OSGNA™
Ohio Society of Gastroenterology Nurses and Associates

The Scope

Summer 2013

President's Message


2013 President, Joan Metze

I hope all are enjoying the summer. I know for me it is a busy time with all the gardening that needs to be done. I am glad for warmer temperatures so that the children can enjoy swimming and playing outside.

I was fortunate enough to go to the national conference in Austin, Texas. I had never been to Austin before and it is truly a fun town. Unfortunately, we did not win region of the year, but there is always next year. This year's winner was Region 62 Old Dominion. However it was so neat to see so many GI nurses and associates in one place. It is such a great opportunity to network, and learn what is new and on the horizon for GI. Also the vendor program is a great opportunity to see what new equipment is available and ask questions of the company representatives.

Every year at the conference resolutions are presented and voted on by the House of Delegates. This year only one resolution out of four presented was adopted. That resolution was that: "SGNA develop a format at the annual meeting for regions to display their successes and education provided to our members". This will now go to the board where it will be discussed and voted on.

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Officers

President .....Joan Metze
Past President .....Debbie Vance
President Elect .....Terri Geil
Secretary .....Kim McNary
Treasurer .....Karen Strader-Helton
Education/Legislation .....Shirley Flowers
Historian/Newsletter.....Sandy Amos

Our Medical Advisors for 2012-13 are Dr. Carmen Meier and Dr. Christopher South. Thank you for your dedication and service.

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The theme for 2012-2013 is "Blending Our Talents -Orchestrating Better Outcomes". The conference next year will be closer to home. It takes place in Nashville, Tennessee and I encourage everyone to go. It is earlier next year and a day shorter. It is May 2-6th so mark your calendars.

We are still looking for new board members. We will be having a board meeting in the very new future and I will let everyone know when and where it will take place. Everyone is invited and it would be a good way to see firsthand what is involved being on the board.

I sent everyone information via email about the GI Conference in Columbus, Ohio in September. It looks like a very interesting program. I hope many of you can attend. We do hope to develop an active partnership with OGS in the future when they plan these events so we can apply and offer CEs instead of CMEs to our nurses. With that being said you can use a small number of CMEs for re-certification.

Enjoy your summer and live each day to the fullest.

Joan

Open Invitation to All Members

This is an open invitation to all members to attend any quarterly board of director meetings in 2013 and 2014. We need to prepare, educate and mentor those who are interested in running for office for the 2015-2017 term. Several current board members plan to step down and pass the gavel to our future leaders.

SGNA requires that each region provide its members with contact hours, quarterly newsletters and that the board of directors meet quarterly too. We usually meet at the Jefferson Outlet Mall food court (half way between Cincinnati, Columbus and Dayton) to discuss how we are going to accomplish the SGNA requirements. We always meet the evening before the spring educational conference.

There are benefits of being a Board member. OSGNA pays for the Boards annual dues and waives the spring educational conference fees. All of this is dependent on available funds.

Please consider pursuing an active interest in OSGNA by contacting Kim McNary through this website or check the website for Board meeting location and dates.

Education Article

by Sheetal Sharma, MD, Ohio State University Wexner Medical Center

A Journey Through the Small Bowel: Small Bowel Endoscopy.

One of the last remaining main challenges in the gastrointestinal tract has been the study of the small bowel. The main challenge of evaluating the small bowel has previously been accessing lesions of interest beyond the very proximal small bowel that can typically be assessed by standard upper endoscopy. Typically, evaluation of the duodenum and proximal jejunum has occurred via standard upper endoscopy and push enteroscopy. In the last decade with the advent of deep small bowel enteroscopy, lesions and abnormalities that were previously difficult to localize are now able to be evaluated. Currently there are 4 main endoscopic systems to evaluate the small bowel; Single Balloon Enteroscopy (Olympus), Double Balloon Enteroscopy (Fujinon), Spiral/Rotational Enteroscopy (Spirus), and several Device Assisted Enteroscopy (DEA) and overtubes. Access is either in the antegrade or retrograde approach depending on the location of the lesion of interest. The ability to approximate the location of any lesion of interest is of critical importance of course, and is accomplished via either capsule endoscopy or CT/ MR enterography radiological studies. The advantage of DEA is that it has the ability to combine diagnostic and therapeutic modalities in one study. Contraindications for DEA, large esophageal varicies, excessive small bowel surgeries, and a fixed/immobile bowel.

The DBE system was introduced by Yamamoto in 2001, and its Push-Pull technique allows for pleating of the small bowel over the enteroscope and thereby allowing for deep advancement. The single balloon enteroscope was introduced in 2007 by Olympus, and builds on a more simplistic system. A recently introduced device assisted enteroscopy. Spiral enteroscopy is an enteroscope is passed through an overtube with raised spirals, and allows for rapid enteroscopy, with shorter duration of accomplishing deep endoscopic evaluations. The indications for deep enteroscopy include diagnostic as well as therapeutic modalities, including; Obscure/Occult GI bleeding, Inflammatory Bowel Disease, Polyposis syndromes, Malabsorption/Chronic Diarrhea, Masses/ Abnormal Imaging, AVMs/Mucosal lesions, Polyp Removal, Dilation placement, and Foreign Body Removal. Push Enteroscopy, which involves insertion of the endoscope into the jejunum, without assistance of the balloon system has a diagnostic yield of 24-56%. The yield is 41% of overt obscure GI bleeding, 33% in persistent occult GI bleeding, and 26% in occult OGIB. Combination of antegrade and retrograde allows for total enteroscopy with a diagnostic yield of 43-81%, and treatment success of 43-84%.

Capsule endoscopy was first introduced in the early 1990's, and is non-endoscopic way to evaluate the small bowel. A swallowed video capsule, with approximately 8-10 hours of battery life with wireless transmission is swallowed, and takes images throughout the small bowel. Video Capsule Endoscopy (VCE), visualizes the entire small bowel, but lacks ability of therapeutic interventions. VCE is able to better detect clinically significant obscure GI bleeding compared with standard endoscopy (56% vs 26%). The rates quoted in the most recent studies, suggest that 30-40% of the small bowel can be imaged in this method.

In recent literature, deep enteroscopy can be used for those with who have failed standard colonoscopies; and is most common in referral cases, removal of large polyps in the cecum that cannot be removed due to excessive looping/tortuous colons, or fixed anatomy. DEA is considered the new gold standard for evaluation of the small bowel. All DEA should be done with carbon dioxide insufflation of the GI tract, all should be done at high volume centers, and in those without active contraindications. Use of DEA has revolutionized out ability to evaluate and treat small bowel diseases.

Spring Education Conference Photos

2013-2014 Board Members from left to right Joan Metze (President), Kim McNary (Treasurer), Sandi Amos (Historian/Newsletter), Debbie Vance (Past President), Karen Strader Helton (Treasurer) and Shirley Flowers (Eduction).

A group of attendees from Columbus, Ohio.

A group of attendees from Cincinnati, Ohio.