New Zealand Society of Gastroenterology

Issue: 32 Sept 2016

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Closing Soon

Applications for the 2016 NZSG Janssen Research Fellowship

The applications close on 30 September (see page 7 for more information)

Update from Your President

Dear friends and colleagues

This newsletter finds me in a reflective mood. Not least as it is the last one that I will preside over. Please control your hurrahs.

This year is the ***50th Anniversary*** of the New Zealand Society of Gastroenterology, which had its first meeting at Green Lane hospital in February 1966 at which time Dr Alan Donaldson Cameron became the Foundation President. We are celebrating this happy anniversary at the upcoming Annual Scientific Meeting in Hamilton, where we have invited Professor Gil Barbezat to start the meeting off with a resumé of the society's history and contribution of its members to the scientific world of gastroenterology.

The program put together by Jim Brooker and his colleagues looks like another smasher. Innovative additions include video abstracts and the web-cast of some of the major sessions. The meeting continues to be an attractive place to present the work that is going on quietly around New Zealand; we had 67 abstracts submitted for the luminal and liver free papers.

We hope you can join us there to celebrate, network, be educated…..and eat birthday cake.

On the more frustrating side of life we are *STILL* waiting for the Ministry to sign contracts to allow the re-ignition of NEQIP. I have started to work on the formalisation of EGGNZ and looking at accreditation, albeit without the promised contract. The deadlines for getting Bowel Cancer Screening kick-started in its watered-down form are galloping towards us, so please get your endoscopy user groups fired up for the next NZGRS census, which is now overdue, and will be the first thing for the nation's endoscopy units to tackle.

On a happier note, as you will be aware a pet interest of mine has been the promotion of nutritional care in New Zealand, and I am pleased as punch to announce the NZSG & University of Auckland Nutrition Course, to be held at the Auckland Medical School in February 16-18th next year (see save-the-date notice on page 4 of this newsletter). This is aimed at *trainees* in gastroenterology, general surgery and intensive care, but if sufficient places are available society members will be welcome. We have secured Dr Andrew Rochford, the Education Secretary of the British Society of Parenteral and Enteral Nutrition, and instigator of the University College of London Nutrition Course as our as chief convenor.

Finally it's the time to consider your role in the society. We have 2 unfilled positions on the executive so now is the time to nominate or be nominated.

Thank you a for your support and interest in the society's activities this past 2 years and I look forward to being allowed to have a drink before the awards announcement on Thursday night in Hamilton!

Best wishes,

Russell

Editorial

Welcome to this latest edition of the Newsletter for the New Zealand Society of Gastroenterology. This issue truly spans centuries, from Bramwell Cook's article on John Read's 1820 "instruments to remove poisons from the stomach..." to Thomas Caspritz' review of the recent Auckland hepatitis meeting outlining the treatment of viral hepatitis today and tomorrow.

David Rowbotham offers a review of the 'matching day' and it is refreshing to see that the number of applicants to the National Advanced Training Scheme in Gastroenterology is steadily rising and we even seem to become an option for Australian registrars. This might also be a reflection of the improving training conditions as testified by Heidi Su's article.

Lastly, I would like to direct your attention to the announcement of the third IBD kids Camp Purple to be held in early 2017 near to Wellington. This annual event is a true success story and its importance for our young patients with IBD cannot be underestimated. I wish you all an interesting read of this newsletter and look forward to seeing you for our big birthday bash in Hamilton when the society turns 50.

Michael

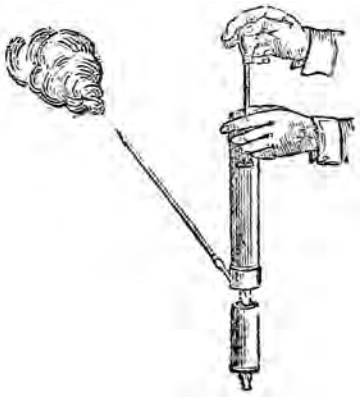
From the past - the beginnings of Gastroenterology in New Zealand

By Dr Bramwell Cook

While the first three stories in this series focussed on endoscopy instruments, this final instalment looks at some other treasures.

In August 1820 John Read, a horticulturalist, was granted a patent for 'instruments for removing poisons from the stomach, alleviating costiveness, and other complaints of the stomach and bowels'. His instrument was patronised by eminent physicians and sanctioned by the Royal College of Surgeons. However, he was not pleased that to find that, within four years, more than 20 manufacturers were making his instrument, many of whom used his name. The instrument shown, made by Kidston in the 1830s, is identical in design to Read's pump.

Read's syringe was used for gastric lavage, enemas, vaginal cleansing, urinary bladder washouts and as a breast reliever. For person-to-person blood transfusions, the danger of injecting air was said to be avoided. Although small in size, it was immensely powerful. Its simplicity of construction with two ball valves was a novel feature that gave it a robustness that was not seen with lever-operated valves.



To revive a person Read wrote: 'For the purpose of introducing the smoke of tobacco into the intestines, I have fitted a canister to the syringe, by which the operation is performed with more certainty and ease than with the old medical apparatus... Unscrew the cap of the canister, and take out the perforated plunger; put in the tobacco (half an ounce or an ounce) and replace the plunger lightly upon it; then put on the cap and insert it into the end of the syringe; hold a lighted candle close under the bottom of the canister, and a stroke or two of the piston of the syringe will light the tobacco. The caoutchouc tube being now fixed to the side branch, and the pipe introduced into the rectum, the tobacco smoke is forced into the intestines.'

In 1861, Henry Gray, lecturer on anatomy at St George's Hospital, gave this advice regarding the removal of foreign bodies in the oesophagus: 'Small pointed bodies, such as pins, needles, fish-bones, nails, and so forth may be removed occasionally by a flexible sound, to the extremity of which is attached a skein of thread, so as to form an infinite number of nooses in which the foreign substance may become entangled. Or a probang, to which a piece of dry sponge is fastened, has sometimes been successfully used in the extraction of similar substances. Flattened bodies, such as pieces of money, may be removed by a flat blunt hook.'

From the past - the beginnings of Gastroenterology in New Zealand cont'd

Gross' bristle probang, sponge and gum elastic shaft

Sponge probang

Report on the Hepatitis Meeting, August 2016, by Dr Thomas Caspritz

On the 25th and 26th of August 2016 the NZ Society of Gastroenterology with support from Gilead held the Hepatitis Update in the Heritage Hotel Auckland. It was a well attended and well organized meeting with about 65 delegates, including nurses and doctors. Unlike the previous Hepatitis Update meetings both Hepatitis B and C were covered this time.

The dinner topic on Thursday was about "New models of Hepatitis Care-tales from East London". Professor Graham Foster from Queen Marys, University of London and Barts Health in East London, runs a clinical research program studying the natural history of viral hepatitis, its impact upon patients and their communities, and novel therapies for this disease. He explained the difficulties in delivering Hepatitis Service to East London related to low socio-economic status, high unemployment and the diversity of a population with a high proportion of immigrants. He reported on a viral hepatitis screening program in the Pakistani community, where 5500 participants were screened in a local mosque, with excellent compliance. There was a high prevalence of HCV infection (around 3.5%), but only 30% of those who tested positive attended for therapy. There was also about 1-2.5% prevalence of HBV in the screened population. Some practical problems like language barriers or working hours of the immigrants complicate engagement.

Friday morning started with a provocative talk: "HBV-are we doing it wrong?" by Professor Foster. He stated that the currently established dogma of 4 phases of chronic Hepatitis B infection may be wrong, and asked: "Are the clinical phases real?" A meta-analysis of 246 patients with normal ALT, deemed to be in the "inactive carrier" phase, showed that 25% had significant Fibrosis, and 1 % cirrhosis. He suggested that quantitative HBsAg levels may be helpful to define active or inactive HBV.

Furthermore, there are clearly substantial differences of HBV mortality between races, e.g. comparing Bangladeshi and African populations. An HBV trial in Zambia revealed that in patients with normal ALT and low HBV DNA load, 68% already had significant disease on Fibroscan. He asked whether Africans have a more malignant type of HBV?

He mentioned a 1996 paper about the dynamics of HBV infection, a cellular model of HBV infection, in which the immature hepatocytes can be infected whereas mature hepatocytes cannot. He wondered whether the phases of HBV infection are related to the maturity of hepatocytes.

Report on the Hepatitis Meeting, August 2016 Cont'd

Prof Ed Gane then spoke on the "cure of Hep B". The benefits and disadvantages of long term oral antivirals were discussed. He pointed out there is only a very low rate of HBsAg clearance, and also that the risk of HCC is reduced, but not eliminated. On the other hand there has been a change in the main indications for liver transplantation in NZ over time. Previously Hepatitis B was a major indication, while today it accounts for only about 10% of local liver transplants. He also noted there are some problems with long term oral antivirals: e.g. there are no accepted stopping rules for antiviral treatment, especially for HBeAg negative HBV.

New drug classes for HBV: capsid/core inhibitors, several drugs are in development. Another concept involves SIRNAs (small interfering RNA). Are there ways to activate the immunity against HBV? TLR-7 receptor agonists work, at least in an animal model.

Later a number of interesting and complex cases were discussed. One of them was a Tenofovir induced Fanconi Syndrome, which should remind us to monitor patients on Tenofovir for nephropathy, e.g. with regular 6-12 monthly checks of renal function, phosphate, urine dipstick and urine protein.

After lunch the focus changed to Hepatitis C. Some real world data for OBV+PTV/r+DSV+/- RVN from the German hepatitis C registry documented excellent effectiveness between 96-97 % for GT1 non-cirrhotic, and 93-96% SVR with cirrhosis. There was also a 96% SVR rate for previous treatment with Teleprevir or Boceprevir. It was mentioned that the Harvoni response may be decreased on PPI, as Ledipasvir is pH dependent.

The future was then covered: some promising data was shown for HCV. 8 weeks of SOF/VEL+GS9875 treatment in naive GT1-6 (!) achieved 94-100% SVR. 12 weeks treatment of experienced GT1-6 incl. previous DAA failures resulted in 100% SVR.

The evolution from all oral treatment with SOF/RVN in 2013 will continue to all oral pan-genotypic regimens, probably as short as 8 weeks. The question remains, when we will have those drugs available in NZ?

Last there was the entertaining debate between Dr Stephen Gerred and Dr Michael Burt about whether or not Hepatitis C should be treated in the community by primary care providers. The debate was not fought using data, but personal opinions and holiday photos. Dr Gerred (arguing for treatment in primary care) won, sorry Michael….

Dr Thomas Caspritz

THE UNIVERSITY OF AUCKLAND
Te Whare Wānanga o Tāmaki Makaurau
NEW ZEALAND

New Zealand Society of Gastroenterology Inc

SAVE THE DATE

NZSG & University of Auckland Nutrition Course

16-18 February 2017

University of Auckland Medical School, 85 Park Road, Grafton, Auckland

Priority will be give to physician, surgical and intensive care trainees

For expresssions of interest - please contact anna.pears@racp.org.nz

Crohn's and Colitis Kids Camp January 2017

Camp Purple Live, CCNZ's camp for children and teens with IBD, will be hosted outside Wellington on the Kapiti Coast in January 2017. The annual five-day camp helps children, aged 9-16 years, build self-confidence, independence and self-esteem all in a safe and supportive environment geared to children with IBD. This year's activities will include go karting, archery, swimming, horse riding, rock climbing and a visit to an Adrenaline Forest.

The camp is unique and its value cannot be understated. The children get to meet kids their own age often for the first time who understand the challenges they face. Our volunteers, virtually all of whom have IBD themselves, will include a police detective, a formal All-White and a championship swimmer.

Running concurrently with the camp is a two-day parents' seminar providing education from various speakers and an opportunity to network with other parents. All costs to the camp and the parents' conference (including airfares) are underwritten by CCNZ and its generous sponsors. Spaces for the camp and parents' seminar are limited.

If you know of a child or parents interested in attending, applications can be requested from Nicola at campenquiries@crohnsandcolitis.org.nz.. If you are interested in joining the medical team who were the winner of the 2016 Minister of Health Volunteer Health Care Provider Award, contact Karen Murdoch at karen.murdoch@hawkesbaydhb.govt.nz

YOU ARE INVITED TO CELEBRATE NZSG'S 50TH ANNIVERSARY

Gastro National Match Day Report

The NZ National Match for advanced training in Gastroenterology is now in its fourth year. The 2016 Match Day was held on 7 July at Greenlane Clinical Centre. 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 2016 to December 2017).

As well as the Clinical Heads of each Training Unit around the country (or their nominated representative), the Match Day is attended by the Chair of the RACP Advanced Training Sub-Committee (Gastroenterology). Hopefully the ATS will now keep its title as, over the past couple of years, it has flip-flopped from being called the SAC to the ATC to now the ATS. The Match Day process, under the oversight of the Gastro ATS recommends candidates to positions with particular DHBs. 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 haven't had a recommended candidate turned down yet!

Unfortunately the Auckland weather didn't come to the party this year and thick fog at Auckland Airport the night before the Match Day caused a lot of regional flights to be cancelled. As the Match Day itself starts with briefing for interviewers at 07.00 hours and then the first interview at 07.20 hours, there was not any opportunity for those attendees whose flights had been cancelled to actually make it up to Auckland in time. Hence, disappointingly, we had to proceed without any representative from Hawkes Bay or Palmerston North. This was a particular shame for Palmerston North as this would have been their first official representation and allocation of advanced trainee as part of the Gastro Match. Never mind Tom Boswell and James Irwin … see you next year!

I must offer thanks to a number of people who work very hard in the build up to the Match Day to make the whole thing run smoothly. Firstly to Denise Corlett (Recruitment Manager) and all of her staff at the Northern Regional Alliance for doing the donkey work. Thank you to my willing select band of Gastroenterologists who volunteered to trawl through the CV's of new applicants to enable me to short list. Thank you to the heads of departments who make the effort to travel to Auckland for the day (and often 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.

We are cognisant of the fact that, although the Match Day works well for new applicants to the scheme, it is not at all ideal for assessment and allocation of incumbent advanced trainees and we are always looking to find a better way. It is very difficult getting everyone (departmental heads/supervisors) in one place at one time, but potentially utilising teleconferencing may be an option for the future (although this may well push up costs). Due to the fact that the NZSG membership rank and file had expressed disquiet about financing the Match process from the Society coffers, this was the first year that we charged a fee for advanced trainees to attend the Match Day. The NZSG Executive Committee didn't want to charge returning trainees the same fee as new applicants (and it was discussed whether they should be charged at all) but, equally, it was felt very important not to put off would be new applicants by charging an exorbitant amount to even apply for consideration of advanced training in Gastroenterology. In the end it was settled on fees of $200 for new applicants and $50 for incumbents. These fees did not seem to put off new applicants as we had a reasonable number apply, including applicant numbers from Australia that are slowly creeping up over the years.

Any comments about the entire match process from applications to issues about the match day itself or the allocations process can be made to either Paul Frankish, Chair of the NZ Gastro ATS, or myself.

David Rowbotham

Chair, NZ Gastro National Match Scheme

Introduction to Endoscopy Course

FOUNDATION SERIES

INTRODUCTION TO ENDOSCOPY

Auckland, 21 December 2016

This course is recognised and endorsed by the New Zealand Committee for Recognition in Training in Gastrointestinal Endoscopy

Convened by:
Dr Russell Walmsley – 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:

- Endoscopic techniques
- Patient selection
- Sedation and monitoring
- Understanding the endoscope
- Endoscopy simulation training

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

Registration:
Registration fee $1000.00 inc. GST
Registration closes a calendar month before each course.
A course manual and full catering are provided.

ADVANCED CLINICAL SKILLS CENTRE

THE UNIVERSITY OF AUCKLAND NEW ZEALAND | MEDICAL AND HEALTH SCIENCES

UNIVERSITY OF OTAGO

Gastro National Match Day Allocations 2016 -2017

Allocation	Name	Name
North Shore Hospital	Afrasyab Khan	Sylvia Wu
Auckland City Hospital 1	Kyle Hendry	Junaid Beig
Auckland City Hospital 2	Sri Selvaratnam	
NZLTU 1	Wayna Bai	Kyle Hendry
NZLTU 2	Amanda Chen	Sri Selvaratnam
Auckland Research	Junaid Beig	Ibrahim Hassan
Middlemore Hospital 1	Clare Russell	Afrasyab Khan
Middlemore Hospital 2	Charlotte Daker	Cameron Schauer
MMH Fellow	David McGowan	David McGowan
Waikato 1	Caroline di Jiang	Caroline di Jiang
Waikato 2	Puraskar Pateria	Puraskar Pateria
Tauranga	Cameron Schauer	Charlotte Daker
Hawkes Bay	Jan Kubovy	Henry Wei
Palmerston North	Henry Wei	Ahsan Siddiqui
Hutt	Sylvia Wu	Amanda Chen
Wellington	Sum Team Lo	Sum Team Lo
Chirstchurch 1	James Fulforth	James Fulforth
Christchurch 2	Yanez Peerbaccus	
Chirstchurch 3	Vivek Tharayil	Vivek Tharayil
Dunedin	Charlotte Rowan	Charlotte Rowan

NZSG Annual Scientific Meeting 2016

Dear fellow GI specialists, trainees, nurses, scientists and exhibitors,

The 2016 New Zealand Society of Gastroenterology Annual Scientific Meeting is rapidly approaching. The convening committee and NZSG Executive are delighted to bring you a programme that has been created to have wide appeal, being clinically relevant, stimulating and challenging. We will also be celebrating an important milestone, the NZSG's 50th anniversary.

We have been lucky to attract superb international speakers from North America and Australia for the medical (luminal and liver) and nurse programmes, including the current president of the AGA (Michael Camilleri) and the President of GESA (Ian Norton).

New additions to the programme this year include the first national Capsule Endoscopy symposium on the Tuesday, Liver and IBD Medical Symposia on Wednesday evening and the Endoscopy Video Forum on Thursday afternoon.

In the nursing program, as well as excellent contributions from our international speakers Joan Heatherington (IBD, Calgary) and Rachael Wundke (Liver, Adelaide), there will be research and hands-on sessions supported by our industry collaborators.

In a new innovation selected content will be available for online viewing by conference registrants for a limited period during and after the meeting. This will allow delegates to catch up with sessions they may have missed, or review talks that were of particular interest. This has been made possible due to the support of our sponsors.

The highlights of the social program include the 5th Great Guts 5km Run/Walk and of course the Conference Dinner, themed "Bogan Zombie Apocalypse".

Please take some time to review the programme (***http://www.gastro2016.co.nz***) and start planning your registration, accommodation and of course your costume for the dinner. We look forward to hosting you in Hamilton in November.

Regards

Jim Brooker, on behalf of the committee.

Trainees Corner

NZ Gastro Trainee Endoscopy Training List Survey

Endoscopy training is an important part of the gastroenterology training. The Advanced Training Committee of the RACP had recommended one dedicated endoscopy training list a week for each trainee undergoing a core rotation.

In order to assess the current endoscopy training condition, a survey on the gastroenterology trainee endoscopy lists was conducted in June 2016. This was responded by 14 of the current gastroenterology trainees. The number of trainees at each centre ranged between one and four. Most of the trainees had at least one dedicated training list planned each week (50% had one list a week).

The majority of the training lists had 8 points planned. These lists were often overbooked, although only by 1-2 points. Most trainees got to do additional non-training lists each week, although there is a variation in terms of number and actual procedures performed during these lists. All respondents felt at least 2 training lists a week would be appropriate.

When the trainees had issues with their training lists, most had approached their supervisors, although some had to approach multiple people in the department. While some had a good response to their concerns, many resulted in no significant changes.

In comparison, a similar survey was conducted in 2012, and was responded to by 12 trainees. This cohort of trainees was different to the current trainees as nearly half were considered independent endoscopists. The number of endoscopy lists (training and non-training) attended each week varied between 1 and >4. Half of the trainees had no training lists, 5 trainees (41.7%) had 1 training list a week and 1 trainee (8.3%) had 2 training lists a week.

In summary, there seems to be an improvement in the number of training lists over the last 4 years, which would comply with the RACP training requirement. Most trainees had the appropriate number of procedures listed and had opportunities to attend additional endoscopy lists. There is, however, some variation in the lists and the support each trainee receives. While it can often be difficult to balance training and service needs, ongoing reliable endoscopy training will ensure the development of competent skills of our future workforce.

Heidi Su

NZSG Trainee Representative

Comments from the Chair of the NZ Advanced Training Subcommittee

The NZ advanced training subcommittee received Heidi's report at our last face to face meeting in July and we are grateful to her in providing us with very useful data. Trainees in core rotations need at least one guaranteed training list per week where there are no more than 8 points on a list as per the UK JAG guidelines.

It is very pleasing to note a high level of compliance with this requirement and particularly pleasing to see the improvement since the last census 4 years ago.

The ATS is very keen to ensure high standards of endoscopy training and we are certainly interested to hear from trainees at any sites where there are training issues. The committee receives regular reports from trainees and supervisors and we are well placed to take any appropriate action that is required to ensure high quality training.

To our knowledge all training sites are currently complying with the requirements for training in endoscopy. It is not surprising that there is some variation in lists and support between sites but overall I feel confident that our trainees are receiving high quality training from consultants who take their training responsibilities very seriously.

Dr Paul Frankish

NZSG Janssen Research Fellowship.

Applications close on Friday 30 September for the 2016 NZSG Janssen Research Fellowship.

For further information please see

http://www.nzsg.org.nz/cms2/grants-awards

please send all applications to Anna Pears - anna.pears@racp.org.nz

NZ National Intestinal Failure Service Network and Education Day

The New Zealand National Intestinal Failure Service (NIFS) held its first Network and Education Day in Wellington in mid-May.

NIFS was contracted by the Ministry of Health to firstly document the frequency of intestinal failure (IF) in New Zealand by way of a registry but also to standardise treatment of IF so that patients can be treated closer to home in their local DHB with support and advice provided by a network of experts in IF management across the country. NIFS has worked hard to establish a comprehensive network of professionals across multiple disciplines in each DHB who provide care for patients with IF. The goals of the Network and Education Day were to bring the network together for the first time and engage members to find out what they expect from NIFS.

The day involved some informative lectures, especially an excellent talk on intestinal failure associated liver disease by James Falvey from Christchurch but also a number of focus groups. These firstly addressed the current challenges in managing patients with IF in NZ. Later there were separate sessions for professionals working with children and adults and finally there were sessions for each professional discipline - medical and surgical, nursing, pharmacy and dietetics. It was also great to see representation from compounding companies, the PNDU patient support group and research. The sessions were informative in that while many of the challenges faced by DHBs were obvious and already known to NIFS, others were new issues, problems seen in smaller versus larger DHBs, problems specific to certain patient groups and so on. The information gathered has been collated and will be vital in informing the Programme Plan for NIFS for the coming year and especially the protocols and standards which are currently in progress.

The NIFS team also proposed an important change to the patient registration process and this was agreed by Network members. This has been undertaken in response to feedback from professionals about the previous reporting process being unnecessarily laborious. The word “referral” has also been changed to “registration” to avoid confusion for staff who perhaps would appreciate some advice in managing their patient but who do not need or want to make a formal referral.

A large component of NIFS is providing education, both to staff and to patients with IF. Another Network and Education Day is planned for May 2017 (venue yet to be decided) but NIFS also appreciates the need for ongoing regular education and networking throughout the calendar year. If there are local events that NZSG Members feel would be useful fora at which NIFS can present, please let the NIFS Co-ordinators know on NZNIFS@adhb.govt.nz

PHARMAC extends funding for Exclusive Enteral Nutrition for Crohn’s Disease in Children

Earlier this year, PHARMAC made changes to the funding of enteral formula which can be used as Exclusive Enteral Nutrition (EEN) to induce remission in Crohn’s disease (CD).

Children and young people with new onset CD are frequently already growth retarded with delayed puberty and are at high risk of micro- and macronutrient deficiencies. EEN offers a successful, drug-free induction of remission in over 2/3 of young people with mild-moderate Crohn’s disease. EEN has been shown to be more successful than steroids in inducing remission. It also reduces the high cumulative burden of steroids that these individuals are likely to receive over their lifetime. Therefore EEN is the favoured initial treatment of New Zealand Paediatric Gastroenterologists treating children with CD.

However, in order to be successful, EEN needs to be exclusive. Various studies have demonstrated that partial or nearly exclusive EN is inferior to EEN in inducing remission. However, 6-8 weeks of only drinking formula feeds can be challenging in this age group. In order to maintain adherence, it is important that children and young people not only receive support from their medical teams and families, but also have access to a range of feeds to provide variation in taste and flavour. Furthermore, drinks need to be easy to administer and portable as the vast majority of children with new onset CD are of school age.

The previous arrangement for funding of formula feeds was complex, but essentially any formula was funded if it was to be administered via a nasogastric tube which was counter-intuitive because for children drinking the formula, only powdered drinks were fully funded and carton drinks which are more portable and provide variety in flavour were only partially funded. Most children were unable to comply with making up the powdered feeds themselves while at school as they were too young or did not have access to a kitchen or fridge. Also, the notion that families were saving money because their child was not eating during that period of time and could therefore afford to pay for the formula was not true as feeding a child as part of a normal family diet involves economy of scale and is much less expensive. The NZSG and the Paediatric Gastroenterology National Clinical Network have previously raised this lack and inequity of access to these feeds as an issue.

It is therefore especially pleasing that PHARMAC has recently amended access criteria to these feeds and carton feeds with a full flavour range are now fully funded when prescribed as EEN for children with CD. The NZSG is fortunate to be able to work collaboratively with PHARMAC and the Executive meets with PHARMAC representative on a regular basis. It is therefore important that Members raise any potential issues with pharmaceuticals to the Executive so that we can represent you.