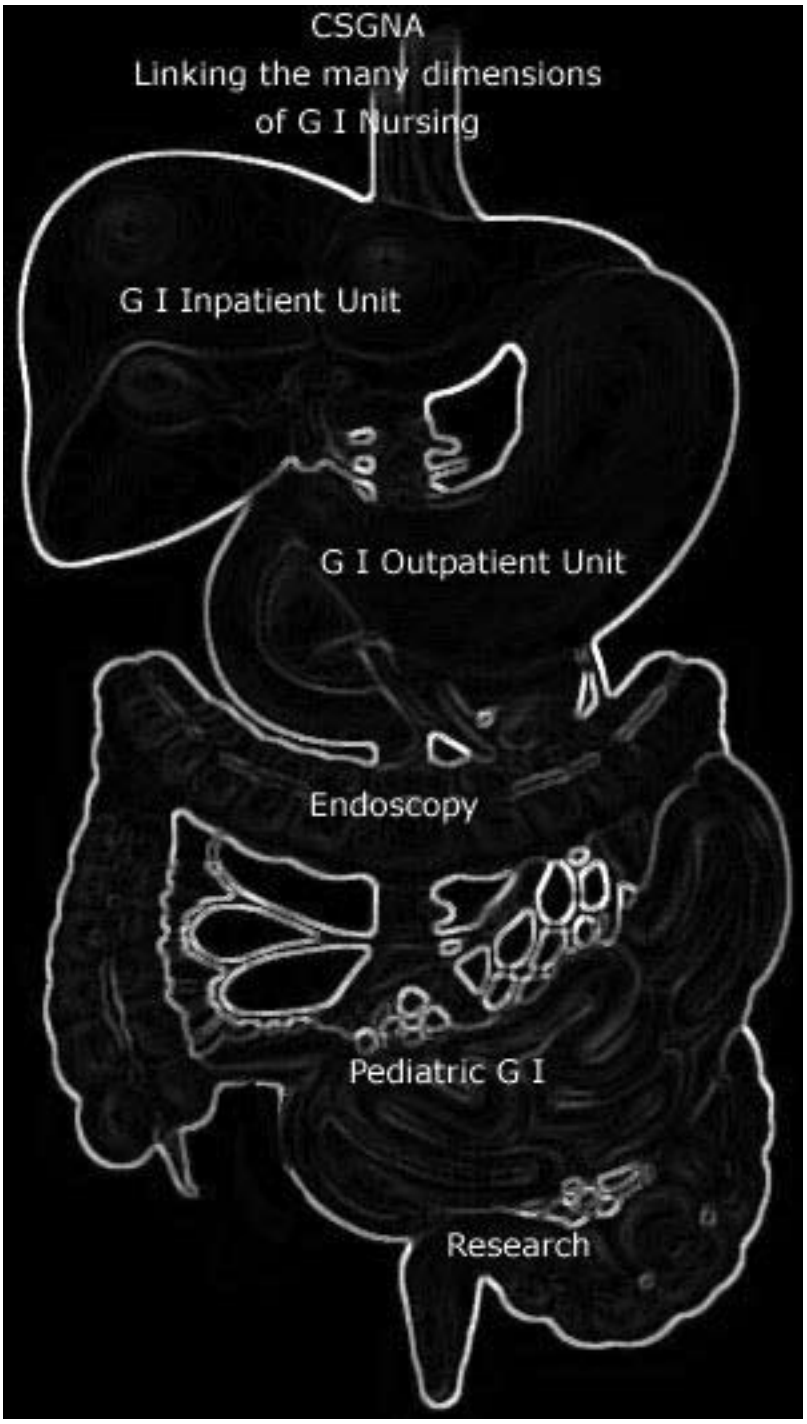
The Guiding Light

CANADIAN SOCIETY OF GASTROENTEROLOGY NURSES & ASSOCIATES

MARCH 2007 VOL. 16 #60



Theme and Logo submitted by the Edmonton Chapter of the CSGNA.

Celebrating the Diversity and Excellence in our Practice!

GI Nurses Day
Friday, May 11, 2007

INSIDE THIS ISSUE:

President's Message

CSGNA has entered a new era. For the past several months, we've had the services of an administrative assistant who has helped several of us in our CSGNA roles. Karen Moricz is a part-time employee of the Canadian Association of Gastroenterology (CAG), working from their Oakville, ON. office. Many of you may have met Karen in Regina. CSGNA currently is also hanging our hat from the Oakville office so we have a permanent address and phone number to which members and others can direct questions and make contact. Memberships, both new and renewals are going through the Oakville office. Our initial commitment to CAG was to trial an administrative assistant's benefit to our organization for a period of one year. However, we recognized that one year was barely enough time for either the assistant or the Board to evaluate how this was affecting individual Board members. It was deemed appropriate to wait until the fall, after the 2007 Halifax conference when we'll have a better idea of the value of this employee to CSGNA.

The benefits are becoming evident as Karen has taken over much of the Membership Director's tasks, arranged bookings for all of us, ordered and mailed CSGNA manuals and provided insight into how we can run more efficient meetings. With her help, we are restructuring our Face to Face meeting on March 24 in Toronto and limiting the meeting to one day time compared to the almost two days previously. Directors will be submitting their reports for circulation and perusal by the entire Board before the meeting and only items of concern will be on the agenda.

Karen's expertise in working with CAG and in organizing events is becoming clearer as we work through this first year. Her knowledge and skills extend beyond most of ours with our nursing backgrounds, enabling us to be attending to working more constructively on our members' behalf. We realize that if we continue in this professional relationship, revision of specific Board roles will need to be made. Certain roles such as those of Practice and Education which are huge in both expectations and time commitments may be restructured. This is one major item we'll be discussing when we meet in March.

As your President, I had the privilege of representing CSGNA at the 6th Annual GI Forum in Vancouver in October. Under Dr. Rob Enns' leadership, this course linked for the first time with the St. Michael's Therapeutic Endoscopy Course from Toronto. In November, I represented CSGNA at the CAG Regional Meeting in Toronto, the first time we've been invited to sit at the table with physician representatives from across the country. I was proud to be asked about the nursing perspective on issues, scheduling, staffing, retention and our willingness to participate in the Global Rating Scale assessment developed by Dr. R. Valori in the United Kingdom. By the time this is published, your institution might be actively participating in this study and its potential for decreasing patient wait times, increasing throughput and decreasing downtime and overtime. CSGNA will be highlighted in an upcoming issue of the Crohn's and Colitis Foundation of Canada's publication, Gut Reaction. Several vendors have stepped forward to dialogue with CSGNA in developing programs which will further enhance opportunities available to active members and promote CSGNA.

Your Board is here for you, the Members. We want to hear how we can best utilize your resources to help you provide the best patient care, offer educational support and opportunities for learning. We are honoured to be your representatives and are always open to hearing innovative ways or means by which we can better serve you.

Respectfully submitted,
Debra Taggart RN, BN, CGRN, CGN[C]

CANADIAN NURSES ASSOCIATION AND CSGNA

Elaine Burgis, RN, CGN[C], President-Elect

Canadian Nurses Association (CNA) is the professional voice of registered nurses in Canada. Through its 11 provincial and territorial nursing associations, CNA represents 126,000 nurses across the country. All registered nurses in Canada are members of CNA, with the exception of Ontario, where their nurses must be members of the Registered Nurses Association of Ontario (RNAO) and Quebec whose nurses must be members of the Yukon Registered Nurses Association (YRNA) or become an associate member of the Nurses Association of New Brunswick (NANB).

CSGNA is one of CNA's 30 associate members. These associate groups, along with emerging and affiliate members, benefit from the networking that is provided through CNA's teleconference meetings and Biennium Conferences. Nursing associations across Canada share many of the same concerns and challenges that CSGNA does. These forums provide an opportunity for ideas to be shared and information to be exchanged.

In 2004, the first CNA certification exam in gastroenterology nursing was administered. Along with 16 other specialities, CNA certification gives nurses an opportunity to demonstrate their professional competence and broad understanding of their nursing specialty. At present, there are 173 registered nurses in Canada who hold a CNA certification in gastroenterology.

Last year, CNA introduced a web-based information service for the Canadian nursing community. *NurseONE* provides up to date health care information to support nurses in their practice. This bilingual site provides support for research for practice in direct care, research, administration and education. The portal is a CNA member benefit and can be accessed from the CNA web site: www.cna-aiic.ca .

CNA will celebrate its 100th anniversary in 2008. Celebrations are planned for next June during the Biennium Conference to be held in Ottawa. Information regarding this upcoming event will be available in *The Canadian Nurse.*

BOARD POSITIONS AVAILABLE SEPTEMBER 2007

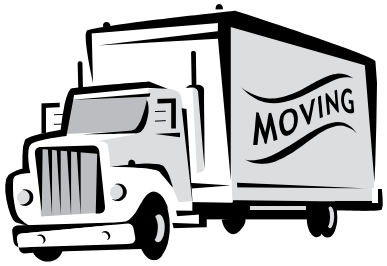
The following Board positions are available this September.

They are:
Canada East
Canada West
Secretary
Practice Director
Education Director

These are two year positions.

Please submit your nomination to
Debra Taggart,
Foothills Medical Centre
1403 29th Street NW
Calgary, AB T2N2T9
by April 15th 2007.

You can also email to:
debra.taggart@calgaryhealthregion.ca.
Please consider stepping out of the box and submitting your nomination. You will grow as a person; not to mention the wonderful experiences and friendships you will gain.



CHANGE OF NAME/ADDRESS

NAME: _____

NEW ADDRESS: _____

CITY: _____ **PROVINCE:** _____

POSTAL CODE: _____ **PHONE:** _____

FAX: _____ **E-MAIL:** _____

[Send change of name/address to the Membership Director and to the CSGNA executive assistant]

CANADA EAST REPORT

What a busy year for the Atlantic region!

Halifax is hosting the 23rd National CSGNA conference.

Please start applying early for scholarships to attend this awesome upcoming conference.

Newfoundland Chapter

Newfoundland had a meeting in November with 12 attendees. The discussion focused on closing the GI units so all could go to Halifax. A February meeting was cancelled due to yet another stormy night. An early March meeting is planned.

New Brunswick / PEI Chapter

Awaiting report from the new executive.

Nova Scotia Chapter

"Come See the Sea" will be the place to be September 21st and 22nd 2007.

The shopping has started for new market place items. Any items or ideas will be much appreciated. All monies go towards scholarships and education.

Hopefully we'll all be thawed out and re-energized by the spring.

Submitted by,
Mabel Chaytor RN, CGN[C]
Canada East Director

DIRECTOR PRACTICE REPORT

Please remember to come to the September meeting in Halifax and review the updated and new guidelines with us. Send in your comments and suggestions. I look forward to your input, ideas and suggestions.

Good luck to all who are writing in April.

I look forward to seeing you in Halifax in September.

My email address is bstefanac@rogers.com

Submitted by,
Branka Stefanac RN CGN[C]
Practise Director

NOVA SCOTIA CHAPTER ANNUAL EDUCATION DAY

On November 4th 2006 the Nova Scotia Chapter of the CSGNA

Hosted their Annual Education day in Halifax. It was a fun day, in which we focused on "The Liver". The program consisted of Anatomy and Physiology of the Liver. Endoscopic changes with Liver Disease, Liver Transplantation, End Stage Liver Disease, Hepatitis C and "Around the World in 70 Days" with a Hepatologist. The speakers were very informative and everyone had a great time and learning experience. A special guest was Lisa Liver who stopped by for a visit.

We want to extend a special thanks to our sponsors AMT Electrocautery. Boston Scientific. Cook Canada, Johnson and Johnson, Pentax and Sci Can. Our focus is now on National Conference planning so we'll be a pretty busy Chapter for the next while.

Evelyn McMullen
President Nova Scotia chapter

LT to RT Karen Amirault RN from Yarmouth, Sandra Matchett RN from Sydney, Lisa Liver, Dr Kevork Peltkian Hepatologist from Halifax, Marion MacMillian RN from Halifax and Tracey Pyne RN from Fredricton President of the NB/PEI chapter.

Canada Centre Report

In Ottawa it's been an unusual winter. We had a green Christmas with very warm weather. Now it's February and winter has arrived with its minus degree temperatures and snowstorms. The holidays are finished and the Chapters are planning their spring educational sessions.

Michèle and I had the opportunity to attend l'Association Québecoise des Infirmières et Assistantes en Gastroentérologie fifteenth conference. We met colleagues from all over Québec. It was very resourceful.

I would like to wish good luck to all the nurses who will be writing their Canadian Gastroenterology Nursing Exam on April 14.

Michèle and I also attended the Feb. 3 Montreal Chapter day conference. This conference was offered in French and English to accommodate all its members. A variety of educational subjects were presented, from different kind of stents, EUS, nutrition, cautherization safety and ergonometry. The event was very successful with 30 nurses in attendance. Boston Scientific, Cook Canada, Bard, Astra Zeneca, Altana and Sci Can were demonstrating their products. Boston Scientific sponsored the food.

The Ottawa Chapter is meeting monthly to organize a day conference which will be held on May 5, 2007. The Chapter executive remains the same for the next two years. The Chapter secretary has sent two newsletters to its members.

The Greater Toronto Chapter had a successful meeting on Nov.7, 2006 with 70 attendants. Olympus did a slide show presentation and the participants were able to do hands on afterward. The Chapter is planning a day conference on Sat. April 28, 2007.

On Nov. 22, 2006 the Brantford General Hospital hosted an educational evening for the Golden Horseshoe Chapter. Dr. Steve Somerton, gastroenterology, presented the history of colonoscopy and Dr. Timothy Gayowski, surgeon, presented "Portal Hypertension: Hepatic Transplantation. The event was sponsored by Carsen and attended by 37 nurses. Another educational session is being organized for this spring which will be sponsored by Boston Scientific. Dr. Mennon will be speaking on "Advancements in Endoscopy".

The Central Ontario Chapter hosted an evening session on Dec.7,

2006. Dr. Alex Lee spoke on "Surgery for benign disorders of the esophagus: Reflux, achalasia etc… Will Lacey spoke on advancement in Olympus. A spring session is being organized which will be sponsored by Boston Scientific.

The South Western Ontario Chapter had a meeting. A detailed summary and experience of the Regina Conference sessions was presented to the 17 attendees. The event was sponsored by Astra Zeneca. A spring educational session is being organized.

On Oct. 17, 2006 the London Chapter hosted an evening educational session. "A Stent Event" was presented by Dr. N. Khanna. The dinner was sponsored by Olympus. A teaching night is being organized for March but not yet finalized.

Submitted by,
Monique Travers RN CGN[C]
Canada Center Director

Newsletter Editors Report

Once again I am expressing my sincere thanks to all the members who submitted articles for this issue of The Guiding Light. As I've expressed many times I simply could not do this with out your help. The cover of this issue is the theme for GI Nurses day this year. It was submitted by the Edmonton Chapter. They are to be applauded for their wonderful theme and logo. It is an excellent idea to base our celebration of GI Nurses day on!

In this issue the scholarship forms are available to the membership as well as the GI Professional Nurses Award form. Take advantage of these opportunities. Apply for the scholarships and submit your fellow members for the GI Professional Nurse Award.

Good luck to all who are writing the certification exam this April. Please send me any education events at the local levels I'd be only to happy to put them in the next issue. Finally congratulations to my fellow board members Elaine Burgis and Mabel Chaytors for having been awarded the 2007 CAG/CSGNA Endoscopy Nurse Bursary.

Submitted by,
Leslie Bearss RN CGN[C]
Newsletter Editor

Education Director Report

Since my last report, time just flew. On November 18, 2006 Monique Travers and I attended the 15th annual conference of the Quebec Nurses and Associates Association in Gastroenterology. A full program from prevention of infection, analgesia and the role of the nurse, oesophagitis, natural products and virtual colonoscopy for colorectal cancer screening was offered to us. It was a great opportunity to exchange with our French colleagues from the province of Quebec.

We then attended in February 3, 2007 the CSGNA Montreal Chapter annual GI Nursing Educational day. Kudos to Georgianna Walters and her team for an excellent program. The program was an incredible pot-pourri from endoscopic ultrasonography by Dr Kevin Waschke to biliary stents by Dr Georges Ghattas and stents in the GI tract by Dr Peter Szego. We were treated with a lecture on nutrition and cancer prevention by Mrs. Rita Motchula, ergonomics in the workplace by Mr. Shane O'Donoghue and cautery safety offered by ConMed representatives Mr. Sylvain Lepage and Sylvain Lariviere. A full program as you can see.

Our teaching manuals can now be purchased through our head office and we hope you are finding them useful. They can be ordered through Karen Moricz at Karen@cag-acg.org

Certification is approaching very fast. It will be held on Saturday April 14, 2007.In Ottawa we have been busy holding every three weeks study group sessions. I would like to wish good luck to all the nurses who decided to embark on the road to Certification.

Last week I spent two days at C N A for the translation of the exam. I would like to remind everyone that you can request to write the exam either in French or in English or request both copies if you desire.

I also would like to remind you of some very important deadlines to submit your requests for funding for the annual conference which will be held this year in Halifax on September 21-22. On the 20 we will be offering a foundation course from 11:00am to 3:00pm .This course is offered to all participants and is designed to assist in preparation for taking certification exam. We will cover other topics than the ones chosen for the conference. There will be an extra fee to attend this session and lunch will be provided. The program is being finalized and will be posted on our website so do not forget to look for the information.

All requests for various scholarships need to be submitted by June 1st

REMINDER

As per Bylaw 18.10 all CSGNA Chapters shall submit an annual educational summary to the Education Director by June 30th annually.

GUIDELINES FOR SUBMISSIONS to *"THE GUIDING LIGHT"*

- Submit all materials by email to the newsletter editor in word format.
- Submissions must be received by the 15th of the month preceding each issue i.e.: Feb15th for March issues, June 15th for July issues and Oct 15th for November issues.
- Include all references or have them available upon request.

of the current year.

CSGNA is offering 12 scholarships of $1,000.00 to be used for travel and accommodation and 1 scholarship of $1,000.00 for a new member who joined CSGNA the year prior to the conference.

SciCan is offering an educational scholarship in the amount of $1500.00. We are asking each Chapter to identify a candidate which they feel has contributed to gastroenterology in the region. There is no application form for that. I would suggest that the Chapter Secretary send in the name of the candidate and list the contributions they have made. To the Education Director at mpaquette@ottawahospital.on.ca by May 31st.

Olympus is offering educational scholarships for the annual conference for a global value of $30,000.00. Look for the information on our website

The GI Professional Nursing Award is an exception to the deadline and must be handed in by May 31st, 2007. For this award we need two nominators who must submit a written statement to support the nomination. You can find the information in the Guiding Light

Lastly the Chapter of the year scholarship. This award is $1000.00 offered to the winning Chapter. This is the second year we offer this scholarship and the competition is strong. I hope the Chapter Presidents are busy gathering all the information for submission by June 30.

The committee is busy reviewing the Chapter packages to make it more users friendly. This is a document the Directors can provide to anyone wishing to form a new Chapter. The revised copy should be ready for distribution in May.

In closing I would like to tell all members that the education committee is there for you so please do not hesitate to let us know your needs.

Respectfully submitted by,
Michele Paquette CGRN, CGN[C]
Education Director

Secretary Report

I would like to wish all the CSGNA members best wishes for 2007. Since the face to face meeting at the 2006 annual conference in Regina, the CSGNA board members have decided not to have a formal email or teleconference meeting before the next face to face meeting scheduled for March 24th 2007. Despite the lack of formal email or teleconference meeting, CSGNA board members communicate regularly electronically via email should any issues need attention before the scheduled formal meeting. Some of the issues are resolved and voted on via email.

As a CSGNA member if you have any comments, concerns or questions at the local or national level you could discuss these with your directors or don't hesitate to contact any of the board members. We are only an email away!

Sincerely submitted by
Usha Chauhan RN, BScN CGN[C]
CSGNA secretary

Canada West Report

Kamloops

It has been a busy time in Kamloops. At one meeting Certification and Capsule Endoscopy were discussed. At another they had a real fun time doing their "True Colors".

Three members are studying hard to write their GI Certification in April. These members attend weekly study groups. Two members are planning to attend the up coming conference in Calgary.

On May 5th, they will present a day-long session on ERCP.

Edmonton

The chapter started the new year with a "Personality Dimensions Workshop" to help understand how different personalities act and where each person falls in the groups defined by the speaker. This will help the chapter to grow as a team and understand each other's approaches better. They thought it was a fun night!! They laughed all nigh long ... besides of course learning a lot! Thank you to Bev Sadler from Abbott who brought supper!

They are busy organizing their spring conference, "April Showers" which will be on Saturday, April 28th. They have some information on the CSGNA website and will have pamphlets out in early March.

As the Certification Exam approaches, the chapter members are hard at studying! Two chapter members plus another CSGNA member plan to write the exam. Good luck, Girls! There is no end to the topics that are being offered as evening presentations. They will have a physician presentation, sponsored by Boston Scientific, on pancreatitis. They will also be looking at a presentation from a chapter member on "Legalities in Charting" and one on "Nexium" from Angie Tymko from AstraZeneca.

Treasurer Marla Wilson has resigned from her position as she will be moving this spring to B.C. Marla has always been an exemplary CSGNA member attending the many conferences across Canada and playing a major role in organizing local conferences and seminars. With her CNA certification, she has been a key role model in the chapter, encouraging members to write the exam. Marla makes it sound like there really is nothing to doing the books as Treasurer, but they all know how really lucky they have been to have had her managing the monies. They will miss her very much and wish her all the very best! In Marla's place, they would like to welcome Jan MacNeil as new Treasurer. They are looking forward to working with her and know she will do an excellent job picking up where Marla has left off

Regina

The first meeting with the new executive was held Monday February 5. The new President is Connie Bender, Secretary Jennifer Taylor and Treasurer Susan Latrace. It was well attended.

A decision to have a come and go tea and tour of their units for GI

Nurses Day. This would give other units in the hospital an opportunity to visit, have a coffee and see how the unit operates.

Regina will also host their annual one day GI conference in October.

Lorie McGeough provided highlights of the fall conference, the evaluations provided positive feedback. They are also very excited about the National Conference in Halifax. After hosting their own conference they now know the importance of networking with coworkers across the country. The educational experience was fantastic and having it in Regina gave more members in Saskatchewan an opportunity to attend and reap the benefits.

Vancouver

The Vancouver Chapter hosted a dinner and educational evening March 7, on the topic "ABC's of Hepatitis". Dr, Kwan, a clinical gastroenterologist with the University of British Columbia, who has an extensive practice with hepatitis patients, was the presenter. Gilead sponsored the event.

Okanagan

The Okanagan Chapter celebrated the 30th year as an endoscopy unit at Kelowna General Hospital the week of Feb 7th and with the 2 original RN's still on staff, it's a pretty special place to work. There was some excitement happening the next week as a couple of the RN's headed to Denver for an endoscopy conference and focused on the ERCP portions of the presentations - should be some great info coming back from that. Two full-time RN's are writing the Canadian Gastroenterology Certification exam in April; one is currently certified through her American exams and will now also have CNA. They are also looking forward to the annual spring Kelowna Digestive Diseases Weekend that will take place in April; always lots of great information and wonderful presentations.

Manitoba

The Manitoba Chapter is actively trying to recruit more members.

They are in the process of planning topics and speakers and getting funding

For a conference which will be held on May 5, 2007 at the Norwood Hotel. The research on Upper Extremity Injuries has been completed and the manuscript for publication has been accepted by the Gastroenterology Nursing Journal. We will see it in print in the June issue. This topic was done entirely by nurses for nurses without the assistance of researchers and without any funding for the project. The reaction to this research project was inspiring because there has been some movement in each facility that employs the nurses involved in the project toward improving their workplaces in terms of ergonomic environment and health and safety issues. President Sue Drysdale is personally very proud of the commitment and sacrifice shown by the members for their involvement in the project and she honours them for having the courage to try to improve the workplace in spite of road blocks along the way. She is certain that this chapter collectively has the gumption to face controversial issues with courage and commitment in order to improve not only their work environment but also their professional practice.

Vancouver Island

Vancouver Island Chapter's business meeting on Feb 8 had a turnout of 12 people, mostly from the 2 endo units. Jeff Grech from Carsen Medical also attended the meeting, as a new member.They is planning a day educational event to be held on May 5. Details will be available at a later date.

Calgary

A planned educational session on the gastric pacemaker will be presented by Dr. Chris Andrews in the spring.

The first ever live endoscopy sessions to CDDW were held on February 18 & 20. Although not a CSGNA activity, many CSGNA members in the Calgary Health Region volunteered their assistance to make this event possible.

Central Alberta

The newest CSGNA chapter had its inaugural meeting on October 25, 2006 and elected officers: President Joanne Glen, Secretary Lisa Westin and Treasurer Audrey Pennycook. On November 20, Joan Heatherington, Nurse Practitioner in Gastroenterology, spoke on IBD to an audience of 48. The chapter was excited by the good response to their first endeavor. Pete Bresee of Olympus Canada sponsored the event.

On February 20, Dr. Amanullah, a local gastroenterologist spoke on Anemia in the GI Patient sponsored by Georgianne Daugela of JanssenOrtho. Thirty people attended the session in Red Deer plus eight more in Ponoka joined by teleconference. The experiment was a success and the chapter hopes to increase opportunities for outlying communities to attend educational sessions with this technology.

Seven new members signed up in the New Year. Three nurses in Red Deer are studying for the certification exam and that will double the current number of nurses who have previously attained the CGN(c) designation.

Joanne Glen R.N. CGN[C]
Canada West Director

Just a reminder that we need donations for door prizes and the silent auction for the National Conference in Halifax September 2007!

ABSTRACT SUBMISSION GUIDELINES

To all CSGNA chapters,

I am writing to request that each Chapter submit an abstract for the Halifax conference in 2007. The deadline for submitting the abstract is April 30, 2007.

I encourage you to submit an abstract because the process is very rewarding.

Share with us what you do in your units. The topics are endless. You could select a research project, an audit, a new procedure, CQI project, etc. …

I look forward to your submission.

Michele Paquette

SUBMISSION:

Abstracts must include identification of area(s) of focus (background information); a description of the problem or issue; discussion of planning, implementation, evaluation; how your issue promoted health care outcomes or professional development in your area

COVER SHEET

Please complete a cover sheet and submit with your abstract. The cover sheet must include title of the abstract, names of all presenters/authors, credentials, and place of employment/academic affiliation. Please indicate main contact's name, telephone number, e-mail address and fax number.

Please note: this information will be used in the conference program should your abstract

Be selected.

FORMAT

Your typed abstract should not exceed one standard letter size sheet of paper, double-spaced, with one-inch margins and standard 12 fonts.

The title, authors, objective, description, and conclusion should appear on the abstract. This abstract will be included as part of the course syllabus.

Please fax or e-mail your cover sheet and abstract in Microsoft Word or word perfect format.

OTHER INFORMATION

All authors are responsible for any expenses incurred in preparing and presenting their poster (including registration and travel expenses).

SELECTION PROCESS

A blind review and selection will be made by the Abstract Review Subcommittee of the Conference Planning Committee.

Selection criteria include relevance to conference, clarity, impact on gastroenterology nurses and associates, or impact on patient outcomes.

Selected abstracts will be developed into presentation format by the authors. Oral presentations will be delivered during a free paper session. Posters will be displayed in a prominent location at the conference. A 30 minute time period will be designated for the authors to discuss the poster and answer questions that delegates may have.

NOTIFICATIONS

All abstracts will be acknowledged upon receipt. Deadline for abstracts is APRIL 30th, 2007. Successful authors must indicate their intent to participate by June 1, 2007 to be included in the conference syllabus.

SUBMIT ABSTRACTS TO:

Those wishing to send in abstracts are welcome to send them to Michele Paquette
CSGNA Education Director
Telephone: 613-737-8384 (W)
Telephone: 613-737-8385 (Fax)
E-mail: mpaquette@ottawahospital.on.ca

FUTURE CSGNA CONFERENCES

HALIFAX 2007

VANCOUVER 2008

TORONTO 2009

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

ACID
ANTRUM
ANUS
ASCENDING
BILE
BODY
CHEW
DESCENDING
DEUODENUM
DIGEST
ILIEUM
JEJEUNUM
PAPILLA
PYLORIS
RECTUM
SALIVA
SIGMOID
SWALLOW
TRANSVERSE

PARISH NURSING: A HEALTH CARE MINISTRY

Jean Hoover, RN, CGN[C], PN (c)

The purpose of this article is to describe what makes Parish nursing distinctive to that of other nursing practices. I am writing from the perspective of my practice as a Parish nurse.

The term Parish nurse refers to an experienced, registered nurse, who has completed his/her formal training, is licensed as an RN in the Province where he/she practices and has knowledge of medicine. Formal training is provided through a structured program at the Theology College in most universities in Canada. Parish nurses are required to possess a strong foundation in their chosen faith and be a part of their Faith community.

Historically, Parish nursing is rooted in the early Church. At that time, the Church was the main source of promotion of healing for the sick. Over time, scholars became more convinced of the importance of integrating faith and healing; not compartmentalizing body, mind and spirit. The Parish nurse became the ideal person to bridge medicine and theology.

As a nurse with a specialized knowledge, the Parish nurse has many roles: health advocate, health educator, health promoter and councilor, and referral agent. The Parish nurse gathers resources that are shared with the client and family. Most importantly, the nurse is an integrator of faith and health.

As a Parish nurse, I am not carrying out "hands-on nursing", nor do I perform invasive procedures, administer medications or seek to replace any existing health services. The challenges that Parish nurses face are to encourage the nursing profession to reclaim the spiritual dimension of nursing care, challenge the health care system to provide "whole person care" and to challenge the faith-based communities to re-establish their healing ministry.

It is my goal that I will empower my clients to become more active partners in the management of their personal body, mind and spirit.

Jean works at the Scarborough Hospital, General Division.

THE GI PROFESSIONAL NURSING AWARD

Criteria:

- Promotes and enhances the image of GI nurse in her 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 May 31, 2007
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)

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 degree of education (RN, Bachelor, Master etc.) specialty certification, any publication, presentation, unit contributions

Nominations must be submitted to CSGNA Education Director by May 31, 2007. 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)

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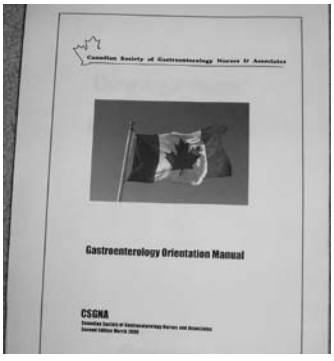

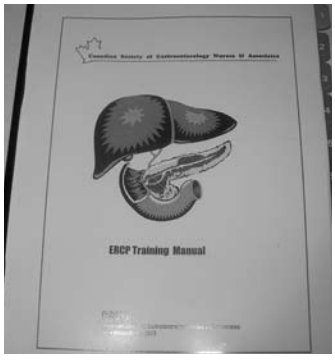

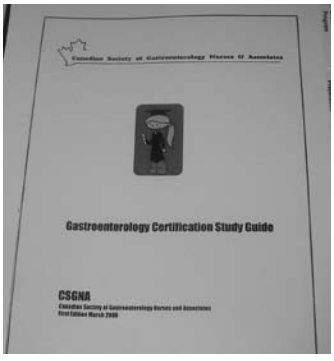

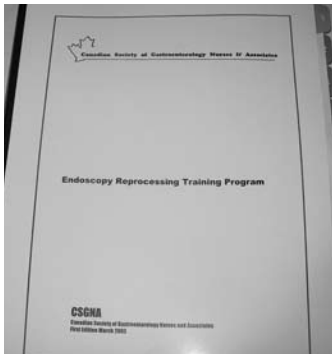

The SciCan Educational Scholarship

SciCan, in conjunction with the CSGNA, is pleased to again offer the annual educational scholarship in the amount of $1500, to be awarded to a member of the 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 a 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. Her address can be found on the back page of The Guiding Light.

Choosing a winner from among the seventeen candidates will not be an easy task! We expect that the caliber 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 are 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. Applications for this scholarship are due May 31st annually.

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.

AORTOBRONCHIAL FISTULA

By Joan McKechnie, RN
Endoscopy Unit, St Mary's General Hospital, Kitchener, ON

BACKGROUND

Postoperative aortobronchial fistulas are rare and late complications of cardiac surgery. Aortic fistulas into the airways may develop after unpredictable periods post surgery and are often the consequence of pseudoaneurysms.

Aortic pseudoaneurysms may arise postoperatively from disruption of one or more arterial wall layers with extravasation of blood into the surrounding spaces. The cannulation site for cardiopulmonary bypass is the most common area but graft to graft anastomosis, saphenous vein anastomosis, aortic and needle vent sites, patch-suture lines and distal or proximal suture lines in aortic replacement have also been reported.

As the pseudoaneurysm enlarges and compresses the airways, a local inflammatory response results with pressure necrosis. Lung erosion develops and as the wall tension of the pseudoaneurysm increases, it ruptures into the airways.

Hemoptysis is the main and often only symptom of the fistula. It may be massive or intermittent and can occur up to twenty-five years after surgery. Aortobronchopulmonary fistulas are more common after resection of descending thoracic aortic aneurysms but can be seen in infancy after patent ductus arteriosus or aortic coartaction repair. In adults, aortic fistulas have also been reported after surgical repair of aortic arch, mitral valve, aortic valve or thoracoabdominal aneurysms.

Diagnostic tests are often unable to directly visualize a fistula because it is usually small and easily occluded by clots. Indications for surgical or endovascular repair relies on clinical suspicion. Urgent treatment is necessary based on the following criteria: hemoptysis, history of previous cardiac or aortic surgery, presence of lung infiltrates on chest x-ray, lung hemorrhage on CT scan and visualization of a pseudoaneurysm. Aortobronchial fistulas are fatal if untreated.

You may be asking yourself what is the relevance of this to GI endoscopy. I would like to share with CSGNA colleagues, an interesting case that involved an aortobronchial fistula. Since the patient was a vague historian, his diagnosis was somewhat baffling initially.

THE STORY

A 37 year old male came to hospital via ambulance after "spitting up" a large amount of blood. He was assessed by the emergency physician. The patient's bloodwork was normal and his vital signs stable. The chest x-ray was unremarkable and did not reveal a definite cause for hemoptysis (such as cancer or TB). The consulting respirologist wasn't convinced the bleeding was of pulmonary origin. A gastroenterology consult was requested to rule out Upper GI Bleed and a gastroscopy was scheduled.

On arrival to the endoscopy unit, a nursing history and a medical history were obtained. The gastroenterologist examined the patient prior to the procedure. The patient could not discern whether he vomited or coughed up blood but described "a gurgling feeling" in his throat. He recalled "spitting up" some blood six months previously but had not sought medical attention. His significant past history included aortic surgery at age fifteen. He smoked 15-20 cigarettes per day.

As per our usual practice, the patient received oxygen via nasal prongs and his vital signs were monitored. After anaesthetizing his throat with Hurricaine spray and administering IV sedation (Fentanyl and Versed), a gastroscopy was carried out.

On gastroscopy, no bleeding site was identified. The only finding was a small amount of old blood in the stomach which was not attributed to a GI Bleed. The patient's condition was stable and he was recovered as per our usual practice.

The patient's history was briefly discussed with our next proceduralist, a thoracic/general surgeon/intensivist. He suspected the patient may have an aortobronchial fistula.

COURSE IN HOSPITAL

The patient was admitted to the respiratory service. A chest CT scan was done because the respirologist was concerned about the patient's possible hemoptysis, given his history of aortic surgery. She suspected that the patient might have communication between his aorta and lung. The CT scan showed a pseudoaneurysm.

A cardiac consult was arranged, an urgent cardiac catheterization was done which revealed a distorted aorta and a pseudoaneurysm – with communication between the aorta and lung. The patient was scheduled for surgery to repair his aortic arch the same day. The patient's recovery was uneventful.

FOLLOW UP

Given this unusual patient presentation, I asked the surgeon to present this case at a CSGNA meeting.

The surgeon provided us with some excellent background information on enterovascular fistulas during his presentation. We learned that the initial procedure the patient had as a teen "coartaction of the aorta" was done to repair a congenital defect. Usually, the first clue of this defect is hypertension, particulary in young males. An aneurysm can develop in 2-27% of cases postoperatively, especially after using Dacron patching which was

true in our patient's case. Aneurysm is often a delayed complication, occurring 15-20 years after the initial surgery and arises in the native aorta opposite the patch. Patients usually present with a massive hemoptysis. These patients have a 75% survival rate after surgical repair of the aneurysm, however, without surgery, this delayed complication is fatal.

During the presentation, we were also updated about the status of our patient. He quit smoking, had some vocal cord palsy and his CT scan was normal.

LESSON LEARNED

In conclusion, if a patient presents with hemoptysis or GI bleeding and has a history of cardiovascular surgery near the bleeding site consider a fistula as the probable cause.

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On Saturday May 5th the Kamloops and Region Chapter of the CSGNA is holding an education day.

ERCP for the Endoscopy Nurse.

If you are interested in attending you can contact Maryanne Dorais at maryannedorais@shaw.ca for more information.

Get Personal with TB in an Endoscopy Setting

By Monique Travers RN CGN[C]

Although we have noticed a decline in active cases of TB in Canada over the last 10 years, many health care workers do not realize that tuberculosis is on the increase and placing them at risk. In Canada, the average annual incidence rate of contracting TB is 4.9 per 100,000 populations whereas in Nunavit it is 110 per 100,000. Last year, 1,574 active TB were accountable in Canada.

Health Care Workers may well believe they have not had contact with Tb recently. But what about that elderly woman with chronic bronchitis or the alcoholic with the smoker's cough the young woman with atypical pneumonia and that recent immigrant with flu.

Any of these people may have infectious pulmonary Tb. But because of our complacency and low levels of suspicion, they may never be tested or treated for the disease.

Nosocomial tuberculosis is known to occur, usually when infectious patients are not recognized and properly isolated.

Health care facilities need to review their infection control plans to prepare for the possible resurgence of tuberculosis and other infectious agents such as severe acute respiratory syndrome, influenza, avian flu and bioterrorist threats.

The hierarchy of control technologies should be implemented at the first point of contact and then continued during medical evaluation, treatment and throughout hospitalization.

Control technology will help ensure that our institution can isolate active disease cases and prevent sickness and perhaps death of their health care workers, uninfected patients and visitors.

TB identification steps

Suspected TB

↓

Verbal screening – Early isolation

↓

CXR

↓

A single sputum by induction or three sputum specimens

↓

Bronchoscopy (if sputum unavailable)

↓

AFB smear (Acid Fast Bacilli)

- Smear: 2hrs
- Determine presence of mycobacterium bacilli but does not determine if bacilli are viable or non-viable.

Culture and Sensitivity

- Results in 2 to 8 weeks
- Mycobacterium bacilli tuberculosis
- Multi-drug resistant strain of Mycobacterium bacilli tuberculosis
- Mycobacterium bacilli non-tuberculosis
  Gordenia: common contaminant
  MAC (Avian Complex): immunosuppress patient
- Airborne infectious disease: Varicelle, Rubeola and Herpes.

TB screen test is only for screening of latent disease

Hierarchy of Control Technology

1. *Engineering environmental controls to improve infection control:*
   - Negative pressure: Air from room released to the outdoor
   - In the absence of negative pressure, special filtration system must be used:
     Hepa filters (High Efficiency Air Particle)
   - Size of the room is important for the dilution of the infectious particles
   - General ventilation: Recommended 15 air exchanges per hour
   - Local ventilation: Booth for sputum induction or aerosol treatment
   - Anteroom: Positive pressure relative to isolation room
   - Ultraviolet light may be used if ventilation is inadequate (germicidal)
2. *Administration and work practice controls:*
   - Written policies and procedures: Ensure rapid identification, isolation diagnostic evaluation, medical management and treatment.
   - Infection control: Airborne precaution

- If presenting with respiratory symptoms, a trained health care worker will provide simple instructions to patient which are to hand wash and wear surgical mask
- Physician will complete a screening tool form for identification of high risk TB patient
- Restricting contact: Isolation
- Limiting and controlling patient transport: N-95 for transport personnel and a surgical mask for patient
- Disinfection: Strict adherence of reprocessing guidelines for disinfection of instruments
- Monitoring isolation procedures
- Control measures for high risk procedures
- Medical surveillance for exposed health care workers
- Workers education and training

3. *PPE*
   (Personal Protective Equipment):
   - Includes barrier protection to prevent skin and mucous membrane exposure
   - Wear long sleeve gown, gloves, goggles or face-shield, respirator N-95 for generating respiratory procedure
   - Fit testing procedure for respirator N-95 annually

Health Care Workers exposure to active TB patient

Patient diagnosed
|
Isolation
|
Environmental Control fails (HCW)
|
HCW exposed to active TB Disease – HCW unaware of exposure
|

Untreated	***Treated***
10% can become active disease	TB surveillance of symptoms (next 5 years) 0.1% can become active disease

Personnel Control Program

1. TB testing in new health care worker with the two-step testing unless prior positive TB test.
2. Annual TB testing. Every 6months for HCW involved in moderate to high risk activities such as bronchoscopy and recovery of these patients.
3. New blood test QTB Gold (Quantiferon TB Gold)
   Advantages:
   - *Differentiate between people who have been vaccinated versus those infected.*
   - *Less expensive – $50.00*
   - *No nurses required for injection*
   - *Does not require interpretation of skin test.*

Accurate identification of patients with confirmed TB is extremely important because the most common source of transmission of TB occurs from undiagnosed patients. Early diagnosis, prompt optimal drug treatment for TB together with isolation of the patient remains the best tuberculosis control in Health Care Institution.

Capnography in the GI Lab

By Maryanne Dorais RN CGN[C]

Recently, I had a Call Back and assisted in an ERCP and Upper GI Procedure with the use of Propofol. The Gastroenterologist would have had great difficulty completing this procedure without the use of this wonderful drug. All was put into place for this patient i.e. the experienced physician certified in administering this medication along with the availability of emergency equipment if required. Monitoring the ventilatory function of the patient became even more of a priority during deep sedation. As the future unfolds, we may see the use of Propofol used more and more in the GI lab. This motivated me to learn more about Capnography, so I thought I would share this with you.

Before the 1980's a patient was monitored by nursing assessment only. Now it is the Standard of Care for a nurse to monitor the patient along with the use of pulse oximetry. Pulse oximetry is a monitor of oxygenation. Oxygen desaturation is a relatively late sign of poor ventilation. The SPO2 decreases when a patient is hypoventilating or apneic. The use of supplemental O2 can mask hypoxemia. Current standard monitoring may not detect apnea until O2 desaturation occurs. Literature supports the use of supplemental oxygen during moderate sedation, and suggests the use of supplemental oxygen during deep sedation. Hypoxemia is defined as oxygen saturation below 90%. The use of supplemental oxygen reduces the frequency of hypoxemia.

Capnography is a non-invasive, continuous measurement of inhaled and exhaled CO2. Capnography accurately monitors respiratory rate and measures ventilation and hypoventilation more effectively than pulse oximetry. One of the greatest assets of capnography is that it can identify situations that can potentially result in hypoxia. It serves as a warning device for apnea and an early indicator of airway obstruction. The line between conscious sedation and sleep is very narrow and the patient drifts quite often into an unconscious state. During this state of sleep, airway obstruction or hypoventilation may occur that may not be detected until hypoxia occurs as is indicated by pulse oximetry. The delayed identification of airway problems leads to a delayed intervention. Capnography could provide early warning in identifying such airway or respiratory problems in advance so that corrective measures could be taken before hypoxia occurs. Capnography may allow for better titration of sedation.

Pulse oximetery, SPO2, measures oxygenation (O2 attached to Hb). The patient's breathing; metabolism, age, disease process and supplemental O2 can affect SPO2. The SPO2 may even remain normal after the patient stops breathing. Capnography, the ventilation vital sign (EtCO2), measures ventilation breath by breath. Hypoventilation or apnea is detected immediately. Increased respiratory rate decreases CO2 causing Hyperventilation. Decreased respiratory rate increases CO2 causing Hypoventilation.

A recent study, Vargo et al. Gastrointestinal Endosc, 2002, studied 49 adults undergoing a therapeutic upper endoscopy who were monitored with the standard methods pulse oximetry, automated blood pressure measurement, and visual assessment. Capnography was also performed. Endoscopy staff was unable to see capnography data.

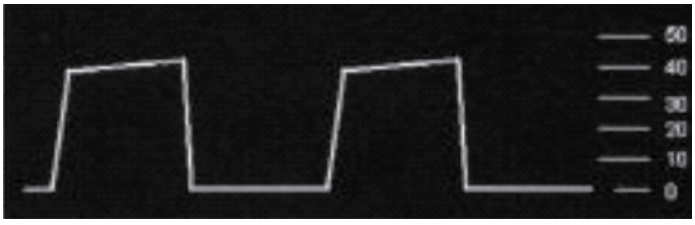
54 episodes of apnea or (cessation of respiration for 30 or more seconds) or disordered respiration (45 sec that contain at least 30seconds of apneic activity) were identified where as pulse oximetry picked up only 27 events. Hypoxemia occurred approximately 45.6 seconds (15-120 seconds) after capnography detection. Visual inspection of the patient by the care providers detected none of the 54 events detected by capnography.

Capnography also detected hypoventilation. No patients suffered adverse effects.

In conclusion there was only documentation in 2.7% of patients with poor ventilation and no documentation for any of the apneic episodes. Capnography indicated disordered ventilation in 56% and periods of apnea in 24% of all patients studied. Certainly capnography provides an early warning device to draw attention to abnormal ventilation. It will not change intervention, only when you do it! Is it only a question of time that capnography will be accepted as a standard of care to enhance patient safety during procedural sedation?

NORMAL RANGE of ETCO2 35-45 mmHg

NORMAL WAVEFORM –
"Square box" baseline CO2 = 0



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3. http://72.14.253.104/search?q=cache:kUM5VfETfjMJ:anesthesia.slu.edu/pdf/Sedation_G...

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APPLICATION FORM
FOR CSGNA ANNUAL NEW MEMBER SCHOLARSHIP AWARD

The Annual New Member National Conference award of $1,000.00 is to be used for travel and accommodation to the Annual National Conference in Canada. Open to members new to CSGNA in the year prior to the conference.

EXCEPTIONS:

1. New member is defined as never previously holding membership with CSGNA.
2. Current members of the Executive and Conference Planning Committee are not eligible for this award.
3. Scholarship is 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. Outline projected financial needs to attend this meeting.
4. Geographical location and related travel expenses will be taken into consideration by the Education Committee when scoring applications.
5. Copy of CSGNA Membership Card.

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

NAME: _____

CIRCLE ALL THAT APPLY: RN BSN BAN MSN OTHER _____

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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

Methemoglobinemia:

Is it time to consider methylene blue as an adjunct to emergency medications in the endoscopy unit as we do flumazenil and naloxone?

Debra Taggart RN, BN, CGRN, CGN[C]
CSGNA, President

On November 23, 2006, Health Canada issued a notice to hospitals on safety information on the use of benzocaine sprays and methemoglobinemia (MHb).

Although reported as a rare occurrence, MHb has been seen several times in Calgary Health Region facilities where physicians typically used benzocaine spray for topical anesthesia prior to esophagogastroduodenoscopy (EGD). Benzocaine spray is now used infrequently except for patients who are having an EGD without sedation. Most reported cases of MHb have been associated with higher concentration of benzocaine 14-20% although this drug is found in many products in lesser concentrations and the condition has been seen in patients who've received benzocaine preparations in concentrations as low as 5%. The most frequently reported cases have come from hospital settings where benzocaine spray is used during intubation, bronchoscopy, endoscopy and transesophageal electrocardiography. However, nitrates such as nitroglycerine and products containing nitrates, such as shoe polish, mothballs, fertilizer, and some industrial chemicals, have caused this disease. Patients most at risk for developing this disease are children under four months of age, those with compromised immune systems, and those exposed to medications or environmental agents containing nitrates.

Methemoglobinemia is both a congenital and acquired condition. Congenital methemoglobinemia is most common in Alaskan Native Americans and Inuit. There are also numerous accounts about the ***Blue People***, the Fugate family in Kentucky who were called this after more than one generation of the family presented with blue coloration to their skin, nail beds, and chocolate-brown lips. MHb occurs when iron in the hemoglobin molecule is ineffective and unable to carry sufficient oxygen to the tissues. Methemoglobin is < 1-2% fraction of hemoglobin in the healthy individual. Signs or symptoms usually present within 20-60 minutes of benzocaine administration. When the methemoglobin level is 15%-20%, the patient is usually cyanotic but may be asymptomatic. When levels reach 20-50%, the patient may complain of headache and lightheadedness, weakness, chest discomfort and palpitations and may exhibit dyspnea. Death occurs when methemoglobin levels reach 70%. In certain individuals, nitrates and benzocaine topical agents convert ferrous iron into ferric iron which results in methemoglobinemia. Whereas ferrous iron binds, transports, and releases oxygen into the tissues, ferric iron does not. Because methemoglobin prevents oxygen from being carried to the cells, initially, the patient with MHb becomes cyanotic, despite apparent adequate respiratory status. Increased oxygenation has no effect on either the cyanosis or oxygen saturation. Pulse oximetry will probably be inaccurate and readings will be inconsistent with the patient's increasing cyanosis. When drawn, arterial blood is described as chocolate brown to black which is sometimes considered of more importance than the actual lab values. Another simple bedside test cited by Armstrong et al (2004), is to place a drop of arterial blood onto filter paper. Arterial blood exposed to air-borne oxygen will turn red when the cyanosis is due to other causes than methemoglobinemia. In the patient with MHb, the arterial blood remains dark brown or black. Based on the patient having received benzocaine spray for a procedure, cyanosis and other symptoms, methylene blue administration should be commenced immediately. Methylene blue reduces methemoglobin to normal hemoglobin which reoxygenates tissue with prompt resolution of symptoms in most cases. Normal oxygenation usually returns within 10-30 minutes of administration of the drug.

Treatment for this potentially life-threatening condition is administration of intravenous methylene blue in a dosage of 1-2 mg/kg of 1% solution over five minutes. Ascorbic acid has also been used but has a slower response rate. The patient should be closely monitored for several hours after methylene blue administration as rebound methemoglobinemia can occur. The second dose should not exceed 1.5 times the initial dose. With prompt treatment, some patients may be discharged the same day. Patients should be advised that their urine and feces might have a bluish-green hue until the drug is completely excreted from the system. Side effects of methylene blue are most often related to overdosage and include nausea and vomiting, diarrhea, abdominal pain, hypertension, diaphoresis, bladder irritation and formation of methemoglobin, the most serious adverse effect of overdose. One source says that a methylene blue dosage of greater than 7 mg/kg by itself can cause methemoglobinemia (Hegedus et al, 2005). Methylene blue is contraindicated in

patients with severe renal impairment, known hypersensitivity to the drug, or in pregnant women, especially if the drug is given into the amniotic sac.

In light of the recent Health Canada directive and the increased awareness of potential death after the use of benzocaine spray, physicians may rethink their practice of routinely using this topical anesthetic. Patient perception of the procedure may be unchanged with the use of the spray and it is this author's opinion that what a patient often does recall post-endoscopy is the terrible taste of the spray. If they've received sedation, they most often remember nothing else. Having become aware of this adverse effect of what may be a routinely used medication in one's endoscopy unit, the registered nurse is obligated to raise this subject with their endoscopists. The change in practice and the availability of methylene blue in settings where benzocaine spray is used may save your patient's life.

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Mixed Bean and Chicken Chili

1tbsp olive oil
2 skinless, boneless chicken breasts halves, diced
1 medium onion, chopped
½ green pepper, diced
2 stalks celery, sliced
2 garlic cloves, crushed
1 tbsp chili powder
19 oz. can diced tomatoes
2.5 oz. can peeled chilies
1 cup chicken stalk
19 oz. can mixed beans, drained
2 tsp sugar

In a large saucepan, heat oil over medium-high heat.
Add chicken and cook until lightly browned.
Add onions, green peppers, celery and garlic.
Cook for 4 minutes, stirring occasionally.
Add chili powder and stir for one minute.
Add tomatoes, green chilies and chicken stalk.
Reduce heat to low. Cover and simmer for 15 minutes.
Add beans and sugar. Simmer for 15 minutes uncovered.

Each 1 cup serving = 167 calories and contains 6.5 grams fiber.

Salmon Patties

7.5 oz. can pink salmon
2 cups leftover mashed potatoes
1 egg lightly beaten
2 green onions, thinly sliced
dash black pepper
1/3 cup dry bread crumbs
2 tbsp. margarine, divided
1 tbsp canola oil

In a medium bowl, mash salmon with a fork.
Add mashed potatoes, egg, green onion and pepper.
Mix well. Chill 30 minutes.
Make salmon mixture into small patties [approx ¼ cup each].
Coat in bread crumbs.
Heat a heavy nonstick frying pan over medium heat.
Add 1 tbsp margarine and oil. When margarine melted, add salmon patties. Fry 5 minutes, until nicely browned. Turn over, add the other tbsp margarine. Cook another 5 minutes, or until browned.

Two Pattie serving size=118 calories

TWIST AND SHOUT

By Joanne Glen R.N. CGN[C]

Colonic volvulus is a twisting of the colon that causes a closed loop of bowel. Gas may enter the loop but is unable to exit, causing distension. Blood flow is compromised and the increased intraluminal pressure can cause gangrene or perforation if not treated promptly. It is a medical emergency that comprises 3-5 % of all large bowel obstructions in adults in the western world. It is more common in Eastern Europe and Asia, thought to be due to the high residue vegetable diets that cause a lot of bulk in the colon. This can cause the bowel to distend and become longer, allowing a loop to form. The sites affected include the cecum and sigmoid colon. Other areas are not usually affected as they are more fixed in the abdomen.

Approximately 25% of volvulus occur in the cecum, and are related to inadequate fixation of the cecum to the posterior abdominal wall. This type of volvulus is more common in young people who present with sudden and constant abdominal pain, vomiting and constipation. Urgent surgical consult is required as these are not easily treatable with colonoscopy or water-soluble enema.

The remaining 75% of cases involve the sigmoid colon. These tend to occur in the elderly, often institutionalized patients who have redundant colon associated with chronic constipation and laxative use. Patients present with lower abdominal pain, abdominal distension, and obstipation and in some cases, vomiting.

Diagnosis can be made in over half the patients by history, physical examination and plain abdominal films which may show a dilated loop of bowel. The loop may be palpable on physical exam. If there is any doubt of the diagnosis, water-soluble enema (such as gastrograffin) may be done. Barium should not be used because of the risk of perforation. CT may also be used to aid in diagnosis.

Reduction of the volvulus is sometimes attempted with a sigmoidoscope or colonoscope and is successful in the majority of cases. As the bowel is decompressed, the loop will untwist. This is less successful in the cecum. Also a rectal tube may be placed at the time of reduction and left in place for up to 48 hours to decrease the risk of early recurrence. Laparotomy is necessary when gangrene is suspected or endoscopic detorsion is unsuccessful.

Recurrence rates are high, indicating the need for elective or immediate surgery which may be fixation of the area (sigmoidopexy or cecopexy) or resection of the involved area. The ischemia can extend beyond the twisted area which will influence the type of resection performed and in sigmoid volvulus a temporary or permanent colostomy may be required.

Nursing Considerations: It is important to resuscitate to restore fluid and electrolyte balance to stabilize before treatment of the volvulus. Accurate intake and output, including emesis, must be recorded. . The patient may have a nasogastric tube and foley catheter. The nurse must assess changes in abdominal pain and distension and alert the doctor to worsening symptoms that may indicate perforation or sepsis. Abdominal distension may compromise respiratory function therefore pulse oximetry should be included with vital signs. Antibiotics may be given, and an enema or rectal tube may be used in an attempt to decompress the bowel. If these are unsuccessful, the patient will be prepared for endoscopy or surgery and will require teaching and reassurance.

Discharge teaching includes appropriate post operative information regarding wound and ostomy care. If the volvulus was treated medically, the patient should be aware that recurrence should be treated promptly. Low fiber diet may be recommended.

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

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