OSGNA™
Ohio Society of Gastroenterology Nurses and Associates

The Scope

Fall 2014

President's Message

Hello,

2014 President, Joan Metze

It is hard to believe it is fall already. I most probably am one of the few people who really enjoy the hot weather and am sorry to see it end. The thought of being cooped up in the house for 5 months does nothing for me except to put me in a depressed state. I just hate going and coming home from work in the dark.

With the coming of the end of the year fast approaching, it means a changing of the board members needs to take place. Unfortunately, most board members are not returning for a new term. We have three of our members who have been shadowing board positions but we still need more volunteers. The board needs 7 members (President, President elect, Treasurer, Education, Secretary, Historian, and Legislator). Please think about becoming a board member and email me your interest at JM52699@aol.com

Continued on pg 2

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.

Conference Photos

Continued from pg 1

Do not forget about the multiregional conference in Kalamazoo MI that takes place October 17-19. If you want more information you can go to multiregionalsgna.net Also consider going to the National meeting in May. It is being held in Baltimore. If you want more information about that conference go to sgna.org. These conferences always provide great information, multiple vendors and a great opportunity to network with other GI nurses. If money is a reason you are not attending both SGNA and OSGNA provided the members an opportunity to apply for educational scholarships. See both websites for applications.

I hope you all enjoy the fall with its vivid colors and cooler temperatures.

Joan Metze

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.

Gastroparesis Demystified; A Chronic and Often Debilitating Condition

J. Royce Groce, MD, MS - Medical Director of Endoscopy

Assistant Professor of Medicine, Clinical - The Ohio State University Wexner Medical Center

Normal gastric emptying can vary based on the amount and composition of the food that is ingested. Dense proteins and fats, in particular, may prolong stomach emptying time in normal individuals. Gastric emptying sintigraphy (Gastric Emptying Study) allows us to evaluate the time that it takes a known quantity of solid food to empty from the stomach. In patients with normal gastric functioning, greater than 40% of a standardized solid meal should empty from the stomach by two hours post ingestion and greater than 90% should empty by four hours. When a person's stomach does not empty enough to meet these criteria, this delay in gastric emptying defines a condition that we call gastroparesis. Gastroparesis is a chronic medical condition that is associated with a delay in the normal gastric emptying time. This may result in symptoms of nausea with or without vomiting and abdominal pain in the majority of patients. Additional symptoms may include early satiety, postprandial bloating and abdominal distension. Often, patients complain of nausea that is worse in the morning and improves throughout the day. They may have emesis that is comprised of undigested or poorly digested food, which may also be worse in the morning. Alternatively, they may have persistent nausea alone. While delay in gastric emptying is required for gastroparesis, you must first exclude other causes of delayed gastric emptying, prior to accepting the diagnosis. These include, but are not limited to, gastric outlet obstruction and medication induced delays. Often, upper endoscopy is performed prior to gastric emptying testing in order to exclude an obstructive process. When the diagnosis of gastroparesis is established, the two main causes are diabetes mellitus and idiopathic or unknown causes. Diabetic gastroparesis is difficult to treat and is progressive in nature. Poor glycemic control may exacerbate the delay in gastric emptying, leading to a vicious cycle of food bolus delay followed by blood sugar spikes that further worsen glycemic control. As the name implies, the cause of idiopathic gastroparesis is unknown. Many people believe that this may be post viral or autoimmune in nature. Patients with idiopathic gastroparesis have a variable course over time. Of these patients, 1/3 improve, 1/3 worsen and 1/3 having stable symptoms.

Other rarer causes of gastroparesis include, but are not limited to, post-surgical nerve injury, neurological conditions, known post viral or autoimmune conditions and certain infiltrative processes, such as scleroderma or CREST syndrome. While all of gastroparesis associated symptoms are not directly related to the delay in gastric emptying, we often aim our treatments towards improving this delay. This is largely done by a combination of dietary modifications; small frequent meals that are high in liquid content and low in fat content and by the use of certain medications, such as metoclopramide or erythromycin may also be used to accelerate gastric emptying. Unfortunately, the use of these medications may be limited by their side effects. In severe refractory patients, an implantable gastric stimulator, or "gastric pacemaker" is sometimes used to accelerate gastric emptying. While the purpose of this device is to increase emptying, there has not been good evidence that any resultant improvement in symptoms is related to increased emptying. Additional symptomatic treatment is often provided for the patients' nausea, vomiting and abdominal pain. Standard antiemetics, such as promethazine, prochlorperazine and ondansetron are used for nausea with variable response. Some people advocate an "off label" use of dronabanol, a synthetic cannabinoid derivative, which may be particularly helpful in patients who have nausea without vomiting. Gastroparesis associated abdominal pain is thought to be secondary to visceral hyperalgesia and may be similar to a neuropathy. As such, this is primarily treated with pain modulating medications, such as tricyclic antidepressants, gabapentin, pregabalin or duloxetine. These medications decrease the brain's ability to sense pain inputs and are thought to be helpful for these patients, although these are also used off label.