Thursday 7th & Friday 8th March 2013
Hilton Sydney, Australia
Ballroom Level 3

Incorporating the Westmead Endoscopy Symposium
Nurses’ Workshop – Wednesday 6th March, 2013

INTERNATIONAL FACULTY
- John Anderson – Gloucestershire
- Paul Kortan – Toronto
- James Lau – Hong Kong
- Horst Neuhaus – Düsseldorf
- Pinghong Zhou – Shanghai

SPECIAL GUEST
- Peter Cotton - Charleston

AUSTRALIAN FACULTY
- Luke Hourigan
- Raj Singh

TOPICS INCLUDE
- Colonoscopy
  - Optimising insertion
  - Best practice withdrawal and adenoma detection
  - Enhanced imaging modalities/Optical diagnosis
  - New techniques and technology
- Barrett’s Oesophagus
  - Detection of inconspicuous neoplasia and dysplasia
  - Approach to endoscopic therapy
- Endoscopic stenting for benign and malignant disease
- Endoscopic treatment of perforations and fistulas
- Endoscopic ultrasound
- ERCP: complex and basic therapeutics
- Direct cholangioscopy
- Balloon and capsule enteroscopy
- Novel endoscopic haemostatic therapies
ADVANCING THE ART OF ENDOSCOPY
Come and visit the Olympus booth!

EVIS EXERA III
Welcome!

Dear Colleagues and friends

It is my great pleasure to welcome you to the Sydney International Endoscopy Symposium, our 6th Annual Westmead Endoscopy meeting. I would also like to welcome those who are joining us online from Europe, North America and Asia. Once again we have set ourselves the goal of a comprehensive demonstration of diagnostic and therapeutic endoscopy. I believe that this year will be our most successful event yet.

We are delighted to welcome six truly outstanding clinicians from abroad; John Anderson, Peter Cotton, Paul Kortan, James Lau, Horst Neuhaus and Pinghong Zhou, as our expert faculty. All of them are leaders on the international stage having made numerous outstanding contributions to the practice of Endoscopy over the last ten to twenty years.

Their insights are eagerly awaited.

This year we will especially focus on the fundamentals of core technique. The Symposium’s content has been carefully designed to facilitate discussion. Please relay your questions through the chairs to our proceduralists. A strong emphasis on the cognitive processes behind the delivery of high quality endoscopy will feature. Several novel technologies will also be demonstrated.

On behalf of our Department, Nurses and Doctors alike, I thank you for your support and for interrupting your busy schedules to join us here for these two special days. I believe the international guests, in combination with our Australian faculty and the team from Westmead, will provide an enlightening and informative educational experience for you, and hopefully a very enjoyable one.

Yours sincerely

Michael Bourke
Chairman Sydney International Endoscopy Symposium 2013
Director of Gastrointestinal Endoscopy, Westmead Hospital, Sydney

Nurses’ Workshop 2013

I would like to personally welcome each of you to the 6th Sydney International Endoscopy Symposium Nurses’ Workshop. It is an exciting time for the Westmead Hospital Endoscopy Unit staff to be able to offer another stimulating and educational meeting at the Hilton Sydney in our vibrant city of Sydney.

Building on the success of previous meetings, the Symposium will feature a variety of fantastic presentations and demonstrations related to important aspects in Endoscopy nursing that will excite and increase your understanding in this specialty! There is always something for everyone to take home after attending our workshop!

The Symposium will also provide the ideal forum to stimulate ideas, establish collaborations, allow Nurses to interact and network as well as offering new updates and learn fresh tricks of the trade to promote gastrointestinal / endoscopy nursing.

Nurses are also welcome and encouraged to attend the two full days live high quality transmission from the Westmead Endoscopy Suite, which promises to be a fabulous experience showcasing the skills and wisdom of the internationally renowned guest faculty.

RCNA points will be available for nurses attending the Symposium.

Yours sincerely

Mary Bong
Nurse Unit Manager
Endoscopy Unit, Westmead Hospital
Organising Committee Westmead Endoscopy Symposium 2013
DR JOHN ANDERSON

Dr John Anderson graduated from Liverpool University in 1989 and was based in Ninewells Hospital, Dundee, Scotland for the majority of his gastroenterology training. He is a consultant gastroenterologist at Gloucestershire Hospitals NHS Trust, working predominantly as a specialist therapeutic endoscopist.

Appointed National Endoscopy Training Lead 2007-2011, he was part of the National Endoscopy Team, formed to enhance UK endoscopy service provision and the develop of training and educational programmes for nurses, doctors and trainees. His main interest is in applied adult education theory in skills acquisition. He is currently the Director of the Gloucestershire Endoscopy Training Centre and has been actively involved in the working groups of the Joint Advisory Groups for Gastrointestinal Endoscopy (JAG) and the BSG Endoscopy committee. As joint clinical lead for NHS e-Endoscopy a project, he was involved in the development of a web based learning tool to provided knowledge and applied knowledge underpinning all forms of endoscopic practice.

A/PROF PAUL KORTAN

Dr Paul Kortan graduated from McMaster Medical School in Hamilton and completed his GI training at the University of Toronto. He completed his post-graduate training at the University of Leuven, Belgium and at University of Hamburg, Germany. He joined the Division of Gastroenterology at The Wellesley Hospital, University of Toronto in 1982. Together with his colleagues they established a successful training programme in therapeutic endoscopy which has moved to St Michael’s Hospital in 2000. He is also on staff at The Hospital for Sick Children where he performs interventional paediatric procedures. Dr Kortan’s expertise is in endoscopic management of pancreaticobiliary diseases.

Dr Kortan is a Fellow of the American Association of Gastrointestinal Endoscopy (FASGE) and American Gastroenterologic Association Fellow (AGAF). Dr Kortan is the Director of the GI Fellowship Programme at U of T. He was the recipient of Dr Lou Cole Award for educational excellence for 2010. Dr Kortan is the first holder of the Slaight Family Term Chair in Advanced Therapeutic Endoscopy awarded in 2010.

DR JAMES LAU

Dr James Lau graduated with honors from the Medical School of University of New South Wales in 1987. He joined the Department of Surgery at the Prince of Wales Hospital, Chinese University of Hong Kong in 1993 as a resident. He was trained there in upper gastrointestinal surgery as well as therapeutic endoscopy. Dr Lau was appointed as a Consultant in Surgery in 1999. He became Director to the Endoscopy Center at the same hospital in 2003 and Professor of Surgery in 2007.

Dr Lau is widely known as a surgical endoscopist with research interests in the clinical management of peptic ulcer bleeding. He wrote his MD thesis on the same topic. He has published more than 10 book chapters and 150 peer reviewed clinical papers. Many of his papers appear in the New England Journal of Medicine, Annals of Internal Medicine and Gastroenterology. His current research projects include the supplementary role of angiographic embolization to endoscopic therapy in management of severely bleeding peptic ulcers and others. His part time hobbies include endovascular surgery and en-bloc resection of tumors with major vessels.

PROF HORTST NEUHAUS

Professor Horst Neuhaus is the Chief of the Department of Internal Medicine of the Evangelisches Krankenhaus Düsseldorf, teaching hospital of the University of Düsseldorf.

Horst Neuhaus graduated from the University of Bonn, Germany, in 1979. In the same year he received his medical degree. After his training in gastroenterology, he became faculty member of the Medical Department II, Klinikum rechts der Isar of the Technical University Munich under the leadership of Professor Meinhard Classen. In 1987, he became head of the endoscopy unit.

In 1992, Horst Neuhaus obtained his “Habilitation” at the Medical Faculty of the Technical University Munich. The thesis was on “In vitro and in vivo studies on electromagnetic shock-wave lithotripsy of gallbladder stones”. In 1995, Professor Neuhaus was appointed as the Chief of the Department of Internal Medicine of the Evangelisches Krankenhaus Düsseldorf, teaching hospital of the University of Düsseldorf. In 2003, he has been President of the German Society of Endoscopy and Imaging Procedures (DGEBV). He has been founder and director on the annual Düsseldorf International Endoscopy Symposium since 1999.

PROF PINGHONG ZHOU

Dr Pinghong Zhou is currently a specialist in therapeutic endoscopy, as well as a general surgeon of Zhongshan Hospital, Fudan University, Shanghai, China.

Dr Zhou graduated from Shanghai Medical University in 1992, and obtained his doctorate degree from Fudan University in 2003. Having completed his basic surgical training in the department of general surgery of Zhongshan Hospital from 1992 to 1998, he started his training in digestive endoscopy as a senior resident in 1999. He also received the most comprehensive training in various areas of advanced endoscopy, such as EUS under the mentorship of Kenjiro Yasuda in Kyoto Second Red Cross Hospital of Japan in 2000, ESD under Hiroyuki Ono in Shizuoka Cancer Center of Japan in 2006, ERCP under Peter B Cotton in the Medical University of South Carolina, USA in 2008.

His main research focuses on endoscopic diagnosis and treatment of gastrointestinal tumor. He is one of ESD pioneers in China and has gained much experience in EMR, EPMR and ESD. Recently he is very interested in endoscopic resection of submucosal tumor (SMT) and tunnel endoscopic surgery, such as peroral endoscopic myotomy (POEM) of esophageal achalasia.

The attendance of the international faculty has been graciously supported by our Platinum Sponsors
Professor Meinhard Classen, father of European endoscopy and inventor of sphincterotomy, wrote: “This book is just wonderful, historical and entertaining. Endoscopists all over the world should read it.”

Dr Jerry Waye, President of the World Organization of Endoscopy (and Colonoscopy magician) wrote: “A completely enjoyable chronicle of one famous gastroenterologist’s life journey with interesting and entertaining travels along the way. A tale that every endoscopist must read.”

From chapter 6. I presented endoscopic removal of stones at the Royal College of Surgeons in London in 1976. The President, a wine connoisseur, stated that they should perhaps license a few medical gastroenterologists to perform the technique, but should charge “corkage” for each stone.

From chapter 17. The king arrived eventually at 10pm with a retinue of princes. He cut short my usual discussion of informed consent with a gesture of trust that I found rather menacing, backed up as it was by a rippling of Korans around the procedure room…….

From chapter 18. On September 11, we were dozing at 30,000 feet over the Atlantic…….

All proceeds from sale of the book go to the “Peter Cotton Endoscopy Training Fund” (in the MUSC Foundation) to support postgraduates seeking advanced endoscopic training.
Precisely place biliary stents with unprecedented control.

In palliating the biliary tract you need a stent that facilitates accurate, controlled placement, that maintains patency and that minimizes migration. The Evolution Biliary Stent gives you all that and more. Available fully or partially covered or completely uncovered to meet varying clinical situations, the Evolution features platinum core wire construction that delivers excellent, full-length radiopacity, while dual-stepped flanges ensure position after deployment. You will always experience unprecedented control with Evolution—the only stent delivery system on the market that features controlled release and recapturability.

Cook Medical—Delivering the clinical advantage.

Warning: The safety and effectiveness of this device for use in the vascular system have not been established. Not for sale in all jurisdictions.

www.cookmedical.com
Nurses’ Workshop Program

Nurses’ Workshop - Wednesday 6th March 2013

0730  Registration opens

0830 - 0835  Welcome Note – MARY BONG

SECTION 1

0835 - 0905  Advanced resection and innovation in the endoscopy unit: ‘A team sport’ – PROF MICHAEL BOURKE

0905 - 0935  Anticoagulants, antiplatelet agents and iatrogenic bleeding in Endoscopy – DR NICK BURGESS

0935 - 1005  Carbon dioxide in Endoscopy – advantages and anaesthetic considerations – SUSAN LANE, ENDOSCOPY ANAESTHETIC NURSE

1005 - 1035  Current quality initiatives in Endoscopy in the UK – VICKI HEDLEY, LEAD NURSE FOR ENDOSCOPY SERVICES, ST GEORGES HOSPITAL, UNITED KINGDOM

1035 - 1105  Morning Tea and Trade Displays

SECTION 2 – Workshop Presentations

1105 - 1120  Unravelling guidelines standards and quality improvements – DI JONES, PRESIDENT SIGNEA

1120 - 1135  Electrosurgery in Endoscopy – DR VU KWAN

1135 - 1155  The ABC of GI Research – DR NICK BURGESS

1155 - 1210  Patient’s journey to PEG and beyond – CATHY ZACCARIA, CNC NUTRITIONAL SUPPORT SERVICE

SECTION 3 – Workshop demonstrations - Co-ordinators: Judy Tighe-Foster / Jeneviah Junio / Nicky Stojanovic / Kerry Flew

3 Demonstration stations

1215 - 1330  20 minute Workshops

Station 1 DI JONES / HELENA LINDHOUT / ROBYN BROWN
  Table 1 • Standards and Guidelines
  Table 2 • Quality improvements initiatives

Station 2 VU KWAN / BETTY LO / ADENIKE ADEYEMI / NICK BURGESS / REBECCA SONSON / MARY BONG
  Table 1 • ERBE and APC probe
  Table 2 • Endoclot
  Table 3 • Thermal probes

Station 3 CATHY ZACCARIA / SALLY PIGGOT
  Table 1 • PEG policies and guidelines
  Table 2 • Trouble shooting PEGs
  Table 3 • Dummy demonstration

1330 - 1430  Lunch and Trade Displays

SECTION 4

1430 - 1445  Quiz - Zion Siu

1445 - 1515  Detection and management of small polyps – VICKI HEDLEY, LEAD NURSE FOR ENDOSCOPY SERVICES, ST GEORGES HOSPITAL, UNITED KINGDOM

1515 - 1545  Unlocking the liver – everything you wanted to know but were afraid to ask – DR VU KWAN

1545 - 1615  Quiz prizes presentation

1615 - 1620  Closing remarks and thank you

1630  Afternoon Tea and Trade Displays

Each delegate will receive a stylish satchel bag, courtesy of Cook Medical – available for collection when registering.
## Symposium Program

### Day One – Thursday 7th March 2013

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tr>
<td>0730</td>
<td>Registration opens</td>
</tr>
<tr>
<td>0830 - 0833</td>
<td>Welcome – <strong>Michael Bourke</strong></td>
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<tr>
<td>0833 - 0835</td>
<td>Official Conference Open - <strong>Danny O’Connor, Chief Executive, Western Sydney Local Health District</strong></td>
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<tr>
<td>0835 - 0900</td>
<td><strong>GI bleeding 2013: Current status and new therapeutic approaches – James Lau</strong></td>
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<tr>
<td>0900 - 0910</td>
<td>Discussion</td>
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<tr>
<td>0915 - 1030</td>
<td>Live Endoscopy Session 1 - Chairs: Vu Kwan, Michael Swan, Paul Edwards</td>
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<tr>
<td>1030 - 1100</td>
<td>Morning Tea</td>
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<tr>
<td>1100 - 1120</td>
<td>New innovations in endoscopic treatments of tumours: Tunnelling and full thickness resection – <strong>Pinghong Zhou</strong></td>
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<tr>
<td>1120 - 1300</td>
<td>Live Endoscopy Session 2 - Chairs: Dev Samarasinghe, Mark Appleyard, Pinghong Zhou</td>
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<tr>
<td>1300 - 1400</td>
<td>Lunch</td>
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<tr>
<td>1305 - 1325</td>
<td><strong>Endoscopic Ultrasound Special Interest Session – :</strong> The technique and indications for EUS-guided drainage of pancreatic cysts <strong>Yury Starkov,</strong> Professor of Surgery, Chief, Division of Endoscopic Surgery, A.V. Vishnevsy Institute of Surgery, Moscow, Russia</td>
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<tr>
<td>1325 - 1330</td>
<td>Discussion</td>
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<tr>
<td>1400 - 1530</td>
<td>Live Endoscopy Session 3 - Chairs: Nghi Phung, Philip Craig, Rick Hope</td>
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<td>1530 - 1600</td>
<td>Afternoon Tea</td>
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<tr>
<td>1600 - 1625</td>
<td>Teaching and learning colonoscopy: “the do’s and don’ts” – <strong>John Anderson</strong></td>
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<tr>
<td>1625 - 1635</td>
<td>Discussion</td>
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<tr>
<td>1635 - 1700</td>
<td>General Endoscopy Quiz – <strong>Bronte Holt</strong></td>
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<td>1700</td>
<td>Close</td>
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<tr>
<td>1700 - 1800</td>
<td><strong>Experts on the spot – Mini-Symposium:</strong> Humility and the humble polyp Chaired by Luke Hourigan, John Anderson, Horst Neuhaus and Michael Bourke</td>
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<tr>
<td>1830</td>
<td>Coaches depart promptly for Symposium Reception</td>
</tr>
<tr>
<td>1845 - 2045</td>
<td>Official Symposium Reception – Sydney Opera House ‘Opera Point Marquee’; Delegates to make their own return travel arrangements</td>
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</tbody>
</table>

*Tickets still available – see registration desk*

**SYMPOSIUM RECEPTION**

at Sydney Opera House ‘Opera Point Marquee’

Enjoy drinks and canapés on the picturesque Sydney Harbour foreshore! The Opera Point Marquee offers a magnificent vantage point to enjoy one of the world’s most famous views. The venue makes the most of this setting with a private outdoor reception area and clear walls which will ensure you enjoy the vista from every angle.

*Coaches will depart the Hilton Sydney Hotel from 6.30pm sharp (one-way transfer), alternatively, you can make your own way to the venue, allow approximately 20 minutes from the Hilton Sydney Hotel.*
### Day Two – Friday 8th March 2013

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>0730</td>
<td>Registration opens</td>
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<tr>
<td>0830 - 0900</td>
<td><em>Endoscopic complications: Mea culpa</em> – Paul Kortan and Peter Cotton</td>
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<tr>
<td>0900 - 1030</td>
<td>Live Endoscopy Session 4 - Chairs: Stephen Williams, Rita Lin, Peter Cotton</td>
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<tr>
<td>1030 - 1100</td>
<td>Morning Tea</td>
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<tr>
<td>1100 - 1230</td>
<td>Live Endoscopy Session 5 - Chairs: David van der Poorten, Mark Appleyard, David Ruppin</td>
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<tr>
<td>1235 - 1300</td>
<td><em>Biliary pancreatitis: How to recognise and how to treat</em> – James Lau</td>
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<tr>
<td>1300 - 1400</td>
<td>Lunch</td>
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<tr>
<td>1400 - 1530</td>
<td>Live Endoscopy Session 6 - Chairs: Eric Lee, Alan Moss, Thao Lam</td>
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<tr>
<td>1530 - 1600</td>
<td>Afternoon Tea</td>
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<tr>
<td>1600 - 1630</td>
<td>The Peter Gillespie Lecture <em>New Endoscopic Therapies. Where are we and where to?</em> – Horst Neuhaus</td>
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<tr>
<td>1630 - 1645</td>
<td>Awards for the Quiz Winners – Bronte Holt</td>
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<tr>
<td>1645 - 1700</td>
<td>Closing Remarks</td>
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**Mark your diary NOW, next year’s Symposium dates!**

**Wednesday 5th - Friday 7th March, 2014**

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<th>March 2014</th>
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<td>16</td>
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<td>23</td>
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</table>

Each delegate will receive a stylish satchel bag, courtesy of Cook Medical – available for collection when registering.
Abstracts
GI bleeding 2013: current status and new therapeutic approaches

James Lau

The two treatment modalities that have been shown to reduce mortality in patients who present with acute non-variceal upper gastrointestinal bleeding are endoscopic therapy and the use of proton pump inhibitors (PPI). Endoscopic therapy should consist of either hemo-clipping or thermo-coagulation with or without pre-injection with adrenaline. PPI therapy before endoscopy downstages stigmata of bleeding in peptic ulcers, reduces need for therapy but without impact on clinical outcomes. PPI therapy after endoscopic hemostasis to high risk ulcers (actively bleeding and with vessels) significantly improves patients’ outcomes. Newer endoscopic hemostatic methods include a hemostatic powder, clips that are more secure and capture more tissue such as the Instinct ® and OVESCO® clips and Over-stitch®. Future clinical research should direct at a subgroup of patients predicted to fail endo-therapy – these are often elderly patients with major bleeding from larger ulcers (> 2cm) located at posterior duodenal bulb and lesser curve of stomach manifested in shock. Angiographic embolization to the bleeding artery is being evaluated as an alternative surgery in patients with massive bleeding failing endoscopic control. In addition, an ongoing trial evaluates the role of pre-emptive angiographic embolization to high risk ulcers after initial endoscopic hemostasis.

Teaching and learning colonoscopy: “the do’s and don’ts”

John Anderson

Colonoscopy is a complex psychomotor skill posing significant challenges for both trainers and trainees. Training effectively requires active input from the trainer as against a 'supervising' role. Uniform language and technique ensure a consistent and reproducible approach to training, which needs to develop and progress with trainee experience.

The main concepts and themes behind effective training will be covered, in addition to some misconceptions and poor training practice which can perpetuate poor technique and ultimately sub-optimal performance of individuals.

For the trainee, it is important to recognize what represents a good training environment and experience. The need to develop both technical and non-technical skills will be covered.

Biliary pancreatitis: how to recognize and how to treat

James Lau

Passage of small gallstones or sludges through the ampulla of Vater causes biliopancreatic reflux and acute pancreatitis. It is important to establish a biliary etiology in patients presenting with acute pancreatitis as this has therapeutic implications. An increased serum level of alanine aminotransferase is associated with a high probably of gallstone pancreatitis (positive predictive value = 80-90%). Choledocholithiasis can be accurately confirmed using endoscopic ultrasonography (EUS), magnetic resonance cholangio-pancreatography or ERCP. EUS in addition can readily diagnose the presence of biliary sludge in the gallbladder. Early endoscopic sphincterotomy reduces rate of local pancreatic complications and mortality in the subgroup of patients with persistent biliary obstructions and cholangitis. In the treatment of local complications of pseudocyst and walled off pancreatic necrosis (WOPN), endoscopy is now preferred over surgery. Drainage of pseudocyst should be guided by endosonography. Compared to a ‘blind’ endoscopic puncture, EUS guided puncture is more likely to be successful and can avoid interposed vessels and bleeding. The reported technical success rate of EUS guided pseudocyst drainage is between 82-94% of cases. When compared to surgical necrosectomy, endoscopic debridement of pancreatic necrosis is associated with reduced incidence of pancreatic exocrine and endocrine insufficiencies, pancreatic fistulas and organ failures.

New innovations in endoscopic treatments of tumours: Tunnelling and full thickness resection

Pinghong Zhou

Endoscopy Center and Endoscopy Research Institute, Zhongshan Hospital, Fudan University

The attempt to resect gastrointestinal (GI) submucosal tumors originating from muscularis propria by endoscopy was not recommended due to the risk of incomplete resection or high risk of perforation during procedure. New innovations such as tunnelling and full thickness resection are now available at our center for those patients. Tunnelling technique is a novel approach which was initially developed for the purpose of establishing an access for natural orifice transluminal endoscopic surgery (NOTES). Meanwhile, it brought a great idea for endoscopic procedures by using the submucosal tunnel as an operating space. Full thickness resection is a thorough resection of the submucosal tumor, creating a GI wall defect which needs the high expertise of current. The current status of these two procedures and also the closure technique by metallic clips will be discussed.
**Abstracts**

**Endoscopic complications: Mea culpa**

**Paul Korton**

**ENDOSCOPIC COMPLICATIONS: Mea Culpa**

**PAUL KORTAN UNIVERSITY OF TORONTO ST. MICHAEL’S HOSPITAL**

**RISK REDUCTION IN ENDOSCOPY**

**PRIMUM NON NOCERE**

**“AN OUNCE OF PREVENTION IS WORTH A POUND OF CURE”**

**SETTING THE STAGE**

1. Before the procedure
2. During the procedure
3. After the procedure

**BEFORE THE PROCEDURE**

- Is the procedure really indicated?
  - Although the procedure suggested by various MDs, the final responsibility lies with the endoscopist
- Is the endoscopist trained to perform the required procedure?
- Are the patients and family members fully prepared?
- Informed consent is a process, not a paper

**ESSENTIAL ELEMENTS FOR INFORMED CONSENT (patient and family member)**

1. The patient’s pertinent medical diagnosis and test results
2. The nature of the proposed procedure
3. The reason the procedure is being suggested
4. The benefits of the procedure
5. The risks and complications of the procedure including the relative incidence and severity, that is important to the patient’s decision-making process
6. Reasonable alternatives to the proposed procedure
7. The patient’s prognosis if the intervention or test is declined

**ASA/ANTI-PLATELET AGENTS/ ANTI-COAGULANTS for high risk procedures**

- ASA
  - Need not be discontinued
  - We will D/C for large polyps
- ANTI-PLATELET AGENTS (CLOPIDOGREL, TICLOPIDINE)
  - Discontinue 7 –10 d before procedure
- WARFARN
  - Discontinue 5 d before procedure
- DAPTAPRAN
  - Discontinue 2 d before procedure
- HEPAPRIN
  - LMWH-Discontinue at least 12-24 hrs before procedure
  - Unfractionated heparin 6-8 hrs

**INTRAPROCEDURE**

- Time out?
- Monitoring
- Administration of sedation
- Insertion of endoscope, performance of diagnostic and therapeutic elements until complete removal

**“TIME OUT IN SURGERY”**

Death rate at baseline: 1.5% p= 0.003
Inpatient complications: 11% p=0.001

**“TIME OUT IN ENDOSCOPY”**

- To minimize
  - Wrong person
  - Wrong procedure
  - Wrong site
- To have all necessary accessories

**MONITORING**

- Pulse oximetry and supplemental O2
- Hemodynamics
- Capnography
- Bispectral (bis)

**COMPLICATIONS OF SEDATION**

- Hypoventilation
- Respiratory arrest
- Bradycardia
- Cardiac events – Ischemia, MI (remember epinephrine injections)
  - Use small amounts incrementally
  - “Sedate and wait”
  - Keep naloxone and flumazenil handy
Endoscopic complications: Mea culpa (continued)

Paul Kortan

**COMPLICATIONS OF “SIMPLE PROCEDURES” (be vigilant)**

- The rarity of serious endoscopic complications may result in reduced vigilance
- After 5000 uneventful gastroscopies it may be tempting to short-cut the consent process
- Pay attention to detail, one procedure at a time

**COMPLICATIONS OF COLONOSCOPY**

- Diagnostic colonoscopy
  - 0.2% - 0.35%
    - Sedation-related, perforation
- Therapeutic colonoscopy (highly variable)
  - 2.3%
    - Bleeding, perforation and post-polypectomy coagulation syndrome
- Mortality
  - 0.005%

**BLEEDING RISK REDUCTION**

- Cold polypectomy for small polyps
- Injection of epinephrine
- Detachable snares
  - Pedunculated polyps with thick stalks
- Clips
- Management of antplatelet agents and anticoagulants

**COLONOSCOPIC PERFORATION**

- Incidence 0.07 - 0.1%
- Blunt trauma from endoscope
- Barotrauma
- Unintended resection of muscularis propria
- Coagulation necrosis of muscularis propria

**RECOGNITION OF PERFORATION AT THE TIME OF COLONOSCOPY**

- Injection of dilute indigo carmine methylene blue helpful in determining the plane of resection
  - Blue - intact submucosa
  - White - into muscularis propria
- Bourke’s Target sign - white center surrounded by blue
- Tension pneumoperitoneum

**NON-LIFTING SIGN**

- Positive: cancer in the polyp
- Negative: does not rule out cancer
- False positive – previous snare resection
- Indicates invasion or submucosal fixation

**COMPLICATIONS OF ENDOSCOPIC BILIARY SPHINCTEROTOMY**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Claims</th>
<th>Complications</th>
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<tbody>
<tr>
<td>ERCP</td>
<td>2.3%</td>
<td>2/3</td>
</tr>
<tr>
<td>Pancreatitis</td>
<td>0.07%</td>
<td>0.005%</td>
</tr>
<tr>
<td>Pancreatic duct injury</td>
<td>0.2%</td>
<td>0.005%</td>
</tr>
<tr>
<td>Pancreatic perforation</td>
<td>0.07%</td>
<td>0.005%</td>
</tr>
<tr>
<td>Pancreatic necrosis</td>
<td>0.07%</td>
<td>0.005%</td>
</tr>
<tr>
<td>Perforation</td>
<td>0.07%</td>
<td>0.005%</td>
</tr>
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**PATIENTS AT HIGHER RISK FOR POST ERCP PANCREATITIS**

- PRE-ERCP
  - SUSPECTED SCD
  - PANC leaks/diversion
  - PRIOR ACUTE/RECURRENT PANCREATITIS
  - NO CHRONIC PANCREATITIS
  - YOUNG AND FEMALE

**INTRA-PROCEDURE**

- INJECTIONS SPHINCTEROTOMY
- INJECTIONS CANALIZATION
- INJECTIONS AMPULLACTOMY
- BALLOON DILATION OF SPHINCTER
- PANCREATECTOMY INJECTION (ANY, MULTIPLE, TO HEAD)

**ERCP**

- Pancreatitis risk reduction
  - Careful patient selection/indication
    - MRCP or EUS for purely diagnostic exams/low pretest probability
  - Wire guided cannulation
  - Pancreatic stents
    - High-risk patients
    - Overcomes ERCP-related papillary edema
    - Threshold risk reduction
    - Small diameter/short stents

**ASSISTANTS AND TEAM APPROACH**

- Assistants
  - Complication rates tied to endoscopy assistant experience
  - Improved polyp detection with experienced assistants
  - Communication
  - Check settings
  - Familiarity
Endoscopic complications: Mea culpa (continued)

Peter Cotton

Digestive endoscopy has come to dominate the lives of most practicing gastroenterologists. Not all procedures go well. Reasons for disappointment include technical and clinical failure, adverse events and process issues.

Technical and clinical failure

Sometimes it is just not possible to get where you need to go (to the cecum or the bile duct), or to do what you had planned to do (dilate a stricture or place a stent). In some cases the “fault” may lie with the patient. There may be anatomical issues (prior pelvic surgery, or a biliary bypass), or awkward pathology (tortuous stricture or large polyp). Many of these factors cannot be overcome, even by experts, but many are known beforehand, which led to the development of scales of difficulty or complexity (1). These can be used to advise patients about the likelihood of success in their particular case. Technical failure is more often due to lack of training and expertise by the endoscopist. Variations in the ability to reach the cecum or to access the bile duct are well documented, as are variations in detecting lesions. Clearly these problems can be addressed and overcome (at least partially) only by better training, and, more controversially, by ensuring that procedures are done only by those with proven competence. This should involve stringent credentialing processes, with accountability, using report cards and benchmarking. I favor a certification process for more complex and risky procedures, such as ERCP, which are often done in USA by endoscopists with inadequate volumes.

Some procedures may fail because of poor patient toleration, which is one reason for the trend towards using anesthesia for more complex procedures. Others are completed according to plan, but fail to help the patient. This may involve missing a diagnosis (perhaps a technical error), but more often because a treatment provides little or no benefit (stenting for chronic pancreatitis or sphincterotomy for “sphincter of Oddi dysfunction”). Reducing the likelihood of a poor outcome, despite technical success, thus depends on clinicians understanding the chances of success through their knowledge of the literature and of their own results. This is essential if they are to advise patients effectively, including the possibility of referral to someone with more expertise in that area.

Adverse events

Patients are most unhappy when something “goes wrong” and they suffer an adverse event. These can happen before the endoscope is introduced (reaction to prophylactic antibiotics or bowel preparation), during the procedure (hypoxia), immediately afterwards (pain due to perforation), a few hours later (pancreatitis after ERCP), or can be
Abstracts

delayed for several days or weeks (delayed bleeding). Some events (viral transmission) may be so far delayed that the connection is difficult to make, or is missed completely. Documentation of these events requires a precise lexicon (2).

Factors increasing risk include the patient’s chronic health status (age, cardiac, pulmonary and other co-morbidities, nutrition, coagulopathy, immunosuppression and obesity), any effect of the presenting illness (sepsis, anemia), and the setting (urgency and environment). The nature of the planned procedure also affects the risk (bleeding after treating varices, or pancreatitis after ERCP).

Managing adverse events

Obviously, when things “go wrong”, the specific issues have to be addressed promptly and efficiently, and explained carefully to the patient and family, who hopefully will remember that they were informed about the possibilities beforehand. No matter how bad you feel, it is a mistake to grovel in distress. However, it is important to show that you care, and that you share their disappointment. Keep in touch, even when the patient has to be transferred elsewhere. Behave professionally, just as you would if things had gone well. Failure to do so will raise questions, generate resentment and may foment legal action (3).

Process issues

Delays, discourtesies and lack of rapport may leave patients and families unhappy even when the technical and clinical outcomes are good, and when there have been no adverse events. These can be avoided only by assiduous attention to such quality issues in the endoscopy unit. It is self-evident that all of these risks are less likely to occur when the endoscopist, team, patient and family are all well prepared for the specific procedure. Let’s continue to strive to do better.


New endoscopic therapies. Where are we and where to?

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Modern changes in flexible endoscopy have been mainly driven by an increasing variety of indications, new technologies and economics. The selection of diagnostic endoscopic methods depends on the clinical setting which includes screening, surveillance of risk conditions for neoplasia or evaluation of symptomatic patients. In therapeutic endoscopy progress has been made with regard to treatment of early GI neoplasia, benign and malignant gastrointestinal strictures, bleeding and management of even complex of pancreatoibiliary diseases. Selected areas of research are endoscopic treatment of obesity, reflux disease, motility disorders (fig. 1) and full-thickness resection, e.g. of submucosal tumors. Enormous improvement in endoscopic and endonsonographic imaging has increased the accuracy of detection, discrimination and confirmation of mucosal lesions as well as local tumor staging. Targeted and minimally invasive techniques of tissue sampling facilitate the histological diagnosis. Referral centers of endoscopy should provide advanced imaging and indication-based options of endoscopic access to sites of interest. These include e.g. video-capsules, ultraslim endoscopes, instruments for evaluation of the small bowel or specially designed therapeutic endoscopes. Endoscopes which allow triangulation for independent maneuvering of accessories are currently under evaluation. Their development as well as the introduction of new accessories like knives, clips, sutureing machines, thermal devices and various implantable stents, sleeves or valves have been accelerated as spin-off technologies of NOTES (Natural Orifice Translumenal Endoscopic Surgery). These advanced techniques increase options of tissue resection and ablation, tissue apposition, bridging or closure of lumena or fistulae and creation of anastomoses. This progress could be only made by modern options of endoscopic management of procedure related complications. The best centers will provide a wide array of advanced interventions depending on specialization of the individual institution. Advanced endoscopy has to be considered as a part of a multidisciplinary approach which should include particularly radiology, surgery, oncology and histopathology. Centers should offer appropriate training programs with the use of simulators, animal models and access to animal laboratories. New technologies have to be carefully evaluated preferably in controlled trials and registries are warranted for a variety of recently introduced methods. It is mandatory to improve the level of evidence in several areas of endoscopy. International cooperation is particularly important for evaluation of procedures with different experiences in centers of various countries. The future of innovations in endoscopy will furthermore largely depend on their effect on the quality and the cost of care.
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