New Zealand Society of Gastroenterology

Issue: 19 June 2012

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IBD Symposium 20-21 July 2012

Registration www.thegutclub.co.nz

2012 ASM Call for Abstracts

Deadline 24 August 2012

Update from Your President

Susan Parry

This is the first newsletter for the year and the first that has been overseen by Russell Walmsley, who has taken up his new role as Secretary. On behalf of you all, I want to thank Russell and Alan Fraser for their excellent work as Treasurer and Secretary respectively.

As an Executive we established our work priorities for the year at a face to face meeting on Friday 4th May. The Ministry of Health initiatives to monitor and reduce colonoscopy waiting times (following the introduction of National Colonoscopy Prioritisation Criteria) have certainly put a focus on the Gastroenterology Workforce. In this regard we met with Health Workforce NZ in April and we were made aware of the fact that this body has some potential funding to expand training in priority specialities. Consequently, we asked at least three DHB's with Gastroenterology Services recently credentialled by the Gastroenterology Specialist Advisory Committee (SAC), to consider requesting in their Annual Plan a new or additional Gastroenterology Trainee. This could increase both the number of Gastroenterology trainees and the likelihood that trainees, when qualified, will work in Regional Centres. As another workforce initiative, we have again called for measures that will facilitate the increased use of Gastroenterology Nurses in the clinic setting e.g. IBD, Hepatitis etc.

More structured endoscopy training (particularly with regards to colonoscopy) has been identified as a need by many, including trainees, and this is high on our priority list to progress. It is also important that we advocate for quality in the performance of colonoscopy and therefore we need to address the new sedation training requirements for proceduralists. Tim King has taken up the latter challenge on our behalf - in this newsletter he reports on the inaugural sedation course.

Our relationship with fellow Societies in the region remains important and to both increase dialogue and ensure some uniformity in our approach to common challenges I will attend attend the next GESA council meeting on June 22nd.

Space precludes discussing all matters addressed at the face to face meeting but because we recognise the importance of quality meetings for members the ASM, and co-sponsored meetings such as the IBD symposium, are a constant agenda item.

Finally, I am pleased to advise that Helen Evans, a Paediatric Gastroenterologist, has been co-opted onto the Executive until November 2013. Mark Thompson-Fawcett was previously co-opted as a Surgical member. Given that we also have a Trainee representative in an ex-officio position, we feel confident that we can now better advocate for the needs of all our members. However, it remains crucial that you advise us of your concerns and I am always happy to hear from you as are our office bearers and your local Executive members.

Editorial

Russell Walmsley

There is an unashamed bias towards endoscopy related training matters in this newsletter ('what a surprise' I hear you cry) leading off with the views of Dr David Rowbotham, an advocate of the less-is-more school of sedation. We also have a review of the first of the NZSG-endorsed Safety in Procedural Sedation Course by the Chariman of The Conjoint Committee on Endoscopy along with details of more Endoscopy courses for Trainers and Trainees to attend.

I am happy to consider articles on topics close to any members hearts for future newsletters.

Safety in Procedural Sedation Course

Tim King, Jane Torrie, Paul Baker

University of Auckland, 16th April 2012-05-06

Traditionally sedation practices for endoscopists have been taught by osmosis during an apprenticeship-style training. A tripartite working group in Australia comprising anaesthetists, gastroenterologists and surgeons have recently updated the guideline document for procedural sedation that is endorsed by professional bodies in Australia and New Zealand[1]. The PS(9) guideline includes recommendations about provision of staffing and equipment, planning, monitoring and discharge, as well as the training of proceduralists.
In this context a one-day course was developed for doctors and nurses, with the objectives of practising the management of rare and dangerous events in endoscopy sedation practice that require teamwork. Secondary objectives included development of airway management skills and a systematic approach to the hypoxic patient.

The first course was delivered at the Simulation Centre for Patient Safety on the East Tamaki campus in Auckland. Delegates were three physicians (two trainees) and three endoscopy nurses from around New Zealand.

The messages of the course were well received and feedback has been obtained to help with the design of future courses. It is expected that we will be able to advertise a further course later in the year.

Re-vamped Awards for 2012

Russell Walmsley

With a new strap-line of 'Fostering Good Science', the NZSG Executive have come up with revamped awards for the 2012 ASM, two rounds of Small Research Grants and the prospect of exciting changes in the Research Fellowship.

There will be two Young Investigators awards at the 2012 ASM in Hamilton. These are designed for top researchers, clinical or non-clinical. The **Roche Young Investigator** is for excellence in research in the field of Hepatology, value $2,000, and the **Baxter Young Investigator** award is for excellence in research into luminal disease, also worth $2,000.

There will be a **Best Luminal Paper/Poster** sponsored by Janssen, worth $1,500 and a **Best Hepatology Paper/Poster** sponsored by Roche worth $1,500.

There will be a new **Best Published Paper** award, worth $2,000, sponsored jointly by Obex and Roche Diagnostics, open to any member of the Society who has published a paper in the previous year, to be nominated by a colleague. Award to go to the research Group/Unit involved.

We are also aiming to alter the timing of the Ferring Research Fellowship so that applicants will know what their year will hold for them before the July interviews come around. We are also negotiating the possibility of a research project grant. So watch your emails and the website www.nzsg.org.nz for news in the next few weeks.

Guidance on Surveillance for People at increased Risk of Colorectal Cancer

New guidance from the New Zealand Guidelines Group updates the 2004 guideline 'Surveillance and Management of Groups at Increased Risk of Colorectal Cancer' and follows the publication in June 2011 of the guideline 'Management of Early Colorectal Cancer'.

It is intended for primary and secondary care providers who care for people who have undergone previous colorectal cancer resection, people who have inflammatory bowel disease, people with adenomatous polyps and people with a family history of colorectal cancer.

The guideline, a practitioner summary resource and a consumer brochure are now available for download at www.nzgg.org.nz.

Other guidance can be found in the publications 'Suspected Cancer in Primary Care' (2009) and 'Management of Early Colorectal Cancer' (2011), also available at www.nzgg.org.nz.

Sedation and Endoscopy

David Rowbotham

The Global Rating Scale (GRS) is a tool that enables units to assess how well they provide a patient-centred service. GRS may well, in the future, become an integral part of our everyday lives in endoscopy in NZ. Indeed, at four trial sites, it is already here. The aim of this article is not to describe GRS (http://nz.globalratingscale.com), but to call us to action to get prepared for its possible impending arrival.

Two of the four major domains include Quality and Safety under the umbrella of Clinical Quality. Part of safety in our endoscopy units relates to use of intravenous sedation. It is supposed to be conscious sedation (verbal contact/response with the patient is maintained at all times throughout the period of sedation), but is it really? Doses and use of IV sedation varies from individual to individual and from unit to unit. But how can we realistically measure performance between us when we have no national NZ guidelines for the use and doses of IV conscious sedation. Hence we need to come up with some ... a time-consuming task. But why reinvent the wheel? Why not use the guidelines from the UK? Even the staunchest Republican can't seriously believe that we are so different to Blightey as to make their guidelines not applicable here.

So what about sedation dose? In the UK, Scoping our practice was a 2004 report of the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) that focused specifically on endoscopy. From 1 April 2002 through to 31 March 2003, there were 1,818 reported endoscopy-associated deaths (hospital deaths within 30 days of a therapeutic endoscopic procedure) from a total of 136,000 endoscopic procedures. 73% of these deaths were in patients over the age of 70 years, and 14% were felt (by the NCEPOD advisors) to be associated with an overdose of sedation, almost universally Midazolam. Subsequent recommendations were produced and the first of these was that no more than 2mg of Midazolam should be drawn up into any syringe prior to the endoscopic procedure, and further top-up doses of Midazolam should only rarely be required. This is currently under review and the dose recommendations could come down even further (personal communication).

So, given that GRS will grade us on Quality and Safety domains, how are we doing with sedation practice in NZ? Let's take colonoscopy practice as an example. Anecdotal evidence would suggest we have some improvements to make with average Midazolam usage being closer to 5mg or even higher in some units. Some reading this may ask "Why is this even important"? The clear evidence of association of harm with increasing doses of sedation is irrefutable, but death is the most serious consequence. There are other non-fatal morbidities associated with over sedation such as hypoxia, hypotension, aspiration, cerebral events etc.

Playing devil's advocate (again) ...

But more importantly, in my opinion, in the US, Canada and now Australia deep sedation with Propofol is almost becoming accepted standard practice and the inferred idea that a "quality" colonoscopy experience equates with being unconscious and not remembering a thing is false. Deep or excessive conscious sedation does not make you a good endoscopist. Performing a safe, competent, and thorough colonoscopy procedure can be achieved with low doses of Midazolam, or even no sedation at all. Obviously this does not work for every patient, but you would be surprised just how many of your patients would value the chance to see and remember their colonoscopy procedure, and also have the chance to drive themselves home, go back to work, or have a beer/wine that evening. Using less (or no) sedation should not be viewed as a bad thing. Having a patient who is awake tends to make you a better colonoscopist (personal view).

These issues of quality and safety are not going to go away. GRS has a foot in the NZ door and may become a reality for all of us. Sticking our heads in the sand and ignoring these issues will not make them go away. So how do we move forward? Firstly we need some more robust data to assess where we actually sit in terms of sedation use for endoscopy in NZ. Secondly we need to police ourselves on these issues by adopting some sensible national sedation guidelines to bring us into line with international standards. If we don't then we risk being governed/policed by other bodies and self determination is always preferable.

Note: The NCEPOD data relate to therapeutic endoscopic procedures, but there is no reason why sedation issues should be any different for diagnostic endoscopy.

Disclosure: I am biased. All of my patients (public and private) get the option of unsedated colonoscopy. The uptake of this offer is over 25% and the response after the procedure is almost universally positive.

Registrar Annual Training 2012

James Irwin

The 2012 gastroenterology registrar training meeting was held at the Langham Hotel over two days in March. This annual meeting is a great opportunity for trainees from different parts of the country to socialize, compare training experience and discuss future training plans. 18 trainees attended from around the country.

The programme was organized by Tom Boswell and Nathan Atkinson. It included presentations and organized debate. Trainees again had the opportunity to meet directly with Alan Fraser and Susan Parry of the SAC to discuss training issues, debate endoscopy training as well as the recording of endoscopy training with Tim King of the Conjoint Committee. Speakers attended from Auckland, Christchurch, Wellington and the Hawke's Bay. Thank-you to Sanjeev Deva, Dominic Ray-Chaundhuri, David Rowbotham, Rachael Harry, Ian Wilson, Malcolm Arnold, John Perry, Alasdair Patrick, Ross Boswell, Mike Rutland, Ed Gane, Murray Barclay, Tim King, Alan Fraser and Susan Parry for speaking to us. If you are invited (or begged) to speak at this meeting in the future, consider it an excellent opportunity to influence New Zealand's future gastroenterologists - whether to alter our sedation practice in endoscopy, or to lure us all to the Hawke's Bay!

Thank-you to Gilead Sciences and Ferring Pharmaceuticals who sponsored the meeting.

Back row: Mahendra Naidoo, Alex Huelsen, Anurag Sekra, Elena Eliadou, Tom Boswell, Alex Lampen-Smith, Sutharshan Kannuthurai
Middle row: Jeffrey Ngu, Geogry Kini, Jeremy Rajayanagam, Judy Huang, Esra Venecourt-Jackson, Estella Johns, Tien Huey Lim
Front row: Chris Cederwall, Ben Griffiths, James Irwin, Nathan Atkinson

Announcements

NZSG Representatives for External Organisations

PHARMAC Pharmacology Therapeutics Advisory Committee (PTAC) -

Gastroenterology Subcoomittee - Russell Walmsley, Alan Fraser, Simon Chin, Murray Barclay, Ed Gane

Special Foods Subcommittee - Simon Chin, Russell Walsmley

SAC - Alan Fraser, Tony Smith, Susan Parry, Simon Chin

Upcoming GI Meetings

Australasian Viral Hepatitis Conference
Auckland, 10-12 September 2012
Abstract Deadline: Closed on 27 April 2012

NZSG ASM
Hamilton, 14-16 November 2012
Abstract Deadline: 24 August 2012

APAGE Asian Pacific Digestive Week
Bangkok, 5-8 December 2012
Abstract Deadline: 31 July 2012

Australian Gastro Week
Adelaide, 16-19 October 2012
Abstract Deadline: Closed on 1 June 2012

International Society for Gastrintestinal and Hereditary Tumours
Cairns, Australia, 28-31 August 2013

Upcoming Courses

Introduction to Endoscopy

Dates: **20-21 June 2012**

12-13 December 2012

Venue: **Auckland University**

Course Information:
This two day course is designed for entry level endoscopists about to begin either gastroenterogical or surgical training. It will cover information and technical skills for learning basic gastroscopy and colonoscopy. This course is a requirement if you are intending to work in the Gastroenterology Unit at Middlemore, Auckland City or North Shore Hospitals.

Registration:
http://www.fmhs.auckland.ac.nz/som/acsc/registration.aspx, or contact Christine Halkett, (09) 373 7599 extension 89304

Train the Colonoscopy Trainers

Date: **2-3 August 2012**

Venue: **Auckland Hospital**

Registration:
Up to six delegates can be accommodated. Balance of physicians and surgeons is encouraged.

Please contact TimK@adhb.govt.nz or Russell.Walmsley@waitematadhb.govt.nz to register your interest.

NZSG Research Recipeints

The NZSG is pleased to have awarded the following research grants in in September 2011 as part of our new small grants awards:

James Falvey, Macrophage migration inhibitory factor in IBD: a new biomarker? - $7,000

Geogry Kini, Seasonal levels of Vitamin D and correlation with Crohn's disease activity - $5,000

Russell Walmsley/Sue Larsen, Investigation of Parenteral Nutrition in Aotearoa - $10,000

These three studies will make a significant contribution to the gastroenterology research environment in New Zealand. There is a good balance between basic science research and clinical science. The Executive is hopeful that these small grants will boost the quality of research work presented at our annual scientific meetings.