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## Update from Your President

Issue: 29 Sept 2015

Kia ora friends and colleagues.

Well, as predicted the complexities of the year have piled up at a frightening pace.

Since last you received any official news the world of

Endoscopy Governance has gone topsy-turvy. Many of you will have been aware of impending announcements around bowel cancer screening and been involved in the National Endoscopy Quality Initiative Project (NEQIP) at a grass-roots level for the last 3 years or more, and so appreciate the amount of work and time involved in getting any endoscopy house in order. Over the last 3 months the Ministry-commissioned SAPERE group about the future of NEQIP and Endoscopy Governance may well also have consulted you.

The planets have now aligned such that just as the SAPERE report is published recommending Ministry of Health pump-prime funding of Endoscopy Governance and Quality work, and Jonathan Coleman announces that plans to take a business case to Cabinet by the end of the year to consider rolling out Bowel Cancer Screening from early 2017, the funding for NEQIP is cut. Magic.

This impending collapse of the QI work and lack of movement towards any Quality Assessment invigorated clinicians involved in Endoscopy to grasp the initiative and take the lead on Governance. Your Society, in conjunction with the RACP, RACS and their training groups NZAGS and Gastro ATC, the NZ Nurses Organisation, Conjoint Committee on Training in Endoscopy, NEQIP remaining staff member, and the Clinical lead of the BCSP, have formed the **Endoscopy Governance Group for New Zealand (EGGNZ)**.



With your President as interim Chair, we have picked up the baton and with no budget, but a lot of enthusiasm and good will are beginning to formulate a way forward.

Our agreed core objectives are:

To set acceptable standards for competence in endoscopic procedures.

To quality assure endoscopy units.

To quality assure endoscopy training.

To quality assure endoscopy services.

We have already outlined our aims and proposed structure for Endoscopy Governance to the Minister of Health and are in direct negotiation with the Ministry.

We have no constitution yet, and are developing memoranda of understanding with various groups. Obviously other major players are the Ministry of Health, District Health Boards, Health Workforce New Zealand and the private sector and we are engaging with them already.

A number of other groups that have a stake in endoscopy in New Zealand are being approached for opinions on the problems they face and solutions they see. These include Paediatric Endoscopists and patient groups.

If you have constructive thoughts on Endoscopy Governance-related issues please send them to EGGNZ, c/o the NZSG office at [anna.pears@racp.org.nz](mailto:anna.pears@racp.org.nz).

May the force be with you all.

Russell

## Coming Soon

### Applications for Grant & Fellowship

The 2015 applications close on 30 September (see page 8 for more information)



## Editorial

Welcome to this edition of the NZ Society of Gastroenterology Newsletter. This time we have quite a variety of articles on offer and we hope you enjoy the read.

It all starts off with two articles regarding the activities of ANZGITA. Dr Schlup has just returned from Fiji and seemingly enjoyed his experience. In anticipation of our 50<sup>th</sup> anniversary next year, Dr Bramwell Cook, official archivist for the society has prepared a series of articles looking at the beginnings of gastroenterology in NZ – very interesting to read. All the hype about the upcoming colorectal cancer screening program in NZ affects the society tremendously and we asked A/Prof Susan Parry to summarise the recent events.



Lastly, Dr Richard Newbury is whetting our appetite for the ASM in Rotorua. I assume you have all registered and booked your flights and accommodation.

Michael Schultz

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## ANZGITA

Join us in the Pacific and Myanmar!!! We need you!

ANZGITA welcomes like-minded Gastroenterologists, GE nurses (and others) to join us in our efforts to support our region. We now have over 60 members. In the last 12 months, the Australian and New Zealand Gastroenterology International Training Association (ANZGITA) has incorporated, built its Board with a broad range of relevant expertise, developed its relationships with RACS, RACP, ASGE, the Australian Government's Dept of Foreign Affairs and Trade (DFAT), the Fiji National University, and Yangon General Hospital. Training programs are in place in Fiji, Myanmar and the Solomons. Universal acknowledgement of these initiatives has encouraged further development - from the trainees, trainees, local academia, local ministerial and Australian Embassy/High Commissions.

The experience is overwhelmingly rewarding and positive for our team members and of course for our partners on the region. The programs to date have pioneered a highly acknowledged and receptive formula of engagement in the region, including all the South Pacific countries, and recently also Timor Leste (East Timor), Nepal and others.

ANZGITA would love you to join us. We make it easy for you to engage. The teaching is not arduous - all postgraduates will have covered the topics. It is a wonderful way to pass your talents to those who most need them. ANZGITA is looking to recent and to retired Australian and NZ graduates to meet the teaching demands. ANZGITA has had outstanding commitments from our colleagues in New Zealand: Tony Smith, Dinesh Lal and Martin Schlup. Martin has just returned from Fiji, full of the rewards of the experience. ANZGITA calls all you all to join us! it is such a rewarding and life changing experience! If you are interested please contact Frank at [secretary@anzgita.org](mailto:secretary@anzgita.org).

Professor Finlay Macrae

Chair

ANZGITA

[www.anzgita.org](http://www.anzgita.org).





## ANZGITA Continued

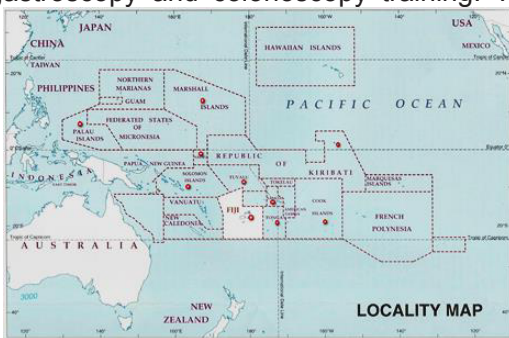
### Two weeks in Fiji by Martin Schlup, Dunedin

I recently had the chance to spend two weeks at the Colonial War Memorial Hospital in Suva as a member of the ANZGITA training group. This training organisation was recently incorporated as the Australian & New Zealand Gastroenterology International Training Association (ANZGITA); its aims are to enhance endoscopy and gastroenterology services across the Pacific Islands. It was a very interesting and rewarding experience; there were 16 trainees as well as 11 endoscopy nurses from all over the Pacific Islands.

The trainees had quite different levels of experience; some registrars, some established physicians and surgeons but most had no or very little endoscopy experience. The 4 weeks course was very much focussed on basic, hands-on gastroscopy and colonoscopy training. There were 2-3 trainers (gastroenterologists), 2 endoscopy nurses from



Australia and the local, very capable team. The trainees were given hands-on experience right from the start – perhaps somewhat different from training in NZ and Australia. The trainers' roles were to supervise, advise and if necessary take over and progress the procedure – most days some 9-11 procedures were performed.



The endoscopy suite has just very recently moved into a new theatre complex with a modern set-up equivalent to endoscopy suites in NZ. There were several Fujinon instruments available; cleaning is still done in the old fashioned Glutaraldehyde way; new washing machines lacked replacement parts. This is one of

the main problems – while the “hardware” is available and of good quality accessories are often in short supply.

There was quite a range of pathology – quite a few normal endoscopies, some very large gastric ulcers I hadn't seen for quite a long time and amoebic and typhoid colitis. Bowel cancer is uncommon as is GORD but functional dyspepsia is a quite common problem as well. I also had the opportunity to join ward rounds where Diabetes, heart disease and respiratory illnesses are very common. The staff have to rely on good clinical practice as access to various investigations and other resources are decidedly limited. There is a high prevalence of Hepatitis B – in blood donors the prevalence is around 7%. Antiviral treatment is at present not available though there is strong lobbying to change this.

We were made to feel welcomed very warmly by the local team particularly Joji Malani who was integral in setting up this program, and May Ling Peng the main organiser of the program. The trainees and local staff appreciate having outside specialists coming to Suva and share our experiences with them, though in many ways, I learned as much as I hope I have been able to contribute. There is a need to improve endoscopy services in the Pacific region not only in terms of basic training but also in providing continuity and support for those working in small isolated areas.

Since my return I have been asked quite often if I would go back – the answer is an unequivocal yes. I encourage you to support this program in any way possible; if you have any accessories no longer needed I am happy to send them on to Suva.



## Bowel Cancer Screening Update - Dr Susan Parry

This month (September 2015) you will have the opportunity to join in regional discussions to help the Ministry of Health consider what a national bowel screening programme might look like.

The discussions follow a national meeting held in Wellington on 19 August, to update the health sector on bowel screening. About 160 people attended. The regional discussions will allow the sector to explore how screening services could be structured locally, regionally and nationally and what the resourcing implications may be. Regional meetings will be held in Hutt Valley, 8 September; Christchurch, 16 September; Palmerston North, 21 September; Auckland, 22 September; and Hamilton, 24 September.

The discussions will inform a business case, which Health Minister Hon Jonathan Coleman expects to take to Cabinet in December to consider a potential staged rollout of a national programme from early 2017.

It is going to be a busy time. However, a lot of work has already been done. The Waitemata District Health Board Bowel Screening Pilot has provided valuable insight about how to deliver a potential national bowel screening programme in New Zealand. The pilot started in 2011 and has been extended to 2017. It targets 50-74 year olds and has an approximate eligible population of 136,000. If a national bowel screening programme is approved, we expect it will be slightly different from the pilot, while taking a number of insights from it.

A successful screening programme has many components. It must be equitable for all and quality focused, with appropriate infrastructure and systems so people are fully supported through the programme. That includes having a capable, well-trained workforce available to meet demand within an agreed timeframe and robust quality standards to ensure quality of service and to minimise risk.

Workforce capacity is critical and will be part of our regional discussions this month. Services like colonoscopy must be able to cope with extra volumes created by national bowel screening. Rollout of a potential national programme could only happen as workforce capacity allows.

Planning for potential colonoscopy volumes is already underway. We have done some modelling to obtain data to help district health boards work out capacity and capability requirements. Estimated volumes are based on current symptomatic and surveillance outpatient colonoscopy volumes. They take into account the 20 percent increase in symptomatic referrals observed in the first two years of the Waitemata pilot and target 60 to 74 year olds. The pilot indicates that the most bowel cancers are found in this age group.

Ultimately, the quality of endoscopy in New Zealand will be a key determinant in the success of a bowel screening programme. Draft quality standards have been developed and used in the Waitemata pilot. We may take that a step further and look at an accreditation programme if a national programme goes ahead. I encourage you to take the opportunity to join in the regional meetings and help us plan for the future.

If you have any particular questions please email us at [bowelcancerteam@moh.govt.nz](mailto:bowelcancerteam@moh.govt.nz)



## Gastro National Match Day Report

The third year of the NZ national match for advanced training in Gastroenterology was held on 9 July in Auckland at the old National Women's Hospital at Greenlane. This national matching scheme recommends allocation of posts to advanced trainees in Gastroenterology in NZ. Remember that the Gastro Advanced Training Committee or ATC (which is the new vibrant and upmarket name for the old SAC) and this matching process can only recommend candidates to positions with DHBs, but it is then up to the DHBs to offer the positions and actually employ the trainees.

Advanced trainees already on the national scheme list their preferences, and these are taken into account when the final mash up occurs at the end of a very long day for the Departmental Heads, but we cannot always guarantee everyone's individual wishes. The national matching scheme is a two way process. The scheme guarantees trainees a three year advanced training programme in Gastroenterology & Hepatology but, in return, the trainees must buy in to the fact that we are required to provide a level of Gastroenterology service to the NZ public and this does require us to fill all of the vacant slots at all of the hospitals currently on the national scheme. There are plans to extend the numbers of trainees as extra training sites and posts come on line over the next year or so.

Special thanks to Anna Pears, Executive Officer of the NZSG for her hard work in advertising the match process throughout the College trainee membership and coordinating the process of applications, to NRA for coordinating the preparations through numerous teleconferences and for hosting us on the day, and to Susan Parry for acting as ATC Chair when Tony Smith had to step down. As of 1 August Paul Frankish has taken over at the helm of the ATC.

Any comments about the entire match process from applications to issues about the match day itself or the allocations process can be made to either Paul Frankish, Chair of the NZ Gastro ATC, or myself.

David Rowbotham

Chair, NZ Gastro National Match Scheme

Allocation	Name	Name
North Shore Hospital	Helen Myint	Priyanka Lilic
North Shore Endoscopy Fellow	Hui Syn Chan	Hui Syn Chan
Auckland City Hospital 1	Jan Kubovy	Helen Myint
Auckland City Hospital 2	Hannah Giles	Afrasyab Khan
NZ LTU 1	Priyanka Lilic	Clare Russell
NZ LTU 1	Sylvia Wu	David McGouran
Liver Research	Debi Prasad	Debi Prasad
Middlemore Hospital 1	Siva Pulusu	Charlotte Rowan
Middlemore Hospital 2	Sum Team Lo	Sylvia Wu
Middlemore Research Fellow	Ming Han Lim	Ming Ham Lim
Tauranga Hospital	David McGouran	Sum Team Lo
Waikato Hospital	Yanez Peerbaccus	Sri Selvaratnam
Waikato Hospital	Wayne Bai	Wayne Bai
Hawkes Bay Hospital	Sri Selvaratnam	Jan Kubovy
Hutt Hospital	Heidi Su	Heidi Su
Wellington Hospital	Riaz Shaik	Riaz Shaik
Christchurch Hospital 1	Shwan Karim	Yanez Peerbaccus
Christchurch Hospital 2	James Fulforth	James Fulforth
Christchurch Hospital 3	Amanda Chen	Hannah Giles
Dunedin Hospital	Kyle Hendry	Kyle Hendry



## NZSG recommendations for the use of Computerised Tomographic Colonography (CTC) and Colonoscopy in investigations of GI disease

The position of CTC in the investigation of lower GI disease has not yet been defined, with few comparative studies and software developments occurring rapidly. The use of CTC is attractive to Health Boards where endoscopic services are stretched, and so it has been proposed that the use of CTC be increased in many regions of New Zealand.

The New Zealand Society of Gastroenterology feels that appropriate use of CTC is an advantageous addition to the range of investigations possible, especially in an aging, increasingly comorbid population. These recommendations are designed as basic principles to be taken into account when CTC is being integrated into GI services. 1. We strongly recommend that all referrals for investigations of lower GI symptoms should be triaged through a single pathway to allow rational use of CTC and colonoscopy resources. 2. Via such a common triage route we recognise the following patient groups to be more appropriately investigated by the following modalities.

### **a. Consider referral for CTC**

- Symptomatic patients over age 80 where histology is not required.
- Patients with comorbidities when colonoscopy presents a higher risk  
e.g. patients on warfarin therapy, respiratory risk from sedation.
- Patients presenting with abdominal mass.
- Following failed or incomplete colonoscopy.

### **b. Consider referral for Colonoscopy**

- Patients with diarrhoea/ loose motions as a predominant presenting symptom.
- For polyp surveillance.
- Suspected inflammatory bowel disease.
- Patients <40 years old.

3. Much as colonoscopy services now are subject to continuous Quality Assurance, CTC services should have regular audit, reporting outcomes through the governance group for GI services.

## 2015 ASM

It seems like just 2 minutes have passed since Russell rang to confirm that Rotorua would be hosting the ASM in 2015, 18 months later and we are almost there.

From last year's meeting in our most populous city to our more compact but fabulous Rotorua, the feel will be different. The parking will be free and in the absence exorbitant city rate rises, the Novotel will be luxurious at a fraction of the cost.

Jokes aside, I know I am not the only one who thoroughly enjoyed last year's conference in Auckland, so we fully intend to continue with the momentum and deliver a conference that is fun, exciting, educational and memorable. The theme of this year's conference is 'ethnic differences in GI disease', appropriate given our location, with sub themes of 'GI disease in pregnancy' and 'GI disease at the transition to adulthood'. We have been fortunate to secure a stellar line up of international speakers, providing insight into topics that have intrigued me personally lately, so I hope they will you too. Plus local distinguished speaker's on topics increasingly relevant to NZ in 2016 bowel screening, NASH and a practical skin cancer session, to name some.

In keeping with tradition, the social Great Guts run is set to be a fun and scenic start to Thursday morning as it incorporates Sulphur Point with the sun rise across the lake. On Thursday evening we are pulling out all stops for a conference dinner themed Star Wars to Star Trek and all things sci-fi!

I look forward to welcoming you all to Rotorua on the 25<sup>th</sup> November.

Richard Newbury  
Convenor

## Queenstown Research Week

The 1<sup>st</sup> **GutHealthNetwork Digestive Disease Satellite Symposium** as part of the **Queenstown Research Week** was a great success.

Thanks to the *New Zealand Society of Gastroenterology* and numerous other sponsors we were able to invite not only top NZ researchers but also an impressive number of internationally reknown speakers and enjoyed two days exploring the gaps in modern patient mangement, hearing of cutting edge sience, and networking.

Our key note speaker A/Professor Elaine Petrof, Queens University, Kingston, Ontario, Canada delivered a fantastic overview about faecal microbial transplantation in recurrent *C. difficile* infection and other conditions. Dr Jason Tye-Din, The Walter and Eliza Hall Institute of Medical Research, Melbourne, Australia emphasized the upcoming clinical trials for coeliac vaccines while Professor Matthias Ernst, Ludwig Institute for Cancer Research and La Trobe University; Melbourne, Australia and Professor Rob Ramsey, Peter MacCallum Cancer Centre, Melbourne delved into the immunology of colorectal cancers and potential new treatment avenues.

It was impressive and reassuring to hear about the significant advances at the fundamental science frontier here in New Zealand and overseas. For the full program, go to: <http://www.queenstownresearchweek.org/>



## Gut Health Network Symposium



GUT HEALTH NETWORK

We decided, after a successful inaugural meeting at last years ASM in Auckland to do it again!

Rotorua will see the 2<sup>nd</sup> edition of the GutHealthNetwork Satellite Meeting on Tuesday 24<sup>th</sup> November from 12:30 to 5.00pm.

Key note speaker Rupert Leong, Clinical Professor of Medicine at University of Sydney and UNSW promised to look critically at the recent scientific advances and their impact on daily clinical care. The main program will highlight New Zealand-made research and features talks about novel molecular techniques for colorectal cancer screening, an update on gastric dysrhythmias, the place of exclusive enteral nutrition in IBD and the effect of TNF- $\alpha$  on tight junctional proteins. Professor Nigel French from Massey University will provide a view from outside the box looking at the effect of the environment on health and disease. Finally, Dr Blair Lawley, microbiologist will take us on an interesting journey on the attempt to treat chronic pouchitis.

The Satellite meeting is scheduled for Tuesday 24<sup>th</sup> November starting at 12:20pm.

Save the date!



## From the past - the beginnings of gastroenterology in New Zealand

In preparation for the 50<sup>th</sup> Anniversary of the NZ Society of Gastroenterology we take the opportunity to look back on how far we have come as a profession. In the next few newsletters Branwell Cook the Society's Archivist has kindly offered to provide a series of articles on the history of Gastroenterology in New Zealand.

### Gastroscopy: Early Days in New Zealand by Bramwell Cook, Christchurch

Gastroscopy came of age in 1932 when Rudolf Schindler, together with the instrument maker, Georg Wolf of Berlin, and Norbert Henning, produced the Wolf-Schindler Gastroscope, later known as the Schindler Flexible Gastroscope. At the time it was hailed as 'the greatest single advance in the history of gastroscopy'. The eyepiece contained the last two of 51 optical elements in the gastroscope. Flexibility was minimal.

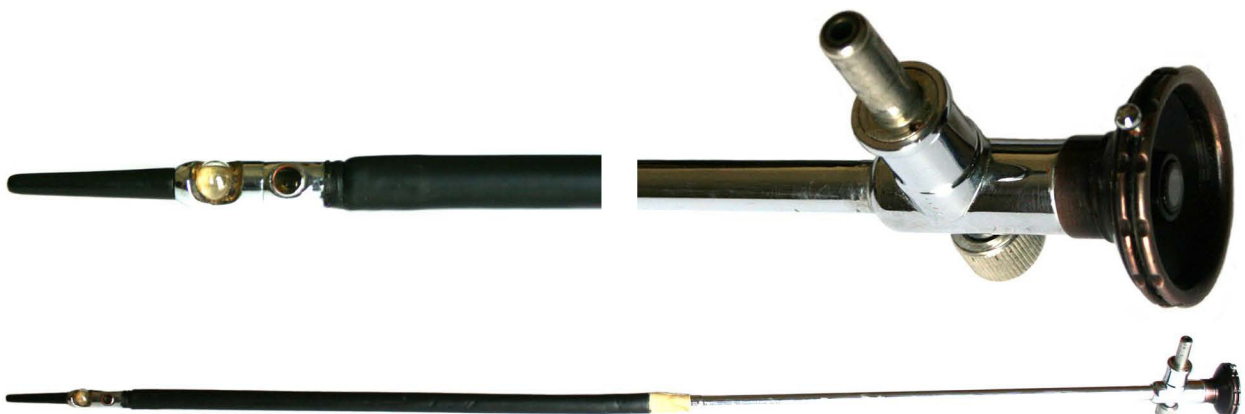
Schindler, a Jew, was arrested and sent to Dachau concentration camp in 1934. Released six months later, he was given an appointment in Walter Palmer's department in Chicago before relocating to Los Angeles in 1943. In 1938: 'Only real drawback to Dr Schindler's gastroscopy is the difficulty in getting his instrument properly made. The one he uses was made in Germany and so far none have been made in this country.' In 1947, flexible gastroscopes were made by three firms in Chicago, Metro-Tec, Cameron and Eder.

Dr Eric Snow McPhail graduated in 1923 and became FRCSEd in 1926. He then entered general practice in Rangiora. In the mid-1930s he visited London where he learnt the art of gastroscopy. In 1938, he wrote a paper that described his own experience and included a page of 12 gastroscopic pictures, in colour. He was appointed an honorary surgeon at Christchurch Hospital and had rooms in Harley Chambers where he used his German made Schindler Flexible Gastroscope. McPhail joined the New Zealand Division of the Royal Navy Volunteer Reserve in the early 1930s and was called up for service in 1939. Based at Devonport, Auckland, he never used his gastroscope again.

There is a Schindler Flexible Gastroscope made by Wolf, Berlin, on display in Dunedin Hospital, with a note 'John Maxwell Clarke, c1946'. Father of Professor Alan Clarke, Maxwell Clarke graduated in 1920 and became FRCS in 1930. He was medical superintendent at New Plymouth Hospital and later Director of Surgery, Auckland Hospital, from 1938. Serving in WW2 he was later surgeon at Green Lane and Middlemore Hospitals. It is tempting to speculate that Maxwell Clarke obtained his gastroscope from McPhail, who was now in Auckland.

Thomas Ritchie Anderson, graduating in 1942, was as a house surgeon at Christchurch Hospital before joining the Air Force. He became a squadron leader in the Pacific. On his return to Christchurch he entered general practice. Anderson went to Los Angeles for six months in 1948 where, with Schindler, he gained experience in the art of endoscopy. He returned to Christchurch, commenced regular gastroscopy lists in Christchurch Hospital and Calvary Hospital (now Southern Cross Hospital) and in his private rooms until 1964. Anderson's well-worn Schindler Flexible Gastroscope can be seen in The Cotter Medical History Museum, Christchurch.

In Wellington, Alan Tennent, an anaesthetist from 1938 and the first gastroscopist, and Allen Erenstrom, a general physician who was appointed gastroscopist from 1956-1966, used Schindler Flexible Gastroscopes.



Schindler Flexible Gastroscope



## Crohn's and Colitis Kids Camp January 2016

Earlier this year Crohns and Colitis NZ hosted its first camp for children and teens with IBD. The camp was an incredible success and a second camp is planned this coming summer, from 24-28 January 2016.

It will be a unique opportunity for these children to foster friendship with peers who understand the disease in an environment that will build self-confidence and independence. The camp will be fully staffed with volunteer medical and ancillary personnel and all costs (including plane fare) will be covered by the organisation. The age range will be from 9 through 16. If you know of any children who you think would benefit from this experience, we would appreciate it if you could give their families this email address and have them request a registration packet: [campenquiries@crohnsandcolitis.org.nz](mailto:campenquiries@crohnsandcolitis.org.nz).

We only have space for 50 children from across the country so early registration is strongly advised if a child is to secure a space. The venue will be Living Springs in the Christchurch area. The success of the camp rests on identifying children who you think would benefit most from the experience. For more information you can contact us directly or through the camp email address.

Please take a look at this video from last year's camp from the NZ Herald:

[http://www.nzherald.co.nz/life-style/news/video.cfm?c\\_id=1503081&gal\\_cid=1503081&gallery\\_id=147807](http://www.nzherald.co.nz/life-style/news/video.cfm?c_id=1503081&gal_cid=1503081&gallery_id=147807)

Andrew Day, Paediatric Gastroenterology, University of Otago and Richard Stein, Gastroenterology, Hutt Valley DHB

### AbbVie Educational Travel Grant

A travel grant is available to registrars, researchers and nurses working in the field of gastroenterology who do not have the financial means to attend and present their research at scientific meetings and to organize collaborative visit to overseas Centres of Excellence. If you wish to apply please complete the form on our website [www.nzsg.org.nz](http://www.nzsg.org.nz) and send to Anna Pears, Executive Officer [anna.pears@racp.org.nz](mailto:anna.pears@racp.org.nz)



### 2015 Abbvie Research Grant

A grant of up to \$35,000 is available. Applications close on 30 September for the AbbVie Research Grant. Please see the NZSG website for the criteria for application [www.nzsg.org.nz](http://www.nzsg.org.nz)

### Janssen Research Fellowship

A fellowship of up to \$65,000 is available. Applications close on 30 September for the Janssen Research Fellowship. Please see the NZSG website for the criteria for application [www.nzsg.org.nz](http://www.nzsg.org.nz).

Send all completed applications to Anna Pears, Executive Officer [anna.pears@racp.org.nz](mailto:anna.pears@racp.org.nz)

### RACP Trainee Research Awards for Excellence – in the field of adult medicine

Call to all RACP trainees for abstracts – finalists will present their research at the 2015 ASM in Rotorua, with the chance to win an opportunity to present at the 2016 RACP Congress. Abstract submissions closing date 18 September 2015

Please contact Jenny Butt for further details: [Jennifer.Butt@racp.org.nz](mailto:Jennifer.Butt@racp.org.nz)



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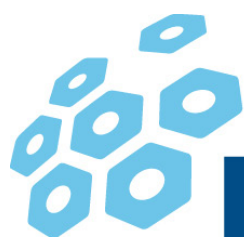
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