MARCH 2007

Gastroenterology
IN PRIMARY CARE

PCSG

JOURNAL OF THE PRIMARY CARE SOCIETY FOR GASTROENTEROLOGY

Community ENDOSCOPY

AN OXYMORON?

By Jacqui Pountney

Ten years ago, in October 1996, an Endoscopy Unit was opened in Bridge Cottage Surgery in Welwyn, Hertfordshire. This was a purpose built unit built as part of a rebuild of the original GP surgery but it was also designed to be used as a Minor Operations Theatre too.

These were the days of Fundholding and the Unit catered for mainly patients from the Practice but also for some from other Practices nearby. Our GP Endoscopist, Dr Roger Aubrey, has always been a believer in screening for patients at a high risk of bowel cancer and that was what we concentrated on. As the years came and went, fundholding disappeared and we came under the auspices of our local Primary Care Trust. This made little difference to our practice at the time and our work continued, with patients regularly coming from three out of eight other Practices within the PCT.

All our equipment had been bought from Olympus Keymed and they alerted us to the fact that our Washer Disinfector – an AutoDis 3 – was going to become obsolete in September 2005. We then spent a year in discussions with our PCT about how we were going to fund a replacement. Thus began a journey into the realms of high finance and HTM2030[1], a configuration that was to haunt us for long months ahead. One year on we were no further forward with the purchase of a new machine despite quotes being given to the relevant people within the PCT.

Then came the biggest blow of all, when in September 2005 with no new machine in situ, we were shut by the PCT for using obsolete decontamination equipment. Around the same time, they merged with a PCT in the north of the region and the budget deficit was compounded. However, there was a chink of light appearing as they also informed us that they were very keen to see the Endoscopy Unit continue as part of Practice Based Commissioning. Many meetings on, with first one commissioner and then his replacement, it became clear that the PCT would no longer fund us as they had been doing and it was down to us to finance ourselves by selling our services to the PCT. In order to meet our running costs and still put money aside for future replacement equipment, we were going to have to increase our cost per patient yet still be a player in the market of PCT allowed patient-choice. However we still would not be able to fund the biggest problem we had, namely a new Washer-Disinfector.

There were many times in the six months that we were closed, when we wondered why we were trying to continue when everything was stacked against us, but as a team we remained committed to the belief that we make a difference to patients' lives and their bowel disease. It was a huge learning curve for as we took the opportunity to update our skills and knowledge, we rewrote all our patient information leaflets, protocols and guidelines, we learnt about patient pathways, budgets, patient-choice, market forces, tariffs, HTM2030 and the GRS. We met with others and exchanged ideas but most of all, aimed to get our unit up and running again.

We are – and remain - very grateful to our local League of Friends who in early 2006 came to our rescue and provided the funds for an Olympus

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This issue...

EDITORIAL

The NHS supertanker has had its outer hull compulsorily holed along its entire length and breadth with the admission of the private sector to the provision of NHS services. The declared intention is not to sink the leviathan but to introduce plurality of provision in the move of up to forty percent of diagnostic and low-tech treatment services to community settings. However the January letter from the GPC sees this as "the threat of the advance of the private sector", a threat felt equally by primary and secondary care.

At the same time there is a real opportunity currently to move parts or all of services traditionally delivered in hospitals to community settings closer to the patient in teams headed up by GPs with special interests in line with the Government White Paper of January 2006 "Our Health, Our Care, Our Say, a new direction for community services". This can best take place in a safe manner with quality assurance by working seamlessly with the relevant secondary care services "more of the innovative schemes that take consultants out to the community-based centres", but up to now there is a poor track record for such cooperation. There are still reports of displays of hostility towards GPs delivering parts of services traditionally lodged in secondary care (though this is nothing new and there was significant expansion under fundholding). This can be offset against ongoing primary care grumbling about new resource year on year being sucked into secondary care leaving very little for primary care development.

All this may be set to change as Practice Based Commissioning gets underway, a necessary counterforce to Payment by Results which without restraint would suck the entire NHS budget into the secondary care arena. Both of the main political parties seem determined that this commissioning mechanism is here to stay. However, it comes as no surprise that commissioners have their hands severely tied, working with budgets already carrying severe deficits ("increasingly desperate measures as PCOs seek to balance their books" - Hamish Meldrum, January 2007), and with the new confounding factor of compulsory top-slicing of budgets to pump-prime the arrival of independent sector. In the south west the successful bidder is guaranteed funding to deliver 2500 endoscopies a year for a five year period. This causes a great lack of clarity when trying to plan changes in service delivery pathways and there has certainly been a great lack of transparency and indeed secrecy about the detail of the independent sector involvement. This appears "unfair" - to favour preferentially providers who have yet to prove whether they can or cannot deliver the relevant services. It is a classic donkey-and-carrot situation, with the carrot, as far as the NHS is concerned, being always just out of reach. The other side of the coin is that huge amounts of extra resource have been put into the NHS but outcomes in terms of patient services have not changed very much. This may be because of the prescripted slavish pursuit of targets and waiting times which most would agree hamper efforts to redesign services to provide genuinely better outcomes for patients.

Compounding resource difficulties is the passion for quality standards agendas affecting all parts of public life and the erection of ever more hoops and hurdles for hard working professionals to jump to prove themselves worthy to practice – so it is refreshing to see in this issue how a small community endoscopy service survived closure and continues to provide a highly responsive service with waiting times of only two and a half weeks (and score well on the new Endoscopy Global Rating Scale (GRS). So the message to colleagues who are motivated to redesign service pathways and deliver endoscopy or more general gastroenterology services in the community is to work through your proposal with local commissioners and get started. **The window of opportunity is now**, failure to act now (either by primary or secondary care clinicians) will result in the big independent healthcare providers moving in to take over services and even run the commissioning.

Finally and to focus on more GI orientated themes, the GP with Special Interest (GPwSI) in Endoscopy framework document is finally at the Department of Health waiting to take its place in the portfolio of revised GPwSI frameworks due for release in the spring. This document was originally submitted in autumn 2002, and has been intensively revised over the last 2 years and is badged by the RCGP. The Endoscopy Global Rating Scale is now being taken up by endoscopy units all over the country, including community units. The PCSG has the task of organising appraisal for GP endoscopists, further training of GP endoscopists in post, and training for succession in community endoscopy. Particularly we would like to hear from doctors who have undergone gastroenterology training as SpRs and have changed for a pathway entering general practice (the last cohort of doctors to be able to do this). Do please make contact with the Society, or the Editor directly – details on back page.

So there are many miles to go before any of us reach the end of 2007, but we can hope that by then some worthwhile milestones will have been passed in developing further gastroenterology services in primary care. And Community Endoscopy is not an apparent contradiction in terms (Oxford dictionary definition of an Oxymoron!).

Dr Richard Spence

Patient Safety

Implications for Endoscopic Procedures

The NCPOD report, "Scoping our Practice" in 2004 looked at deaths occurring in patients with 30 days of having diagnostic and therapeutic upper GI endoscopy. This was the basis of Professor Bramble's talk at the York Regional meeting of the PCSG.

Procedure type	Number of deaths	Total number of procedures	Mortality
PEG	986	16,648	6%
ERCP	381	23,606	2%
Upper GI	102	40,931	5%
Lower GI	102	40,378	<1%
Total	3669	128,563	3%

A complication is any untoward incident or event related to an endoscopy that has an effect on the patient's subsequent management. Causes relate to factors such as the condition of the patient at the time of the procedure, the type of procedure and the experience of the operator.

Patient factors

Patient risk is best assessed using the American Society of Anaesthesiologists (ASA) scoring grades.

In a study of inpatients that died within 30 days of a therapeutic endoscopy, clinicians were required to assess the patients' risk of dying within 30 days of the procedure. Based on the condition of the patient clinicians were asked to assess the risk of dying as none, slight expected or definite. The outcome reflected the ASA status of the patient

ASA Grade Definition

I Normal healthy individual
II Mild systemic disease that does not limit activity
III Severe systemic disease that limits activity but is not incapacitating
IV Incapacitating systemic disease which is constantly life-threatening
V Moribund, not expected to survive 24 hours with or without surgery

ASA status	none	small	definite	expected	no answer	total
1	2	10	12	4	1	29
2	61	47	97	15	2	222
3	157	50	355	46	11	619
4	72	20	464	97	8	661
5	9	0	91	77	177	178
no answer	15	7	37	8	67	109
total	316(18)	134(8)	1056(60)	247(14)	65	1,818

Procedural Factors increasing risk of complications in Upper GI endoscopy

The greatest risk during diagnostic OGD is perforation of an undiagnosed pouch or tumour. Dilatation of strictures carries a risk of perforation which increases if the stricture is long or malignant. Dilatation of achalasia requires disruption of the muscle and is also associated with an increased risk of perforation. It can be made worse because the oesophagus is often dilated and contaminated with food residue that intensifies the resulting mediastinitis if perforation occurs.

Insertion of a PEG is also risky because the stomach is intentionally perforated and during the procedure an overlying transverse colon could also be caught. Diathermy of tumours and polyps can cause transmural damage and late perforation. After therapeutic endoscopy pain and tachycardia should alert the clinician to a potential problem before any other clinical signs are apparent.

To minimize the risk of perforation of malignant strictures only minimum dilation should be done and for benign strictures it is better to do little and often, restricting the balloon force to 13-15 mm of Hg. It is very important to visualise the dilated oesophagus post procedure as the sooner a perforation is discovered the better the prognosis. Small perforations such as those caused by guide wires, have a good chance of self sealing if the patient is kept nil by mouth.

Perforation – factors that affect outcome

Better	Worse
Small hole (guide wire)	Big hole (endoscope/dilator)
Confined to mediastinum	Pleural breach
Obstruction overcome	Obstruction still present
"Clean" oesophagus	"Dirty" oesophagus
Immediate recognition	Late recognition
No signs of sepsis	Sepsis present

Golden rules after dilatation of oesophageal strictures

- Any complication after dilatation should be presumed to be a consequence of leakage until proven otherwise.
- Prompt recognition is important to determine appropriate therapy.
- Most guide wire perforations can be managed conservatively.
- Tumour perforation may result in a need for emergency surgery including oesophagectomy.

Complications associated with Lower GI Endoscopy

The colon is very thin, especially from the transverse colon proximally. **Diverticula are even thinner comprised only of mucosa.** Perforation and avulsion of the mesentery during flexible sigmoidoscopy and colonoscopy is a risk and is most commonly associated with poor technique.

There is a 0.2% incidence of perforation occurring in diagnostic procedures and the risk doubles when a therapeutic procedure is added such as polypectomy.

Patients often suffer with post procedural pain if too much air is insufflated during polypectomy and diathermy in itself can lead to pain if a transmural burn occurs during polypectomy. This is much more likely to occur with hot biopsy of sessile polyps in the thinner more proximal colon. Professor Bramble has taken to either using cold biopsy of these lesions or leaving them alone. The incidence of serositis from a transmural coagulation burn is 1% in out patient polypectomies.

Human error during these procedures is characterised by failure to acknowledge that one is at fault and is often related to unfamiliarity of a particular technique. The longer complication is left undiagnosed the worse the outcome and denial by the operator of fault often leads to repeated complications in the future.

Continued on back cover

AspECT

The Aspirin Esomeprazole Chemoprevention Trial (AspECT) is recruiting 5000 patients for 10 years of follow-up

Gastro-oesophageal reflux; incidence and its main complication

Gastro oesophageal reflux disease affects up to 30% of the population in the UK.

The disease affects 30% of the population symptomatically and up to 10% of the population have endoscopic changes. Reflux disease has been associated with increased days lost from work, major changes in quality of life as well as serious sequela. Barrett's oesophagus is the most serious end of the spectrum where up to 1.5% of the adult population can be affected. The reason that Barrett's oesophagus should be prevented is that it has a cancer risk of about 5% over the patient's lifetime. In order to treat these patients successfully there is a need for large randomised control studies to produce an evidence base and integrated care pathways in which to manage these patients.

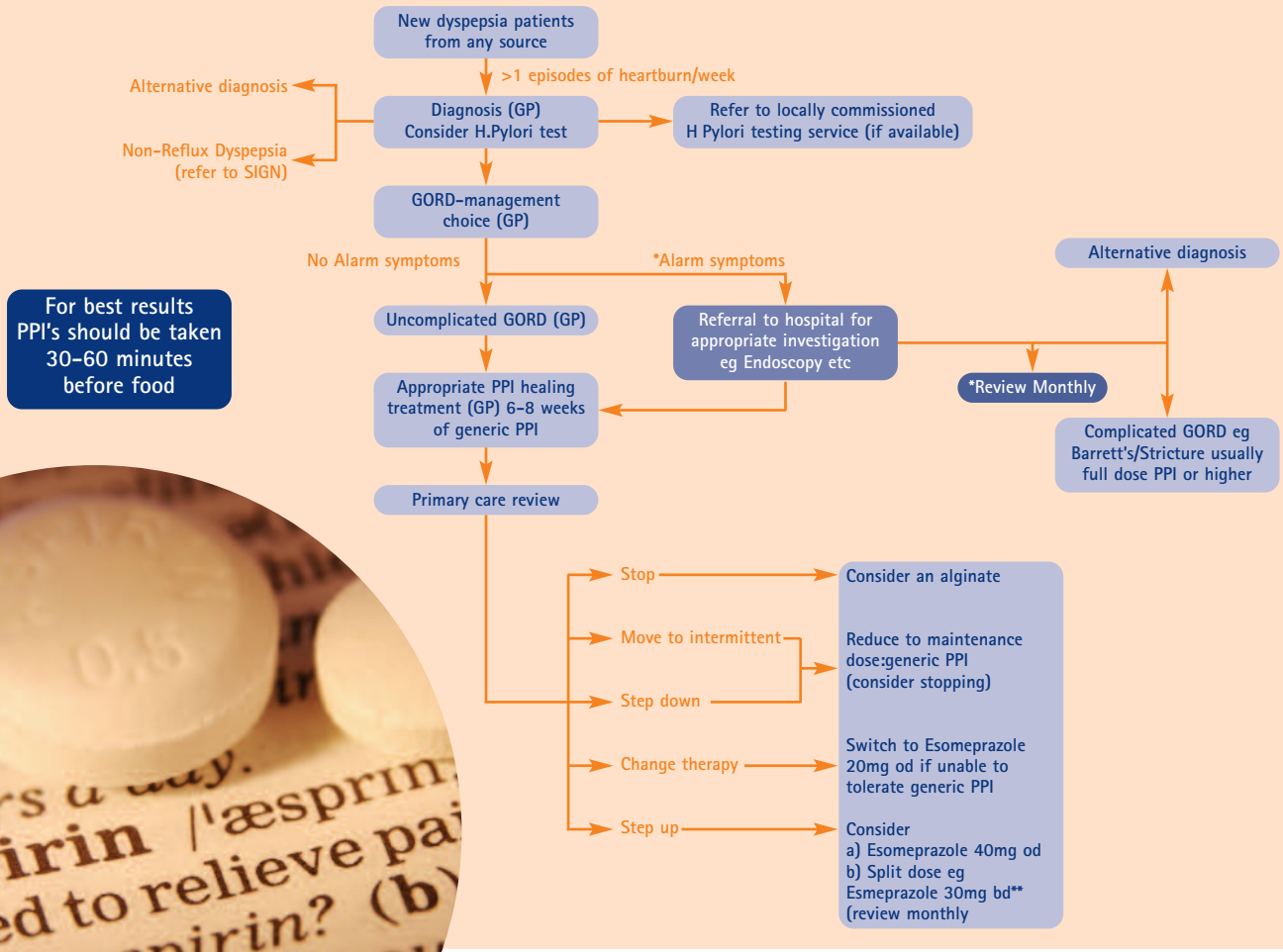
Gastro-oesophageal reflux and integrated care pathways

The biggest issue with treating reflux in primary care is that there are often very poor integrated care pathways where patients can be jointly managed effortlessly between primary and secondary care. As a consequence, we propose one integrated care pathway which we outline in our attached diagram, figure 1. The most important aspect of this integrated care pathway is that most patients, up to 80%, can be managed on low dose PPI where 20% of patients need higher dose and more effective PPI management. It is important to realise that patients put in one group or the other may have to change. As a consequence, patients with longer term reflux disease and those with severe endoscopic changes like Los Angeles criteria C&D or Barrett's oesophagus will have to move from the low dose PPI to the higher dose PPI group.

Large trials underway to address issues of reflux disease management

Patients with Barrett's oesophagus should still be endoscoped every two to three years according to British Society of Gastroenterology guidelines, although the evidence is that this may not be cost effective. To provide the evidence base there are randomised controlled clinical trials such as the Barrett's Oesophagus surveillance study (BOSS) which will be run nationally from the middle of 2007. There is then an issue of what we do with these patients who get severe gastro oesophageal reflux disease and progress to Barrett's. The Aspirin Esomeprazole Chemoprevention Trial (AspECT) is one of the trials in gastroenterology with 50,000 years of follow up (that's 5000 patients to be

Figure 1 - LEICESTERSHIRE INTEGRATED CARE PATHWAY GORD PROCESS MAP



recruited for 10 years). This aims to decrease the conversion rate of 5% throughout the patient's lifetime down to 2_% by using low dose aspirin in a randomised control study with either low dose PPI therapy or high dose PPI therapy. The randomisation schedule is in figure 2.

Primary and secondary care collaboration

We need primary care to work with us in secondary care to make sure that patients are recruited both from secondary care endoscopy units as well as primary care endoscopy specialists. We want both the AspECT and BOSS trials to be representative of communities in both settings.

Conclusion:

Gastro oesophageal reflux is one of the commonest conditions affecting adults in the western world.

The AspECT trial is one of the largest trials in gastroenterology and needs input and recruitment from primary care (please contact the trial office). There is a lack of evidence base and the AspECT clinical trial will provide a way of primary and secondary care working together to provide this.

Severity of GORD

- **MILD** 2-5 episodes heartburn mild/short lasting/week
- **MODERATE** >5 episodes/week heartburn, but not every day
- **SEVERE** Daily episodes heartburn (at least one of: very frequent, long lasting or very painful)

*Review Options

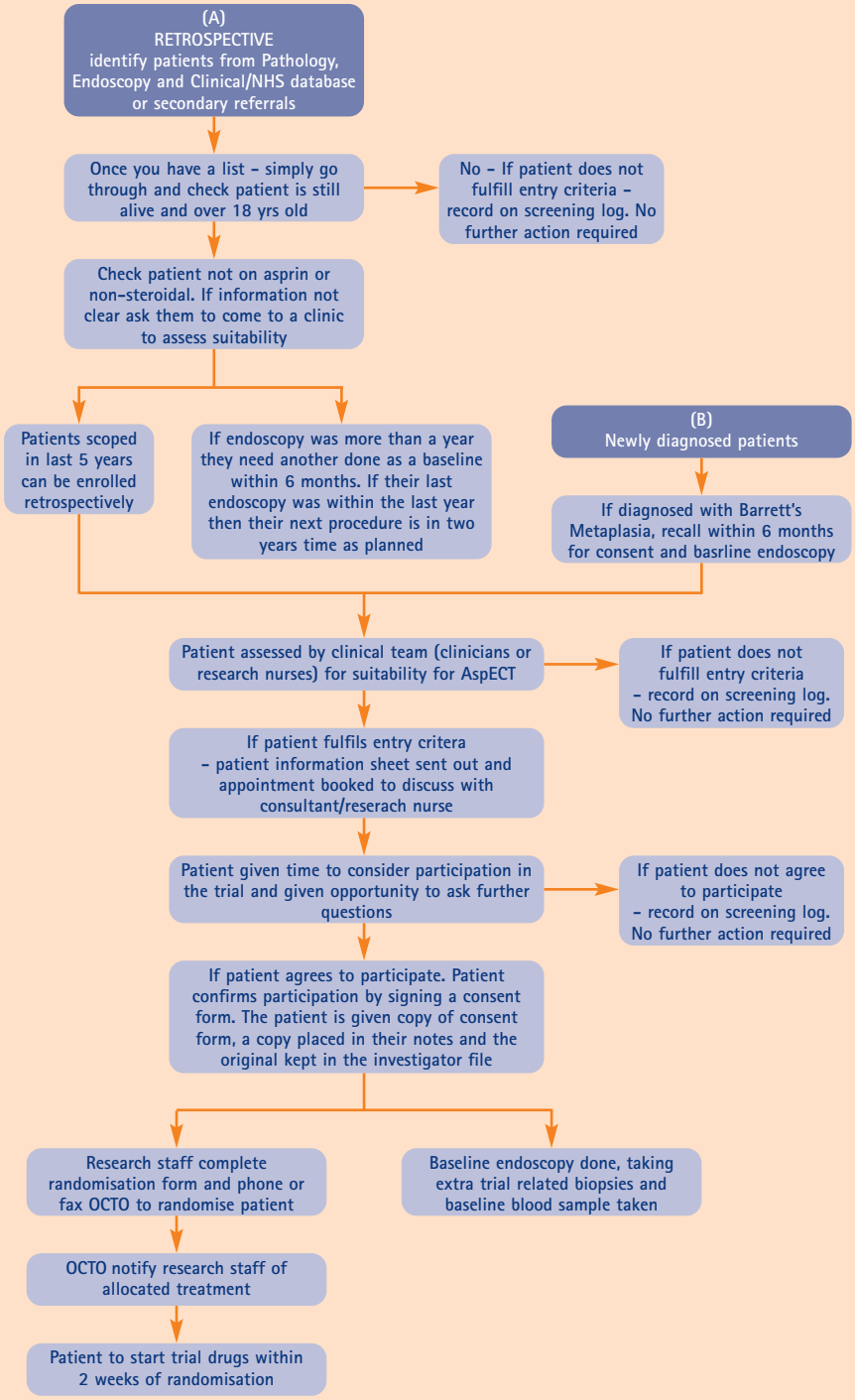
- Failure of response to current PPI therapy – consider trial of more potent PPI eg esomeprazole and/or referral for endoscopy
- Step down therapy if symptoms are controlled

*Alarm symptoms

- Unintentional weight loss =>3kg
- Gastrointestinal Bleeding
- Previous Gastric Surgery
- Epigastric Mass
- Previous Gastric Ulcer
- Unexplained Iron Deficiency Anaemia
- Dysphagia and Odynophagia
- Persistent continuous vomiting
- Suspicious barium meal

**Unlicensed dose

Figure 2 - AspECT PATIENT RECRUITMENT



Esomeprazole 20mg Symptomatic treatment N=1250	Esomeprazole 80mg Strong acid suppression N=1250	No aspirin
Esomeprazole 20mg + 300mg aspirin Reducing 150, 75 if necessary N=1250	Esomeprazole 80mg + 300mg aspirin Reducing 150, 75 if necessary N=1250	Aspirin
Low dose PPI	High Dose PPI	

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NEW CONCEPTS IN GASTRO-OESOPHAGEAL REFLUX DISEASE

Gastro-oesophageal reflux disease (GORD), is a common problem in the community, in the consulting room and in the endoscopy suite. The population prevalence of symptoms consistent with a clinical diagnosis of GORD is probably in the range 10-20% in western societies; lower prevalence rates have been recorded in the Far East and South East Asia, although incidence and prevalence both appear to be rising in these countries. (Fig 1) There is also evidence of a parallel, possibly related, rise in the incidence of adenocarcinoma of the oesophagus in western countries. Lagergren's important paper in the New England Journal of Medicine, published in 1999, (NEJM 1999; 340; 825-831) drew attention to the association between the duration and intensity of acid exposure and the development of adenocarcinoma of the oesophagus.

Figure 1 Global Variation in the prevalence of gastro-oesophageal reflux disease, defined as at least weekley hearturn and/or acid regurgitation

The Montreal Project

Studying reflux disease - its epidemiology, natural history and therapy - has been bedevilled for many years by problems with terminology and the consistent use of definitions. In order to address this problem the Montreal Project was launched by a group of primary and secondary care clinicians and funded by an unrestricted grant from AstraZeneca (who took a completely hands-off stance throughout the development of the project and the publication of the results). In all, 40 primary and secondary clinicians from approximately 20 countries around the world were involved, and a core group (Nimish Vakil from Milwaukee, Sander van Zanten from Canada, Peter Kahrilas from Chicago, John Dent from Adelaide, Australia and Roger Jones, London) undertook a series of careful systematic reviews of all aspects of the definition, epidemiology, investigation and diagnosis of reflux disease. The quality of evidence contained in the papers identified during the systematic reviews was assessed according to the GRADE system, recently published in the British Medical Journal (BMJ 2004; 328; 1490-4). As well as sifting the evidence obtained from the systematic reviews, we undertook a three-stage Delphi process, in which all members of the wider group of 40 clinicians had the opportunity to vote on a series, initially over 50, of statements relating to reflux disease and we finally produced a consensus document which was published in August 2006 in the American Journal of Gastroenterology (AJG 2006; 101; 1900-20).

A new definition of GORD

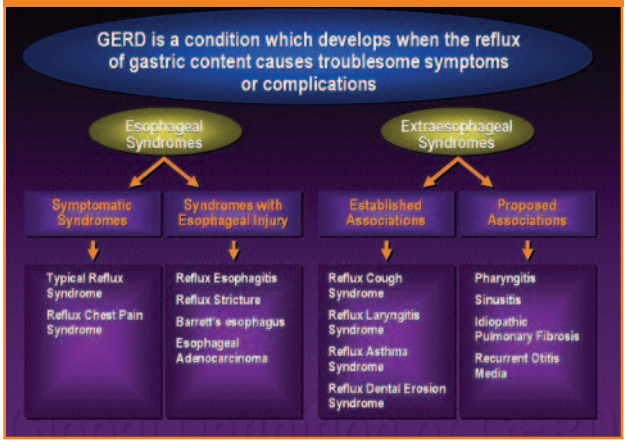
The overall framework in which we described a range of new concepts in reflux disease is shown in Fig 2. In this scheme GORD is defined as a condition developing when the reflux of gastric contents causes troublesome symptoms or complications - the patient is at the centre of this definition and the disease is present when the symptoms are troublesome.

The symptoms created by reflux were then grouped into two broad categories, oesophageal and extra-oesophageal. The 'symptomatic' syndromes include the typical reflux symptoms and the reflux chest pain syndrome, conditions in which acid reflux per se can cause significant problems without necessarily causing mucosal injury (oesophagitis). We abandoned terms such as atypical chest pain or non-cardiac chest pain, recognising that chest pain indistinguishable from ischaemic heart disease could be produced by acid reflux. The second set of oesophageal syndromes were those involving oesophageal injury, and run from reflux oesophagitis, through stricture formation and haemorrhage, to Barrett's oesophagus and on to oesophageal adenocarcinoma. (Figs 3 and 4)

The extra-oesophageal syndromes are grouped into two sections. The first of these are those in which we found good evidence from the systematic reviews of a plausible link between reflux and the extra oesophageal symptom - hence the reflux cough, reflux laryngitis, reflux asthma and reflux dental erosion syndromes. For all of these we found good evidence of a causal relationship with acid reflux.

The remaining associations include pharyngitis, sinusitis, idiopathic pulmonary oedema and recurrent otitis media, for which there is no compelling evidence of an association with reflux.

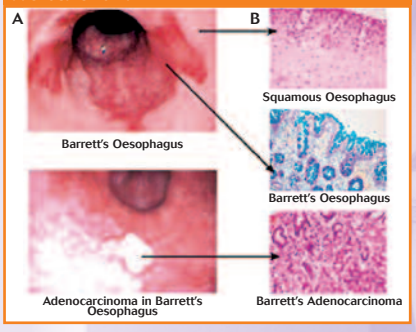
Figure 2



Vakil N et al. Am J Gastroenterol 2006 In Press

Figure 3 Barrett's Oesophagus

Figure 4 The development of oesophaagael adenocarcinoma



Key messages

We were able to distil a number of key messages of particular relevance to primary care that relate to the investigation and diagnosis of reflux disease.

1 GORD creates a high symptom burden, and the definition of GORD, of which heartburn and regurgitation are cardinal symptoms, involves assessing the troublesomeness of these symptoms to patients also in relation to their impact on quality of life.

Implication: a patient-centred approach to definition, a recognition of the importance of exploring impact on quality of life and an awareness of the scale of the problem.

2 The diagnosis of GORD can almost always be made on the basis of symptoms alone; conversely the concept of non-erosive reflux disease (NERD) must be well-understood.

Implication: non-endoscopic diagnosis and commencement of treatment is appropriate. Conversely, negative endoscopic findings in the presence of typical symptoms are consistent with the diagnosis of GORD/NERD.

3 Chest pain, closely mimicking ischemic heart pain, and significant sleep disturbances are frequently manifestations of GORD.

Implication: think about GORD in undiagnosed chest pain and otherwise unexplained sleep disorders.

4 The spectrum of reflux disease runs from symptomatic GORD through the complications of haemorrhage and stricture into Barrett's oesophagus and on to adenocarcinoma.

Implication: GORD is not necessarily a trivial disease, and may be associated with the development, over time, with serious complications, for which duration and intensity of acid exposure, among other factors, are likely to be important.

5 There is a poor relationship between symptoms and endoscopic appearances in GORD.

Implication: An endoscopy in the majority of cases gives poor guidance on therapy and can be avoided, at least initially.

6 Suppression of acid is effective in alleviating heartburn and this provides strong indirect evidence for the association between acid reflux and heartburn.

Implication: use patients' responses to PPI therapy and consequent improvement in quality of life to strengthen diagnosis and to monitor treatment, rather than thinking about doing serial endoscopies.

7 Dysphagia is a common feature of GORD but is only troublesome (i.e. progressive) in a minority of patients.

Implication: take a careful history in patients with dysphagia. Contrast studies and endoscopies should not be knee-jerk responses, and treatment may improve the situation.

8 The new definition of Barrett's oesophagus and the concept of endoscopically-suspected endothelial metaplasia need to be understood.

Implication: important in understanding endoscopic diagnosis and the rationale for including some patients in surveillance programmes.

9 Cough and other respiratory symptoms, including asthma, can be made worse, and possibly initiated, by GORD, although this is unlikely to be the mechanism in the absence of typical reflux symptoms - heartburn and regurgitation.

Implication: Check for GORD symptoms in patients whose respiratory symptoms are poorly-controlled for no apparent reason.

Conclusions

As a result of a series of systematic reviews and an international Delphi process a new global definition of GORD has been generated, which provides fresh information to support better management of GORD, particularly in terms of diagnosis and the use of investigations in primary and secondary care.

PCSG YORK MEETING

The second Northern regional meeting of the PCSG took place on the 9th February in the historic city of York. Delegates were treated to a strong line up of speakers, generating healthy discussion around many topical issues. The absence of the perennial discussions about pay and working conditions was probably due to concerns about bigger threats and challenges ahead rather than any recent improvement in that regard.

Professor Mike Bramble, a PCSG regular, got the ball rolling with a presentation on patient safety, and in particular how we should be keeping the patient central to that ideal, rather than concentrating on procedure driven targets. This is highly relevant with the Colorectal Cancer Screening Programme around the corner for most of us.

Professor James Mason brought the views of an economist to the discussion, and with a healthy cynicism for NICE endearing him to the audience, introduced the idea of the 'health basket', for which all stakeholders in health care should decide on its contents before heading for the checkout.

We were treated to a review of current management of Hepatitis C by Dr Sushma Saksena, under-diagnosed and under-treated by most. Professor Greg Rubin and Lisa Rook presented their theories and practice for engaging the non-compliant IBS sufferers. With small numbers of patients in most General Practices perhaps an area where PBC may be helpful. Dr Simon Smale gave us guidance on difficult dyspepsia patients, increasingly prevalent in practice it seems as the rate of Helicobacter infection fall. Dr Raghu Raghunath presented his work on repeat PPI prescribing. PPI'S, an area where PCT Pharmacists interfere significantly, yet patients probably instinctively self-medicate.

The meeting was rounded off in style by Dr Sean Kelly, who gave us an update on current thinking about the management of Barrett's Oesophagus, and his own criteria for screening. I'm not too sure Homer Simpson would make a great Health Secretary though!

All healthy evidence of a thriving, enthusiastic and committed band of GP Gastroenterologists north of the 'Watford Gap' and we are all looking forward to next years Northern Regional PCSG meeting.

Dr John Kilgour, GP, Leyland, Lancashire

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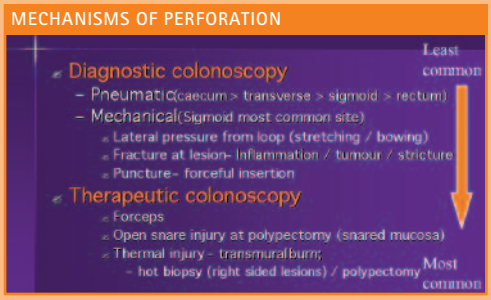
Patient Safety

Implications for Endoscopic Procedures

Continued from page 3



The commonest site for a perforation, 64%, is in the sigmoid usually due to stretching, blind intubation with too much force or intubation of a diverticulum. 13 % occur in the caecum due to polypectomy because of the thin wall.

Haemorrhage is the commonest serious complication of therapeutic colonoscopy. It occurs in 1.6% of therapeutic procedures and can happen up to 2 weeks post procedure. The mortality from haemorrhage is 1 in 10,000. It is important to stop warfarin and aspirin before and leave off for at least a week after a therapeutic procedure. Polyp size and sessile nature increases the risk of post polypectomy haemorrhage.

Are complications avoidable?

In the aviation and nuclear industry risk reduction is taken very seriously and they have developed a system for assessing and reducing errors. It is called the HEART method which is an acronym for human error assessment and reduction technique. It is a comparison based method for assessing error and the relative strength of causes on the likelihood of making that error and puts a numerical score on the risk. Having estimated the probability of mistake, HEART identifies ways of prevention.

Applying HEART to endoscopy, the main contenders for causing error are unfamiliarity due to inexperience, new techniques or being faced with an unusual condition. Unfamiliarity increases the risk of complication by a factor of 17 times. Other error producing factors are time shortage, not heeding warning signs, distractions in the endoscopy room and inadequate information about the patient such as not reading the medical records thoroughly beforehand. On average these elements can individually increase the risk by a factor of 10. The risks multiply rather than add, so if unfamiliarity (17X) and time shortage (10 X) co-exist the base line increased risk is 170.

Complications decrease with experience of the operator, as would be expected, with 85% of then occurring in the first 40 colonoscopies performed by an endoscopist.

By acting on the likely causes of errors occurring during endoscopy we can hopefully avoid many of the complications.

Event Diary

26/29 March 2007
British Society of Gastroenterology, Glasgow

Sat 30 June/Sun 1 July 2007
Endoscopy Meeting, Brighton

12 October 2007
Annual Scientific Meeting/AGM, RCP, London

Community ENDOSCOPY

Continued from front

ETD3 Washer-Disinfector and in April 2006 we were open for business again. We are aiming to see 400 patients a year for Flexible Sigmoidoscopy but have the capacity to expand further. We are also looking into the possibility of providing a non-sedated Gastroscopy service, but to do all this will need some more dedicated Endoscopists, so if you are in our area and would like some endoscopy work; give us a call!

So, Community Endoscopy – an Oxymoron? Not any more. Ten years ago we were fairly unique but these days, as more and more community units open, we are proving that we can and do provide a very valuable service for patients. Our October GRS scores showed us that our standards are on a par with our local acute trusts and shows that in some areas we can provide a better service too.

Author Jacqui Pountney is the Endoscopy Sister at Bridge Cottage Surgery, Welwyn Garden City, Hertfordshire.

Reference: 1 HTM2030 – Health Technology Memorandum 2030 (1997) Washer Disinfectors NHS Estates:London

Jacqui says "As for HTM 2030 -. It's a nice thick document all about washer disinfectors (WD) and legal requirements and all that is necessary to be compliant with existing and anticipated legislation and standards. Our PCT infection Control Nurse brought it to my attention first off but all the WD companies know about it and can quote reams to prove that their machine is the best! It is actually impossible to be fully compliant with it as you would have to be able to weigh the machine before and after each washing cycle to prove that there was no residue water in any pipework, and a hundred other nonsensical things like that! It does give you a framework to build your spec to for the WD of your choice though and as some of it is a legal requirement as far as it goes; it does need a bit of reading. I have to confess to have been selective in my reading as it's not the most exciting read!"

Readers! Any gastro trained SpRs in the Hertfordshire area who have switched paths to enter general practice? Contact Jacqui at jaconline@btinternet.com

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