FEBRUARY 2009

Gastroenterology IN PRIMARY CARE

JOURNAL OF THE PRIMARY CARE SOCIETY FOR GASTROENTEROLOGY

Report from the PCSG

Endoscopy MEETING

EAST MIDLANDS CONFERENCE CENTRE, NOTTINGHAM - 26 NOV 08

The Primary Care Society of Gastroenterology (PCSG) endoscopy meeting in Nottingham provided the opportunity for primary care endoscopists to learn more about and discuss a wide variety of topics, including the use of transnasal gastroscopy, the evolution of practice-based commissioning and issues of patient consent, an overview of bowel cancer screening and the latest on the accreditation process that is coming into play for endoscopists.

Transnasal Gastroscopy

Dr Steve Fox, GP, Little Waltham, Essex

Transnasal gastroscopy, as an alternative to oral endoscopy, has been proposed to improve patient tolerance, enable unsedated procedures in the majority of patients, reduce procedure room time and allow for better communication with patients.

The use of this approach by gastroenterologists sharply varies between countries: while it is dramatically increasing in Japan, the adoption of this technique in Western countries has been slower.

Patient experiences have been favourable, with it described as a pain-free experience in which the gag reflex is not triggered and in which patients can breathe comfortably and talk normally throughout the procedure. Around 90% of patients prefer transnasal gastroscopy to oral endoscopy. The recovery time for patients is no different from oral gastroscopy and patients can drink straight after the procedure and then go home.

There a few disadvantages associated with the procedure, but these can be largely overcome. They include epistaxis in <1% of patients, which is usually minor and self-limiting, some degree of nasal discomfort, smaller biopsy samples (overcome by taking more samples) and a slightly smaller visual field.

Preparation of the patient includes spraying each nostril with 5% lidocaine and 0.5% phenylephridine prior to the insertion of a 5.3mm nasal catheter coated with 2% lidocaine into the most patent nostril. The patient then lies in the conventional left lateral position and the nasal catheter is removed immediately prior to intubation. The endoscope is guided along the middle meatus, along the line of least resistance and proceeds conventionally once the epiglottis is identified.

Several studies indicate that success rates are high (~90%) and the procedure is tolerated in around 98% of patients without complication.

With appropriate training and equipment, this procedure offers a viable alternative to traditional oral endoscopy that is more likely to be accepted by the majority of patients.

Continued on page 4

This issue...

EDITORIAL

This New Year 2009 issue of GiP focuses on endoscopy and GPs (no surprises there). My last editorial coincided with a global high spot when Barack Obama was elected US President; this one could be thought to emerge from a corresponding low when we have plunged into recession with the hitherto strong British pound devalued and wobbling and almost overtaken by the euro. But hard for snow lovers like me to be down in the dumps when the UK has experienced its first decent snow dump in many years, causing problems admittedly but giving a refreshing breath of air promising renewal to the bright landscape outside the window!

On the front page of the last issue I hope you read Dr Andrew Summers' article about the assessment and revalidation of GP endoscopists. Rather than seeing this as a threat, it is an opportunity for GPs practising endoscopy to lead the way with systematic appraisal and revalidation. Andrew has put himself into the firing line by representing the RCGP (and PCSG) at JAG, the Joint Advisory Group of the Royal Colleges and associated groups which was originally established to set the standards for endoscopy training. JAG is now looking to expand its remit to include the appraisal and re-validation of established endoscopists whatever their clinical grade and wherever they work. Andrew has also become accredited as a screening colonoscopist, and as an assessor of colonoscopists applying to be screeners, no mean achievement for a GP since the bar is set high.

The first GP endoscopist appraisal pilot has now taken place this month in Torbay Hospital endoscopy unit. Four GPs volunteered themselves as appraisees (like lambs to the slaughter?) and were appraised by two consultants and two GPs (including Andrew). As one of the lambs I can relate that the experience was certainly stressful but also rewarding and educational. One of the greatest things about medical practice is that there is something new to be learned from every working day, and it was good to learn some omissions and new tricks for my own practice after more than 30 years of doing 'gastroscopies'. There is a short feedback on the experience from Dr Mike Cohen (also Bristol) and myself on page three of this issue.

Current news from Andrew Summers is that "the second day will be in April and follow the same formula but with more structure and we will include lots of points from the first day such as providing a tour of the unit, introductions to the nurses, summary sheet of the patient's problems and co-morbidity, sending out a copy of the consent form with the programme details, requesting the audit data before the day etc. We are, of course, only looking at upper GI for the moment, but plan to include sigmoidoscopy and colonoscopy in due course although the number of practitioners is smaller."

The centre pages carry a highly informative endoscopy quiz put together by Dr John Galloway (Kings Lynn) with answers on page 10, and a report from the PCSG Endoscopy symposium from November 2008. Dr John O'Malley (Wirral) has written an excellent article on informed consent in this issue which should be heeded by every endoscopist. If something goes wrong, much will hang on how the patient's consent was obtained. This issue should therefore provide a useful resource for GP endoscopists, many of whom work in isolation whether in hospital or community settings. Our total numbers may have halved since the surveys of the mid 1990s so it is an aim of the PCSG to be in regular touch with every GP endoscopist, but if we don't have an email address (or postal address) for you we shall not succeed. Please do make sure that we know where you are, and something about your endoscopy situation.

Dr Richard Spence

The Society would like to acknowledge support from the following members of the Corporate Membership Scheme:

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TORBAY HOSPITAL - 23 JAN 09

GP Endoscopist

PILOT APPRAISAL DAY

Dr Mike Cohen, GP Endoscopist in Bristol, wrote this feedback from the day:

Preparation

I was keen to get involved with this pilot as I have never been formally appraised in endoscopy. Indeed currently I rarely see a consultant colleague and my parallel list is done by an experienced nurse practitioner who tends to ask me for guidance.

This appraisal would be only for upper GI endoscopy. I received a letter outlining the plan for the day and giving me some things to consider prior to my appraisal.

These included:

- Number of procedures done
- What procedures did I do?
- Did I have a supervisor or mentor?
- What contact did I have with other endoscopists?
- Percentage retroflexion to view cardia?
- Percentage D2 intubation?
- Mean sedation rates?
- Complications?
- Significant events?

I was asked to consider how I kept up to date and what I read.

A summative upper GI Endoscopy DOPS assessment form was sent for my perusal.

I needed to produce evidence for Hepatitis B immunity and sign a form to allow me to be given a contract with the local NHS Trust for the day. I had to declare all criminal convictions.

On the day we were met by the appraisal team and had coffee and refreshment - much needed after an early start. Whilst one of us had a discussion regarding our 'endoscopy portfolio' the other had his DOPS assessment. I should add I do not have an extensive upper GI endoscopy portfolio and now only keep records for colonoscopy procedures. **Perhaps I need to reconsider this.**

My discussion was wide ranging and quite challenging. My appraisers wanted to know what I was doing and how I managed particular situations. Was I aware of recent guidelines and local policies with respect to patients taking anticoagulants management of endoscopy in patients with diabetes? I was given some clinical scenarios to discuss. Governance issues regarding the management of acute GI bleeds in my hospital was also discussed. The discussion lasted an hour and was formative and helpful.

I was then **observed** performing two upper GI endoscopies from start to finish. This included consenting the patient. Time was then devoted to constructive feedback.

I then had a final session with my appraisers discussing and writing my **personal development plan** for the forthcoming year.

The delegates then joined the appraisers for lunch and there was a round robin discussion about appraisal for GP endoscopists and the logistics of getting it up and running nationally.

It was a stimulating morning but also a bit nerve racking. I liken the endoscopy experience to playing golf on a course you don't usually play, with hired clubs and with guys you don't usually play with. It can affect your game but the appraisers were aware of this and told us they do take it into consideration.

It has however focused my mind and lit a few fires. I returned to my next list feeling very focused and enthusiastic.

If there is an opportunity to get involved in the pilot I'd grab it.

Dr Richard Spence, GP Endoscopist, also from Bristol, wrote:

It was a good day and surprisingly stressful even for experienced endoscopists! A bit like a mini version of Finals... but in fact an inevitable feature of an appraisal.

The arrangements, welcome and endoscopy environment could not be faulted. The experience of performing in a different environment was enjoyable and the points of difficulty related to unfamiliar notes, unfamiliar consent form (particularly), and different 'kit'.

We did not have to cope with a different reporting system. The experience mirrored my own real life experience of 'being moved' from one hospital to another two years ago with no induction whatsoever and where there was NO reporting system (for five years) so had to handcreate a simple Word based report on the spot, or hand-write (like most Consultants), and where pathways for patients with serious diagnoses were different and where in fact no GP reports or histology were sent out for six months+ from my lists (all amended and functional now!)

My learning points from the day were:

1 Proper evaluation of the patient's comorbidities and drug treatment, (operator "nerves" probably caused this omission, ie not normal practice!)

2 L hand position on scope, umbilical outside wrist, helps one hand control of up-down, left-right wheels, as in colonoscopy

3 Suck tip dry pre-intubation to avoid any tracheal spill causing coughing

Re **2** and **3**, it's GREAT to learn new tips even after 35 years of practice!

The hour's personal discussion led to two particular aspirations:

1 Desirability of attending local user group meeting - I would hope three monthly

2 Desirability of shared/supervised list twice a year. This needs to be properly provided with fewer points than a standard service to enable learning/discussion

Naturally the appraisal process comes with a considerable price tag for unit/appraiser/appraisee time and backfill and this needs to be costed into service delivery planning.

Ideally an appraisee who does 'tops and bottoms' could be appraised for both on the same day with two of each. Where concerns arise there needs to be pathways for refresher learning and reassessment.

Continued from page 1

GMC consent issues

Dr John O'Malley, GP, Moreton, Wirral

John O'Malley's full article on Consent appears on page 8 so the summary here is abbreviated but contains some practical matters that will help endoscopists.

This year the General Medical Council (GMC) published guidance on consent, setting out principles for good practice in making decisions.

Principles for good practice in making decisions (GMC)

- **Listen to patients and respect their views about their health**
- **Discuss with patients what their diagnosis, prognosis, treatment and care involve**
- **Share with patients the information they want or need in order to make decisions**
- **Maximise patients' opportunities, and their ability, to make decisions for themselves**
- **Respect patients' decisions**

Consent should be requested by the physician undertaking the endoscopy and not junior members of staff. This makes logical sense, since this person is best placed to explain the procedure and its associated risks and more able to answer patient questions. (However in many units trained nurses obtain the patient's consent before the patient meets the endoscopist.)

Consent is usually agreed in written form. However, many patients (~70%) never read the consent form that they have signed. Giving and getting consent is a process, not a one-off event. It should be part of an ongoing discussion between the doctor and the patient.

Digesting and implementing the new GMC guidance will be essential in the management of patient consent in the future and 'serious or persistent failure to follow this guidance will put your registration at risk.'[1]

Practiced based commissioning

Stewart Findlay, GP Bishop Auckland, County Durham

There are a number of opportunities in practice based commissioning (PBC) and payment by results (PBR) for primary care. However, many primary care practitioners are asking why they should get involved in PBC since PCTs have seemed reluctant to include them in the process. Government aims for the NHS have been outlined, whereby money will follow patients through a tariff-based system involving self-governing independent hospital trusts that will include practice-based budgets.

So it would seem that PBC is here to stay. It has cross-party support, is central to the recently publicised world class commissioning and the Darzi next stage review and has support from around 63% of general practitioners (GPs).

PBC was set up initially to establish a balance between PBR and a primary care budget. In practice, the budgets have been indicative budgets and do not always reflect practice needs. In theory, a practice can keep 70% of any efficiency savings it makes by PBC, but it has to use them to improve services for patients.

Practices may choose to work alone but it is often best to work in groups or networks to improve efficiency, achieve economies of scale and to work together in areas of service redesign. In theory, any group of clinicians can take on a budget but, in practice, it is likely that, at least initially, only those general practices with sufficiently developed infrastructure will be able to manage one effectively.

Budgets will include the costs of community staff, mental health care, all prescribing and all PCT management costs. Specialist services and commissioning are excluded, pay and independent contractor budgets.

PBC groups are responsible for dealing with negotiations with acute care trusts and local authorities. As a result there are opportunities for joint care, pathways and protocols between primary and secondary care. Therefore PBC can act as a lever to push people together in order to provide better services for patients.

At the forefront there will always be a need to provide best value for money and best value care, with choice for patients.

World class commissioning has presented a number of challenges for PCTs which have to demonstrate that they are competent as commissioners and can deliver this agenda. In order to do this they will have to collaborate with clinicians, engage with the public and fuel the market. Many PCTs are not managing to achieve this and it is hoped that this will be a stimulus for PCTs to start engaging more with clinicians and to listen to their point of view.

Darzi's vision for primary community care emphasises the need for a customer focus and that it is not enough just to offer efficient services. Patient education, involvement and choice, and the introduction of patient-controlled budgets for long-term conditions have been proposed. The onus is on GPs to get involved not only in the provision of care but in the commissioning of care within PCTs and the development of clinical leaders.

In County Durham a quality contract has been developed to address many of the issues that were important to primary care clinicians. It set out the standard of service GPs and their patients could expect from hospital-based services but also detailed the service secondary care colleagues could expect to receive from primary care, particularly around the quality of referral letters and pathways of care.

Being a provider is foremost in most GP's minds and practices who wish to develop and provide a service through PBC must submit a business case to their PCT for assessment and approval. Ultimately, the role of the PCT in the future should be to license providers and ensure free choice for patients.

The future of PBC will include more local services, more competition and the development of integrated care organisations.

Bowel cancer screening

Professor John Scholefield, Professor of Surgery, Nottingham University Hospitals, Nottingham

There is compelling evidence to show that screening for colorectal cancer can save lives. Colorectal cancer is the third commonest malignancy in the UK, is equally prevalent in men and women, and usually occurs in later life (aged 60-70 years). The recent decrease in mortality in recent years may reflect a tendency towards earlier diagnosis, possibly as a result of increased public awareness of the disease. Surgery remains the mainstay of treatment for colorectal cancer, but early diagnosis makes it more likely that the tumour can be completely resected and thereby improves the chance of a cure.

Early diagnosis in colorectal cancer is challenging because the symptoms of bowel cancer are very similar to the symptoms of a number of benign bowel conditions such as

haemorrhoids, irritable bowel syndrome and diverticular disease. Most colorectal cancers will occur in people between the ages of 65-75 years, but the peak incidence for adenomas is slightly earlier at 55-65 years of age. Thus screening for colorectal cancer should target these age groups. In addition, there are some individuals in the population who will have inherited a much higher susceptibility to colorectal cancer. These individuals tend to develop colorectal cancer before the age of 50 years and, therefore, screening for these high-risk individuals needs to be tailored to their individual risk pattern.

The vast majority of colorectal cancers result from malignant change in polyps (adenomas) occurring in the lining of the bowel 10-15 years before malignant change occurs. The best available evidence suggests that only 10% of 1 cm adenomas undergo malignant change after 10 years. The incidence of adenomatous polyps in the colon increases with age, and although adenomatous polyps can be identified in up to 20% of the population, most of these are small and unlikely to undergo malignant change. There is a relatively long time course for malignant transformation from adenoma to carcinoma and outcomes are markedly improved by early detection of adenomas and early cancers. Thus there is great potential to reduce the mortality from this disease by detecting adenomas and early cancers through screening asymptomatic individuals. The vast majority (90%) of adenomas can be removed at colonoscopy, obviating the need for surgery.

In order for a screening test to be applicable to large populations, it has to be inexpensive, reliable and acceptable. Faecal occult blood (FOB) tests, which detect haematin from partially digested blood in the stool, are the most extensively studied screening tests for colorectal cancer. The overall sensitivity of FOB tests is around 50-60%, though their specificity is high. In screening studies using FOB tests, individuals were invited to take two samples from each of three consecutive stools. Compliance was around 50-60%, but with population education this could be improved significantly. Individuals with more than 4/6 positive tests need colonoscopy. Several large randomised studies have shown that FOB screening is feasible and two studies have shown that such screening reduces mortality from colorectal cancer. In the Nottingham study, for every 100 haemoccult-positive individuals, 12 had cancer and 23 had adenomatous polyps. The screen-detected cancers tended to be at an earlier stage than those presenting symptomatically. The downside of FOB screening at present is its relatively low sensitivity which means that some cancers will be missed on each round of screening. The Nottingham data suggest that screening every 2 years only detects 72% of cancers. There has been a move towards more sensitive immunologically based FOB tests in mainland Europe, but these are ten times the cost of current FOB tests. Computed tomography (CT) colography is another potential screening tool. It is unlikely that either of these will be used for population-based screening programmes, mainly because of cost.

Safety and Medical Aspects of Endoscopy

Roger Leicester, Trust Director of Endoscopy, St George's Hospital, London

Sharing good practice is one of the cornerstones for improving endoscopy services and patient care. St George's endoscopy unit, led by Mr Roger Leicester, has been influential in the redesign of endoscopy services and the Joint Advisory Group on endoscopy (JAG). JAG, representing all professional groups involved in endoscopy, remains an extremely important part of the infrastructure of endoscopy in the UK.

St George's endoscopy unit have made many changes in their endoscopy service process in order to reduce waiting times and to improve quality for patients. Many of the changes that have been made in the development of St George's services are improvements championed by the endoscopy Global Rating Scale (GRS). All endoscopy units are now strongly encouraged to use the GRS to identify and prioritise areas in need of attention. Great strides have been made in the development of the GRS. It has been underpinned with measures to improve its validity, and a web-based reporting system has been created to make completion and review of results more straightforward. The GRS has achieved widespread acceptance and significant improvements in the scores of all twelve items of the scale have been achieved by many groups.

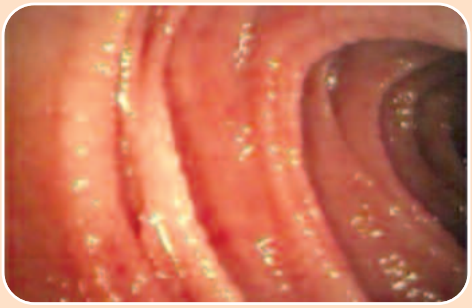
Providing an effective endoscope decontamination service within a safe environment is an essential requirement for every endoscopy unit. A quality assurance tool has been designed to encompass all the decontamination standards in a format that would be relevant to end users and which can be used by endoscopy teams to self assess their decontamination environment and processes against national standards.

A major part of the work of JAG has been developing the accreditation process for bowel cancer screening and training. This accreditation process integrates an assessment of service delivery and training. Both competence and performance are assessed as part of this process. Competence refers to a level of expertise sufficient for independent practice. Performance provides an indication of how good an endoscopist is. The accreditation process will be mandatory for those units wishing to participate in the Bowel Cancer Screening programme and for those seeking accreditation to deliver training. It is also anticipated that all individuals who have not received a certificate of competence as a trainee will have to be re-validated.

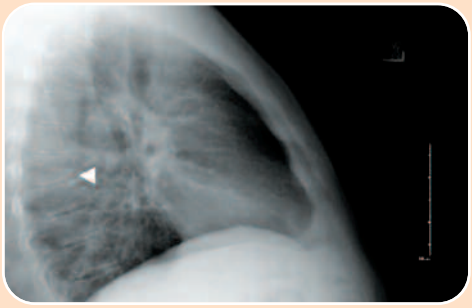
Reference 1: http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance/Partnership.asp

Lesion Recognit

1 Patient presented with backache, what is the diagnosis? What technique is shown in the second picture?



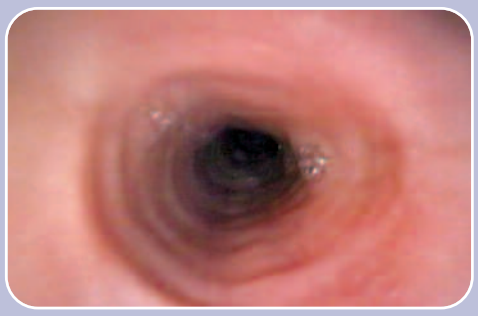
2 Cause of patient's backache?



6 Patient started this condition of the colon after treatment for an infected ingrowing toenail

7 Diagnosis?

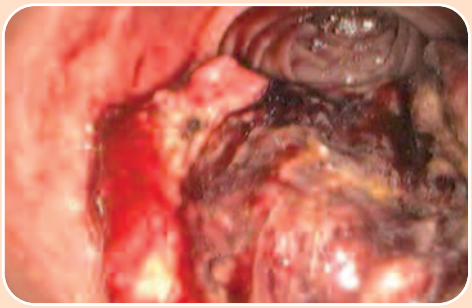
8 This 28 year old has suffered with dysphagia for 10 years



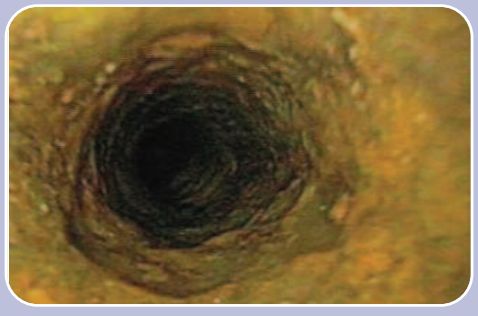
12 Cause of rectal bleeding?

13 58 year old smoker presents with abdominal pain & bloody diarrhoea

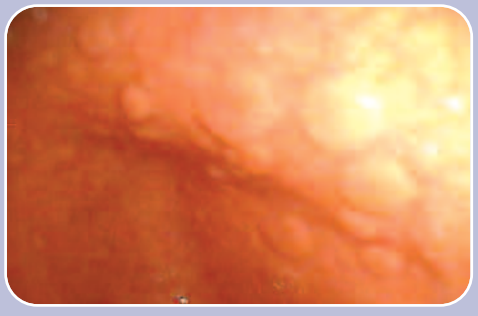
14 Duodenal lesion, patient visited a dermatologist 3 years previously



18 What's this oesophageal condition called?



19 Appearance in stomach of 19 year old girl who presented with haematemesis

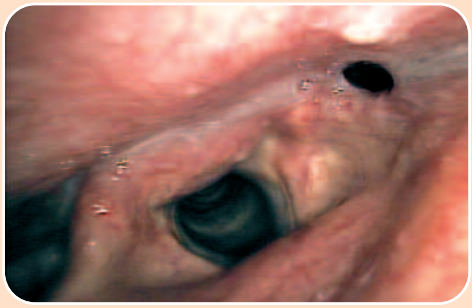


20 Diagnosis?

ion Quiz

Dr John Galloway from Kings Lynn produced this quiz for the GP Endoscopists Symposium in Nottingham. **Answers on page 10...**

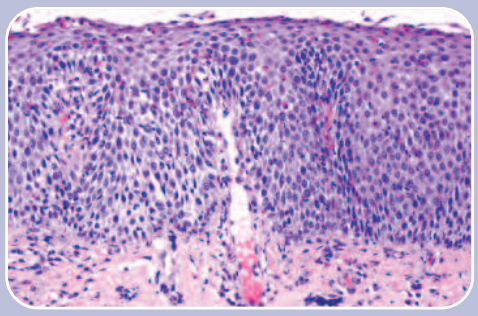
3 Presented with choking episodes



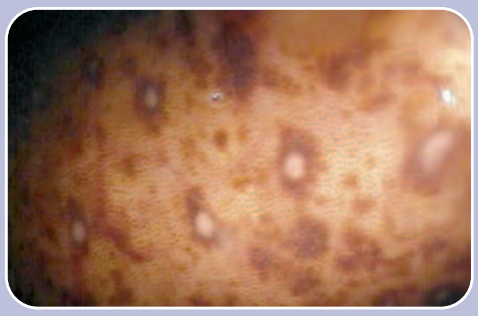
4 Husky voice

5 Cause of rectal bleeding and tensmus?

9 Histology from previous picture, what does it show?



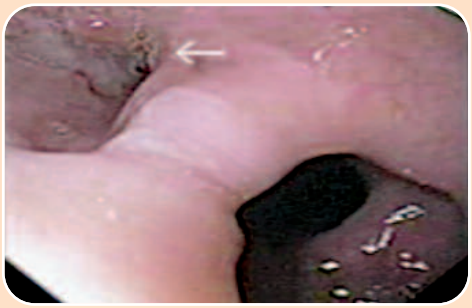
10 Appearance in the colon, what symptom is patient suffering from?



11 Lesion in colon?

15 What are these gastric lesions in a 48 year old lady with PH of Ca breast & recent onset of dyspepsia?

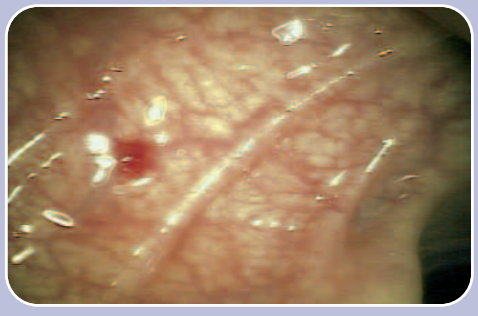
16 Appearance of oesophagus in patient on infliximab? Diagnosis?



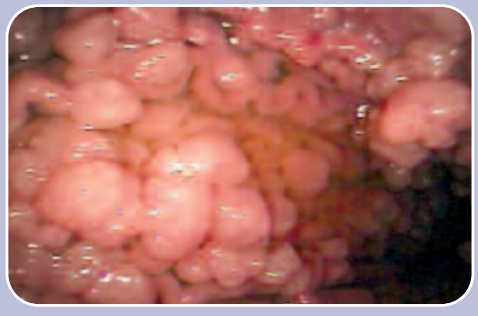
17 Barium swallow of the same patient

21 What are these lesions called in a hiatus hernia?

22 Presented with iron deficient anaemia



23 What are these gastric lesions?



CONSENT

The whole truth or only a bit of the truth?

Sometimes words or phrases are used so widely that we fall in the trap of thinking we are all using the same meaning. Children often have a simplistic way of looking at words which often extends into adulthood. The word 'suffer' as in 'suffer little children to come under me' always had connotations of pain until I was told it meant allow. In much the same way, we all assume we know what consent means but as I will explain, what we assume is not necessarily the truth.

To start with, we have to go back to first principles and see why it is so important and will continue to be. The importance of consent comes from the foundations of the very law itself. We all have a fundamental right to have our bodies protected from the interference of others. The importance of this is backed up by law with exceptions having to be strongly justified as in lawful arrest. It is further backed up by the law with serious consequences such as civil actions for damages and even criminal charges of assault. It has further been enshrined in the Human Rights Act which has incorporated Article eight of the European Convention on Human Rights. In much the same way exceptions have to be justified to contravene such rights, consent must satisfy certain qualities.

Consent should be:
- **Voluntary**
- **There must be a competency to consent**
- **The patient must understand the nature of the treatment**

Voluntary does not just mean the patient must agree but also he must be free from all influences. The latter is important in endoscopy as some endoscopists, often for reasons of space, still consent in the endoscopy room. This places undue influence on the patient with the patient feeling he/she is holding up proceedings by asking questions or even questioning the consent form.

Competency to consent would take up another article but it has to be remembered that competency is issue specific. That means that although a patient may not be able to make rational decisions in one field of life, it does not mean there is a lack of competency overall.

The final piece needed for consent is that the patient must understand the nature of the treatment or procedure. In other words, the patient must give informed consent.

Before we ask how much or little we should tell patients to make them **informed**, let's explore how we got to this point.

Over the centuries, it was very rare for a doctor to discuss risks or benefits of treatments or procedures. In fact, Hippocrates believed they should be told as little as possible.

'Perform your duties calmly and adroitly, concealing most things from the patient while you are attending him... turning his attention away... revealing none of the patient's future or past condition.' This even became part of the Hippocratic oath and it wasn't till the 20th century and the Declarations of Helsinki and Stockholm that it was felt important to inform patients. Over that same century, a shift began where the autonomy of the patient became more important and this was heightened after the Nuremberg Trials. Autonomy, coming from the Greek 'auto' or self and 'nomos' or law, literally means self rule. Along with the other aspects we discussed before, autonomy, for it be real, needs to be fed by access to information or else it is a sham.

Why else did informed consent become important? The early days of medicine often had one treatment for one or sometimes many illnesses, as in bloodletting. As medicine progressed, multiple treatments became available for specific diseases thus changing the decision away from yes/no to which. Since each treatment had its own success rates and risks, someone had to make a decision and doctors became aware that a paternalistic approach was not taking into account the priorities of the patient. For example, the treatment for carcinoma of the larynx is either radiotherapy or surgery. The latter gives a longer survival at the price of losing one's voice. The former might preserve the voice but gives a much shorter lifespan to the patient. The choice depends on what is more important to the patient. What choice would a patient who enjoys singing make?

There has also been a change in the doctor/patient relationship. The former relationship based on the imbalance of knowledge is slowly being eroded with better education and the internet (good and bad). The problem is that there is too much information and the role of the doctor in the future may well be to be guide rather than a fountain of all wisdom. The role of the law could be said to be the bridge imposing upon doctors a duty to provide such guidance.

This is, on the face of it, a good thing. Better informed patients are more likely to be compliant with therapy where they have a role in the decision and tolerate side effects better when they are warned. Doctors learn to communicate better and the relationship becomes one of trust rather than one based on an imbalance of knowledge.

But there are problems. The first is the very term 'informed consent'. It is really composed of two different actions, the first is to get the patient's consent to a procedure and the second is to adequately inform him/her of the risks and benefits involved. So who is informed? It is not clear whether informed means the information given or what is understood. Also it's not clear at what point the uninformed becomes the informed, bringing us to the thorny subject of when is enough, enough?

The legal profession has a different attitude to truth than the medical profession. The phrase 'The truth, the whole truth and nothing but the truth' underpins the whole legal system with the serious crime of perjury awaiting those who try to undermine it by lying.

Contrast that with the following scenario. If a doctor was in the witness stand and the patient was the barrister, the doctor/ patient relationship would certainly become strained. We take pride, sometimes, in our clouding of the truth even portraying it as therapy. We cite the worry, full

disclosure may cause as reasons not to tell the whole truth along with the concerns we may confuse patients (God forbid they make the wrong decision i.e. the one we want them to make!) and that, with some justification, it would take up too much time. The extra burden put upon patients at a time of distress also weighs heavy on some doctor's minds.

Where is the point of balance between telling too little and telling too much? The rules, based on common law, are murky to say the least and require the ability to look into the future. The courts would say that a doctor should disclose what a normally prudent doctor would disclose. But this paragon of virtue can only know he has said enough when the court has decided he has. There is also the danger that by giving too much information we will actually inhibit genuine communication and reduce understanding. The consent process could take longer than the procedure!

Various ways of improving communication have been developed including the advent of written information. However, these are often not read and patients have been shown to have a poor recall of what has been read. There is also the real danger that the information is 'spun' in such a way to highlight the benefits and downplay the risks. How much is understood is also questionable. A paper from Byrne et all showed a worrying lack of understanding after consent with 27% not even aware of what organ was being operated on and 44% unaware of the basic facts of the operation.[1] Another paper found that 70% of patients don't even read the consent form.[2]

There is also confusion as to what does not need to be disclosed. It is often said that **obvious risks** such as death from general anaesthetic are so widely known they do not need to be mentioned. However, who says they are widely known and surely as this is the most serious risk, it should be mentioned? The need to mention haemorrhage and infection are also debated again on grounds of being obvious but others would say disclosure means that patients may recognise the signs earlier.

Should we mention our level of experience? In former times, the need to disclose how many endoscopies you had done, complication and success rates would have not crossed most doctor's minds but following the Bristol heart scandals, will doctors have to? After all, personally, wouldn't we all want to know how experienced someone was in the procedure we are about to undergo?

There is endless debate in the courts on how much should be told with one side believing that it should be based on what a reasonable group of doctors would say is a significant risk (shades of medical paternalism) or what a patient considers a significant risk taking into account their priorities in life. Reduced risk does not mean reduced importance. A tiny chance of a temporary hoarse throat following intubation would mean very little to most patients but a great deal to an opera singer.

There is also the further question as to who does the consenting. As much as possible, the person doing the procedure should consent or if not, the delegated professional should be adequately trained. One study showed that 37% of junior doctors were obtaining consent for procedures of which they, themselves, had little knowledge.[3]

The GMC in 2008 brought out a set of guidelines reaffirming the importance of giving patient as much information as possible but left open what level that was.[4] However, it did remind us how far we had come form the days of Hippocrates when it stated that; *"Serious or persistent failure to follow this guidance will put your registration at risk"*

Despite the above, very few cases get to court based on problems with informed consent alone. The present system fails patients as it does not enforce their rights to information. This is despite excellent clinical information that they are not getting the information they need to make autonomous decisions It also fails doctors, giving them little or no guidance on how much to say and even when the courts do, it is retrospective. That is not to say, there is not a pressure to change the status quo.

The problem for doctors is that informed consent is still in its infancy and like all infants, they develop the ability to bite. The teeth, enforcing informed consent, may well come sooner than we think.

Dr John O'Malley,
GP, Moreton, Wirral

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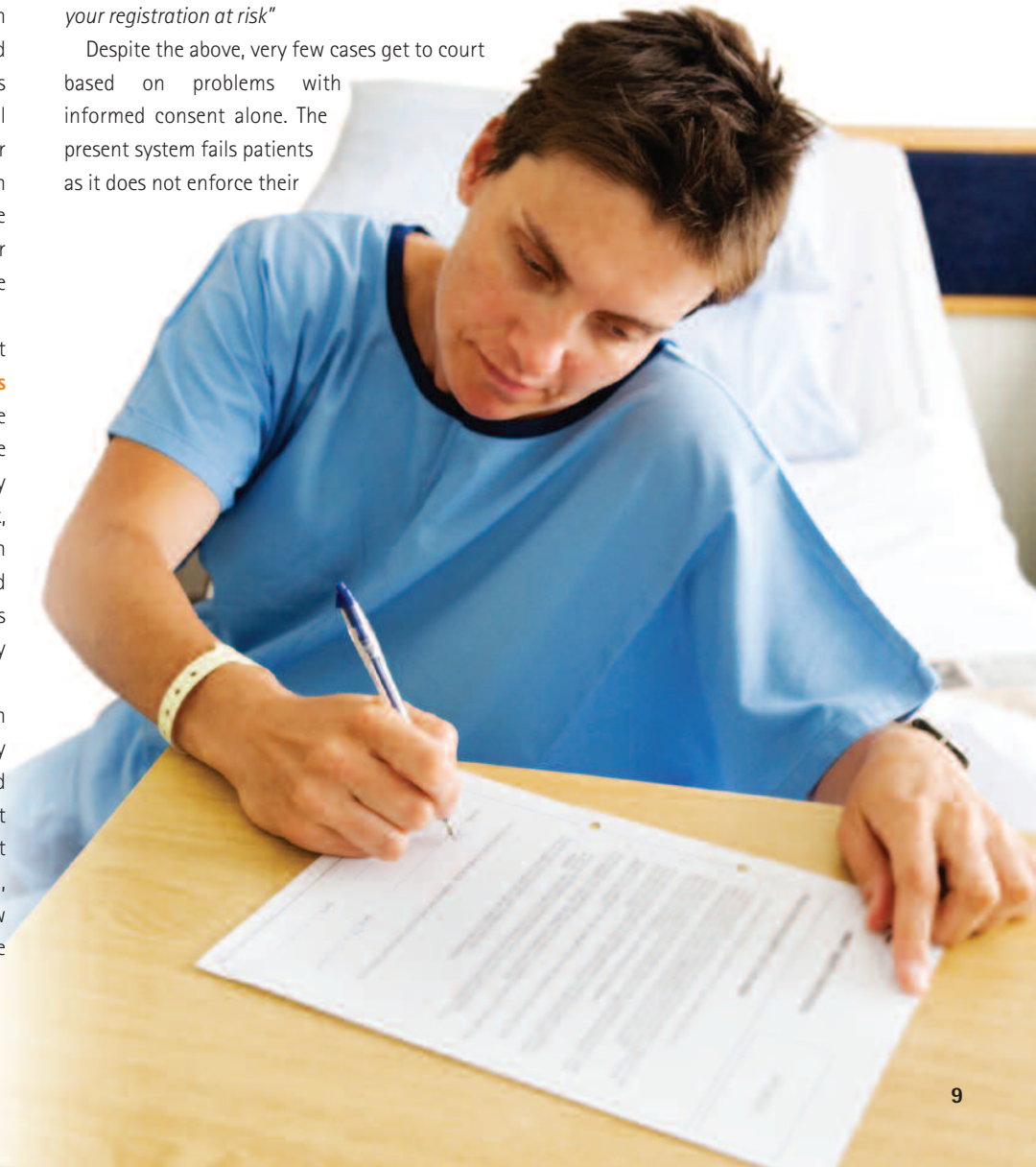
1 Byrne D.J., Napier A., Cuschieri A., 'How informed is Signed Consent? (1988) 296 *BMJ* 839

2 Lavelle-Jones C., Byrne D.J., Rice O., Cuschieri A.'Factors affecting Quality of Informed Consent' (1993) 306 *BMJ* 885

3 Mulcahy D., Cunningham K., McCormack D., Cassidy N., Walsh M. 'Informed consent from whom?' (1997) 42 *J.R. Coll. Surg. Edinb.* 161

4 www.gmc-uk.org



Answers and learning points from the Endoscopy Quiz

1 Coeliac disease. The dye spraying makes it easier to see the mosaic pattern of the abnomal mucosa.

2 Vertebral collapse due to osteoporosis

3 Pharyngeal pouch/diverticulum

4 Vocal cord polyps

5 Solitary rectal ulcer

6 Pseudomembranous colitis caused by Clostridium difficile – post antibiotics

7 Oesophageal varices

8 Eosinophilic oesophagitis

9 Eosinophil infiltration

10 Melanosis coli from laxative abuse – patient suffered with constipation

11 Lipoma in colon – showing "cushion sign", indentation with biopsy forceps

12 Haemorrhoids!

13 Ischaemic colitis

14 Malignant melanoma in the duodenum

15 Antral erosion and malignant secondary

16 Crohns disease of oesophagus

17 Radiological appearances in Crohns oesophagus

18 'Black oesophagus' = acute oesophageal necrosis (get out fast!)

- Endoscopy is notable for a circumferential black colouration of the oesophageal mucosa that stops abruptly at the gastroesophageal junction
- Can present as gastrointestinal bleeding. It has an associated high morbidity and mortality
- Complications - death (~30%), stricture (~10%), perforation (<10%) and mediastinitis (<10%) can occur
- Risk factors include cardiovascular disease, haemodynamic shock, gastric outlet obstruction, alcohol abuse, trauma/surgery, malnutrition, infection, and chronic diseases such as diabetes, malignancy, renal insufficiency, and pulmonary disease.

19 Collagenous Gastritis

- Well demarcated nodular lesions that are flat, with a central depression-scattered throughout the gastric body and antrum.
- Histology shows a discontinuous eosinophilic sub epithelial band with entrapped capillaries and inflammatory cells.
- Rare disorder - most often present with anaemia, haematemesis, or abdominal pain
- Can be associated with microscopic colitis or Coeliac disease

20 Ascaris lumbricoides

21 Cameron ulcers/erosions

- Erosions called Cameron ulcers -characteristic lesions seen in patients with large hiatus hernias and iron deficiency anaemia
- Appearance may be quite subtle and are often missed unless looked for specifically.
- First described by Cameron and Higgins in 1986

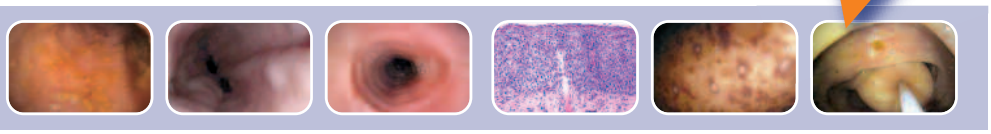
22 Colonic angiodysplasia

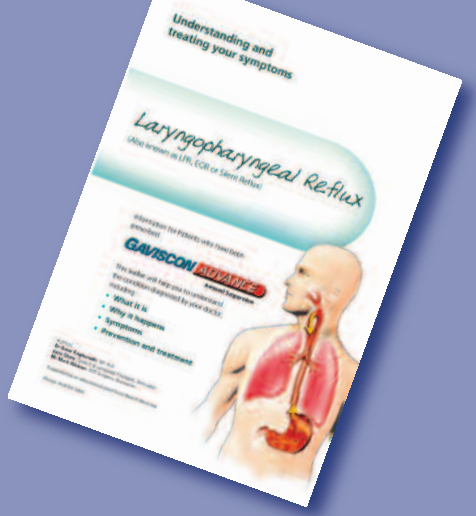
23 'Fundal' (or 'simple') gastric polyps

- Incidental findings or in association with polyposis syndromes - FAP and Gardener's syndrome.
- Generally assumed to be benign lesions
- Small number of well documented case reports of gastric adenocarcinoma developing from FGPs in patients with FAP
- Possible relationship between chronic PPI use and FGP - ? Due to hypergastrinaemia
- Inverse relationship between FGPs and H.pylori with reports of regression on acquisition of H pylori infection

Editor's comment, re 23: 'fundal' polyps, they occur in the fundus and body of the stomach. I used to biopsy them regularly but have more or less given up having never received a report other than benign and simple. I confess they still make me nervous since patients on longterm PPIs develop large numbers of these so I tend to biopsy some when size approaches 1 cm or more, though I have no evidence base for this. The hypergastrinaemia associated with prolonged PPI use can also result in benign ECL cell hyperplasia appearing in the fundus as small nodules endoscopically. Please write in to the office or comment in the PCSG JISCmail if you have different views or know some published evidence.

Comments on John Galloway's quiz would be welcome.





New aids

FOR GPs AND PATIENTS

Reckitt Benckiser has launched two new resources: a booklet to aid the diagnosis and management of GORD, with a specific section to help during patient consultation, and a patient leaflet entitled *'Laryngopharyngeal Reflux: Understanding and treating your symptoms.'*

The booklet will help GPs to diagnose and explain GORD to patients and how their recommended/prescribed treatment works through a series of pictures. The patient leaflet on Laryngopharyngeal Reflux offers simple, clear advice on symptoms, prevention and treatment for anyone who has been prescribed Gaviscon Advance.

If you would like copies of these documents please contact the PCSG secretariat at:

020 7836 0088

kirsty.moulsley@hsdcommunicate.com

So Advanced you can now Rx it for hoarseness, cough and sore throat associated with laryngopharyngeal reflux

Gaviscon Advance Aniseed Suspension is now licensed for:[1]

- Management of the symptoms of laryngopharyngeal reflux (hoarseness and other voice disorders, cough and sore throat)
- Use with a PPI

Gaviscon Advance continues to lead the way in the effective treatment of heartburn and reflux symptoms.

AN ADVANCED REFLUX SUPPRESSANT

GAVISCON ADVANCE

sodium alginate and potassium bicarbonate

PRESCRIBING INFORMATION
GAVISCON ADVANCE ANISEED SUSPENSION

Active Ingredients: Sodium alginate 1000mg and Potassium bicarbonate 200mg per 10ml dose. Also contains methyl and propyl hydroxybenzoates.
Indications: Treatment of symptoms resulting from the reflux of acid, bile and pepsin into the oesophagus such as acid regurgitation, heartburn, indigestion (occurring due to the reflux of stomach contents), for instance, after gastric surgery, as a result of hiatus hernia, during pregnancy, accompanying reflux oesophagitis, including symptoms of laryngopharyngeal reflux such as hoarseness and other voice disorders, sore throats and cough. Can also be used to treat the symptoms of gastro-oesophageal reflux during concomitant treatment with or following withdrawal of acid suppressing therapy.
Dosage Instructions: Adults and children 12 years and over: 5-10ml after meals and at bedtime.
Children under 12 years: Should be given only on medical advice.
Contraindications: Hypersensitivity to the active substances or to any of the excipients, including the esters of hydroxybenzoates (parabens).
Precautions & Warnings: Each 10ml dose has a sodium content of 106mg (4.6 mmol) and a potassium content of 78mg (2.0mmol). This should be taken into account when a highly restricted salt diet is recommended, e.g. in some cases of congestive cardiac failure and renal impairment or when taking drugs which can increase plasma potassium levels.
Each 10ml contains 200mg (2.0mmol) of calcium carbonate. Care needs to be taken in treating patients with hypercalcaemia, nephrocalcinosis and recurrent calcium containing renal calculi.
These medicinal products contain Methyl hydroxybenzoate and Propyl hydroxybenzoate, which may cause allergic reactions (possibly delayed).
There is a possibility of reduced efficacy in patients with very low levels of gastric acid.
If symptoms do not improve after seven days, the clinical situation should be reviewed.
Treatment of children younger than 12 years of age is not generally recommended, except on medical advice.
Side-Effects: Very rarely (<1/10,000) patients sensitive to the ingredients may develop allergic manifestations such as urticaria or bronchospasm, anaphylactic or anaphylactoid reactions.
Basic NHS Price (excl VAT): 250ml - £2.61, 500ml - £5.21.
Marketing Authorisation: PL 00063/0108 – Gaviscon Advance Aniseed Suspension.
Supply Classification: GSL, through registered pharmacies only.
Holder of Marketing Authorisation: Reckitt Benckiser Healthcare (UK) Limited, Dansom Lane, Hull HU8 7DS.
Date of Preparation: February 2009
Gaviscon, Gaviscon Advance and the sword and circle symbol are trademarks.

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to Reckitt Benckiser on 0500 455 456.

1. Gaviscon Advance Aniseed Suspension SmPC, November 2008.

JOURNAL OF THE PRIMARY CARE SOCIETY FOR GASTROENTEROLOGY

ASPIRIN

Taking aspirin or ibuprofen could guard against stomach cancer, even if only in low doses, according to a British study published Friday 5 January 2009.

People who had taken aspirin at least once in the last 12 months were 36 percent less likely to develop cancer in the middle or lower parts of the stomach, compared to those who had taken none.

Taking similar levels of a non-steroidal anti-inflammatory drug (NSAID) such as ibuprofen reduced the figures by 32 percent, according to the study published in the British Journal of Cancer.

Protection against cancer increased with the dosage of painkiller taken, it found. *"We found that the risk of non-cardia (middle and lower) stomach cancer was lower in people who had taken aspirin, and this risk lowered the more regularly they took it,"* said **Christian Abnet of the US National Cancer Institute**.

"Interestingly, our results didn't show a significant cut in the risk of oesophageal or cardia (upper) stomach cancer, so it's important that we continue to review data that suggests otherwise," she added.

But **Lesley Walker of Cancer Research UK** warned that it was premature to make blanket recommendations. *"It's far too early to recommend that people take aspirin to protect themselves from these cancers. In cancers where survival is low, understanding how to prevent the disease is crucial, but more research is needed to discover how side effects can be balanced with the benefits.*

"Cancer Research UK would urge people to speak to their doctor before taking aspirin regularly," she said.

Abnet added: *"The number of people who survive at least five years following a diagnosis of stomach or oesophageal cancer is low, so it's important to increase our understanding of ways to prevent the disease and to investigate aspirin as a possible preventative drug."*

Editor Spence, notes: So the battle over the stomach and aspirin and NSAIDs will become hotter yet! Strong and clear guidance is needed. Every endoscopist worries about visible bleeding in the stomach associated with aspirin and NSAID ingestion, particularly in the older population. In my own general practice, two patients died within a week of each other with catastrophic upper GI haemorrhage from occult ulcers. Our Significant Events action plan led to all patients over 75 having NSAID prescribing reviewed (mostly stopped). If continued, a PPI was co-prescribed for gastroprotection (how effective?) and 'Cox-2' NSAIDs used in some cases.

Event Diary

23-26 March 2009
BSG Annual Meeting
Scottish Exhibition & Conference Centre, Glasgow
Contact: 020 7935 3150 for information

25 March 2009
Networking Buffet Lunch at BSG Annual Meeting, followed by PCSG Symposium
Scottish Exhibition & Conference Centre, Glasgow (see right for more information)
Contact: Kirsty Moulsley
020 7395 1917
kirsty.moulsley@hsdcommunicate.com

13-14 Oct 2009
BAPEN Annual Conference
Cardiff International Arena
Contact: Correen Finney
01527 457850
bapen@sovereignconference.co.uk
www.bapen.org.uk

INVITATION

Dr James Dalrymple, Chair of the PCSG, would like to invite you to a networking buffet lunch to be held at the BSG conference on Wednesday 25 March 2009, 12:30-13:30 in the Levan Room at the SECC, Glasgow.

Lunch will be followed by the PCSG Symposium in the Boisdale Room 14:00-17:00, to which you are also welcome, as long as you have registered for the BSG conference. Programme as follows:

Chair: Dr James Dalrymple & Dr John Galloway

14:00-14:30
Hepatitis C – the epidemic that didn't happen
Dr Martin Philips, Norwich

14:30-15:00
Colonocytes – the new diagnostic tool in bowel cancer
Dr Jeremy Gibson, Taunton

15:00-15:30 Coffee

15:30-16:00
Quality criteria for primary care gastroenterology: development and evaluation of a decision support system
Prof Roger Jones, London

16:00-16:30
IBD Standards – a new framework of care
Richard Driscoll, London and Dr John O'Malley, Wirral

Please RSVP to Kirsty Moulsley, PCSG Secretariat, c/o hsdcommunicate, 21 Tower Street, London WC2H 9NS
Tel 020 7395 1917 kirsty.moulsley@hsdcommunicate.com

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