New Zealand Society of Gastroenterology

Issue: 35 September 2017

In This Issue:

Research Grants!

The next round of applications closes on 31 January 2018 (see page 4 for more information)

Update from Your President

It has been an exciting year for Gastroenterology so far and the year is not over yet. We were preoccupied this year with the Bowel Cancer Screening Program and the successful roll out in Lower Hutt and the Wairarapa. Our colleagues were often enough in the media and I can only start to imagine the pressure on those units. The fact that we do get population-wide Bowel Cancer Screening is fantastic and we have all been reassured by A/Prof Susan Parry that this programme will be successful. It has to be. However, success will largely depend on each and every individual unit as well as gastroenterologists and surgeons to make it happen. Already at this point in time, sincere thanks go to Dr Russell Walmsley and Dr Malcolm Arnold and all the others who are tirelessly trying to catch up with the developments and have either established with their teams the standards for endoscopy and endoscopy units or resurrected the also important GRS through NEQIP. These initiatives will not only be guaranteeing a successful bowel cancer screening programme but will make endoscopy across the nation a high quality, safe and patient orientated procedure. The Society has been significantly engaged in this process and our voice was heard.

The necessary workforce to implement these programs will continue to be an issue for the foreseeable future. Thanks to the team around Alan Fraser and Auckland University as well as the support from various DHBs around the country, we now see that training of nurse endoscopists is finally taking off and we should see the benefits in the not too distant future. More registrars are being trained than ever before.

On the next page of this newsletter you will find a report by Dr Estella Johns on the recent Hepatitis meeting just in case you were unable to attend in person. As always, the Crohn's and Colitis Kids Camp Purple, this time in El Rancho on the Kapiti Coast, was a great success. The Society supported a petition written by 12 year old Nicole Thornton and submissions will be heard by the Health Select Committee soon after the upcoming election. It is great to see young people getting involved in politics.

I would also like to point your attention to the ANZGITA update by Dr Martin Schlup in this issue. New Zealand gastroenterologists are getting more and more interested in helping our Pacific neighbours. Several of our colleagues have taken up the opportunity to pass on their knowledge and to train up and coming endoscopists in the Pacific Islands. Martin's report makes an interesting read and maybe you will get enthusiastic enough to put your name forward for one of the next trips planned by ANZGITA.

I hope you enjoy this edition of the September 2017 newsletter, please do not forget to put your hand up for nomination to join the Executive Committee. It has been a pleasure in my first year to serve as your President and it has been even more so, a pleasure to talk and meet on a regular basis with my colleagues on the Executive Committee. We do however need your support as the issues that the New Zealand Gastroenterology Society is facing are multiplying constantly. If you want to be involved in shaping the future of gastroenterology, please consider getting nominated for a position on the Executive Committee.

Finally, my term as President rolls over for another year but is then up for a new person to take this position. We are also therefore looking for a President Elect at the November AGM.

Enjoy this issue of the Newsletter.

Yours,
Michael Schultz

Hepatitis Update Meeting Report by Dr Estella Johns

This year's unofficial theme was "reality or dream" which may give you a clue to what Ed thinks about at 2am. The international guest speaker was Dr Kosh Agarwal from King's College Hospital in London who was put through his paces.

Hepatitis C

For those feeling a bit jaded by DAAs, there was little mention of 100% SVRs and plenty of opportunity to reflect that however green the grass elsewhere access to pangenotypic regimens will be to no avail if we cannot find the patients to treat. Ministry data presented shows while 2051 patients were treated with Viekira Pak in the first 12 months numbers have dropped sharply as hospital clinics run out of stockpiled patients. While a third of patients are treated in the community this includes hospital-supported clinics and is not the success story we were hoping for.

Dr Agarwal talked about the NHS model of care, which ties a financial incentive to maintaining a "run rate", that is a treatment target per month. In areas that have treated their waitlist (such as Kings) this is forcing innovation in case finding and delivering community-based treatment. There is no such incentive in NZ and as individuals we must start looking outside of our clinics.

In order to meet the WHO targets of elimination of HCV by 2030 we need to increase diagnosis to 2000 a year and treatment to 5000 a year. This will require a multi-pronged approach with discussion touching on point of care and targeted testing, treating those with active addiction to interrupt transmission, and providing treatment via primary care. The concluding debate, always tongue in cheek, was entitled "GPs will eliminate HCV from NZ, hospital specialists will not" and canvassed both sides of the issue including the challenges facing GPs who operate a business model and face significant workforce shortages in some areas. Better regimens (Epclusa and Maverit) will help significantly with no baseline genotyping required, minimal interactions and no requirement for on-treatment monitoring.

To make any headway towards eradication we must be able to treat our G2-6 patients and modeling data highlighting this has been submitted to PHARMAC to support funding for pan genotypic regimens. This will also address the morally troubling inequity that sees 45% of our HCV patients currently unable to access publically funded therapy as well as the paradox that many of those most in need and most likely to benefit from therapy cannot access it.

Other points touched upon included:

1. The efficacy of HCV treatment

- listing for transplant for HCV in the UK has already declined by 50%
- real world data is as good as that seen in clinical trials
- treatment can be too late – Dr Agarwal suggested a MELD of 15 as a cut off, Dr Stedman that a MELD of 18 is predictive of death despite treatment.

2. HCC risk with DAA therapy – Dr Agarwal does not believe the Barcelona data was presented in a balanced or responsible manner. In the pan genotypic era all patients will be treated pre transplant regardless.

3. The need for advocacy – the key difference between the Australian and NZ situation.

Hepatitis B

Discussion was aided by some excellent case presentations. The avoidable tragedy of the patient cured of their haematological malignancy only to die from hepatitis B reminds us of the importance of engagement with your haematologists and oncologists, as well as clear protocols and lines of responsibility as to who is responsible for the decision to start anti-viral therapy and when to stop it. Other topics included delta coinfection (key point – test for it don't just tick the special authority box, they may have a higher viral load than you expect – check the antibody level first and if positive do the RNA as 30% will have cleared it) and HBV in health care workers. The risk is only significant in those performing exposure prone procedures with a high viral load - no transmissions have been reported with a viral load of 10^4 IU/mL. The recommended cut off is 10^3 or 1000 IU/mL which is relatively easy for an e-antigen negative patient to achieve (with Lamivudine cheap to self-fund if required), but a much more fraught situation for a young e-positive patient who may require a year or more of Entecavir to reach this threshold.

Conclusion

The reality is we are dreaming if we think HCV in NZ is going to be solved for us without advocacy and innovation on all our parts, not just the few major players we are accustomed to relying on. We are challenged to actively look for opportunities outside of the triaging inbox and to make a noise that Pharmac cannot ignore.

Overall this was an excellent meeting. The support of Pharma (in this case Gilead) is invaluable and hopefully can continue in a changing landscape.

NEQIP Report by Malcolm Arnold July 2017

A substantial amount of work has been done in the past months both by the NEQIP team and individual endoscopy units, but much work will still be required to bring units up to the standards required for bowel cancer screening. Enthusiasm for and pride in providing a quality service is firmly established in endoscopy units and we can make this quality improvement programme work for the benefit of our patients. There may be substantial cost implications but that is beyond the remit of NEQIP and this report. We feel strongly that it is important for us to engage with units in person rather than simply by phone, email or teleconference, and trust that we can continue to help units meet the standards required and which they strive to achieve. As evidenced in the comparisons of the census performed in September 2013, September 2015 and March 2017, there has been a decline in some areas in each domain, as the NEQIP work was in remission. Staff undertaking this work need the resources to undertake this work again, understand it, and implement the agreed measures so that QI and QA become business as usual, with ongoing audit, reassessment and improvement.

In many of the domains in which scores are low the prime reason for this is the absence in those units of policies or guidelines, as well as the absence of appropriate patient surveys and involvement in those units. Through the KMS (whereby existing policies and guidelines can be shared by units who have these with units who do not, requiring some local alterations only) and NEQIP establishing best evidence based practice, we aim to enable the introduction and dissemination of such policies and practices, thereby allowing those units to improve their GRS scores and achieve the standards required.

The summary recommendations offered from our assessment of the observations we have made and the data we have looked at to date are as follows:

1. Quality of Procedure

a. Set up a Governance body (i.e. Endoscopy Users Group) in each DHB
b. Establish KPIs–to be developed by EGGNZ (based on GRS as per unit standards and agreed nationally)
c. Set up processes to collect data, and report details & analysis to the governance body(EUG) on a regular basis

2. Comfort

a. Agree a method of measurement – Gloucester Comfort Scale Recommended.
b. Set up a process to collect these data
c. Set up patient surveys (examples available to all DHBs via the GRS-based Knowledge Management System (KMS))
d. Report back to governance body (EUG)

3. Timeliness

Set up weekly meetings for booking referred patients – clinical staff to review performance

4. Staff Orientation

a. Each unit should develop, or adapt those prepared by other units (and available through the KMS) for local situations, a Unit handbook, listing procedures and policies
b. New staff should be taken through the Direct Observed Practices workbook before being given responsibility (this is available on KMS for Nursing staff)
c. There should be regular staff meetings for all staff in the Endoscopy Unit

5. Training

a. Data on training need to be reported robustly both in recognised training centres and in those units where training is done on an ad hoc basis. Different issues may be raised in both these scenarios.
b. An array of issues with regard to quality and governance, accreditation, assessment of ongoing quality performance and retraining is being addressed currently by EGGNZ. NEQIP will continues to monitor performance via GRS, and EGGNZ will put in place mechanisms to address issues.

There are other recommendations in response to specific issues - see table “Clinical Quality Domain” on page 5.

The single most useful tool to improve almost all aspects of the GRS is the setting up of a governance structure for each unit. The Endoscopy User Group (EUG) is a structure that NEQIP support and which has proven to be of great value in those units who use it well.

To reinforce or instigate this the NEQIP Clinical and Nursing lead need to meet and discuss with each unit how this can be developed for them locally. The recommended terms of reference, membership structure and function are

NEQIP Report Cont'd

available to all in the KMS. Interaction and communication between different units is to be encouraged to allow sharing of ideas and solutions. This is the top priority for the NEQIP team.

The NEQIP team have found that in almost all endoscopy units, service commitments are currently a priority and that time and allocated nursing resource is rarely evidenced for quality and learning. There is a great degree of enthusiasm for quality in this workforce and a great deal of potential for improvement. Nursing numbers, training and resource for quality activities is seen by NEQIP as a major issue to be addressed throughout DHB endoscopy units. We run the risk of considerable burn out amongst this essential and invaluable group of colleagues.

In the short term we will be concentrating on the early rollout centres for bowel cancer screening (Tranche #1 Waitemata, Hutt and Wairarapa DHBs, and Tranche #2 Counties Manukau and Southland DHBs) assisting in raising the GRS scores in keeping with EGGNZ developed Unit and Individual standards where there are issues to be addressed.

Work to Date
Self-assessment proformas were again sent to each of the DHBs in early 2017, for completion and return. In addition to this all 29 endoscopy units serving the 20 DHBs were asked to complete the GRS census by 31 March 2107 (Questionnaire/GRS assessment form as before and please see appendix 3 for a copy of this). Two of the 29 units were unable to complete the census data due to workload and resourcing issues as they concentrated on efforts to bring wait times under control and comply with Ministry targets. *The control of wait times remains a challenge for most units, with many units working extra hours to achieve the MOH targets, and several outsourcing to private endoscopy units. This work cannot be sustained by the workforce indefinitely.*

Eight Endoscopy units did not complete the training statements in the census as there are no formal trainees at those units (though almost all units with surgical registrars train them in endoscopy as part of their general surgical education since some endoscopy experience is a requirement of surgical training by the RACS. We intend to ask all units in the next census to complete the questionnaire for this domain).

The NZGRS census is a snapshot of a unit at the time of completing it. There is no mechanism for units to add comments to explain a situation. The questions seek binary (yes/no) answers.

Once census details are analysed recommendations are made to individual units to help them find mechanisms of improving quality standards to achieve the best results possible within their capacity. It is likely that some units will require resource allocation to meet standards set for BCS. These should include input from DHB quality units to help analyze data and develop protocols and policies where those are not yet in place. It should of course be noted that the GRS tool includes the Knowledge Management System (KMS), whereby units can enter online details regarding the solutions they have found locally to issues which may affect other units. Utilising these saves considerable work being repeated by many units where it has already been done elsewhere and the NEQIP team are encouraging unit lead nurses, and those endoscopy nurses who are given projects, to discuss issues with endoscopy teams in other units and to combine ideas and suggestions The NEQIP team will then help ensure that details of solutions reached are entered onto the KMS for the benefit of others. Where units have scored a D in many descriptors, improvements could be made relaitively easily by utilising and auditing patient surveys (electronically, on line, via survey monkey or in hardcopy) as well as the auditing tools available via the Provation reporting system which is in use by the majority of DHBs (currently only one DHB does not yet use Provation). Scores in these descriptors are very likely to have improved in many units by the time of the next census once data from Provation and results of patient surveys (which NEQIP are promoting considerably) become available. This data analysis work could usefully be performed by audit and quality units in DHBs, allowing nursing staff and medical personnel to concentrate on their core business.

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 2018**. For more information on the eligibility, conditions and application process, please go to the NZSG website www.nzsg.org.nz.

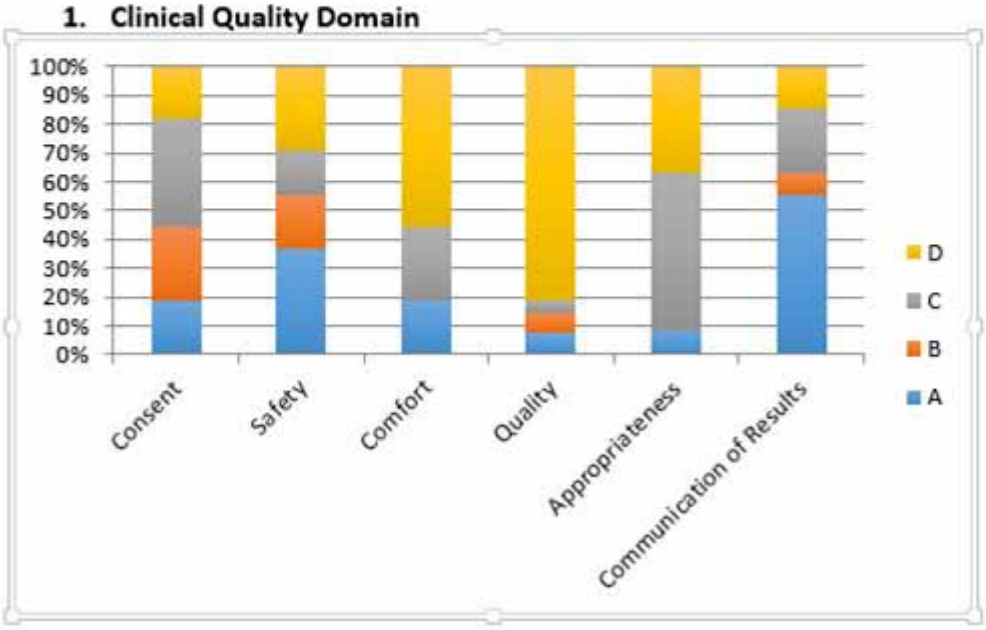
NEQIP Report Cont'd

QI Endoscopy

National Census Results 2017

In each table the Percentage of No answers from units completing the census has been documented

1. Clinical Quality Domain



GRS scales for Clinical Quality Domain

	Consent	Safety	Comfort	Quality of Procedure	Appropriate-ness	Commu-nicating Results
A	18.5%	37%	18.5%	7.4%	7.4%	55.6%
B	25.9%	18.5%	0%	7.4%	0%	7.4%
C	37%	14.8%	25.9%	3.7%	59.3%	22.2%

Summary of the results for Clinical Quality Domain

- The highest scoring item (ie the item scoring the lowest percentage of self-rated level D) was **Consent** (18.5% at level D)
- The lowest scoring self-rated item (ie the item scoring the highest percentage of self-rated level D) was Quality of the Procedure (81.5% at level D)

For standards to improve, the importance of the results of the data collected must be understood. Until the NEQIP team is able to contact each team at individual DHBs, it is difficult to ascertain why the scoring is so low in certain areas (as previously mentioned the GRS tool does not allow for comments, explanations etc). In some areas it is a reasonably straightforward task to correct problems (introduction and local adaptation of policies produced by other units and available through the KMS, use of patient surveys etc) and NEQIP will endeavor to identify areas of concern where low scores have been documented and address those with the clinical and nurse leads in those

NEQIP Report Cont'd

units. Some examples of descriptors scoring low in many units and recommendations to be made by NEQIP are as follows:

1.Consent and Patient information

The Code of Health and Disability Services Consumers' Rights" – Right 6 (The Right to be Fully Informed) and Right 7 (The Right to Make an Informed Choice and Give Informed Consent) are the documents that ensure that the patient has the right to have all the information required to provide informed consent for the planned procedure. This consent should be obtained outside the procedure room in an area that is quiet, and has privacy so patients are able to discuss concerns and ask questions without other people nearby overhearing. Withdrawal of consent is a right also and scores for these two descriptors in the GRS were as follows:

	Measure	No
1.13	Failure to comply with withdrawal of consent guidance is registrered as an adverse clinical incident	51.85%
1.7	All consent signatures are obtained outside the procedure room	40.74%

The 'in room' consent process is widely practised for a variety of reasons and a number of measures are able to be implemented to allow units to alter this practice, though of course many have considerable facility issues which prevent this. Such issues may require resource allocation by the DHBs involved.

Recommendation

New builds should be designed with private rooms for the consent process to take place. For those units where a new build is not planned an office or clinic room should be allocated or adapted for the consenting process to be performed before the patient is taken into the procedure room and all units should ensure patients are aware that they may withdraw their consent even after the procedure has begun. Individual units may have their own policy on this, and otherwise there is one available on the KMS (supplied by Hawkes Bay DHB).

Tracheo-Oesophageal Fistula / Oesophageal Atresia - There is more to it than Paediatric Surgery

An article from a patient, who has been chewing on her story for 48 years.

My reason for writing to you in this newsletter is to draw your attention to how well we have done over the years. I want to pose points and questions, and hope for feedback and input as to where the future might lead us… for adults today and those of tomorrow. Where do we go from here?

To introduce myself, I was born before breakfast on Friday the 17th of January 1969 in Taihape. I had my first surgery to begin the repair process, at 18 hrs old in Wellington Base Hospital. The last surgical procedure was achieved on the 20th September 1993 also in Wellington, at the time it was called a gastric uplift. In Auckland where I live now, it is referred to as an Ivor-Lewis. In between, were numerous attempts to get the best out of either the existing oesophagus, or transposed colon graft. I subsequently have endoscopic dilations to stretch narrowing scar tissue approximately every two years. In my life I have met a total of four other Tof/Oa patients in New Zealand, but through Facebook I have come to know so many more all over the world.

Recognition that this is not just a paediatric condition: When a child is born with this condition there are a number of established repairs considered, and then the team takes the best course for the child's particular degree of disruption. The surgery being worked on and better techniques have meant that survival and life expectations have improved immeasurably. All will permanently effect the way the child is able to eat, and absorb food **for the rest of their life**. The repair is a repair, not a cure. Over time all surgery has a finite functionality. How do we in New Zealand deal with the ongoing needs of these patients? Is there monitoring, are there statistics as to the ongoing needs?

Oesophageal Atresia Cont'd

Research Adults who are receiving care How many of us are out there in our 20's 30's 40's and 50's? Where are they? Who treats them? Are they being treated, and are their issues seen as related to Tof/Oa? Are our protocols here in N.Z in line, ahead, or behind the **best** practise globally? Are specialists here aware of the work being done for adults internationally? Last Sept I attended the 4th International Oesophageal Atresia Conference, held in Sydney. I was surprised that with it being so close to New Zealand, (The 3rd was in Rotterdam in 2014 and the 5th will be held in Rome in 2019), that there were only three New Zealand docs in attendance; and all were Paediatric specialists.

I do not believe I can be the only one who has survived this far. I am very grateful for the continuing care that I receive. I have an active relationship with my GP, my gastro genius Mark Lane at Auckland City Hospital, the Nutritional support and advice from Kerry McIllroy, and the Respiratory Services who pick me up when the aspirations and swallowing get too tough.

I would also like to draw your attention to four organisations involved in support of both Patients and their families, and professionals in the field. www.tofs.org.uk are an internationally known charity started by families affected by this condition in the U.K, they have produced a book called THE TOF BOOK, (updated and enhanced from their first book The TOF Child) which has now been updated and includes a section on Adult issues and care. There is a hard copy of this book in the Parents support resource room at Starship Hospital; and is also available on https://www.amazon.co.uk/dp/0953626512/ref=cm_sw_r_cp_ep_dp_YuKHybQG2KDSQ. This charity is part of the global network EAT http://www.we-are-eat.org/, an international federation of OA patient groups), whose primary function is to network with and support medical professionals and their professional bodies, in particular with The International Network on Esophageqal Atresia (INoEA) who organise the conference I attended as a patient in Sydney last September.

Another charity a little closer to home in Australia, and one we are hoping to work closely with,is OARA www.oara.org.au. They were also started by parents but work with professionals in research and support. There are a number of Facebook support groups, but I notice that there appears to be few professionals in them. One facilitated by a Taupo Mum here in New Zealand, goes under the title of NZers born with TracheoOesophageal Fistula (TOF) and Oesophageal Atresia (OA). There are about 28 of us connected through it, however I am the only adult from New Zealand, with the others being parents of children aged from approximately 11 years through to newborns. The support given to each other through these groups is phenomenal, and allows us to feel that we, though possibly isolated, are not alone. If professionals were involved maybe that shared knowledge would do the same for you.

The European Society for Paediatric Gastroenterology Hepatology and Nutrition (ESPGHAN) (North American Society NASPGHAN) is a multi-professional organisation whose aim is to promote the health of children with special attention to the gastrointestinal tract, liver and nutritional status. Interestingly they have produced guidelines for the treatment of TOF children, which includes information for transition and TOF Adults:ESPGHAN-NASPGHAN Guidelines for the Evaluation and Treatment of Gastrointestinal and Nutritional Complications in Children with Esophageal Atresia-Tracheoesophageal Fistula. J Pediatr Gastroenterol Nutr.2017;63(5):550-557)

To conclude I want to pose a few more questions….

What about those who care for us? Where do they go for support and answers when challenges arise? Why are there so few studies in the longer term outcomes and treatments? We patients who are now adults are constantly been told by our specialists, there are no studies, there is no evidence as to what will work, when what has been treatment starts to fail. Do specialists not talk to each other? Are old histories not looked into? Where has the knowledge and experience gone? Where do we go from here?

For those who want to contact me in working together, to find some solutions my details are

Ellen Coleman
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Report of the Crohn's and Colitis Kids Camp

Richard Stein, Gastroenterologist, Hutt Hospital

As most of our readers know, Camp Purple Live is Crohn's and Colitis New Zealand's annual camp for children and teens with inflammatory bowel disease. This past January, 57 children arrived in Wellington for the five day camp which was held at El Rancho on the Kapiti Coast. Children arrived from all corners of NZ, from Whangarei to Invercargill. They shared experiences, challenged their limits, and, most importantly, made new friends and learned they are not alone.

The week culminated in a trip to Adrenaline Forest where the children amazed the volunteers with their determination and fearlessness. The camp, including airfare for out of town children, is entirely free (as well as a two day parent educational and networking seminar which runs concurrently with the camp).

The camp also received media attention this year. On the third day of camp, the children spent the day in Wellington. They visited Te Papa, rode on the cable car, visited the Planetarium, and took a tour of Parliament. Not surprisingly, some of the children (and volunteers) had to stop along the way to use the toilet. On the tour of Parliament they asked their tour guide how to go about getting a law in NZ similar to "Ally's Law" in the States. Ally's Law is named after Ally Bain, a fourteen year old girl with Crohn's disease. Ally was denied access to the employee toilet by a store manager in Chicago, resulting in an embarrassing public accident. Ally and her family fought and were successful in passing a law in the State of Illinois to guarantee access to employee toilets for people with IBD. There are now similar laws in 15 other States. Coincidentally, the Parliament tour guide had Crohn's disease himself. He explained the legislative process to the children. Immediately on the return to camp, with the help of one of the volunteers, twelve year old Nicole Thornton wrote a petition to enact a law similar to Ally's Law in NZ. It was signed by all 57 campers, the four doctors and four IBD nurse volunteers, along with thirty of the other camp volunteers. Over 3,000 signatures were added within a week. The Petition was sponsored by the Hon Trevor Mallard, MP and is presently sitting in the Health Select Committee. The NZSG has sent a letter on behalf of its members endorsing the petition. Hearings will be held by the committee soon after the upcoming election.

Nicole Thornton meets with Hon Trevor Mallard, MP for Hutt South

The next Camp Purple Live and parent seminar will be held in the Auckland region at Camp Adair. The camp will run from 11-17 January and the parents seminar on 11-12 January. If you know of any children or caregivers who might be interested in attending, please have them request an application at campenquiries@crohnsandcolitis.org.nz or visit the CCNZ website at crohnsandcolitis.org.nz. Feel free to contact me if you have any questions or are interested in volunteering at richard.stein@huttvalleydhb.org.nz. Camp Purple Live is made possible through generous grants from Abbvie, Janssen, Pharmaco, Baxter, Boston Scientific, ANZ Staff Foundation, EFCCA, Olympus, several Rotary Clubs and Masonic Lodges, as well as gifts from many individual donors.

NZSG Introduction to Endoscopy Course

Another successful training day was held in Christchurch on May 24. This is one of 2 annual courses, with the other held in Auckland, generally in December.

We had a keen faculty consisting of regulars Drs James Falvey, Teresa Chalmers-Watson, Associate Professor Tim Eglinton (our surgeon representative) and myself. Dr Jeffrey Ngu, a new SMO at Christchurch was welcomed into the fold also.

There were 6 keen trainees, of which 4 were surgical and 2 gastroenterology registrars. It was very rewarding to watch them progress over the day, and in the case of 2 local attendees seeing this knowledge brought into clinical practise.

We are grateful to Anna Pears who plays a large role in the organisation of these courses. I wish to thank local colleagues, our Nurse Manager, Boston Scientific and Obex. I especially want to acknowledge the immense contribution of Esther Scott and Tony Jamieson from Olympus.

Dr Steven Ding
Convenor

L to R: Jenny Langrish (Boston Scientific), Joel D'Souza, Esther Scott (Olympus), Somnath Palit, Steven Ding, Tom Burton, Jeffrey Ngu, James Falvey, Denise Foster (Obex), James Tan, Vivel Tharayil, Teresa Chalmers-Watson, Junaid Beig

The Bowel Cancer Screening Programme

The roll out of the BSP has begun!

In July 2017, Hutt Valley and Wairarapa DHBs were the first to roll out the BSP after the successful pilot in Waitemata. We are excited to be first to provide this service which will not only detect cancer at an earlier stage but will also prevent bowel cancer.

We have all been closely following the pilot in Waitemata and have been impressed with the results. Much has happened in the 4 years since the pilot started. Across New Zealand we see improved capacity and improved quality, both requirements of a National Bowel Cancer Screening Programme.

Make no mistake; a lot of work has been done over the past year to get us to this point and we are still working through capacity issues. We have however been well supported by the executive teams of both DHBs, a dedicated team established to support the programme as well as the Ministry of Health. All stakeholders including Histopathology, Radiology, Surgery, and Primary care have all worked hard to make this a reality. We have had a strong focus on equity and have held many meetings with community groups such as Pacifica.

Indicative dates for other DHBs in this progressive roll out have been announced. The time required to prepare for such a programme is long so my message is…. Start now!

Jeffrey Wong

Clinical Lead BSP Hutt Valley DHB & Clinical Head of Department

Gastro National Match Day 2017

The NZ National Match for advanced training in Gastroenterology is now in its fifth year. The 2017 Match Day was held on 6 July at a new venue, the offices of the Northern Regional Alliance (NRA) on Great South Road in Penrose, Auckland instead of our previous venue at Greenlane Clinical Centre. Fortunately, however, all of the interviewers and interviewees managed to congregate in the same location on the same day.

The purpose of the Match Day is to interview and select new applicants onto the national advanced training scheme in Gastroenterology in NZ, as well as "matching" returning incumbent advanced trainees to specific training positions around the country for the coming year (December 2017 to December 2018). It is of note that Gastro is very much a leader in the field in NZ in terms of National Rotations. We set up the process from scratch in 2013, based loosely on the Australian model, and have since fielded enquiries from other specialties such as Rheumatology, Renal, and Respiratory (the three R's) as they look to implement something similar in their specialty filed.

The Gastro Match Day is attended by the Clinical Heads of each Training Unit around the country (or a nominated representative), as well as by the Chair of the RACP Advanced Training Sub-Committee (Gastroenterology). This year was the first time we could officially welcome representatives of the newest training units of Hawkes Bay and Palmerston North. Inclement Auckland weather in 2016 cancelled regional flights preventing Tom Boswell and James Irwin from attending, so it was good to see them in person this year. 2017 was also the last time we would see Paul Frankish in his role as Chair of the Gastro ATS as he is stepping down next year.

The Gastro Match Day process itself, with the oversight of the Gastro ATS, recommends candidates to training positions with particular DHBs (as well as some Fellowships, both Clinical and Research). This is not a formal job offer, however, as it remains up to the discretion of the individual DHBs to formally offer the positions and actually employ the advanced trainees. Having said that, we still haven't had a recommended candidate turned down yet!

As always, nothing of this size and complexity happens without a lot of hard work behind the scenes so I want to offer thanks to a number of people who help me make it happen at all, and happen smoothly. Thank you to Denise Corlett (Recruitment Manager), and all of her staff at the Northern Regional Alliance (especially Annabelle Baker) for hosting the event. Thank you to the select band of Gastroenterologists who helped me short list the new applicants. Thank you to the department representatives who travelled to Auckland for the day (usually the night before due to the very early start). Finally thanks to Anna Pears, Executive Officer of the NZSG for her hard work in advertising the match process throughout the College trainee membership and coordinating the process of applications.

One realisation that did come out of the Match Day process this year was the fact that there had been no new female applicants to NZ Gastro this year. This prompted Tom Boswell to question me why, so we did some digging and have ascertained no clear answers, but look out for a potential poster on this topic at the NZSG ASM in November.

Any comments or feedback about the entire match process can be made to me, or Paul Frankish, Chair of the NZ Gastro ATS.

David Rowbotham
Chair, NZ Gastro National Match Scheme

Location	December 2017 - June 2018	June 2018 - December 2018
NZLTU 1	Cameron Schauer	Vivek Tharayil
NZLTU 2	Henry Wei	Charlotte Rowan
Liver Research	Thomas Mules	Sethu Nagappan
ACH 1	Charlotte Rowan	Samir Seleq
ACH 2	Ibrahim Hassan	Henry Wei
NSH	Samir Seleq	Cameron Schauer
MMH 1	Yanez Peerbaccus	Yanez Peerbaccus
MMH 2	Sri Selvaratnam	Sri Selvaratnam
MMH Fellow	Sum Team Lo	Sum Team Lo
Waikato 1	Ahsan Siddiqui	Ahsan Siddiqui
Waikato 2	Jerry Chin	Jerry Chin
Tauranga	John Llewelyn	Ibrahim Hassan
Hawkes Bay	Junaid Beig	John Llewelyn
Palmerston North	Anthony Whitfield	Junaid Beig
Hutt	Amanda Chen	Anthony Whitfield
Wellington	Caroline di Jiang	Caroline di Jiang
Christchurch 1	Charlotte Daker	Charlotte Daker
Christchurch 2	Vivek Tharayil	Thomas Mules
Christchurch 3	Mehul Lamba	Mehul Lamba
Dunedin	Afrasyab Khan	Afrasyab Khan
NSH Fellow 1	Kyle Hendry	Kyle Hendry
NSH Fellow 2	Jan Kubovy	No appointment
MMH Fellow (non core)	Hannah Giles	Hannah Giles
Waikato Fellow (non core)	Wayne Bai	Wayne Bai

Burden of Disease Report - Crohns & Colitis NZ

On the 2nd of November 2017 Crohn's and Colitis New Zealand Charitable Trust will publish their Burden of Disease Report (BoDR) for New Zealanders with Inflammatory Bowel Disease(IBD). A presentation of the BoDR will be given at the NZSG ASM in Auckland in November.

This project is an in depth analysis of available data about IBD in New Zealand and managed by Suzanne Snively ONZM, Health Economist, MoreMedia Enterprises.

The project included two workshops of key partners in the health pathway including specialist IBD clinicians, patients, their families, health statisticians and other key personnel including a psychologist and pharmacist, which the focus on improving health and economic outcomes.

The study is modelled after the Australian BoDR and the earlier Canadian BoDR. A key outcome of the Report is a research hypothesis about how the New Zealand pathway to care could lead to better outcomes (while reducing long-term personal and economic costs). This hypothesis will be the focus of a proposal to the Health Research Council for a five year, five million dollar grant for further research with the aim of increasing the effectiveness of services, better access to pharmaceuticals, and community support to improve health outcomes for patients with IBD.

Once published the Report will be available as a hard copy. It can also be downloaded from the CCNZ website at www.crohnsandcolitis.org.nz

The vision of CCNZ is to empower patients and their families, to demystify and normalise IBD, and to make the lives of the 20,000 New Zealanders affected by it more liveable.

We would like to acknowledge the very generous grant from Janssen Pharmaceuticals who provided funding for this important study.The analysis carried out for this study was entirely independent, wholly under the direction of the CCNZ Steering Committee.

Brian Poole QSM
Co Chairman
Crohn's & Colitis NZ Charitable Trust

IBD Nurses Travel Award

A travel award of excellence and contribution to IBD nursing is being offered by CCNZ. It is to be used for overseas travel to further develop the recipient's career by attending a scientific meeting or conference where there is a focus on IBD.

Last year, through the generosity of Abbvie, CCNZ were able to send IBD nurse, Sarah Cook; IBD CNS from Waikato DHB, to the European Crohn's and Colitis Organisation (ECCO) conference in Barcelona – an experience that Sarah said "heightened her passion for IBD patients".

At the recent New Zealand IBD nurses conference our Co Chairman, Dr Richard Stein, was delighted to present this year's travel award to Nideen Visesio; IBD CNS from the Waitemata DHB, enabling her to attend the 2018 ECCO Conference in Vienna.

There will be an opportunity for IBD nurses to apply next year, details of which will be sent out in the New Year. This award is to recognise an individual nurse and the contribution he or she has made to the wider IBD community. We invite clinicians to encourage their Nurses to apply.

Trainee Update

It has been another fantastic year for the trainees. We have 9 new trainees joining the programme this year, making up a total of 22 of us. It is worth mentioning Palmerston North Hospital took on gastro trainee for the first time this year, and the feedback has been all positive.

The individualized endoscopy training lists and well-supported clinical exposure will provide great learning opportunities for the future allocated trainees.

We were privileged to have two days of dedicated teaching at the Annual Trainee Conference held in Auckland co-sponsored by Ferring and Gilead earlier in the year. Excellent presentations were delivered all-round. Throughout the year, our teaching schedule consists of half-day video conference hosted by a designated training site every month with 2 consultants and 2 registrars presenting. We are very grateful for gastroenterologists around the country who contribute to our training in different ways.

Sylvia Wu

Trainee Representative

ANZGITA Update by Dr Martin Schlup

ANZGITA has been providing support to Honiara Hospital on the Solomon Islands for a few years after joining forces with Eileen Natuzzi, an American surgeon who has been visiting the hospital for many years.

Solomon Islands comprises some 900 plus islands that extend from South East to North West extending over a very large area; it is one of the poorest and least developed Pacific Nations with a population of about 600,000, mostly Melanesians with a mix of Polynesians, Micronesians and other ethnicities.

The capital, Honiara, is on Guadalcanal where one of the fiercest WW II battles was fought – relics of this are still very visible in many places. The main and referral hospital is in Honiara right on the coast and quite a picturesque setting but prone to be inundated by storm surges and hurricanes. Closer up the poor state of the buildings becomes apparent; a new hospital further inland is planned but funding remains dubious.

Medical and nursing staff who are very dedicated, work long hours in a difficult environment with very limited resources while dealing with serious and often advanced pathology. Patients from outside of Honiara may have to travel long distances; public transport is largely non-existent and there is no air retrieval. Diabetes is one of the major public health problems and has increased markedly over the last 10 years or so – attributed to people moving away from their traditional food.

The endoscopy unit is sited in the small and run-down theatre complex in a small, cramped room. There is no dedicated recovery or cleaning area – fortunately a new endoscopy unit is in the late stages of planning. While I was there Pentax donated and installed a new Pentax system which vastly improved the quality of endoscopy.

Overall endoscopy numbers are fairly small with gastroscopies more in demand. For several months last year there was no endoscopy at all as the air conditioning stopped working and the room got too hot to work – reflecting the difficulties staff has to deal with. Serious and often advanced lesions such as gastric but also some colonic cancers are not uncommon while inflammatory bowel disease and diverticulosis is largely unheard of. Surgery remains the main modality of therapy, chemotherapy is hardly used as too expensive.

The ANZGITA team, two doctors and two nurses were made to feel very welcome; the local team appreciates these visits that aim to enhance local skills and competence. Overall a very interesting and satisfying experience; working in the Islands one has to set aside expectations and standards based on NZ – it is in a way surprising that places not too far away from NZ have to work under very different circumstances. I encourage colleagues to consider contributing to this program providing their time and expertise.

FOUNDATION SERIES

Introduction to Endoscopy

Christchurch, 24 May 2017
Auckland, 6 December 2017

Convened by:

Dr Steven Ding - Christchurch Course
Dr Russell Walmsley - Auckland Course
with invited faculty

It is a one-day course designed for entry-level endoscopists and will cover the information and technical skills for learning basic gastroscopy and colonoscopy.

Course content:

- Understanding the endoscope
- Set up of an endoscopy room
- Understanding electrocautery
- Sedation and monitoring
- Hands-on introduction to endoscopic devices
- Endoscopy simulator Training

Venue:

Christchurch:
University of Otago
Christchurch School of Medicine
and Health Sciences

Auckland:
Advanced Clinical Skills Centre
Gate 3, 98 Mountain Road
Epsom, Auckland

Registration

For further information contact:

Anna Pears
Phone: +64 4 460 8126
Email: anna.pears@racp.org.nz

Registration fee $1000.00 inc. GST

Registration closes 30 days prior to each course date. A decision to continue with the course will be taken on this day.

Full catering will be provided.

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