year Good Luck!

Joan Rumsey, CGN(C)
Canada East Director

DIRECTOR OF CANADA CENTRE REPORT

This will be a very busy year. Some of the members are studying for their Gastroenterology Certification exam to be held in April. The CSGNA will be hosting the World Congress of Gastroenterology which will be an extraordinary event for us. I encourage all of you to attend so that you may share your ideas and knowledge with colleagues around the world.

The Golden Horseshoe Chapter hosted an educational session in Nov. 29 on Colorectal Screening, Infection Control issues in Endoscopy and C-Difficile. It was attended by 80 participants and sponsored by Cook Canada. Next session will be held in April or May on Variceal gluing and G.I. bleed management. It will be organized by Credit Valley Hospital and sponsored by Steris.

The Central Ontario Chapter held an educational session on Nov. 2 on Colorectal Carcinoma – A Surgeon's perspective and Reusables versus Disposables Items, sponsored by Boston Scientific. Well attended. The spring conference will be on Hepatitis. Further info will follow.

On Oct. 27, the Greater Toronto Chapter held a Chapter meeting and had an election:

Cathy Bidwell new president, Donna Joncas secretary and Jacqui Ho treasurer. Sandy Saioud from Carsen spoke on Reprocessing. Next conference will be held, end of March and one at the beginning of June. Further info will follow.

The South Western Ontario Chapter hosted an education evening Nov. 24 on Management of Upper G.I. Non-Variceal Bleed, sponsored by Altana and Solvay & Pharma. Next educational session will be in spring. Further info to follow.

The London Area Chapter organized an educational session on "Air" Is Human and Oxygenation on Conscious Sedation Patient, which was held on Nov. 8, and sponsored by Altana Pharma Inc. Well attended. Next conference, in March will be on "ERCP and Complications.

The Ottawa Chapter also had an election: president, Therese Carriere and secretary Francine Nyentap. An educational session was held on Jan 18, on Herbal Medicine in GI Setting, sponsored by Cook Canada and Fibertech. Very well attended. Next session will be in spring. At present time, working on poster for WCOG.

The Montreal Chapter is organizing an educational session for this spring which will be sponsored by Boston Scientific. As Montreal will be the host city for the WCOG, they are looking into different ways of obtaining support from local businesses.

Regards,
Monique Travers Rn, CGN©
Director of Canada Centre

CANADA WEST DIRECTOR REPORT

When we reflect on all the things we have learned in the past year or even in just the past few months, "Wow!" is what many of us are saying! The changes that have been presented and those that have occurred have set new heights and demands in our Practice of Nursing.

As G.I. Nurses, we are ever so fortunate to be involved in such a constantly evolving field of technological progress. With this said, we all feel "tasked to the max" within our work lives. It can be daunting and even a struggle to get involved in extra curricular work activities after hours and to keep the momentum going.

I continue to be impressed with the camaraderie and commitment of so many CSGNA Chapters. Meeting regularly, planning events, socializing

and learning too! And so importantly, a very impressive number of members are registered to write the C.N.A Certification Exam in April. Kudos to all of you!

I salute Marianne Dorais for her allegiance to GI Nursing Practice by forming the Kamloops and Region Chapter. This is the 18th CSGNA Chapter. Welcome Aboard!

Kamloops and Region Chapter

At the inaugural meeting of the newest CSGNA Chapter, held in January, an Election of Officers concluded that Maryanne Dorais would preside as President. Joining her on the Chapter Executive is Secretary Dee Dee Kian and Treasurer Lori Taylor. Congratulations to all of you.

Geographically, Kamloops BC is 325Kms Northeast of Vancouver. Maryanne has included in that Chapters' boundaries; Lillooet, Lytton, Salmon Arm, Williams Lake, Quesnel, and Prince George BC. Prince George is another 500 Kms to the North.

This is a great accomplishment! Wishing Kamloops and Region Chapter of CSGNA much success!!

The members are already planning an Education Day to be held in late May or early June. Three are registered to attend the WCOG in Montreal; we look forward to meeting you there.

Manitoba Chapter

Sue Drysdale, Secretary, reports that on February 2, The Manitoba Chapter held a dinner meeting at the Fusion Grill in Winnipeg. 26 members enjoyed the evening and the meal, which was sponsored by Altana Pharma, Inc.

Dr. M. Cantor was the guest Speaker, who spoke on E.U.S., which he is performing at H.S.C.

The Chapter is planning a Spring Conference on April 23, 2005 and has secured some dynamic speakers for this event including Dr Michelle Alpha. Brochures will be sent out in March.

President, Jennette McCalla encouraged members to make arrangements to attend the World Congress in Montreal in September

Regina Chapter

President Linda Buchanan, reports that the Regina Chapters' Annual "GI Days" held in October 2004 was another great success attributable to the hard work of all their members.

The Pasqua Hospital now has endoscopic ultrasound (EUS) up and running. Already, the GI Nurses involved have seen the remarkable benefits of this new technology to patient care and say it has proven to be very exciting.

The next meeting will be held in the spring to continue planning for the CSGNA National Conference being held in Regina in September 2006. Also, the planning continues for "GI Days" date to be set for next October.

Calgary Chapter

President Evelyn Mathews reports that the Chapter met on January 20. They are planning a 4-hour education session that will be held on June 11. The focus of this session will be the Liver. The next meeting will be held on February 24 to further plan this event.

Nominations and Elections of Chapter Executive were held with the outcome that The Chapter executive remains status quo (all executive members in by acclamation!).

The Calgary Chapter has a sure–fire enticement method of encouraging members out to their meetings that always includes an educational session. They combine a dinner evening out and get sponsorship from their Vendors. It really works!!

One member is preparing for the C.N.A. Exam

Vancouver Island Chapter

Irene Ohly reports that there are 4 members registered to write the Certification Exam from Victoria and 2 members from Nanaimo.

Unit in-service sessions continue to provide their members with educational information. They are fortunate to participate in other GI related classes offered at the University of Victoria.

The Chapter is hoping to provide some assistance to 4 of their members who are registered to attend the WCOG Conference in Montreal. Other members would love to attend but as with everywhere else, this is solely dependant on Staffing levels at each of these Units.

Okanagan Chapter

Secretary Jean Tingstad submitted the following information about their Chapter activities. They have a new Chapter President, Bethany Rode, taking over from Karen Parchomchuk. Welcome Bethany!

Three of their members attended an Okanagan Gut Club meeting in December. The presentation was by Dr. Bruce Yacyshyn on the topic "Designer Genes." The focus of this informative presentation was the treatment of IBD, and what to expect in the next five years.

Three nurses are busy studying to do the C.N.A. Certification Exam in April.

One member from the Okanagan Chapter is planning on attending the WCOG.

Vancouver Regional Chapter

President Adriana Martin and Chapter Secretary Monica Brennan report that a Chapter Education Day is set for April 9. To be held at Lion's Gate Hospital in North Vancouver. The focus of the program will be on the Liver- The Liver that the Nurse wants to know. Thankfully, those of us working in Endoscopy never get to see one! But we do see the effects of Liver related problems within our GI Endoscopy Practice quite regularly! Watch for brochures that will be sent out in the first week in March.

At least two Chapter members will have written the Certification Exam the week before this event.

Respectfully Submitted by
Nala Murray RN, CGN(C)

DIRECTOR PRACTICE

This year new Position and Guideline will be presented in respect to personal protective equipment, jewellery and false nails in the Endoscopy unit. Infection Control guidelines will be updated to reflect and take into account the latest in infection control from the SGNA, the APIC Text of Infection Control and Epidemiology and both the latest research and evidence based studies. These will be presented to the CSGNA executive prior to the Annual Conference in Montreal, and if approved will be published in the Guiding Light in the September issue.

In order to continue developing new issues, we need your input. Please keep the questions coming and if you would like to chat on line in order to prepare for the upcoming certification – you are welcome to join in each Monday evening at 8 pm to 10 pm. Good luck to all who are writing in April.

Branka Stefanac

EDUCATIONAL REPORT

Where did the year go? The clock is ticking way too fast.

Certification: How are the brave ones doing in reviewing their manuals in preparation for the certification exam? If you need any study material please contact me and I will forward you what we have prepared for study groups. We are hoping to release in April a binder with study modules and practice questions. CNA is planning to develop a guide in preparation for certification exam and this guide would be generalized enough that it would fit any specialty. Look for it on CNA website in the next three months. This year at the World Congress in Montreal we will offer the certification course on the Sunday September 11. The format will be changed.We will do a mock exam and we will allow time for questions and answers.

Professional Nursing award: A reminder that the deadline for submission is March 15. Look within your peers who promote and enhance the image of the GI nurse in her hospital. Learn the recognition criteria (included in the Guiding Light) and make sure to nominate this wonderful person. The nomination form is in the Guiding Light. The GI nurse must be nominated by at least two nominators. Talk about it at your staff meetings and take action. People are doing great jobs and we want to recognize them.

Orientation Manuals: We apologize for the long delay but we should be able to have the final product done by June. We will keep you posted.

Scholarships: You may be eligible for a CSGNA annual scholarship award to attend the National annual conference. Submission must be received by May 1.

This year there is a new Educational scholarship offered by SciCan. It is worth $1,500.00 and is to be awarded to a member of CSGNA. The award will go to a person who has made a significant contribution to GI advancement. In order to encourage applicants from all parts of Canada, each CSGNA Chapter will be asked to submit one qualified candidate for the scholarship. The choice of which candidate to submit rests with each Chapter. Submission must be received by May 31st of each year. See the Guiding light for more details.

In conclusion I would like to invite as many nurses as possible to attend the World Congress 2005 meeting in Montreal starting September 11 to 14. This conference will be unique. It will gather hundreds of gastroenterology nurses and GI Associates internationally and we will be exploring many facets of nursing practice. ***Even if the deadline for abstracts is passed [Feb 18th/2005] should you want to submit one and share with your colleagues what you do well you may e-mail signea@aol.com to ask if your abstract can be submitted. See you in Montreal.***

Submitted by Michele Paquette CGRN,CGNC

UPDATE FROM YOUR TREASURER

Once again our financial information will been sent to our accountant at Pricewaterhouse Coopers Assurance and Business Advisory Services for our annual review. This information will be published in our annual report.

I would like to congratulate the Calgary Chapter on the financial success of the 2004 National conference;. GREAT WORK Ladies. The national conference is the main fundraiser for the National component of the CSGNA with 10% going to the hosting chapter.

Last year at our National Conference our Market place was a great success, thanks to all who helped make this happen, especially Joan Rumsey. Luggage tags & 50/50 tickets were a hit.

I would like to remind all chapters that have not sent in their year-end reports, to please complete them and send to me ASAP . If you do not have a copy of this form please let me know & I will e-mail or send it to you.

MEMBERSHIP DIRECTOR REPORT

Our membership stands strong with 623 members at present. This is marginally higher than last year at this time. While our membership numbers are steady, we are not experiencing growth. We know that field of Gastroenterology is growing, especially in the area of endoscopy units and private clinics. We need to find a way to find those working in these areas and encourage them to join CSGNA.

As we look forward to our Montreal Conference in September, please remember that registration for the conference is through SIGNEA. **THERE WILL NOT BE AN OPPORTUNITY TO JOIN CSGNA WITH REGISTRATION FOR THE CONFERENCE.**

Membership renewal forms will be sent out in April for membership renewal due June 1st. Membership renewals not received by this date will result in forfeiting your continuous membership years, by which qualification for scholarships and awards are measured. As always, I ask that you print all your information clearly to avoid address errors. A pre-printed address label applied to your form is great!

Chapter Presidents may request a membership list for Chapter meetings and events. Please send a request for your list 1 week prior to your event. That way, you will have the most up-to-date-list of your local members.

Please feel free to contact me regarding any membership questions and suggestions to promote our association.

Respectively submitted
Elaine Burgis
burgis@rogers.com

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@hhsc.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

FUTURE CSGNA CONFERENCES

WORLD CONGRESS MONTREAL 2005

REGINA 2006

HALIFAX 2007

VANCOUVER 2008

TORONTO 2009

INFECTION CONTROL: DISINFECTION OF THE AIR SUPPLY

Pauline Porter,R.N., BScN.
St. Michael's Hospital
Therapeutic Endoscopy Unit

As a front line worker in a busy Endoscopy Unit that services a large homeless, immigrant and indigenous population the risk for infection is present. In a perfect world the unit would be aware of the need to isolate a patient to prevent and control communicable disease from spreading. Unfortunately the need to isolate is not known until after the procedure. It is difficult to use the correct method of infection control if the need is not communicated. What else besides communication and the use of negative or positive pressure rooms are available to protect the front line workers?

There is a technology available that treats the air supply. It uses an old technology, ultraviolet light. Ultraviolet light has four principal wavelengths, UV-A, UV-B, UV-C and UV-V. Ultraviolet light is a portion of the electromagnetic spectrum that lies beyond the purple edge of the visible spectrum. The UV-A wavelength is responsible for sun tanning in the human skin. The UV-B causes sun burning. The UV-C wavelength is absorbed by DNA and can cause cancer and mutation. It is this wavelength that is most effective in inactivating bacteria and viruses. The UV-V is absorbed strongly by water and air and can only be transmitted in a vacuum.

The UV-C is short wave radiation. Its' primary uses are for the destruction of bacteria and other microorganisms. The UV-V is primarily used for oxidization that neutralizes odors in the air. Together the two ultraviolet wavelengths work to destroy the contaminant; UV-C penetrates the cells membrane destroying the cell's DNA while the UV-V destroys the chemicals of the dead cell. The UV-C and UV-V attack the microorganism on a molecular level. It changes the DNA of the cell. These changes produce incorrect codes being transmitted from the altered DNA, which leads to the destruction of the microorganism. This technology is recommended by The Centers for Disease Control for destroying viruses.

The use of Ultraviolet light will destroy biological, chemical contaminants and odors such as bacteria, viruses, mold, mildew, smoke, formaldehyde and cleaning solvents. This is a technology that should be in use in high risk areas. Again this is another device that could protect the front line workers and patients.

To achieve the aim of prevention of the outbreak of air-borne diseases the use of UV technology and negative pressure and or positive pressure rooms should be a standard in Endoscopy units.

NEW INTERNATIONAL RATE

Starting for the 2005 Annual Course International Attendees will receive a $50 discount on SGNA Course Registration. For more information go to www.sgna.org or call 800/245-7462. Program and registration material will be available 12/1/04.

SGNA
32nd Annual Course

"Passion for GI Nursing: Pass It On!"
May 13-18, 2005
Minneapolis, MN

Board Positions Available

September 2005

There are several Board positions available this September. They are:

Secretary

Treasurer

Education Director

Practice Director

Director Canada West

Director Canada East

These are two year positions. The job descriptions can be found on our website @ www.csgna.com Please submit your nominations to Nancy Campbell, 6596 Delorme Ave., Orleans, Ontario K1C 6N6 or fax to 1-613-837-5049 or Email to nlcampbell@sprint.ca. Please consider stepping out of the box and submitting your nomination. I can guarantee that you will grow as a person; not to mention the wonderful new experiences and friendships you will encounter. We would like to have you on our team!

National Director Positions for Nomination

Elaine Burgis, Membership Director

It's time again to consider becoming actively involved in CSGNA by sending in your nomination form for a National Executive position. National positions are a two-year commitment and open only to active members. Along with this term comes the enriching experience and personal growth that can only be gained by promoting our speciality.

Along with a National position comes a commitment to CSGNA. Directors must attend all Annual Conferences and Face-to-Face meetings, and participate in teleconferencing meetings or e-mail meetings. They must submit reports to each issue of the Guiding Light, so that our membership stays up to date with the association and it's activities.

Positions open for nomination and a short job description follow. Full duties of the National Directors are in the November 2004 issue of the Guiding Light.

Secretary: records the minutes of all meetings, forwards minutes to all Directors and provides a summary for submission in the Guiding Light, compiles the Annual Report, issues all notices of meetings

Education Director: responsible for certification, oversees scholarships, provides approval for education content of Annual Conferences, expands and improves publications to support members, generates ideas for education

Regional Directors – East and West: encourages and assists chapters in their region, is the liaison with their Chapters, reports on Chapter activities. *You must be a member of the appropriate region to be eligible for these positions.*

Practice Director: monitors, develops, updates and acts as the resource person for practice guidelines, position statements and standards.

Treasurer: maintains all financial records at the National and Chapter level, is a member of the Annual Conference Planning Committee, arranges for annual financial audit and reports financial records to general membership.

Nominations for National executive positions are due by May 1st. Nomination forms are available in each issue of the Guiding Light. Along with the form, a current curriculum vitae (CV) is required.

In June, the annual report is sent to all members. The annual report contains all CVs of the candidates for positions. A ballot form is included. Please take the time to read the CVs of all candidates, and forward your vote.

Members! It's time to get involved!

SYNOPSIS OF CSGNA EMAIL MEETING NOVEMBER 29 TO DECEMBER 3, 2004

1. **REVIEW AND ADOPTION OF AGENDA**:
   A motion was passed to accept the minutes from the Calgary meeting and adopt the agenda for the email meeting. Usha/ Monique

2. **REPORTS:**
   Canada EAST- NFLD, NS, PEI/NB chapter

3. **TREASURE:** Edna reported that the Calgary conference expenses were not finalized, but it looks like we will have approximately $42,000.00 profit. This was a very successful conference and the profit made from this conference was the second highest to date.

4. **Bylaws:** New bylaw
   5.0 MEMBERS
   5.2.1 Any RN serving in an executive position at the Chapter or National level shall be an active CSGNA member.
   It was noted that there are a few bylaws in the Guiding Light in which nouns and verbs do not agree these will be reviewed in April.

5. **Calgary conference report**: Thank-you Calgary for a stimulating conference, 80% of the conference attendees rated the conference as four or five.

6. **Survey results**: Three surveys were handed out to at the Calgary conference. There were 296 registrants at the conference. The results are as follows:
   GNJ: 115 responses, majority felt that it was too expensive to purchase the Gastroenterology Journal an individual CSGNA member and that the endoscopy department should subscribe to the journal.
   CSGNA WEBSITE: 101 responses most were aware of the website and 86 had accessed it in the past year. Helpful information on the website was the guidelines, position statements, chapter and board members name with contact information, infection control information, and certification and education sessions. Some suggestions were to have the website up to date with current GI issues.
   The Guiding Light: 87 read the Guiding Light, 86 found the information in the Guiding Light useful. Some of the suggestions were to have humorous stories and more topics related to the nurse working in the GI unit, articles on GI drugs, more pediatric articles, and job descriptions both at the national and local level.

7. **NEWSLETTER:** Leslie is always looking for commitments for articles from the members and the executive boards.

8. **PUBLIC RELATIONS**: Jennifer and Mary Carboneau at Webray are developing guidelines for submission website submissions. All submissions go through Jennifer for review. She is looking for photos from the past National Conference to post the website.

9. **PRACTICE:** Guideline "Patient having Bronch" will be renamed to "Care of patient Undergoing a Broncoscopy."

10. **MEMBERSHIP:** Elaine reported that our current membership is 601. Elaine is also developing the chapter the criteria so we can establish a new award.

11. **MARKETPLACE:** Joan is shopping for interesting articles for the marketplace.

12. **WORLD CONGRESS 2005:** Cindy Hamilton presented the draft program which will be finalized before the face to face meeting
    FACE TO FACE CONFERENCE: Ottawa April 8-10, 2005

Submitted by Usha Chauhan

Just How Boring is Endoscopic Ultrasound for the GI Endoscopy Nurse???

Nala Murray RN, CGN(C.) Clinical Nurse Leader
GI. Clinic, St Paul's Hospital

As our G.I. Endoscopy Unit prepares for the progress of the latest technology in Gastroenterology Endoscopy, nurses are asking a number of questions.

Endoscopic ultrasound (EUS) will be introduced to us at St.Paul's Hospital in Vancouver BC starting in May 2005. Our Unit has been fortunate to take on three new Gastroenterologists and EUS happens to be a specialty for two of them!

Our EUS patients, we are told, will tend to receive a lot more sedation for these procedures and will require more extensive monitoring and recovery time. We ask, what patient care issues are unique to this population? How will we properly prepare our patients for this Procedure? What Patient Care teaching will we provide? How much time or extra staff will be required to recover these patients so that we maintain the Standards of Nursing Care? What impact does this have on these patients' care and the routine of our Ambulatory GI Unit?

How will we cope with the extended stay of these elective patients?

How will the nurse assistant learn the anatomy and physiology of this high tech modality? What is it that the GI Nurse will find interesting in this new diagnostic tool? What role will the nurse play other than acting as "nurse anesthetist"?

What equipment and handling of such will require skills performed by the nurse assistant?

As the Physician decides to puncture a pancreatic pseudocyst with a fine wire needle, in which the nurse has skillfully prepared and passed to. How does the nurse learn what area the Physician actually sees?

Various shades of black and white and gray and then some other colours are what the nurse sees on the Ultrasound imaging screen, nothing like the pinks and identifiable landmarks we see on an endoscopic colonoscopy exam.

How long will it take for us nurses to be comfortable with this new stuff?

We, as G.I. Nurses are so fortunate to be in a constantly evolving field of technological progress. So, it is never boring!

Industry is striving for the best patient care and outcomes. We are lucky to have access to very knowledgeable clinicians associated with our Vendors and Physicians. As each new technology emerges we must rely on every resource available to teach us and answer every question. Networking with other nurses who have paved the way is also a very valuable resource, as well as the 600 or so members of the CSGNA.

It's really very exciting to be a part of "cutting edge technology" and new advances in patient care.

Our GI Endoscopy Unit nurses are excited to participate and become knowledgeable and proficient in this new technology for the betterment of patient care and positive patient outcomes. We look forward to networking with all of you- those that have walked this path and those that are about to embark.

Let's all keep our minds open to these concepts and ideas, embrace the new, reveal your knowledge and all of your skills openly and readily to others. Each of us has a very impressive gift. It is really essential that we share.

Our team of nurses presented Dr. Eric Lam with these questions and the following is his take on Endoscopic Ultrasound. For your educational pleasure please read the following.

KNOWLEDGE QUIZ ON PPE:

What type of PPE would you wear?

1. Giving a bath?
2. Suctioning oral secretions?
3. Transporting a patient in a wheelchair?
4. Responding to an emergency where blood is spurting?
5. Drawing blood from a vein?
6. Cleaning an incontinent patient with diarrhea?
7. Irrigating a wound?
8. Taking vital signs?

Answers on page 35

Endoscopic Ultrasound at SPH, Vancouver

Dr. Eric Lam MSc. MD FRCP(C), Clinical Instructor
Division of Gastroenterology, St. Paul's Hospital

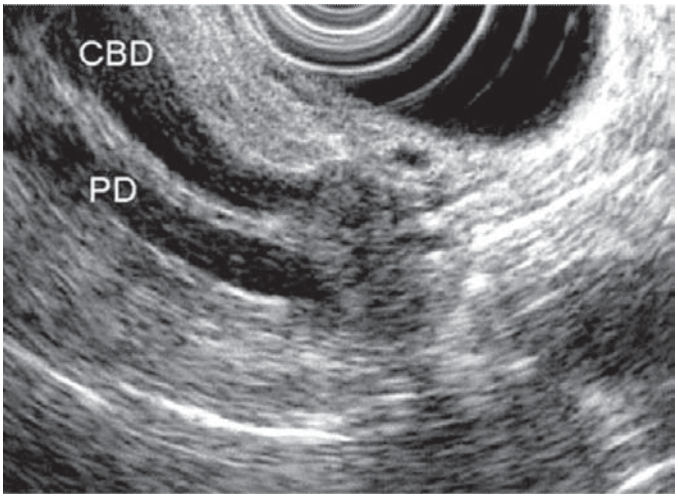
In the summer of 2005, St. Paul's Hospital in Vancouver is expected to have facilities for endoscopic ultrasound (EUS). EUS is a relatively new technique in Canada that enables the gastroenterology team to look at structures outside the lumen of the gut. In a specially designed endoscope, an ultrasound transducer is attached to the tip. This enables the gastroenterologist to place the transducer and therefore image organs deep in the retroperitoneum and mediastinum. Since the resolution of ultrasound is better when the transducer is closer to the organ of interest, it has advantages over conventional trans-abdominal ultrasound when imaging the pancreas, bile ducts, and the layers of the GI lumen wall.

There are two types of endoscopic ultrasound scanning fields: radial and linear. Radial echoendoscopy provides a 360 degrees ultrasound scanning field that is perpendicular to the shaft of the endoscope. It therefore gives a circumferential view of structures surrounding the lumen. It is ideal to look for choledocholithiasis, investigate recurrent idiopathic acute pancreatitis, T stage luminal cancers, look for neuroendocrine tumours and image the depth of polyps or ampullary tumours prior to resection.

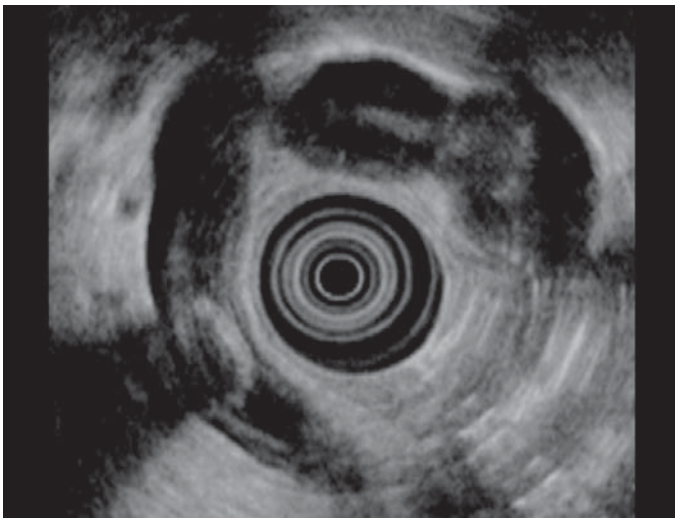
The linear echoendoscope has its scanning field that is parallel to the shaft of the endoscope. Although this limits the ultrasound visualization, the linear echoendoscope advantage is that it enables the gastroenterology team to perform a fine needle aspiration biopsy. Since the biopsy needle emerges parallel to the shaft of the endoscope, the needle can be seen in its entire trajectory and therefore guided to the lesion of interest while avoiding vascular structures. Linear echoendoscopy is therefore ideal to biopsy suspicious lymph nodes in the middle mediastinum, upper retroperitoneum and peripancreatic lymph nodes. It can also be used to stage pancreatic cancer, and obtain a tissue diagnosis within the same procedure.

Diagnostic and therapeutic EUS is an evolving step in the management of upper GI tract cancers. It gives the gastroenterologist more information about the nature of the GI pathology and is linked to other gastroenterology procedures. For example, in a patient with low to moderate probability of choledocholithiasis, EUS can be performed before a therapeutic ERCP to document the presence or absence of bile duct stones and therefore select patients to which an ERCP would be beneficial.

The procedure is carried out in much the same way as a diagnostic gastroscopy. Patients undergo intravenous sedation but often require more medication throughout the procedure because of the longer time it takes to image all structures. The procedure takes about 30-45 minutes depending on what is specifically asked of the endosonographer. The complication rates of a diagnostic EUS is similar to that of a gastroscopy and is usually related to sedation.

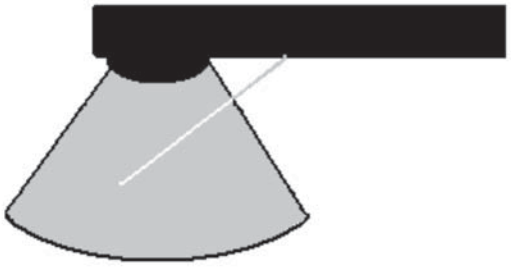


The "double duct sign".
A tumour in the head of the pancreas.

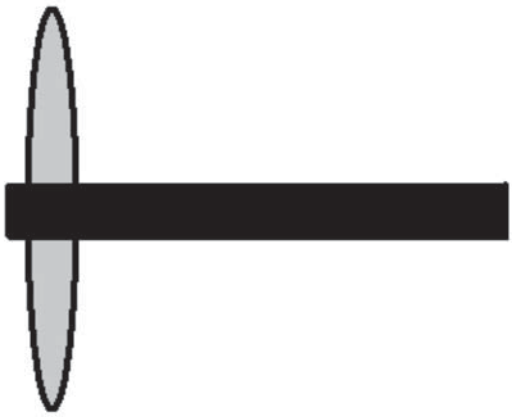


Radial echoendosonography of choledocholithiasis.

Nurses will need to familiarize themselves with the pertinent anatomy of the upper retroperitoneum and mediastinum to understand the capabilities of EUS. The technique also requires the learning of how to handle endoscopic fine needle biopsy and the handling of biopsy specimens. With new technologies and a motivated team approach to EUS, keeping up with changing developments in the field will eventually benefit our patients.



Linear scanning field of a linear echoendoscope with an EUS FNA needle.



Radial scanning field of a radial echoendoscope.

Canadian Society of Gastroenterology Nurses & Associates

Foundations: GI Certification Prep Course

CSGNA is pleased to once again offer you the preparation course for the Canadian Gastroenterology Certification exam. We call it "Foundations." It will take place in conjunction with the World Congress being held in Montreal in September, 2005. This course is an excellent review of anatomy & physiology. This year we are planning to include a mock exam. Cost will be $50.00 Canadian. If you are planning to write the 2006 GI Certification exam or, simply want to explore the possibilities, this course is a must! For further information and a registration form please consult our website www.csgna.com. Register early as space is limited.

Announcing the SciCan Educational Scholarship

SciCan, in conjunction with CSGNA, is pleased to announce an annual educational scholarship in the amount of $1500, to be awarded to a member of CSGNA for use in attending the National CSGNA Conference (conference registration, hotel, flights, meals, etc.). The award will go to a person who has made a significant contribution to GI advancement and education in her/his hospital or community.

In order to encourage applicants from all parts of Canada, each CSGNA Chapter will be asked to submit one qualified candidate for the SciCan Educational Scholarship. The choice of which candidate to submit rests with each Chapter. The application should consist of a one-page description of the candidate's contributions to endoscopy in the region. All other selection criteria that pertain to CSGNA educational awards apply. **Applications should be sent to the Education Director of the CSGNA by May 31st of each year.**

Choosing a winner from among the seventeen candidates will not be an easy task! We expect that the calibre of applicants will be very high, and neither SciCan nor the CSGNA executive believes that they we should stand in judgment of the applicants and deem that one is more deserving than the others. Therefore, assuming that the seventeen candidates all meet the criteria, a draw will be made for the winner. That person will be announced in the June/ July issue of The Guiding Light and will be presented a commemorative plaque at the CSGNA annual meeting. The winner's name and photograph will also be published on SciCan's website.

The inaugural SciCan Educational Scholarship will be awarded to attend the World Congress in Montreal in Sept 2005. Applications for this scholarship are due May 31, 2005.

SciCan is a Canadian manufacturer and distributor of medical and dental products. Our medical products in Canada include the Innova endoscope washer-disinfector, Statim sterilizer, Fujinon endoscopy systems, US Endoscopy endoscopic accessories, Medicart endoscope transport systems, SciCan endoscope storage cabinets and Medisafe instrument cleaners. SciCan is pleased to support the CSGNA and its goal of keeping its members abreast of developments in the field of Gastroenterology. We are privileged to work with such a dedicated, professional and fun-loving group of people.

CARROT BUNDT CAKE

1 Philadelphia cream cheese
¼ cup sugar
1 egg beaten
2 c flour
1 ¾ cup sugar
2 tsp baking soda or powder
2 tsps of cinnamon
1 tsp salt
1 cup oil
3 eggs beaten
3 cups of shredded carrots
½ cup chopped nuts

Cream cheese and ¼ cup sugar and 1 egg and beat till smooth – set aside.

Dry ingredients: add oil, eggs, and mix until most, now fold in carrots and nuts.

Pour half of dry ingredients on the bottom of the bundt cake mould, then the cheese mixture, and carefully spoon rest spoon the rest of the carrots and nuts mixture.

Bake at 350 for one hour cool.

Ogilve's Syndrome: Acute Colonic Pseudo-obstruction

Submitted By: Nancy Campbell RN CGN©

DEFINITION:

Acute Colonic Pseudo-obstruction (Ogilvie's Syndrome) is a disorder characterized by gross dilatation of the cecum and right hemicolon. The dilatation may occasionally also extend into the rectum. This dilatation occurs in spite of the absence of any anatomic lesion that would obstruct the flow of intestinal contents.[1]

ETIOLOGY:

The precise cause of Ogilvie's Syndrome is unknown

Common clinical conditions associated with Ogilvie's syndrome include:

Trauma-especially fractures

Obstetrical surgery especially if spinal anaesthesia used

Pelvic, abdominal or cardiothoracic surgery

Major orthopedic surgery

Severe medical illness such as pneumonia, myocardial infarction or congestive heart failure.

Neurological conditions.

Retroperitoneal pathology such as malignancy or hemorrhage.

One of the above plus metabolic imbalance (especially hypokalemia, hypocalcemia or hypomagnesemia) and/or the administration of narcotic, phenothiazide, calcium channel blocker, alpha-2-adrenergic antagonists or epidural analgesics can also be precipitating factors.[1,4,5]

MANIFESTATION:

It is more common in men and in patients who are over 60 years of age. Typically the patient is recovering uneventfully post-operatively, and is already eating when his abdomen becomes grossly distended, often causing his breathing to become laboured. In the early stages, peritoneal signs are usually absent. Their presence may suggest impending perforation. However, bowel sounds are present in almost 90% of patients with the abdomen being tympanitic. Nausea, vomiting, abdominal pain, constipation, and diarrhea are the primary manifestations although these occur with variability. However, abdominal distention is always present. Laboratory findings may exhibit electrolyte abnormalities such as hypocalcemia, hypokalemia, and hypomagnesemia. Plain and upright abdominal xrays show a dilated colon.[1]

MANAGEMENT:

Management may include conservative, pharmacological, and/ or surgical interventions.

CONSERVATIVE INTERVENTIONS:

A colonoscopy or gentle water soluble enema is essential for confirming the diagnosis. In addition the hyperosmolic enema often serves to evacuate the colon.[14] Decompression of the colon via a colonoscopy and placement of a decompression tube may also be effective. It is not necessary to reach the cecum for effective decompression to be achieved. Reaching the hepatic flexure with aspiration of proximal contents usually collapses the right colon. If an abdominal xray following colonoscopy documents a collapsed cecum enemas can be administered until there is spontaneous passing of flatus and stool.[11,12,13] There is no colonic diameter that mandates decompression. When supportive measures have failed and the colonic diameter has reached 11 to 13 centimetres or there is evidence of clinical deterioration, decompression is indicated.

All possible precipitants should be removed i.e opiates, anticholinergics.[2,3] Patient should be kept NPO and parenteral fluids administered. A nasogastric tube to intermittent suction should be inserted. Electrolyte imbalances should be corrected. A rectal tube attached to gravity drainage should be started. Gentle enemas can be administered although they have been associated with perforation.

PHARMALOGICAL INTERVENTIONS:

The quickest, most effective method documented to induce rapid colonic decompression is by the administration of neostigmine 2.5mg intravenously over a 1 to 3 minute interval.[6,7,8,9,] The median response to neostigmine is 4 minutes. When neostigmine is administered the patient should be on a cardiac monitor and atropine should be available to be given to counteract the vasovagal (nausea, bradycardia, vomiting) response often generated by the administration of neostigmine. This regimen may be repeated up to three consecutive times until success is achieved. The patient should be kept supine for at least 60 minutes after receiving neostigmine due to its hemodynamic effects.[1] The use of erythromycin has also been documented to be effective in the treatment of Ogilvie's Syndrome. Erythromycin binds to motilin receptors in the bowel and stimulates smooth muscle contractions thus possibly resolving the obstruction.[10] It may be administered either intravenously or by mouth.

SURGICAL INTERVENTIONS:

When all of the above measures fail to resolve the pseudo-obstruction, surgery may be indicated. A cecostomy tube may be placed either percutaneously, laparoscopically or by the conventional open method.[15] When perforation of the bowel has occurred combined right hemicolectomy, ileostomy, and mucous fistula is the operation of choice. In patients with nonviable bowel but without perforation, a right hemicolectomy with primary anastomosis can be safely performed with little risk of serious complications.

ASGE GUIDELINES:

The American Society for Gastrointestinal Endoscopy (ASGE) guidelines recommend initial conservative therapy after mechanical causes of obstruction have been excluded for patients without significant abdominal pain or signs of peritonitis and those who have one or more potential factors that are reversible. Conservative therapy includes appropriate management of predisposing factors, nothing by mouth, nasogastric decompression, aggressive use of optimal body positioning, and often placement of a rectal tube with or without prior use of limited tapwater enemas. Patients should be placed in a prone position with the hips elevated on a pillow or the knee chest position with the hips held high. These positions should be alternated with right and left lateral decubitus positions each hour. Conservative therapy can be continued for 24-48 hours provided there is no pain or extreme (>12cm) colonic distention. Patients should have serial physical examinations and plain abdominal xrays every 12-24 hours. Pharmacolgical therapy with neostigmine therapy should be considered for patients at risk for perforation, failing conservative therapy. Colonic decompression should be attempted in patients who fail or who have contraindications to neostigmine (i.e.patients with bradyarrythmias or those receiving beta adrenergic antagonists) Surgical decompression with cecostomy or colectomy should be reserved for patients who fail endoscopic and pharmacological therapy and for those in whom exploration, lavage, or drainage of the peritoneal cavity is indicated for other reasons.[1]

SUMMARY:

Ogilvie Syndrome is an acute condition that requires close monitoring and intervention or combination of interventions to resolve. This condition can be fatal.

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12. Strodel WE, Brothers T: Colonoscopic decompression of pseudo-obstruction and volvulus. Surg Clin North Am 69:1327,1989.
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15. Duh QY, Way LH: Diagnostic laparoscopy and laparoscopic cecostomy for colonic pseudo-obstruction. Dis Colon Rectum 36:65,1993.

CHANGE OF NAME/ADDRESS

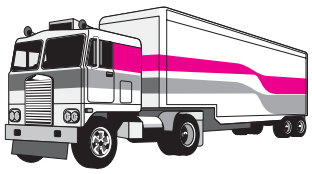
Name: _____

New Address: _____

City: _____ Province: _____

Postal Code: _____ Phone: _____

Fax: _____ E-Mail: _____



MOVING?
LET US KNOW!

Remember to send in your change of address!

PPE (Personnel Protective Equipment): Are you up to date?

Written by M Paquette CGRN,CGNC Education Director

The intent of this article is to provide an update to the hospital worker on the latest recommendations for the application of PPE in the Endoscopy Suite.

Why must we use PPE?

To prevent transmission of respiratory and other pathogens to workers and clients in Health Care facilities during all procedures that have the potential to generate droplets, aerosols or transfer microorganisms either by direct or indirect contact. As a rule you will never be sorry for over-protecting yourselves.

Routes of transmission:

A. Contact:

Direct: Transfer of microorganisms from direct physical contact between infected individual and susceptible host (body surface to body surface).
Indirect: Passive transfer of microorganisms to a susceptible host via intermediate object (contaminated instrument) or surface contaminated (eg: MRSA-Clostridium Difficile).

B. Droplet:

- It is a contact transmission but requires special considerations.
- Refers to large droplets.
- Generated from respiratory tract of patient when coughing or sneezing.
- Droplets are propelled a short distance < 1m and are deposited on nasal or oral mucosa of new host.
- Example of organisms transmitted this route: influenza, rhinovirus.

C. Airborne:

- Dissemination of microorganisms by aerolization.
- Organisms are contained in small airborne particles and remain suspended in air for long period of time.
- Control of airborne transmission is the most difficult as it requires control of air flow through special ventilation system.
- Example of disease transmitted this route: tuberculosis,varicella, measles, small pox.

D. Common Vehicle Transmission:

- Single contaminated source such as food, medication.
- Transmits infection to multiple hosts
- Result: explosive outbreak

E. Vector borne transmission:

- Transmission by insect vectors.

Factors influencing PPE selection:

1. Type of exposure anticipated:
   - This is determined by the type of anticipated exposure, such as touch, splashes, large volume of blood that might penetrate clothing.
   - Category of isolation precautions will require a combination of PPE
2. Durability and appropriateness of PPE for the task. This will affect for example whether a gown needs to be fluid resistant, fluid proof, or neither.
3. Must fit: PPE must fit the user.

Types of PPE:

Gloves: should provide a snug fit on the hands especially around wrist. Gloves if contaminated can become a means for spreading infectious materials. Always work from clean to dirty- avoid touching environmental surfaces with contaminated gloves. If gloves soiled change the gloves before starting the next task.

Gowns or aprons:

3 factors influence the selection of a gown or apron as PPE.

a) Purpose of use
If contamination of arms anticipated, select a gown with long sleeves that fit snuggly at the wrist.

b) Material of the gown: if fluid penetration is likely, a fluid resistant gown should be used.

c) Patient risks: clean gown used for isolation, sterile gown used for invasive procedure like inserting central line.

Face protection:

Masks – protect nose and mouth
– should fully cover nose and mouth and prevent fluid penetration

Goggles – protect eyes
– should fit snuggly over and around eyes
– personal glasses not a substitute for goggles

Face shield – protect face, nose, mouth and eyes.
– should cover forehead,extend below chin and wrap around side of face.
– faceshield can be used as a sustitute to wearing a mask or goggles.

Respirator Protection: 3 types

a. Particulate Respirator(N95)
The device has a sub-micron filter capable of excluding particles that are less than 5 microns in diameter.
b. Half or full-face elastomeric respirators
c. Powered air purifying respirators(PAPR)

Prior to using a respirator your employer is required to have you:

a. Medically evaluated to determine that it is safe for you to wear this mask
b. You must be fit tested
c. You must receive training on how and when to use a respirator

PPE for standard precautions:

Mask and gloves or faceshield to be used during patient care activities that are likely to generate splashes of blood, body fluids.

Gown if any chance of contact of blood/body fluids.

Contact precautions:

Gloves and gown

Airborne Precautions:

N95 mask

Expanded Precautions:

Include contact, droplet and airborne

References

Standards for all Ontario Health Care Gfacilities/Settings for high-risk Respiratory Procedures under non-outbreak conditions April 15, 2004 Centers for Disease Control and Prevention

MOH high-risk procedures and Health Canada guidelines for TB

CCDR Guidelines for Preventing the Transmission of Tuberculosis in Canadian Health Care Facilities and Other Institutional Settings

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

9th Education Meeting of the Society of International Gastroenterology Nurses and Endoscopy assistants (S.I.G.N.E.A.)

Respectfully submitted by Cindy Hamilton RN CGN (C)

Concurrently with the World Congress of Gastroenterology this meeting will take place, in cooperation with the Canadian Society of Gastroenterology Nurses and Associates. (C.S.G.N.A.). Hundreds of gastroenterology nurses and GI associates internationally will be exploring the many facets of nursing practice that make a difference to the health outcomes of the patients we care for in our endoscopy and GI departments.

The Scientific Program will address standards of practice for gastroenterology units, management concepts, state of the art procedures, infection control, nursing research, writing for publication, nutrition, holistic and alternative therapies, drug therapy designing and staffing GI units, ethical issues in gastroenterology and evidence based practice just to mention a few of the topics. All topics will be current and relevant to present and future issues in gastroenterology. A bevy of international speakers will provide an interactive atmosphere and address global aspects of GI. Nurses will be involved in breakout sessions of various topics and there will be live endoscopy sessions from the Wellesley Endoscopy course being held in conjunction with the WCOG.

Objectives of this course:

- To encourage exchange of information with colleagues
- To provide current information in the field of gastroenterology
- To present information about current and emerging diagnostic and therapeutic techniques in gastroenterology and their application to the art and science of nursing.
- To provide and encourage participants to share and exchange information of clinical and research interests.
- To foster collaboration between nurses and other members of the health care team
- To provide opportunity to view current endoscopic equipment and current research progress.

Highlights of this course:

- Opening ceremonies Sunday September 11th
- Nurses welcome reception
- Live endoscopy sessions
- CEU's (education hours) as per CBGNA
- Free paper sessions
- Poster sessions
- Plenary and Breakout sessions
- Canada Night: a celebration of Canada. This evening will take you through a culinary and cultural tour of Canada's most renowned kitchens. *(There is a separate fee for Canada night)*

THE BEAUTIFUL CITY OF MONTREAL:

Old world charm and French joie de vivre combined with a modern style all its own, this is today's Montreal. Canada's second largest city and the second largest French speaking city after Paris the city is a monument to it's cultural heritage. Although the majority of inhabitants are Francophone the city is still an example of the multiculturalism that Canada is so well known for. The weather in September is moderate and a most beautiful time of year in Montréal.

The majority of hotels in Montreal are within walking distance of the convention centre, and most are directly linked to it through Montreal's well known "underground city". The congress is easily accessible by all delegates. Hotel selection can be achieved by logging on to www.omge.org/events/world.htm

The local organizing committee has chosen four hotels in a moderate price range for the nurses to concentrate on. The four hotels are adjacent to one another and a ten minute walk from the Congress and a five minute walk from the shopping and event district of St. Catherine's Street. Please be aware that spaces are limited so book early.

1. Holiday Inn Midtown, 420 Sherbrooke Street
2. Courtyard Marriott, Sherbrooke Street
3. Four points by Sheraton Hotel and Suites, Sherbrooke Street
4. L'apartment Inn, Sherbrook Street

There are many other fabulous hotels available in the conference venue and these are only suggestions.

The final program will be available in the early fall of 2004.

ABSTRACTS

Those wishing to send in abstracts are welcome to send them to SIGNEA Executive Director
Tel: 847.297.5088 / Fax:847.297.5088
E-mail: signeahq@aol.com

Local Contacts: Cindy Hamilton RN CGRN
Chair Local Organizing Committee
Ph: 905-639- 5506 / Fax; 905-639-0557
Email chamilton39@cogeco.ca

Nancy Campbell RN, Vice Chair LOC
email ancampbell@sprint.ca

REGISTRATION FORM

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

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

Tel.: +31 20 50 40 204
E-mail: wcog2005reg@congrex.nl
Faxed forms will not be accepted

Secretariat use ony

Reg. No.

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

Accompanying Persons: (Taking part in the tour program as described in the program announcement)

Last name First name

Main interest

❑ Gastroenterology 301 ❑ Pathology 302 ❑ Basic Science 303 ❑ Surgery 304 ❑ Other 309 _____

❑ Hepatology 305 ❑ Endoscopy 306 ❑ Radiology 307 ❑ Internal Medicine 308

REGISTRATION FEES

(Check your category and fill in the "amount due")

All amounts are in US Dollar (USD)

A. Core Program	On or before January 1, 2005 **Price**	**Code**	On or before April 15, 2005 **Price**	**Code**	After April 15, 2005 **Price**	**Code**	**Amount due**
Participant	$520 ❑	001	$630 ❑	002	$675 ❑	003	$ _____ USD
Fellow-in-training*	$160 ❑	004	$225 ❑	005	$225 ❑	006	$ _____ USD
Press and media**	comp. ❑	012	comp. ❑	013	comp. ❑	014	$ _____ USD

*Must spend most of their time on educational activities and should include proof of their student status, a photocopy of their university card or a letter from the head of their department or university. Not eligible to 15% discount.
**Must provide a copy of their official media accreditation.

A 15% discount will be deducted from your WCOG 2005 Congress registration fee if you are attending BOTH the Core Program (A) and a Post-Graduate Course (B).
One-day registration will be available on-site.

B. Post-Graduate Courses

AGA - Evidence-Based Gastroenterology: Translating the Evidence into Practice
AGA Members $250 ❑ 17 / 77 Non-members $300 ❑ 18 / 78 Trainee - AGA Members ❑ $100 19 / 79 Trainees - AGA Non-members ❑ $140 20 / 80 $ _____ USD

SIED/AIGE - Interactive Course on Upper and Lower Intestinal Disease and Liver — Included in the congress registration fee 76 $ _____ USD

CSF/CAGS - Frontiers in Minimally Invasive Therapies for Digestive Diseases (Live Surgery) — $300 ❑ 21 / 81 $ _____ USD

CSF/CSCRS - Inflammatory Bowel Disease and Surgery — $250 ❑ 22 / 82 $ _____ USD

CSF/CATS - Management of Esophageal and Esophagogastric Junction Cancer — $250 ❑ 23 / 83 $ _____ USD

CSCN - Intestinal Failure, Functional Foods and GI Disease and Health — $175 ❑ 24 / 84 $ _____ USD

AGEQ / SFED - Emerging Technologies and Current Practice in Digestive Endoscopy — TBA ❑ 25 / 85 $ _____ USD

Yale University - Inflammatory Bowel Disease (Post-meeting Conference) (Not eligible to 15% discount) — $475 ❑ 26 / 86 $ _____ USD

C. S.I.G.N.E.A.

S.I.G.N.E.A. participant (Not eligible to 15% discount.) $300 ❑ 007 $350 ❑ 008 $350 ❑ 009 $ _____ USD

D. Social Program

Participants

Opening Ceremony & Welcome Reception, September 11 — Included ❑ 101 $ _____ USD

Canada Night, September 13 — $ 50 ❑ 102 $ _____ USD

SUB TOTAL DUE _____ **USD**

Please turn over

Name _____ **TOTAL DUE REPORTED FROM PAGE 1** _____ **USD**

E. Social Program (continued) — **Price** — **Code** — **Amount due**

Ticket for Participants Attending a Post-Graduate Course Only

❑ Opening Ceremony & Welcome Reception, September 11 — $ 25 — 103 — $ _____ USD

Spouses and Accompanying Persons

❑ Accompanying Persons Program *(Tours are offered from September 10 to 14 inclusively)* — $175 — 060 — $ _____ USD

❑ Opening Ceremony & Welcome Reception, September 11 — Incl. Accomp. Pers. Fee — 104

Old Montréal Walking Tour ❑ Sept 10 201 ❑ Sept 11 202 ❑ Sept 12 203 ❑ Sept 13 204 ❑ Sept 14 205 — Incl. Accomp. Pers. Fee

❑ Canada Night, September 13 — $ 50 — 105 — $ _____ USD

Select one of the following: — Incl. Accomp. Pers. Fee

Bateau Mouche Cruise (without lunch) ❑ Sept 10 206 ❑ Sept 11 207 ❑ Sept 12 208 ❑ Sept 13 209 ❑ Sept 14 210

or Botanical Gardens & Biodome Tour ❑ Sept 10 211 ❑ Sept 11 212 ❑ Sept 12 213 ❑ Sept 13 214 ❑ Sept 14 215

or Discover Montréal Tour ❑ Sept 10 216 ❑ Sept 11 217 ❑ Sept 12 218 ❑ Sept 13 219 ❑ Sept 14 220

Select one of the following: — Incl. Accomp. Pers. Fee

Bateau Mouche Cruise (without lunch) ❑ Sept 10 221 ❑ Sept 11 222 ❑ Sept 12 223 ❑ Sept 13 224 ❑ Sept 14 225

or Folk Luncheon at Cabane à Sucrre ❑ Sept 10 226 ❑ Sept 11 227 ❑ Sept 12 228 ❑ Sept 13 229 ❑ Sept 14 230

Tickets for Spouses Not Taking Part in the Accompanying Persons Program

❑ Opening Ceremony & Welcome Reception, September 11 — $ 25 — 106 — $ _____ USD

❑ Canada Night, September 13 — $ 50 — 107 — $ _____ USD

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

Discover Montréal	❑ Sept 10 231	❑ Sept 11 232	❑ Sept 12 233	❑ Sept 13 234	❑ Sept 14 235	$ 30	$ _____ USD
Old Montréal Walking Tour	❑ Sept 10 236	❑ Sept 11 237	❑ Sept 12 238	❑ Sept 13 239	❑ Sept 14 240	$ 14	$ _____ USD
Biodome and Botanical Garden Tour	❑ Sept 10 241	❑ Sept 11 242	❑ Sept 12 243	❑ Sept 13 244	❑ Sept 14 245	$ 40	$ _____ USD
Bateau Mouche Cruise (without lunch)	❑ Sept 10 246	❑ Sept 11 247	❑ Sept 12 248	❑ Sept 13 249	❑ Sept 14 250	$ 39	$ _____ USD
Bateau Mouche Cruise (including lunch)	❑ Sept 10 251	❑ Sept 11 252	❑ Sept 12 253	❑ Sept 13 254	❑ Sept 14 255	$ 68	$ _____ USD
Folk Luncheon at Cabane à Sucre	❑ Sept 10 256	❑ Sept 11 257	❑ Sept 12 258	❑ Sept 13 259	❑ Sept 14 260	$ 65	$ _____ USD
Cooking Class	❑ Sept 10 261	❑ Sept 11 262	❑ Sept 12 263	❑ Sept 13 264	❑ Sept 14 265	$160	$ _____ USD
Laurentian Day Trip	❑ Sept 10 266	❑ Sept 11 267	❑ Sept 12 268	❑ Sept 13 269	❑ Sept 14 270	$ 89	$ _____ USD
Québec City Day Trip	❑ Sept 10 271	❑ Sept 11 272	❑ Sept 12 273	❑ Sept 13 274	❑ Sept 14 275	$ 82	$ _____ USD
Ottawa, National Capital Day Trip	❑ Sept 10 276	❑ Sept 11 277	❑ Sept 12 278	❑ Sept 13 279	❑ Sept 14 280	$105	$ _____ USD

TOTAL AMOUNT DUE _____ **USD**

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)

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❑ 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 "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 e a r)

By signing this form I accept the cancellation policies.

HOTEL RESERVATION FORM

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Please return this form to:
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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 (d/d) 09 (m/m) 2005 (year) Date of departure: (d/d) 09 (m/m) 2005 (year) Number of nights _____

❑ One bed ❑ Two beds ❑ Non-smoking ❑ Wheelchair accessible ❑ Early arrival ❑ Late departure

The WCOG 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

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Type of Card: ❑ AMEX ❑ VISA ❑ Mastercard ❑ Diners Club (Card must be valid at the time of WCOG 2005)

Card Number Expiry date (m/m) / (y/y)

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

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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:

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❑ Remitted by bank transfer to ABN AMRO Bank, Vijzelstraat 68 & 78, Amsterdam, The Netherlands, Account number: 54.16.32.167
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Signature _____ Date (d/d) (m/m) (year)

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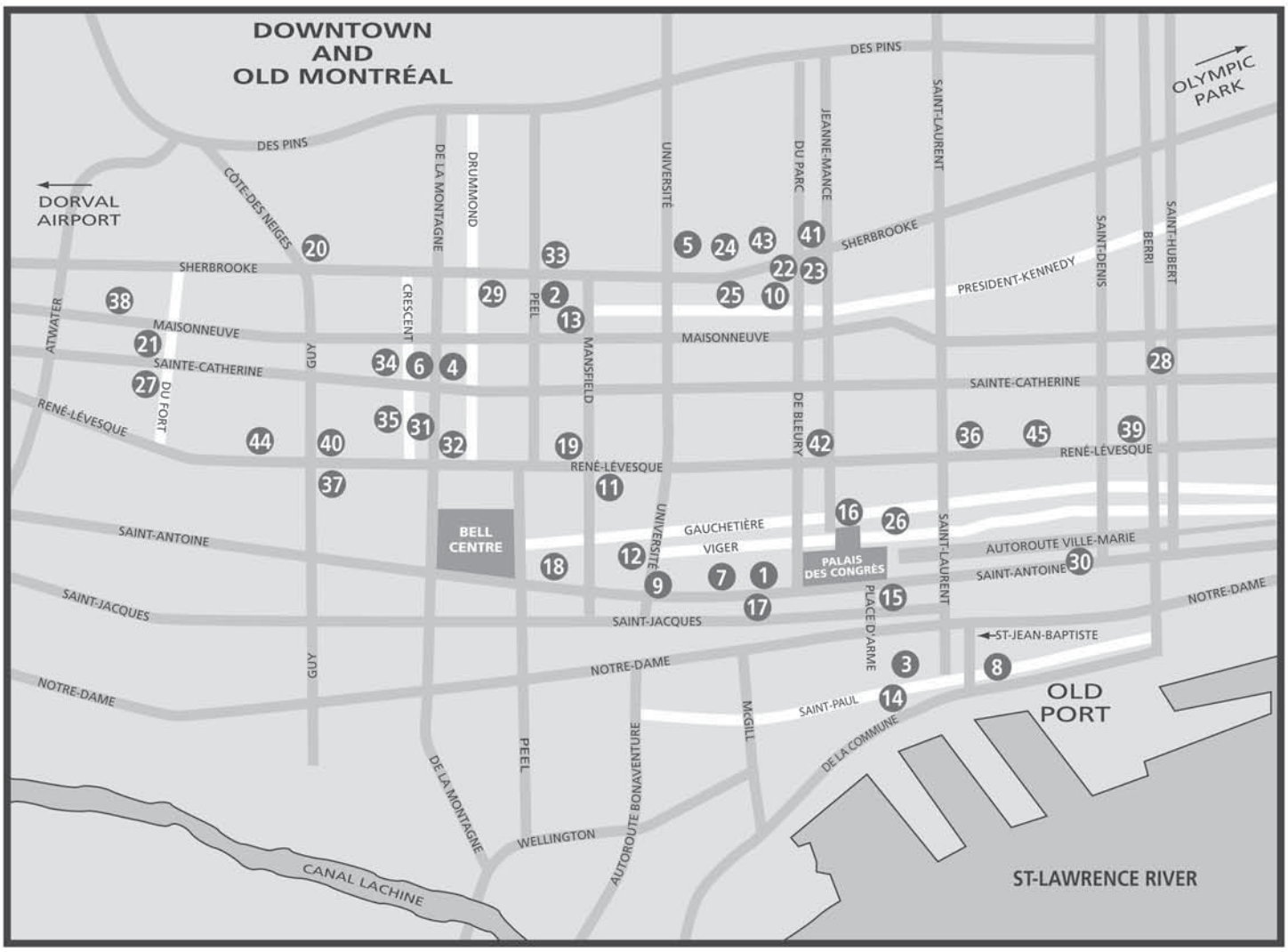
Please turn over

WCOG 2005 OFFICIAL CONGRESS HOTELS

All prices are in USD currency for single or double occupancy and do not include breakfast and taxes.

	Legend	Rate starting from	Code
CATEGORY A			
Inter-Continental	1	242 $	2000
Omni Mont-Royal	2	209 $	2001
Le Saint-Sulpice	3	210 $	2002
Loews Hôtel Vogue	4	265 $	2003
Sofitel Montréal	5	200 $	2004
The Ritz-Carlton	6	242 $	2005
W Hotel	7	228 $	2006
CATEGORY B			
Auberge du Vieux-Port	8	196 $	2007
Delta Centre-Ville	9	126 $	2008
Delta Montréal	10	181 $	2009
Fairmont The Queen Elizabeth	11	188 $	2010
Hilton Bonaventure	12	178 $	2011
Le Germain	13	196 $	2012
Hotel Nelligan	14	189 $	2013
Place d'Armes	15	207 $	2014
Wyndham Montréal	16	165 $	2015
XIXieme Siècle	17	137 $	2016
Marriott Chateau Champlain	18	189 $	2017
Sheraton Centre	19	182 $	2018
CATEGORY C			
Chateau Versailles	20	133 $	2019
Clarion Hotel & Suites Downtown	21	140 $	2020
Courtyard Marriott	22	118 $	2021

	Legend	Rate starting from	Code
CATEGORY C (continued)			
Crowne Plaza Métro Center	23	132 $	2022
Four Points by Sheraton and Suites	24	109 $	2023
Holiday Inn Midtown	25	125 $	2024
Holiday Inn Sélect	26	137 $	2025
Hôtel du Fort	27	137 $	2026
Hotel Gouverneur Place Dupuis	28	132 $	2027
Le Cantlie Suites	29	126 $	2028
Marriott Springhill Suites	30	137 $	2029
Novotel Montréal Centre	31	144 $	2030
CATEGORY D			
Best Western Hôtel Europa Downtown	32	55 $	2031
Best Western Ville-Marie Hotel & Suites	33	104 $	2032
Château Royal	34	111 $	2033
Comfort Hotel & Suites Downtown	35	123 $	2034
Days Inn Downtown	36	95 $	2035
Days Inn Métro Center	37	119 $	2036
Comfort Suites Downtown	38	116 $	2037
Lord Berri	39	90 $	2038
Maritime Plaza	40	119 $	2039
Travelodge	41	104 $	2040
La Tour Centre-Ville	42	99 $	2041
L'appartement-Inn	43	87 $	2042
Le Nouvel Hôtel	44	117 $	2043
Quality Hôtel Downtown	45	97 $	2044



Day 1 – Monday – Sept 12, 2005

7:30-8:00	Registration
8:00-8:15	Welcome and Opening Remarks
8:15-9:15	Nursing in the 21st Century: Challenge of practice/education/research & management
	Speaker: Lucille Auffrey, CNA Executive Director
9:15-10:15	The Maturing Nurse – Ergonomics and Caring for self Feet Hands Back
10:15-11:00	Break/exhibits
11:00-12:15	Video Session
12:15-13:30	Lunch/exhibits
13:30-15:00	Panel Discussion: Professional development in GE Nursing Standards development Assessing competency Training Preparation for emerging roles Speakers: Europe/ Michael Ortman Australia/ ? Di Jones Americas – K. Wright
15:00-15:30	Break/exhibits
15:30-16:30	Endoscopic Cleaning/Infection Control
16:30-17:30	Free Paper Presentation – 15 Minutes each

Day 2 – Tuesday – Sept 13, 2005

8:00-9:00	Management of GERD and its Complications (this would include Barrett, cancer, etc.)
9:00-10:00	Management of GI Bleeding (this might be better broken into two sessions – Variceal and Non variceal ½ hr each with 2 speakers)
10:00-10:45	Break/Exhibits
10:45-12:00	Video Session
12:00-13:00	Lunch/Exhibits
13:00-13:45	Hepatitis, Cirrhosis, and Transplantation Speaker: Dr. K. Orordan – Chicago
13:45 -14:30	SIGNEA Business Meeting
14:30-15:00	Break/Exhibits
15:00-16:00	Functional Testing in GI Lab (this would include pH, Bravo, esophageal, gastroduodenal and rectal manometry, breath tests, etc.)
16:00-17:00	Panel Presentation: Conscious Sedation, Propofol and Nursing Responsibilities Speakers: Europe/ US/ other
17:00-18:00	The Pediatric Patient in the GE setting

Day 3 – Wednesday – September 14, 2005

	Concurrent session		Concurrent session
7:30-8:15	Novel Endoscopic Technologies (this would include spectroscopy, NBI, LIFE, new stuff on capsule and PDT, double-balloon enteroscopy, cryotherapy, widespread mucosal ablation, robotics, endotx for obesity, etc.)		
8:15-9:45	How to create a poster for a conference	8:15-9:45	Developing a competency based orientation
9:45 -10:15	Poster sessionMeet the Authors		
10:15-10:45	Break/Exhibits		
10:45-12:00	Video Session		
12:00 - 13:30	CSGNA Business Meeting (12:00 -12:30) Lunch/Exhibits		
13:30 - 14:30	EMR (this would include complex polypectomy to fill 1 hr slot)	13:30 - 14:30	EUS (this would include topic of cancer staging)
14:30-15:00	Break/Exhibits	14:30-15:00	Break/Exhibits
15:00-15:45	IBD (You may opt for GI Infections)	15:00-15:45	IBS
15:45-16:45	GI Pharmacology/New technology products Vendor forum (SIGNEA to deal with)		
16:45-17:00	Closing Ceremony		
17:00-17:30	Distribution of contact hours		

ZUCCHINI AND MUSHROOM LASAGNE

4 long zucchini
1 lb fresh mushrooms
3 tsp butter
4 crushed garlic cloves
28 oz can spaghetti sauce
5 ½ can oz tomato paste
½ tsp Italian seasoning
8 oz mozzarella or Swiss cheese, grated
1 lb ricotta, well drained
2 eggs
¼ cup all purpose flour

Preheat oven to 350. Slice unpeeled zucchini lengthwise in large pieces, and thicker than ¼ inch use outside pieces, finely copped for sauce mixture

Melt 1 tsp butter in large saucepan add garlic and chopped zucchini. Sauté over med heat for 2 mins remove and set aside on paper towels. Add remaining butter with mushrooms, stir 5 mins, drain fluid off.

Add spaghetti sauce, tomato paste, seasoning, mushrooms and zucchini. Bring to a boil. Simmer uncovered, stirring frequently for 10 mins stir in ½ of the grated cheese and remove from heat.

Cover and set aside.

Place ricotta, eggs and flour in a bowl and beat until smooth.

Cover bottom of dish with zucchini slices. Top with ½ the cheese mixture. Top with ½ tomato sauce. Top with Zucchini slice, cheese layer, tomato sauce. Sprinkle with remaining grate cheese.

Bake for 30 to 40 mins if made ahead may refrigerated for up to 12 hrs.

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IMPLEMENTATION OF ROUTINE ENDOSCOPE SAMPLING

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THE CALGARY HEALTH REGION EXPERIENCE

Although transmission of infection by endoscopes has been reported, it is believed to be a rare event (Moses et al, 2003). In recent years some centres have implemented random scope sampling as a quality assurance program (Malik et al, 2003). Recognizing the importance of such a QA program and in light of isolated incidents throughout Canada, the Calgary Health Region gastroenterology division implemented such a program in 2001.

BACKGROUND

The Calgary Health Region has been progressive in GI endoscopy practice in a number of areas. Dedicated scope cleaners were hired before the advantages of this practice were widely known. The CHR has had a formal Reuse of Single Use Items Committee (RESUIC) since 1995 and several years ago was one of the first centres of its size to implement the use of single use biopsy forceps. An interest in random endoscope sampling was piqued after participation in a national study on patient-ready duodenoscopes (Alfa et al, 2002) and following reports of scope contamination in Halifax in 1999.

METHOD

Five randomly chosen scopes are chosen from each of 5 endoscopy units on a monthly basis. Scopes are cleaned with high level disinfection in 4 sites and sterilization in 1 site. Ten millilitres of sterile water is injected through each biopsy channel and captured in a sterile container. Labeled samples are sent to the central lab for analysis with results reported to units within 48 hours.

DISCUSSION

In the first eighteen months of the program, contaminated scopes were limited to 'sampling error' on the part of the individual collecting the samples, most often from skin flora. Repeat sampling invariably reported no growth. In May 2003, the initial 5 scopes from one site each came back with contamination from pseudomonas putida. Subsequent sampling found the same scopes and others contaminated with this organism. Following discussion with infection control, departments of nursing and medicine, and senior management a decision was made to halt procedures until a source of the contamination could be determined. Further, with input from communications and legal services, the department chose to notify patients who had undergone endoscopy during this period. Nursing and infection control staff using a prepared script notified almost 300 patients. Also, the endoscopy unit was closed to outpatients for 4 days with inpatient scopes being cleaned in another area.

Samples were taken from several sites in and around the automated endoscope reprocessor (AER) including pre-filter water, filters, post-filter water, hose connection at the washer, fluid in the washer, HLD solution in the reservoir, and ethanol alcohol. The source of contamination was found to be a blind pouch at the back of the washer in which sat a couple of millilitres of fluid. This fluid was found to contain pseudomonas putida and other water bugs. Application of a Y-connector eliminated this reservoir and subsequent cultures showed no growth from that site and from the scopes. A potentially more serious organism could have contaminated the scopes through this reservoir and without random sampling; this problem would not have been identified. If contaminated endoscopes were to transmit infection, diseases caused by them may not become apparent until months later and not be attributed to endoscopy (Scortino et al, 2004).

CONCLUSION

This is an inexpensive quality assurance program, which can be performed by any staff. It provides confidence in cleaning protocol being followed at all sites. Initial manual cleaning, thoroughly trained personnel following written protocols, and compliance with manufacturer's recommendations for products and equipment reduce risk of microbial overgrowth in ERCP scopes (Alfa et al, 2002). This confidence extends to the standard being maintained in a Region performing almost 30,000 procedures annually and using different AERs. This program also identifies a breakdown in the system, which can be corrected. If an institution implements this program and a positive scope is identified, action must be taken. The scope must be removed from circulation until it has been resampled and no growth reported. A single scope out of circulation can usually be dealt with; multiple contaminated scopes can seriously impact a unit's operation. A 'paucity' of published data on quality assurance of endoscope disinfection (Pang et al, 2002) challenges endoscopy units to evaluate their own practices and identify the most efficient and cost effective method for ensuring no infection is transmitted at the time of endoscopy.

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THE STOMACH

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D	N	T	O	Y	U	L	U	T	F	A	N	A	H	Y	T	R	Y	I	M	G	O	O	H	D
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E	L	S	P	B	P	R	U	T	J	I	E	Y	R	R	S	C	S	E	A	Y	G	M	E	E
U	N	N	E	I	L	N	R	S	S	E	E	Y	D	D	I	G	U	C	I	R	P	O	J	R

gastric
errosion
juices
acid
motility

bile
rugae
pyloris
antrum
fundas

corpus
body
chyme
digestion
bloating

ulcer
bile
hiatus hernia

Please contact myself about any comments you may have about this newsletter or any ideas for future issues.
E-mail lesliejoy@sasktel.net

CSGNA MEMBERSHIP FEES ARE NOW $50.00 PAYABLE BY JUNE 1st.

SCOPE REPROCESSING CHALLENGES

Branka Stefanac BScN

The flexible endoscopy has become the gold standard in making diagnosis and a valuable therapeutic tool. Both the diagnostic and therapeutic procedures carry with them risks and complications. Some of the complications are directly related to increase in esophageal infections; *Helicobacter pylori;* infectious diarrheas; infectious diarrheas in the AIDS patients; traveler's diarrhea; shigellosis; salmonellosis; giardiasis; amebiasis; *C. difficil;* myobacterial infections; and viral diseases, to mention some. Furthermore, a number of clinically important nematode infestations may be seen and are the responsible parasites, including anisakiasis. In order to minimize the risk of transmission of infection, the healthcare providers are responsible for ensuring that the equipment is cared for and maintained in proper working order, and that guidelines for reprocessing are strictly followed. Flexible endoscopes must be reprocessed in a specified sequence and the process starts right in the procedure room.

Manual Cleaning in the Procedure room:

After the procedure has been completed, the endoscope must be cleaned prior to chemical exposure. Manual cleaning includes purging the air/water channel, and using enzymatic detergent solution for cleaning the outer surface of the endoscope and the entire internal channel.

Certain models of gastroscopes (therapeutic), colonoscopes and duodenoscopes, have an auxiliary channel. Special attention must be given to the channel. Colonoscope and gastroscope channels must be purged using an adaptor and a syringe; with enzymatic solution, followed by water and finally air. The duodenoscope or the ERCP scope has an auxiliary channel that needs special attention as well.

The scope is now ready to be leak tested. It is removed from the procedure room and taken in a container to a dedicated area for scope reprocessing.

Meticulous manual cleaning must precede exposure to the high level disinfectants (HLD) or sterilant. If cleaning is inadequate, the results can be – the transmission of infection by the flexible endoscope. Studies have demonstrated that appropriate cleaning reduces the number of microorganisms.

To ensure adequate cleaning written policies and procedures should be available to staff who work in the endoscopy unit and those reprocessing the scopes. These then must be reviewed and updated periodically.

Reprocessing room:

Leak testing according to the scope manufacturer is done prior to brushing of all valves and accessible channels. All accessories, and removable buttons, if reusable, must be cleaned, brushed and reprocessed. The endoscope, after leak test is done and no leaks are seen, must then be immersed in fresh enzymatic detergent solution, which is flushed through all channels. The process is repeated but now the endoscope is immersed in fresh water. Some automated reprocessors provide for irrigation of enzymatic solution. If not, this step must be done manually prior to beginning the automated cycle.

When automated endoscope reprocessors

Automated washers:

Carefully following the recommended steps, by both scope and automated washer's manufacturer; follow with high level disinfectant or sterilant as recommended for the type or washer that your institution has and do a complete cycle according to the guidelines. Care must be taken to ensure that you have all of the appropriate attachments for the scope that is being reprocessed. The exposure time and temperature for disinfecting of semicritical equipment must be checked after each scope/piece of equipment has been reprocessed, then documented according to your institution's policy.

Final Rinse/Alcohol Purge

The final rinse/alcohol flushing should be the same, irregardless of the water used. Endoscopes should be stored in a well aerated cupboard, preferably closed all the time and air circulating at all times.

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SURVEY ON BRONCHOSCOPY PRACTICES IN ENDOSCOPY UNITS FOR A PATIENT WITH KNOWN/OR SUSPECTEDTUBERCULOSIS AND REGULAR PATIENT.

1. Do you assess risk factors for pulmonary TB on any patients who present for Bronchoscopy?
   ❑ Yes ❑ No

2. If a patient has risk factors (i.e. coughing, fever) do you provide a mask that covers nose and mouth at the reception area?
   ❑ Yes ❑ No

3. What kind of mask do you provide?
   ❑ Surgical ❑ N95

4. Do you have an airborne Precaution Room (negative airflow) as a procedure room to perform a bronchoscopy?
   ❑ Yes ❑ No
   If Yes to #4, proceed to #5. If No to #4, proceed to #6.

5. Do you bring immediately the patient in the procedure room prior to Bronchoscopy if you are dealing with a patient with TB/or suspected TB?
   ❑ Yes ❑ No

6. During performance of a bronchoscopy regardless if patient has TB, what protective gear do you wear?
   ❑ N95 mask ❑ Surgical mask ❑ Gown ❑ Gloves ❑ Goggles ❑ Face shield
   Comments: _____

7. Do you wait a minimum of 1 hour before booking another case if known TB/or suspected TB?
   ❑ Yes ❑ No Comments: _____

Recovery Room Post Bronchoscopy:

8. Do you recover the TB/or suspected TB patients in an airborne precaution room?
   ❑ Yes ❑ No Comments: _____

9. If No to question #8, how do you isolate your TB patient from others in the Recovery Room ?
   ❑ Close curtains ❑ Isolate patient 1 meter from others ❑ None

10. Do you provide a mask post Bronchoscopy to the patient?
    ❑ Yes ❑ No

After the patient leaves :

11. After the patient leaves the unit do you close the door of the Bronchoscopy room?
    ❑ Yes ❑ No

12. Do you wait a certain time period before booking another Bronchoscopy in that room? If yes how long?
    ❑ Yes ❑ No ____ Minutes ____ Hours

13. Do you disinfect the room after departure of patient?
    ❑ Yes ❑ No

Thank you for taking the time to fill this questionnaire. Please fax to: Michele Paquette 613-737-8385 If you prefer filling this questionnaire by e-mail please contact me at mpaquette@ottawahospital.on.ca and I will send you an electronic copy.

WHATS THE SCOPE?

SPOTLIGHT ON THE GI UNIT, REGINA CHAPTER OF THE CSGNA

This is the first installment of a new feature in the Guidinglight. I would first like to extend an open invitation to all other GI and Endoscopy Units to send in a Spotlight on their Units. Let's get to know about each other!

Our GI Unit is part of the Regina Qu'Appelle Health District. We are located in the Pasqua Hospital in Regina. Our Unit consists of 28 admit/recover beds, three procedure rooms and an x-ray room. We do Gastroscopy, Colonoscopy and are the main referral base for ERCP's in Saskatchewan. We have just started Endoscopic Ultrasound. We also perform Esophageal Motility Tests and Hydrogen/Urea Breath Tests. We assist with Liver Biopsies, Paracentesis and Phlebotmy. We also administer Remicade Infusions. Our unit performs over 12000 procedures a year.

Our staff consist of a Fulltime Unit Co-coordinator, six fulltime RN's, six Partime RN's. We have six nurses who wrote and passed their CGN[c], working on the unit. We have two Fulltime LPN's and two Service Aids to clean the scopes. We have four Gastroenterologists that work on our unit. Two work Fulltime on our GI Unit and the other two work one day a week on our GI Unit and the remainder on the Endoscopy Unit at the other hospital in Regina. We also work with six surgeons that perform Endoscopy.

We are a very close knit group of people we work hard but we work together. We often have potlucks on the unit and even invite our Docs. We are in the process of planning the first CSGNA Annual Conference to be held in Regina in 2006. Both the GI and Endoscopy Units in Regina are on the planning committee. We are going to have a wonderful conference and hope many will attend.

I must say that I really love my job. The Nurses, Doctors and other support staff I work with are a great bunch of people. It really is a privilege to work with them.

Leslie Bearss RN,CGN[c]
Newsletter Editor Guiding Light

ACHLASIA

INTRODUCTION

Achlasia is relatively uncommon disorder with an annual incidence of 1 case per 100,000 (1). It will however be seen frequently in any endoscopy unit. Achalasia is characterized by a defect in relaxation of the lower esophageal sphincter (LES). The result is impaired esophageal emptying and a functional obstruction of the esophagus. The following is a review of the disorder and its treatment.

PATHOPHYSIOLOGY

Achalasia is due to degeneration of neurons in the esophagus. This degeneration primarily involves nitric oxide producing inhibitory neurons that relax esophageal smooth muscle. Acetylcholine producing neurons that cause contraction of esophageal smooth muscle are relatively spared from damage. The result is a hypertensive LES which fails to relax when a patient swallows. Neuronal damage also leads to loss of peristalsis in the lower esophagus.

The cause of the inflammatory degeneration of neurons in achalasia is not known. Men and women are affected with equal frequency. The disorder can occur at any age, but first onset is less common in the elderly.

CLINICAL MANIFESTATIONS

Dysphagia for both solids and liquids is the major symptom. Food and saliva enter the stomach only when pressure builds up enough to overcome the non-relaxing LES. With progression of dysphagia, nutrition may suffer and weight loss may occur. This weight loss may be profound. Retrosternal burning (2) and chest pain may be described as a consequence of retained food irritating the esophageal lining. An outright food bolus impaction is rare.

Patients may adopt specific maneuvers such as throwing the shoulders back to enhance esophageal emptying.

There is an increased risk of squamous cell cancer of the esophagus. One study from Sweden suggested that the risk may be increased sixteen fold over that of the general population (3). There is no consensus as to whether patients with achalasia should undergo periodic endoscopic surveillance.

DIAGNOSIS

The symptoms of achalasia develop gradually. Patients often have symptoms for years before seeking attention. Furthermore, in the early course of achalasia, it may be mistaken for gastroesophageal reflux disease (1).

The diagnosis rests on esophageal manometry; however other tests may be helpful. Barium swallow typically shows a dilated esophagus that tapers to a beak-like narrowing at the persistently contracted LES (Figure 1).

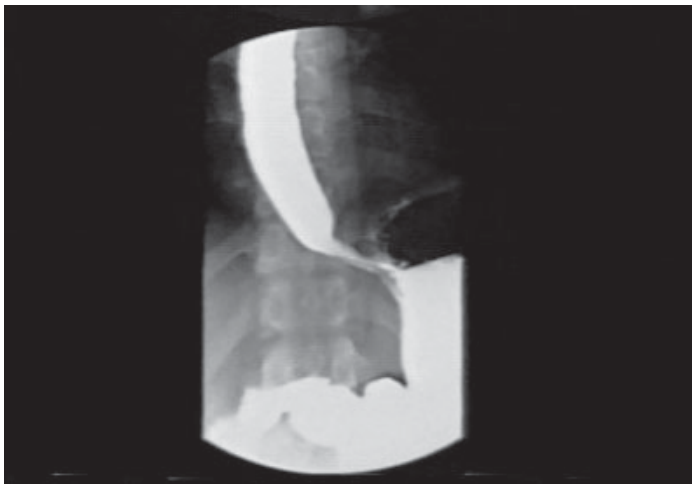

Figure 1: Barium swallow of a patient with achalasia. Dilated esophagus tapering down at the gastroesophageal junction.

Endoscopy is mandatory, not so much for the diagnosis of achalasia, but more for ruling out other disorders. Malignancies of the gastroesophageal junction and gastric fundus need to be excluded. These can mimic the symptoms of achalasia and produce a similar manometry tracing. Endoscopy in achalsia shows a dilated esophagus, often with stasis of food or pills. Gentle pressure on the endoscope may be necessary to pass through the contracted LES.

The manometry findings are as one would expect. Elevated LES pressure at rest, failure of the LES to relax with a swallow, and absent peristalsis in the lower esophagus.

TREATMENT

No therapy can slow or halt the degeneration of neurons. Treatment of achalasia is aimed at reducing LES pressure so that food may pass easily. Four therapies are available (drug treatment, balloon dilation of the LES, botulinum toxin injection of the LES and surgery). Drugs such as nitrates and calcium channel blockers can relax the smooth muscle of the LES. Unfortunately, drug therapy has met with limited success (4). In addition side effects are frequent. Drug therapy therefore is reserved for patients unable to undergo other more invasive treatments.

BALLOON DILATION OF THE LES

Bougie dilation is highly effective for esophageal strictures, but provides only temporary, incomplete relief for achalasia (5). For dilation to be successful, a more forceful stretching of the LES is required. Pneumatic balloon dilation weakens the LES by tearing muscle fibres. At present, the most popular dilator is the Rigiflex balloon (3.0, 3.5,

4.0 cm). It is passed over a guidewire and placed in the LES. Dilation can be done with fluoroscopic visualization to ensure correct balloon position. Alternatively, an endoscope can be passed alongside the guidewire and dilation done with direct visualization. The waist of the balloon should be positioned at the LES.

A variety of protocols for dilation are reported with no clear consensus on which is best. Depending on the protocol used, maximum balloon diameters range from 2.4 to 5.0 cm, maximal balloon pressures vary, balloon inflation may be rapid or gradual, and duration of balloon dilation may be anywhere up to 1 minute (6). Generally, a small balloon should be used to start.

Esophageal perforation is the most worrisome complication. The risk is up to 10 percent (6, 7). Perforation most commonly occurs on the left side of the distal esophagus, an area of anatomic weakness. Early recognition of is critical. With a perforation, patients experience persistent chest pain. Tachycardia, hypotension, shortness of breath and subcutaneous air in the cervical area may also occur. If a perforation is suspected, a gastrograffin swallow should be done.

Between 60 and 80 percent of patients have good short-term results (6, 8, and 9). Approximately 50 percent will need further therapy in the next 5 years (10-13)

BOTULINUM TOXIN INJECTION

Botulinum toxin (BTX) injected directly into the LES results in relaxation. It is injected during routine upper endoscopy using a standard sclerotherapy needle. The LES is visually estimated and approximately 20 units (1mL) of BTX are injected into each quadrant.

BTX injection appears safe with little risk of procedural complication (14). Overall, most patients respond. The drawback is that duration of response is shorter than balloon dilation (15-18). Repeated BTX treatments are often needed.

SURGERY

Surgical myotomy involves cutting of LES fibres. Open and laparascopic approaches are available. The mortality rate is low (0.3 percent). Reflux occurs after sugery in 10 percent (6). Between 70 and 90 percent of patients have relief of symptoms (6). This is similar to results from balloon dilation.

The major advantage of surgery is that the response tends to be more prolonged than balloon dilation. In one study 95 percent of patients were doing well 5 years after surgery (19).

CONCLUSION

Achalasia is a chronic progressive disorder. Recognition is important as good therapy is available. The choice of therapy depends on individual patient characteristics and patient preference. A patient with numerous comorbidities may want to avoid the risk of perforation with balloon dilation or the invasive ness of surgery. For these patients BTX injection is a good choice. For the remainder, balloon dilation and surgery are available. Surgery is associated with better long-term response as opposed to single balloon dilation. On the other hand, balloon dilation may be repeated and is of course less invasive than surgery.

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The GI Professional Nursing Award

CRITERIA:

- Promotes and enhances the image of GI nurse in her/his hospital or the community.
- Participates in professional organizations and National activities for CSGNA.
- Demonstrates creative and innovative methods in patient care.
- Acts as a role model and mentor.
- Contributes to improving quality of care of patients and their family.
- Does volunteer work.
- Encourages certification among peers.
- Is committed to continuing education.

RECOGNITION CRITERIA:

- member of CSGNA
  - Completion of specialty certification.
  - Completion of Bachelor's degree
  - Completion of Master's degree
  - Completion of a post-graduate Nursing certificate.
  - Award Recipient: Recognized with Provincial, National or International Award.
  - Publication: Article, Abstract Editorial in a Journal.
    Author or co-author of a book
  - Presentation: Presented or co-presented at a conference (either oral or poster).
    Presented at a hospital in service
  - Unit contribution: Has written policies and procedures.
  - CSGNA Chapter member, who actively supports and attends CSGNA functions

The GI nurse must be nominated by at least two nominators who must submit a written statement to support the nomination.

Nominations must be submitted to
CSGNA Education Director by March 15, 2005 –
M.Paquette CGRN, CGN(C),
501 Smyth Road,
Ottawa, Ontario K1H 8L6
or fax at 613-737-8385 or e-mail at
mpaquette@ottawahospital.on.ca
(a nomination form can be sent upon request)

Answers to quiz on page 12

1. None
2. Gloves and mask/goggles or face shield
3. None
4. Gloves, fluid-resistant gown, mask/goggles or faceshield
5. Gloves
6. Gloves and gown
7. Gloves, gown, mask/goggles or faceshield
8. None

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.

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

Canadian Society of Gastroenterology Nurses & Associates

The GI Professional Nursing Award

Nomination Form

I _____Name and I _____Name

would like to nominate _____Name

Hospital_____ for the following reasons:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please include educational degree(RN,Bachelor,Master) specialty certification, any publication, presentation, unit contributions.

Nominations must be submitted to CSGNA Education Director by March 15, 2005. M.Paquette 501 Smyth Road, Ottawa,Ontario K1H 8L6 or fax at 613-737-8385 or by e-mail to mpaquette@ottawahospital.on.ca (upon request a nomination form can be emailed to you)

Canadian Society of Gastroenterology Nurses & Associates

C/O EDUCATION CHAIR: MICHELE PAQUETTE, 501 SMYTH ROAD, OTTAWA, ON. K1H 8L6

APPLICATION FORM
FOR CSGNA ANNUAL SCHOLARSHIP AWARD

The Annual National Conference award of $700.00 is to be used for travel and accommodation to the Annual National Conference in Canada.

EXCEPTIONS:

1. Applicant cannot have received **THIS** award in the previous two years.
2. Current members of the Executive and Conference Planning Committee are not eligible for this award.
3. Scholarships are available only to active members.

PLEASE SUBMIT THE FOLLOWING WITH THIS APPLICATION:

1. A written summary of how this scholarship and attendance at the proposed meeting would benefit you in your work.
2. A current Curriculum Vitae.
3. Please specify your past involvement in the CSGNA: e.g., acted as speaker at a meeting, actively recruited new members for CSGNA, aided in the formation of a local Chapter, served on an Ad Hoc Committee, and any Newsletter articles submitted. Describe your current involvement with your Chapter: e.g., fundraising or planning Chapter conferences.
4. Outline projected financial needs to attend this meeting.
5. Geographical location and related travel expenses will be taken into consideration by the Education Committee when scoring applications.
6. Copy of CSGNA Membership Card.

APPLICATION FORM AND SUBMISSIONS MUST BE RECEIVED BY THE EDUCATION CHAIR AT THE ABOVE ADDRESS BY MAY 1 OF THE CURRENT YEAR.

NAME: _____

CIRCLE ALL THAT APPLY: RN BSN BAN MSN OTHER _____

HOME ADDRESS: _____

CITY: _____ **PROV:** _____

POSTAL CODE: _____ **HOME TELEPHONE: ( )** _____

FAX: ( ) _____ **E-MAIL:** _____

HOSPITAL/EMPLOYER: _____

WORK ADDRESS: _____

CITY: _____ **PROV:** _____

POSTAL CODE: _____ **JOINED THE CSGNA IN** _____ **(year).**

SIGNATURE _____ **DATE** _____

Canadian Society of Gastroenterology Nurses & Associates

6596 Delorme Avenue, Orleans, Ontario K1C 6N6

NOMINATION FORM

Please complete this form and submit to the Chair of the Nominations Committee (currently the President of the CSGNA) 150 days (April 15th, 2005) before the Annual Meeting for national office. Ballots will be sent to the active members 120 days before the Annual Meeting and must be returned within 90 days.

Candidates must be active CSGNA members in good standing.

Please include a curriculum vitae with the nomination form.

Name of nominee: _____

Address: _____

_____ Postal Code _____

Phone (home) _____ (work) _____

Employer: _____

Title: _____

Education: _____

CSGNA member since: _____

Offices held: _____

Committees: _____

Other related activities: _____

_____

Explain what has led you to chose to run for national office? _____

_____

_____

I hereby accept this nomination for the position of _____

dated this _____ day of _____ 20_____. Signed _____

Nominated by _____ & _____

CSGNA EDUCATION COMMITTEE POINT SCORING SYSTEM FOR AWARDING SCHOLARSHIPS

Each year as a member (cumulative points)	1 Point
Each year served on National Executive (cumulative points)	3 Points
Each year served on Annual Conference Planning Committee (cumulative points)	3 Points
Each year served on Chapter Executive (cumulative points)	2 Points
Each time submitted an article for publication in "The Guiding Light" not reports (cumulative points)	2 Points
Can demonstrate actively recruited members	1 Point
Each time has acted as speaker at a CSGNA conference or seminar (cumulative points)	2 Points
Each time served on an ad hoc committee of the CSGNA (e.g.) Bylaws (cumulative points)	2 Points
Outlines geographical location and travel expenses	1 Point
Actively participates in Chapter events (E.G.) fundraising	1 Point
Each year as a member on the planning committee for a regional conference (cumulative points)	1 Point
CGN(C)	3 Points
CBGNA certification	1 Point
Typed format	1 Point

REVISED September 2002

M. Paquette, Education Director

Canadian Society of Gastroenterology Nurses & Associates

CSGNA Membership ends May 31st each year.
Elaine Burgis, 102 Tilman Circle, Markham, Ontario L3P 5V3

MEMBERSHIP APPLICATION

(CHECK ONE)

☐ ACTIVE
$50.00

Open to nurses or other health care professionals engaged in full- or part-time gastroenterology and endoscopy procedure in supervisory, teaching, research, clinical or administrative capacities.

☐ AFFILIATE
$50.00

Open to physicians active in gastroenterology/endoscopy, or persons engaged in any activities relevant to gastroenterology/endoscopy (includes commercial representatives on an **individual** basis).

☐ LIFETIME MEMBERSHIP

Appointed by CSGNA Executive.

FORMULE D'APPLICATION

(COCHEZ UN)

☐ ACTIVE
50,00$

Ouvert aux infirmières et autres membres de la santé engagés à plein ou demi-temps en gastroentérologie ou procédure endoscopique en temps que superviseurs, enseignants, recherches application clinique ou administrative.

☐ AFFILIÉE
50,00$

Ouvert aux médecins, actifs en gastroentérologie endoscopique ou personnes engagés en activités en gastroentérologie/endoscopiques incluant représentants de compagnies sur une base individuelle.

☐ MEMBRE
À VIE

Nomme par l'exécutif.

APPLICANT INFORMATION / INFORMATION DU MEMBRE

Please print or type the following information / S.V.P. imprinter ou dactylographier l'information

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NOM DE FAMILLE _____ FIRST NAME
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ADDRESS DE RETOUR _____

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PROV. _____ POSTAL CODE
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CHAPTER NAME
NOM DU CHAPITRE _____

EDUCATION (CHECK ONE)
ÉDUCATION (COCHEZ UN)
❑ RN IA ❑ RPN/LPN I AUX ❑ TECH TECH ❑ OTHER ((EXPLAIN)
AUTRE (SPÉCIFIEZ) _____

CNA MEMBER YES/NO
MEMBRE AIC OUI/NON
❑ CNA CERTIFICATION IN GASTROENTEROLOGY
CERTIFICATION EN GASTROENTÉROLOGIE DE L'AIIC

MEMBERSHIP (CHECK ONE)
ABONNEMENT (COCHEZ UN)
❑ RENEWAL RÉNOUVELLEMENT ❑ NEW NOUVEAU

Please make cheque payable to CSGNA
(Mail with this completed application to the above address)

Prière de libeller le chèque à CSGNA
(Envoyez avec cette formule d'application dûment remplie à l'adresse ci-haut mentionnée.)

CSGNA 2004-2005 Executive

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