New Zealand Society of Gastroenterology

Issue: 21 December 2012

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Closing Soon Reasearch Grants!

The next round of applications closes on 31 January 2013 (See page 5 for more information)

Update from Your President

This has been another successful year for the NZSG culminating in an excellent scientific meeting in Hamilton. These meetings rely on the hard work of the local committee for organizing the medical and nursing programmes and the social events. Thank you to Graeme Dickson and Anne Currie for doing a great job this year. We are also grateful to Claire Bark and the Tangerine Events team for the smooth running of this event. The Claudelands Event Centre was an ideal venue for this conference. The quality of the invited speakers for both the medical and nursing programme was excellent – all the sessions provided high quality learning. It is particularly important to have a large hall for the trade exhibition and for posters. The conference dinner continues to inspire our members and our nurses to dress up with great creativity (and this year some nerve and audacity was required to match the Rocky Horror theme). It was a pleasure to be able to present grants and prizes valued at $100,000. On top of this we have two rounds of the NZSG small research grants which primarily aim to encourage research by our trainees. These grants are for a maximum of $5,000 and the total awarded in a year is up to $35,000. This increase in funding is very exciting - fostering research in New Zealand is part of the core business of the Society.

I would like to thank Susan Parry for her successful term of President. She can now enjoy the more relaxed role as Past-President. The make-up of the Executive will be similar for 2013. There will be a new trainee representative - our thanks goes to James Irwin for his contribution. Russell Walmsley and Jeff Wong remain in the positions of Secretary and Treasurer respectively. They are both doing a great job and we can be confident that the Society will run smoothly for 2013.

The NZSG needs to keep focussed on the many current political issues around

to make sure that our views are heard in any relevant discussions. There continue to be important discussions on training in endoscopy and in governance of endoscopy in NZ. There are ongoing issues with workforce requirements and the appropriate number of training posts in NZ. The move to a national registrar rotation scheme for next year will require oversight of the NZSG. The confirmation of the NZSG Position Statement on Nurse Endoscopy is helpful and will help us to be seen as a constructive partner in future meetings. There will continue to be regular discussions with Pharmac. This year there has been a careful review of the hospital pharmaceutical listing and next year will see the beginnings of discussions on the listing of devices for hospitals. The results and conclusions of the Bowel Cancer screening pilot will have implications for all of us and we need to be closely involved in this area.

We need to try hard to be proactive in all these areas and not simply react to changes that may seem threatening. Your Executive seeks to represent you but does need to get feedback to know if we are on the right track. Some changes take a frustrating amount of time – other changes happen so quickly we are not sure what is going on. Whatever happens, we need to be involved and that is the role of your Executive.

The Annual report presented at the Annual General meeting is now very detailed

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with important information in a wide of areas. This year we received reports from the NZ Liver Transplant Unit, Paediatric Gastroenterology, Specialty Advisory Committee for Gastroenterology, Colorectal Screening and National Bowel Cancer Working Group, NZ Familial Gastrointestinal Cancer Registry, Conjoint Committee, National Endoscopy Improvement Programme and Asia Pacific Society relationships. Please read this - a lot effort goes into making this a useful report of activities of the NZSG and closely affiliated organisations.

We were pleased to welcome David Morris as an Honorary Member of the Society. David has been very generous in giving his time to endoscopy education in recent years.

The focus for many of us now is getting through to Christmas to enjoy a well deserved holiday and time with our families. I wish you all a time of peace and relaxation and I hope you re-emerge for 2013 full of renewed energy and joy.

Alan Fraser
President

Gastroenterology Conferences 2013

European Crohn's and Colitis Congress of IBD
February 14-16
Vienna, Austria
Canadian Digestive Diseases Week
March 1-4
Victoria, British Columbia, Canada
The International Liver Congress
April 24-28
Amsterdam, The Netherlands
Digestive Disease Week
May 18-21
Orlando, Florida, USA
NZSG Annual Scientifc Meeting
November 20-22
Wellington
APDW
September 21-24
Shanghai, China

2011 Small Research Grants - Reports from Recipients

James Falvey

Macrophage migration inhibitory (MIF) as a novel biomarker candidate in IBD

MIF is a pleiotropic pro-inflammatory cytokine the mucosal concentrations of which are elevated in human IBD. Initial reports indicate that plasma MIF is elevated in cases with active IBD and falls following successful medical therapy.

Aim: to investigate plasma MIF concentration against gold standard disease assessment (endoscopy).

Methods: Plasma MIF was measured by commercial ELISA in 140 cases with IBD (85 CD, 55 UC) on who detailed endoscopic disease activity data were available, and 40 controls.

Results: No difference in MIF concentration was observed between the groups. No correlation was observed between MIF concentration and endoscopic IBD severity in either UC or CD. No correlation was observed between MIF concentration and either plasma CRP or faecal calprotectin.

Attempts were made to adapt the commercial ELISA for the measurement of faecal MIF, but were unsuccessful due to the presence of interfering substances in stool.

Conclusion: plasma MIF is not of value as a biomarker of IBD. However MIF inhibition is successful at ameliorating disease severity in murine experimental colitis and safety data is currently being gathered by Phase I trial for systemic MIF inhibition in human subjects. These data therefore provide a useful contribution to this field.

RACP MyCPD Reminder

MyCPD participants are reminded to complete their 2012 CPD claims before the closure date of Sunday 31 March 2013.

From 1 November 2012, CPD activities can also be prospectively entered for 2013.

CPD Unit contact details:

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Geogry Kini

Vitamin D and Crohn's disease activity

Aim: to review seasonal Vitamin D levels (25OHD) in CD patients and the correlation with the CDAI.

Methods: CD patients from database given questionnaires on Vit D supplementation, sun exposure, sunblock application and symptoms for CDAI. Examination and Vit D levels taken in winter (06– 09/2011) and summer (12–03/2012). Patients on supplements or with extensive small bowel resection excluded.

Results: 32 patients (19 F, mean age 39 years). 3 excluded on Vit D supplements. 2 participants did not return questionnaires but had serum 25OHD levels tested. 12 participants had had bowel resection; 3 complete/partial colectomy, one segmental ileal and 8 had ileo-colonoic resection. No significant difference in sun exposure between seasons. In winter all participants had insufficient 25OHD (< 75 nmol/L) and 75.9% were 25OHD deficient (< 50 nmol/L). In summer 55.2% had insufficient and 10.3% were deficient. Mean 25OHD level was 38.81 nmol/L (norm 50– 150nmol/L) in winter (5 – 80, SD 19.48) and 72.47 nmol/L in summer (13 – 119, SD 20.63). Mean CDAI score 103.92 in winter (range 10 – 262) and 90.21 in summer (range 13 – 331). Mixed-effects regression analysis showed **no** statistically significant correlation between seasonal levels of 25OHD and CDAI (r0.53, p > 0.66, 95% CI -1.88 – 2.95).

Conclusion: CD patients might benefit from 25OHD supplementation in winter.

NZSG Small Research Grants

The NZSG is keen to encourage clinical research by gastroenterology and surgical trainees during their period of clinical training. Supervisors may have the ideas and time but need small grants for tests, equipment or part-time staff. The next round of applications closes on **31 January 2013**. For more information on the eligibility, conditions and application process, please go to the NZSG website www.nzsg.org.nz.

Hui Yann Lee

Use of Lightweight Ergonomic Thermoplastic Splint for Endoscopist's Thumb

HY Lee (1), A Claydon (2), D Ellis (3), R Walmsley (1)

(1) North Shore Hospital, Auckland
(2) Tauranga Hospital, Tauranga, Bay of Plenty
(3) Bay Hand Therapy Limited, Tauranga

Endoscopy practice involves repetitive tasks that can lead to joint strain and discomfort (1), reported in 39% in a published survey of colonoscopists, particularly in the hands and fingers (2). A case report of 'colonoscopists' thumb' has described the use of a wrist brace to alleviate left thumb pain resulting from de Quervain's tenosynovitis (3).

Aim: To investigate the prevalence and distribution of joint pain among endoscopists in New Zealand and examine whether the use of a lightweight ergonomic thermoplastic splint improves left thumb pain.

Method: An online survey concerning discomfort during endoscopy was sent to members of the New Zealand Society of Gastroenterology. Endoscopists admitting to experiencing left thumb pain were invited to have an individualised splint fitted. Pain measured by Quick DASH (Disabilities of the Arm, Shoulder and Hand) scores was recorded for 7 days before and after splint use.

Results: 68 endoscopists responded to the survey (49%). 18 (26.5%) reported left thumb metacarpophalangeal pain and 15 (22.1%) carpometacarpal pain.

Seven endoscopists had left thumb splints fitted. Three withdrew from the study due to discomfort from partial restriction of hand movement. Two were lost to follow-up. Two endoscopists remaining each showed reduction in Quick DASH from 4.5 to 0 and 6.8 to 4.5.

Conclusion: Left thumb discomfort during endoscopy is an appreciable problem. A thermoplastic splint may provide relief but compliance is poor. Alternative solutions such as revision of grip and techniques to decrease small wheel use should be considered.

References:

(1) Shergill AK, McQuaid KR, Rempel D. *Gastrointest Endosc* 2009; 70(1):145-53
(2) Liberman AS, Shrier I, Gordon PH. *Surg Endosc* 2005; 19:1606-9
(3) Cappell MS. *Gastrointest Endosc* 2006; 64(5):841-3

Sue Larsen

Report on the outcome of the Investigation of Parenteral nutrition – Aotearoa (IPNA) – Phase One

The IPNA study aims to investigate the current management of parenteral nutrition (PN) throughout New Zealand. It will examine several themes of PN care including, type of PN, indication for PN, complications, catheter care and nutrition support team involevment. Phase One covering the Auckland/Northland region aimed to trial the data collection tools and methods used and collect the first tranch of data.

Phase One has now been completed and, similarly to the UK NCEPOD study, found that practice varies significantly between hospitals and individual clinicians. A review of overall care provided identified that there are several areas of concern in the current practice of PN management.

39% of patients did not have an adequate nutritional and biochemical assessment prior to commencing PN. Enteral feeding was not considered as an alternative method of feeding in 32% of patients. 35% of patients received bags of PN considered to be inappropriate for their needs. Metabolic complications occurred in 58% of patients and central venous catheter complications in 28%. 93% of patients had no documentation that they were or were not at risk of re-feeding syndrome. Nutrition support teams were involved in the decision to commence PN in 61% of cases.

Phase one also demonstrated that the data collection tools used need to be refined in order to ascertain some of the nuances of care provided. It is intended that phase two of this study will commence imminently dependant on funding.

Phase two aims to examine PN care throughout all of NZ. It is essential that current practice is reviewed so that all remediable factors are identified, on completion it is intended that national standards of care will be published to ensure safe provision of PN for all patients.

Sue Larsen
Clinical Nurse Specialist
Nutrition Support Team
Gastroenterology Department
North Shore Hospital

2012 NZSG ASM Awards and Winners

Award	Prize	Winner
NZSG Ferring Research Fellowship	$55,000	David Orr
NZSG Abbott Research Grant	$35,000	Andrew Day/ Richard Gearry
Obex/Given PillCam Scholarship	Package	Hui Yann Lee
Roche Young Investigators Award (Liver)	$2,000	Tien Huey Lim
Baxter Young Investigatros Award (Luminal)	$2,000	John Hsiang
Best Luminal Paper/Poster	$1,500	James Falvey
Best Hepatology Paper/Poster	$1,000	Jeffrey Ngu
Best Published Paper	$2,000	Greg O'Grady

2012 Annual Scientific Meeting

Dear all,

This year's annual scientific meeting was educational, collegial and outrageous! The overseas speakers were excellent and there were many highlights. We kicked off with a tour de force of colonoscopy from David Hewett, were enthralled by Rajvinder Singh's "space-age" endoscopic imaging, highly entertained by Roger Chapman and finally finished with Kenneth Binmoeller. Ken made extremely complex cases look routine and is inspirational as an endoscopist. We also had several excellent lectures from Sue Shepherd and were lucky to have Richard Garcia-Kennedy to share his cytology skills. The support from industry was tremendous and I would like to thank all of our many sponsors. I would also like to acknowledge the contribution of all the local speakers who gave some excellent lectures. Of course I cannot finish without mentioning the conference dinner… Then again, maybe I shouldn't!

Merry Christmas to you all.

Graeme Dickson
Convenor NZSG ASM 2012

2013 Courses

Train the Trainers Colonoscopy Course

Date: April 2013

Contact: Dr R Walmsley or Dr T King

Quality Endoscopy course for established practitioners

Date: July 2013

Contact: Dr R Walmsley or Dr T King

Basic Endsocopy course

Date: Sep 2013

Contact: Dr R Walsmley

R Walmsley:
Russell.Walmsley@waitematadhb.govt.nz

T King: TimK@adhb.govt.nz

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

Position Vacant

The Capital & Coast DHB is looking for an experienced Consultant Gastroenterologist. This role can be part time or full, 30 – 40 hours per week for 12 months.

The role based in the Gastroenterology and GI Endoscopy Service is responsible for providing comprehensive Gastroenterology services, undergraduate medical education and postgraduate specialist vocational training. This includes a wide range of secondary and tertiary services for both inpatients and outpatients located both at our Wellington and Kenepuru Hospital sites.

As our successful candidate, you will have proven skills and experience in both diagnostic and therapeutic gastroscopies and colonoscopies. Role expectations include an on call component with associated inpatient responsibilities. On application, please include a summary of your endoscopy experience.

You will be known as someone who is inclusive and works well with others from various backgrounds and at all levels. You will be eligible for registration with the Medical Council of New Zealand as a specialist who is approved to educate and mentor our registrars in accordance with the Australasian College of Physicians and obligations of the Medical Council of New Zealand.

For further information or interested recruitment agencies wishing to present candidates, please contact our recruitment advisor elena.scheule@ccdhb.org.nz or telephone (04) 806 2547.

Applications close **31 January 2013**.