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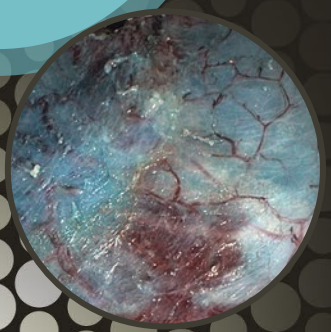
CONFERENCE PROGRAM AND SYLLABUS

Sydney International Endoscopy Symposium 2012

Thursday 8th & Friday 9th March 2012
Hilton Sydney, Australia

Incorporating the Westmead Endoscopy Symposium
Nurses Workshop - Wednesday 7th March, 2012

EXPERTS ON THE SPOT
Mini-Symposium – real time clinical insights from the faculty



International Faculty

- Jacques Deviere - Belgium
- Mitsuhiro Fujishiro - Japan
- Doug Rex - USA

Australian Faculty

- Mark Appleyard
- David Devonshire
- Barbara Leggett

Topics Include

- Colonoscopy
  - Optimising insertion
  - Best practice withdrawal and adenoma detection
  - Enhanced imaging modalities/Optical diagnosis
  - New techniques and technology
- Barrett's Oesophagus
  - Detection of inconspicuous neoplasia and dysplasia
  - Approach to endoscopic therapy
- Endoscopic stenting for benign and malignant disease
- Endoscopic ultrasound
- ERCP: complex and basic therapeutics
- Direct cholangioscopy
- Balloon and capsule enteroscopy
- Novel endoscopic haemostatic therapies

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Welcome!

Dear Colleagues, Ladies and Gentlemen

It is my great pleasure to welcome you to the Sydney International Endoscopy Symposium, our 5th Annual Westmead Endoscopy meeting. Once again we have set ourselves the goal of a comprehensive demonstration of diagnostic and therapeutic endoscopy. I believe that this year will be our most successful event yet.

We are delighted to welcome three truly outstanding clinicians from abroad as our expert faculty. **Jacques Deviere** and **Doug Rex** are leaders on the international stage having made numerous outstanding contributions to the practice of Endoscopy over the last fifteen years. **Mitsuhiro Fujishiro** is one of the new breed of rising stars from Japan.

Their insights are eagerly awaited.

This year we will especially focus on the fundamentals of core technique. The Symposium's content has been carefully designed to facilitate discussion. Please relay your questions through the chairs to our proceduralists. A strong emphasis on the cognitive processes behind the delivery of high quality endoscopy will feature. Several novel technologies will also be demonstrated.

On behalf of our Department, Nurses and Doctors alike, I thank you for your support and for taking the time from your busy schedules to join us here for these two special days. I believe the international guests, in combination with our Australian faculty and the team from Westmead, will provide an enlightening and informative educational experience for you, and hopefully a very enjoyable one.

Yours sincerely

Michael Bourke

Chairman Sydney International Endoscopy Symposium 2012
Director Gastrointestinal Endoscopy, Westmead Hospital, Sydney.

Welcome to Nurses

Once again it is a great privilege for me to welcome my fellow nurses to the Sydney International Endoscopy Symposium Nurses Workshop on Wednesday 7th March 2012 at the luxurious Hilton Sydney Hotel.

I know you will find the program very stimulating, interesting and educational, with interactive hands-on demonstrations related to important aspects in Endoscopy nursing that will excite and increase your understanding in this specialty!

This meeting will also be a fabulous opportunity to come together to interact, network and be updated and to learn new tools to promote gastrointestinal Endoscopy nursing.

Nurses are also welcome and encouraged to attend the two full days live Symposium, which promises to be a fabulous experience showcasing the skills and wisdom of the internationally renowned guest faculty.

RCNA points will be available for nurses attending the Symposium.

Yours sincerely

Mary Bong
Nurse Unit Manager
Endoscopy Unit, Westmead Hospital

Organising Committee
Sydney International Endoscopy Symposium,
Nurses Workshop 2012

International Faculty

JACQUES DEVIERE *Chairman, Department of Gastroenterology and Hepatopancreatology, Erasme University Hospital, Brussels, Belgium.*

Professor Jacques Deviere is the chairman of the Department of Gastroenterology and Hepatopancreatology at Erasme University Hospital, and Professor of Gastroenterology at the Université Libre de Bruxelles. Jacques Deviere graduated from the Brussels Free University in 1983. He obtained his graduation as gastroenterologist in 1988 and as Doctor of Philosophy in 1991.

His spectrum of clinical and research interest includes: Therapeutic gastro-intestinal endoscopy (biliopancreatic and upper GI), Liver Immunology and Pancreatic diseases pathophysiology.

In 1993, Jacques Deviere became associate clinical professor in Erasme Hospital and Brussels Free University and, in 1998, became professor of Gastroenterology and chairman of the department of gastroenterology, hepatopancreatology and GI Oncology. In 1997, he created and became the director of the laboratory of experimental gastroenterology at the University of Brussels.

Jacques Deviere is currently past president of the European Society of Gastrointestinal Endoscopy and has been, between 1996 and 2001, general secretary of the Belgian Society of Gastroenterology.

MITSUHIRO FUJISHIRO *Director, Department of Endoscopy and Endoscopic Surgery, The University of Tokyo, Tokyo, Japan.*

Dr Mitsuhiro FUJISHIRO was born in Toyohashi city, Aichi prefecture, Japan in 1970. He graduated from School of Medicine, The University of Tokyo, in 1995. After finishing two-year training as a general internist, he became a resident of Endoscopy Division and Department of Gastroenterology, National Cancer Center Hospital, Tokyo. The three-year residency was extremely valuable for him to learn fundamental skills of diagnostic and therapeutic endoscopy, especially endoscopic submucosal dissection (ESD) from Dr Hiroyuki ONO and Takuji GOTODA. He returned The University of Tokyo in 2000 as a graduate student in the Department of Gastroenterology.

During the four years in Graduate School of Medicine, he intensively investigated innovation of ESD as a safer and acceptable technique with Dr Naohisa YAHAGI. After Dr. YAHAGI moved to Toranomon Hospital, Tokyo, he became an Assistant Professor in the Department of Gastroenterology, and brought outcomes of ESD throughout the gastrointestinal organs in some conclusions, educating junior endoscopists. He is now the Director (an Associate Professor) in the Department of Endoscopy and Endoscopic Surgery, The University of Tokyo, from April, 2009.

DOUG REX *Professor of Medicine and Director of Endoscopy in the Division of Gastroenterology & Hepatology at Indiana University Medical Center, Indianapolis, USA.*

Dr Doug Rex is Distinguished Professor of Medicine at Indiana University School of Medicine, Chancellor's Professor at Indiana University Purdue University Indianapolis, and Director of Endoscopy at Indiana University Hospital in Indianapolis. He graduated from Harvard College, Summa Cum Laude in 1976 and with highest distinction from Indiana University School of Medicine in 1980. He served as Chief Medical Resident at Indiana University Hospital and joined the faculty at Indiana University in 1985. He received the Outstanding Teacher Award in the Introduction to Medicine course five times and has been awarded the Indiana University School of Medicine Outstanding Teacher Award as well as Department of Medicine's Excellence in Teaching Award. He is a full-time clinical gastroenterologist at Indiana University Hospital.

His major research interests have been in colorectal disease and, in particular, colorectal cancer screening and the technical performance of colonoscopy. He co-authored the colorectal cancer screening recommendations of the American College of Gastroenterology and the US Multi-Society Task Force on Colorectal Cancer. He also authored the recommendations on quality in colonoscopy of the US Multi-Society Task Force on Colorectal Cancer and the American College of Gastroenterology/American Society of Gastrointestinal Endoscopy.

Nurses Workshop Program

Sydney International Endoscopy Symposium 2012
Nurses Workshop

This workshop is endorsed by APEC number 014011002 as authorised by Royal College of Nursing, Australia (RCNA) according to approved criteria. Attendance attracts 6 RCNA CNE points as part of RCNA's Life Long Learning Program (3LP).

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The attendance of Maria Cirocco has been graciously supported by

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Nurses Workshop - Wednesday 7th March 2012

0730	**Registration opens**			
0830 - 0835	Welcome Note by Mary Bong			
	SECTION 1 Moderators : Vu Kwan and Robyn Brown			
0835 - 0905	*Unravelling the small bowel.* Vu Kwan			
0905 - 0935	*Update on micro-testing.* Jimmy Ng			
0935 - 1005	*My research nurse role - how it came about and what it encompasses.* Maria Cirocco RN, GI Research Manager, St Michael's Hospital, Toronto, Canada			
1005 - 1035	*Advanced mucosal resection: assessment and management of colo-rectal neoplasia.* Milan Bassan			
1035 - 1115	**Morning Tea and Trade Displays**			
	SECTION 2 – Hands-on demonstration **Moderators:** Milan Bassan and Judy Tighe-Foster **Floor Co-ordinators:** Jenevieh Junio and Susan Lane			
	Group 1	**Group 2**	**Group 3**	**Group 4**
1115 - 1145 25 minute Workshops 5 minute turnover	*The Ins and Outs of Polyps* Snares, loops and clips Lift recipe and injectors Pinning specimens Lesion classification Demonstrators - Rebecca Sonson, Stephanie Henshaw, Julie Hook and Mark Brook	*GI bleed management equipment* Banders and Coag grasper Super sucker and overtube Clips and Glue Optimal Endoscopic imaging Demonstrators - Amelia Tam, Helena Tsang, Vu Kwan, Mary Bong, Nicky Stojanovic and Maria Cirocco	*Ask the experts - Bugs in water* Micro-organisms in Endoscopy Water filtration Genca updates Demonstrators - Jon Long, Jimmy Ng, Di Jones and Robyn Brown	*'Up the duct'* Guidewires and sphincterotomes Baskets and balloons Cholangioscopy and EHL Demonstrators - Judy Tighe Foster, Su Wang, Milan Bassan and Sandra Ko
1145 - 1215 25 minute Workshops 5 minute turnover	*'Up the duct'* Guidewires and sphincterotomes Baskets and balloons Cholangioscopy and EHL Demonstrators - Judy Tighe Foster, Su Wang, Milan Bassan and Sandra Ko	*Ask the experts - Bugs in water* Micro-organisms in Endoscopy Water filtration Genca updates Demonstrators - Jon Long, Jimmy Ng, Di Jones and Robyn Brown	*GI bleed management equipment* Banders and Coag grasper Super sucker and overtube Clips and Glue Optimal Endoscopic imaging Demonstrators - Amelia Tam, Helena Tsang, Vu Kwan, Mary Bong, Nicky Stojanovic and Maria Cirocco	*The Ins and Outs of Polyps* Snares, loops and clips Lift recipe and injectors Pinning specimens Lesion classification Demonstrators - Rebecca Sonson, Stephanie Henshaw, Julie Hook and Mark Brook
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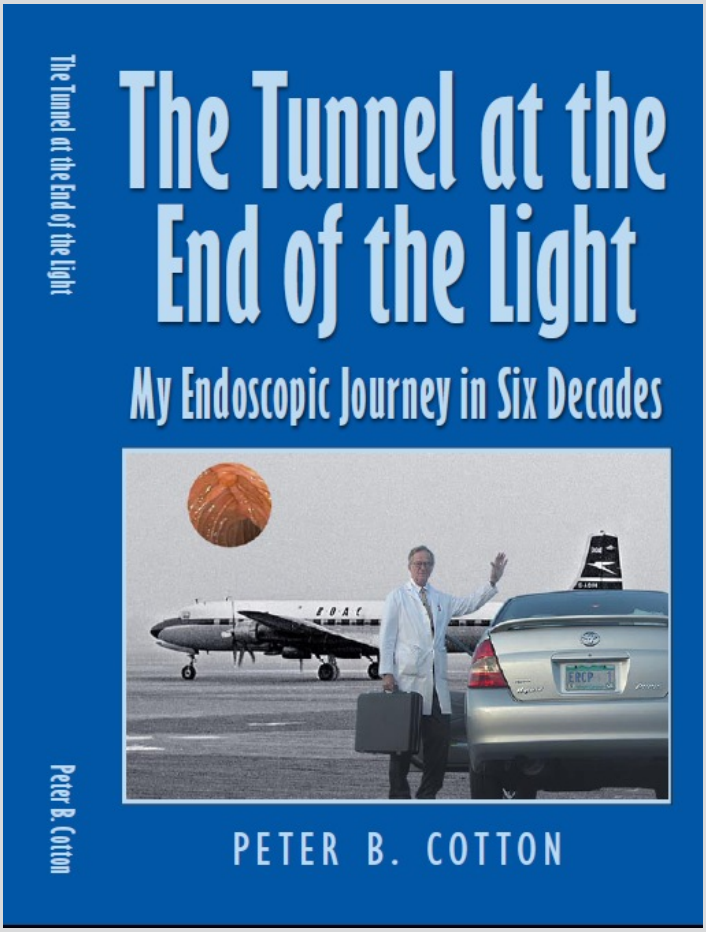
1245 - 1315 25 minute Workshops 5 minute turnover	*GI bleed management equipment* Banders and Coag grasper Super sucker and overtube Clips and Glue Optimal Endoscopic imaging Demonstrators - Amelia Tam, Helena Tsang, Vu Kwan, Mary Bong, Nicky Stojanovic and Maria Cirocco	*The Ins and Outs of Polyps* Snares, loops and clips Lift recipe and injectors Pinning specimens Lesion classification Demonstrators - Rebecca Sonson, Stephanie Henshaw, Julie Hook and Mark Brook	*'Up the duct'* Guidewires and sphincterotomes Baskets and balloons Cholangioscopy and EHL Demonstrators - Judy Tighe Foster, Su Wang, Milan Bassan and Sandra Ko	*Ask the experts - Bugs in water* Micro-organisms in Endoscopy Water filtration Genca updates Demonstrators - Jon Long, Jimmy Ng, Di Jones and Robyn Brown
1315 - 1400	**Lunch and Trade Displays**			
	SECTION 3 Moderators: Di Jones and Mary Bong			
1400 - 1415	Quiz - Quiz Master Nicky Stojanovic			
1415 - 1445	*Bleed Management: Diagnosis and Treatment.* Maria Cirocco RN, GI Research Manager, St Michael's Hospital, Toronto, Canada			
1445 - 1500	Quiz prizes presentation, closing remarks and thank you			
1505	**Close** **Afternoon Tea and Trade Displays** Coaches departing for Westmead Hospital Endoscopy Unit tours (takeaway afternoon tea provided)			
1830	Coaches arrive back to Hilton Sydney Hotel			

Peter Cotton's Memoirs

Available at www.peterbcotton.com

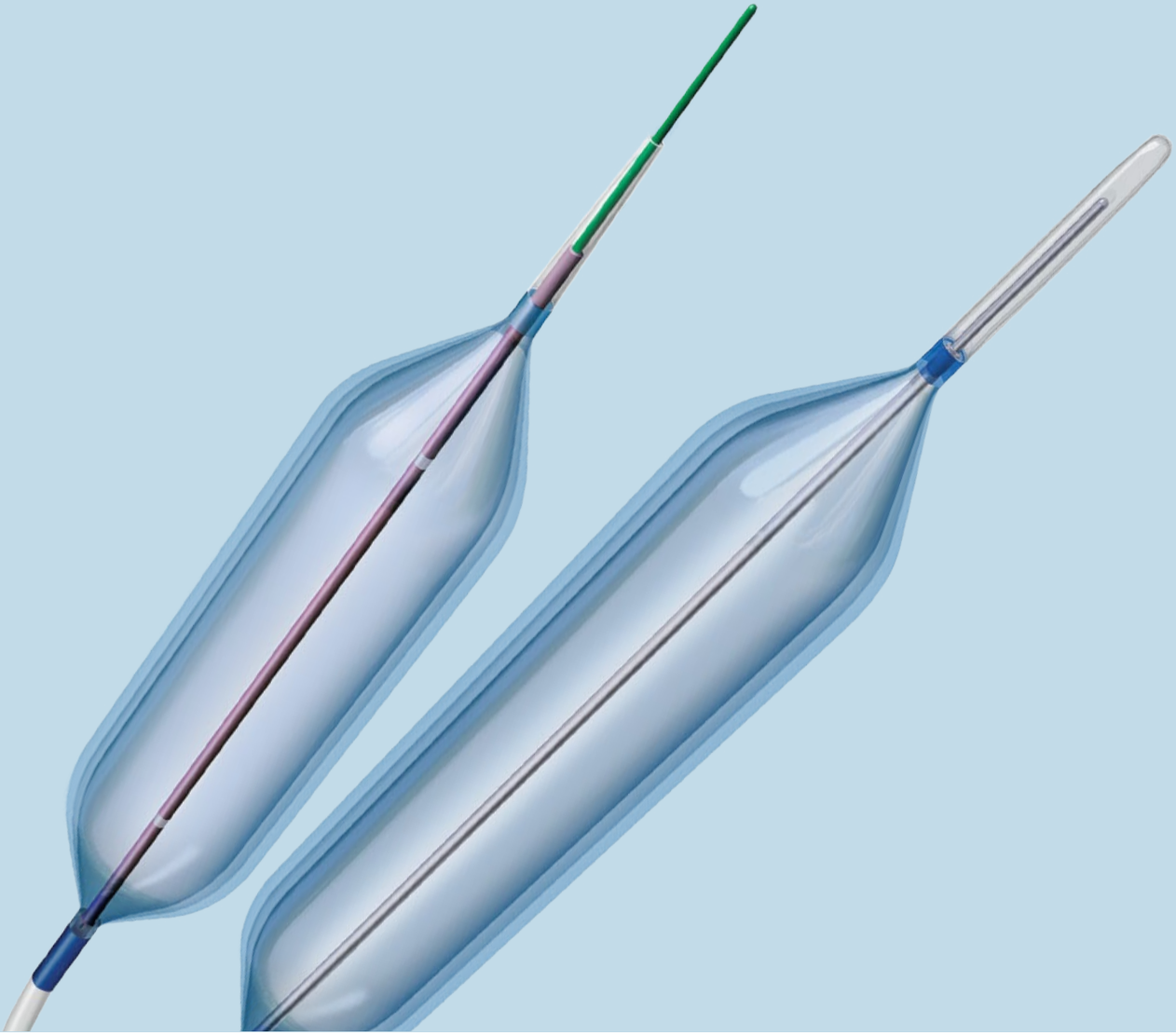


Professor Meinhard Classen, father of European endoscopy and inventor of sphincterotomy, wrote: "This book is just wonderful, historical and entertaining. Endoscopists all over the world should read it"

From chapter 6. I remember presenting endoscopic removal of stones at the Royal College of Surgeons in London in 1976. The President, a wine connoisseur, stated that the College should perhaps license a few medical gastroenterologists to perform the technique, but should charge "corkage" for each stone.

From chapter 13. In the early days, the food at Chinese hospitals was unpredictable and often mysterious. I was presented one lunchtime with "a favorite dish of the emperor to enhance your strength" during a long day of ERCP demonstrations. It was a thin stew, with lumps of gristle floating in it. After I finished, they giggled and said that it was made from the masculine member of the cow - I think they meant bull.

All proceeds from sale of the book go to the "Peter Cotton Endoscopy Training Fund" (in the MUSC Foundation) to support postgraduates seeking advanced endoscopic training.



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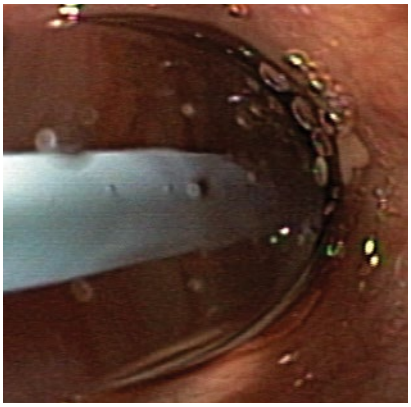

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Symposium Program

Certificate of attendances are available for collection from the registration desk – from Thursday afternoon onwards

Day One - Thursday 8th March 2012

0730	**Registration opens**
0830 - 0833	Welcome. Michael Bourke
0833 - 0835	Official Conference Open - Brad Astill. General Manager Westmead Hospital
0835 - 0905	***Diminutive colonic polyps: Detection, management, surveillance and implications***. Doug Rex
0905 - 1030	Live Endoscopy Session 1 – Chairs: Luke Hourigan, Thao Lam, Vu Kwan
1030 - 1100	**Morning Tea**
1100 - 1120	***Colorectal neoplasia: practical genetics for the practicing endoscopist.*** Barbara Leggett
1120 - 1300	Live Endoscopy Session 2 – Chairs: Rajvinder Singh, Ben Deveraux, Dev Samarasinghe
1300 - 1400	**Lunch**
1400 - 1530	Live Endoscopy Session 3 – Chairs: Peter Loder, Michael Swan, Richard Hope
1530 - 1600	**Afternoon Tea**
1600 - 1630	***Bariatric intervention and the Gastroenterologist.*** Jacques Deviere
1630 - 1700	General Endoscopy Quiz. Milan Bassan
1700	**Close**
1700 - 1800	Experts on the spot - Mini-Symposium: ***The right colon, the serrated polyp and the missed cancer.*** Barbara Leggett, Doug Rex (By pre-registration)
1845 - 2045	**Official Symposium Reception**

*Coaches will depart the Hilton Sydney Hotel from 6.15pm onwards (one-way transfer), alternatively, you can make your own way to the venue, allow approximately 20 minutes from the Hilton Sydney Hotel.

If you would like a seat on the complimentary coach, then simply record your name on the Coach List, next to the registration desk.

Symposium Program

Day Two – Friday 9th March 2012	
0730	**Registration opens**
0830 - 0850	*New innovations in endoluminal stenting: dissolvable, removable and others.* David Devonshire
0850 - 1030	Live Endoscopy Session 4 – Chairs: Gregor Brown, David Van der Poorten, Stephen Williams
1030 - 1100	**Morning Tea**
1100 - 1235	Live Endoscopy Session 5 – Chairs: Luke Hourigan, Rita Lin, David Ruppin
1235- 1300	*Early gastric cancer in the West: Are we missing it…? Whom to target and how to detect and evaluate.* Mitsuhiro Fujishiro
1300 - 1400	**Lunch**
1400 - 1530	Live Endoscopy Session 6 – Chairs: David Abi Hanna, Gregor Brown, Nghi Phung
1530 - 1600	**Afternoon Tea**
1600 - 1630	The Peter Gillespie Lecture – *New therapies in interventional endoscopy. Where are we and where to?* Jacques Deviere
1630 - 1645	Awards for the Quiz Winners - Milan Bassan
1645 - 1700	**Closing Remarks**

Each delegate will receive a stylish satchel bag, courtesy of Given Imaging – available for collection on the last day of your attendance, from the registration desk.

Mark your diary NOW, next year's Symposium dates!

Wednesday 6th - Friday 8th March, 2013

March 2013

S	M	T	W	T	F	S
24	25	26	27	28	1	2
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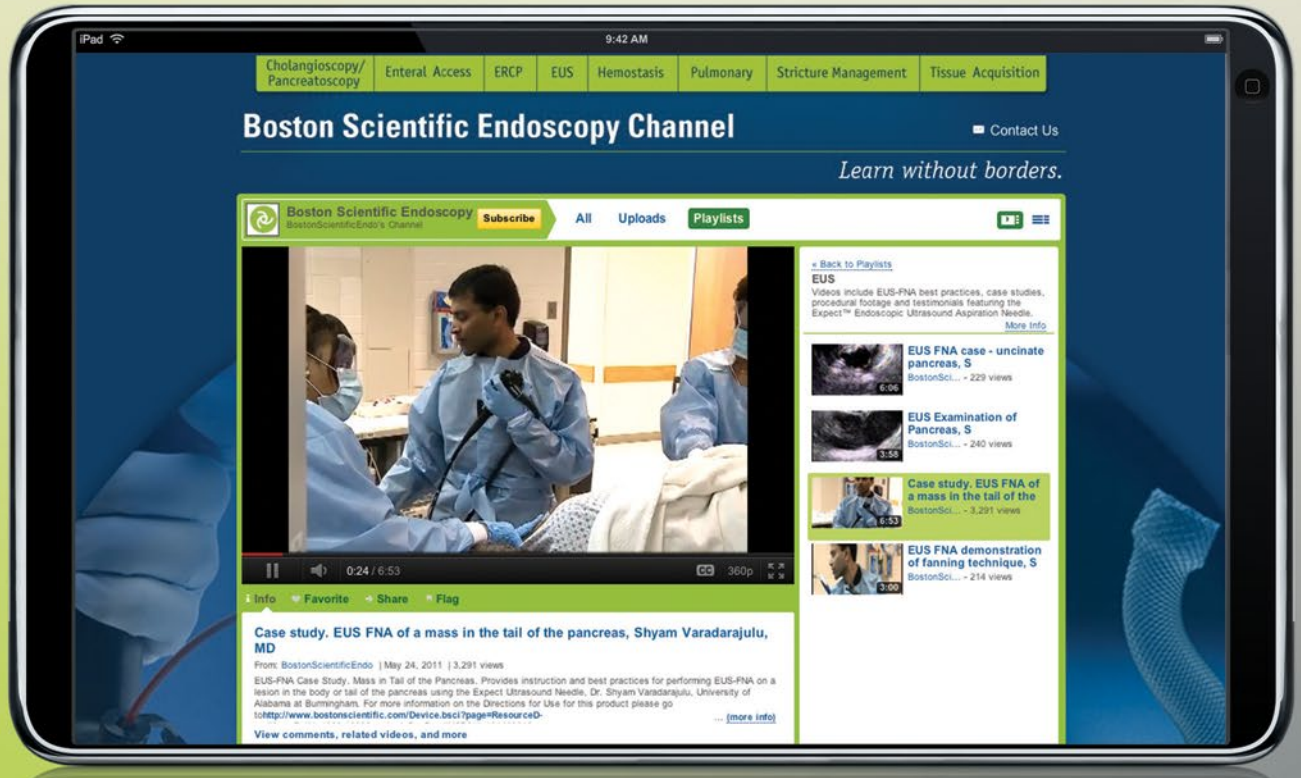

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Endoscopy

ANZ_PSST_11031 November 2011

Diminutive Colonic Polyps: Detection, Management, Surveillance, and Implications

Dr Doug Rex

Professor of Medicine and Director of Endoscopy in the Division of Gastroenterology & Hepatology at Indiana University Medical Center, Indianapolis, USA

Adenoma detection rates vary dramatically between individual endoscopists, often within the same gastroenterology groups. Detection rates differ for large polyps but the variation largely results from detection of diminutive adenomas by high level detectors. While there is evidence that moving overall adenoma detection rates above current targets of 20% reduces interval cancer, there is no evidence that the very high detection rates identified in some recent studies (40-55%) in screening populations, provides a real advantage for cancer prevention. However, the current paradigm for polyp management during colonoscopy is still to detect and remove all precancerous lesions, regardless of their size.

Detection of diminutive adenomas does provide interval cancer protection indirectly, because it affects the choice of surveillance colonoscopy interval when surveillance guidelines are applied to the colonoscopy findings. Thus, a high level detector who finds more diminutive adenomas will bring more patients back at shorter intervals, providing a sort of "double protection" against interval cancers. Similarly, a low level detector will tell more patients that they are normal, and their failure to detect both diminutive and larger precancerous lesions leads to a form of double "unprotection" (failure to detect plus longer surveillance interval assignment). Ideally, financial incentives would be altered so that colonoscopists with higher adenoma detection rates would be paid more per colonoscopy, and also allowed to assign longer intervals when patients have only diminutive tubular adenomas with low-grade dysplasia, since their patients' colons were better cleared during baseline examinations.

Current efforts to create sensible surveillance recommendations are evidence based but corrupted by variable detection at the baseline examination. In addition, cost inefficiencies are added by clinicians who either do not know the surveillance recommendations, do not believe them, or do not follow them because of financial disincentives. These behaviors are particularly unfortunate and illogical when endoscopists have not measured their adenoma detection rates.

Low cancer risk associated with individual diminutive colonic polyps suggests that their resection should be by low risk means. Currently, cold resection techniques are probably best. Cold snaring is generally most efficient and is a technique that is fundamentally different from hot snaring. Tenting is not required and normal mucosa around the lesion, for a diameter of 2-3 mm, should be routinely stripped with the lesion when possible. For tiny lesions, cold forceps resection is reasonable, and jumbo forceps are more effective and efficient.

A new concept in development, which is particularly applicable to diminutive polyps, is real time histologic assessment of histology. A variety of techniques have been shown to be effective, including confocal laser microscopy, endocytoscopy, narrow band imaging, i-Scan, autofluorescence, and the Fujinon Intelligent Chromoendoscopy system. Two potential clinical uses of real time histology for diminutive polyps have been suggested. One of these is the "resect and discard policy." In this approach, the histology of diminutive polyps is assessed endoscopically, and the polyp is then resected and discarded, rather than submitted to pathology. The postpolypectomy surveillance interval is then based on the endoscopic assessment. Cost effectiveness analyses suggest that this is a very cost-effective approach to the management of diminutive polyps. The second potential use of real time histology is to identify distal colon hyperplastic polyps which do not need resection and which can be ignored. This is currently the only set of colorectal polyps that does not warrant removal.

Bariatric interventions and the gastroenterologist

Jacques Deviere, MD, PhD

Department of Gastroenterology, Hepatopancreatology and Digestive Oncology, Erasme Hospital, Université Libre de Bruxelles Brussels, Belgium

Endoscopy is playing a growing role in the management of obesity.

Transoral gastroplasty has been shown feasible and safe. It was demonstrated possible to create a vertical pouch with a distal endoluminal restriction. Another 300 patients were included in a multicentric randomized sham controlled trial. This study showed a significant but modest advantage over the sham procedure but was judged insufficient by the FDA, a feature which led to closure of the company. Duodenojejunal sleeves induce a modest weight loss but are associated with significant improvement of diabetes. They are still a temporary treatment, given the fact that they can be left in place for only 6 months. Other implantable devices mimicking restrictive surgery are also under evaluation.

Endoscopy is also playing a major role in the management of complications associated with bariatric surgical procedures. The morbidity associated with reinterventions is particularly high in this group of patients and culminates in case of leaks occurring after RYGBP, reaching 50% with a mortality of 10%.

Seeking for a less invasive endoscopic treatment for treating this complication is therefore justified and has been proven feasible in some post-bariatric surgery complications. Anastomotic leaks are probably the most difficult complications occurring after RYGBP and sleeve gastrectomies. The use of sealants and sclerosing agents has been described in small series, as well as in attempts to close staple line dehiscence. Endoscopic stiching has also been reported in small series.

The largest experience has been reported in treating post-bariatric surgery gastrocutaneous leaks in 2 recent series using self-expandable metal stent. Salinas et al reported a series of 17 patients with 16 success and 3 complications (mucosal tears and migration to the colon). Eisendrath et al reported on 21 patients who underwent endoscopic treatment of persisting large anastomotic leaks before considering re-do surgery. They described an elegant technique of successive placement of metal stents for closure of the fistula followed by the placement, after 2 to 4 months, of a plastic stent which induces by pressure a necrosis of the hyperplasia and allows the removal of the metal stent.

Experts on the Spot – Mini-Symposium: The Right Colon, the Serrated Polyp, and the Missed Cancer

Dr Doug Rex

Professor of Medicine and Director of Endoscopy in the Division of Gastroenterology & Hepatology at Indiana University Medical Center, Indianapolis, USA

Interval cancers, or cancers that occur after a colonoscopy that had apparently cleared the colon of neoplasia, are associated with a variety of factors, including the proximal colon, prior polypectomy in the same segment, microsatellite instability, the CpG island methylator phenotype (CIMP), performance of colonoscopy by non-gastroenterologists, performance of colonoscopy by physicians with lower adenoma detection rates, lower polypectomy rates, and lower cecal intubation rates, and most recently with the indication of positive fecal occult blood tests at the baseline colonoscopy as opposed to screening. The latter simply reflects a higher prevalence of disease at baseline and therefore a greater opportunity for missing.

The association of interval cancers with proximal location, CIMP status and microsatellite instability, indicates a high probability that the serrated pathway of colorectal cancer accounts for a disproportionate percentage of interval cancers. The serrated pathway, which is believed to arise in serrated colorectal polyps and flat lesions, accounts for about 30% of all colorectal cancers. The World Health Organization classifies serrated lesions into three categories, including hyperplastic polyps, sessile serrated polyps (also known as sessile serrated adenomas) with or without cytological dysplasia, and traditional serrated adenomas. The molecular profiles of these lesions and their locations within the colon suggest that the sessile serrated polyp is the predominant precursor of CIMP-high colorectal cancers.

Serrated lesions have a distinct endoscopic appearance, including pale color, a mucus cap, indiscrete edges, and lack of or relatively diminished number of visible surface vessels. Available evidence indicates that detection of serrated lesions has greater variability among gastroenterologists than does detection of adenomas. Detection of serrated lesions has a strong correlation with adenoma detection and therefore currently there is no mandate to develop a serrated polyp detection target. The use of a serrated detection target would also be hampered by the need to confine the target to the proximal colon, to avoid contamination by large numbers of diminutive distal hyperplastic polyps. There would also be difficulty in distinguishing between hyperplastic polyps and sessile serrated polyps in the proximal colon, which in current community pathology practice is almost certainly unreliable, since it is not very reliable even among expert pathologists. Serrated polyps in the proximal colon are not uncommon, and recent endoscopic series in which the prevalence has been described by high level adenoma detectors have suggested that 18-20% of patients undergoing screening colonoscopy will have one or more serrated lesions proximal to the splenic flexure of some size. The prevalence of large serrated lesions and of sessile serrated polyps is lower and remains incompletely defined.

New innovations in Endoluminal stenting: dissolvable, removable and others

Dr David Devonshire

Director of Endoscopy, Southern Health, Victoria, Australia

Endo luminal stenting for malignant oesophageal, biliary and luminal gastro intestinal disease has been established for many years. Stent technology has progressed to the point where we have a number of options available including partially and fully covered metal stents (SEMS), Plastic stents (SEPS) and biodegradable (BD) stents. Stenting with SEMS in malignant disease can help palliate dysphagia in the oesophagus, malignant biliary obstruction, gastric outlet, small bowel, and colonic obstruction. (Carr-Locke, GIE 2005, Dua, GIE 2007)

Dilation of benign oesophageal strictures had traditionally relied upon rigid Mahoney bougienage, polyvinyl bougies (Savary Gilliard) or balloons (eg. TTS CRE balloons). These tools allowed most strictures to be dealt with long term. Some strictures are truly refractory and require innovative techniques such as needle knife incision, local steroid injection or stents. Stenting for benign disease is appealing but often only led to short term control of strictures because of the high rate of instent stenosis, migration, pain and bleeding. (Triester, Endoscopy 2006).

New innovations in stent design have shown an emerging role in benign diseases, particularly in the oesophagus and biliary tree.

Refractory and complex oesophageal strictures, such as those from peptic disease, corrosive ingestion, post operative anastomotic strictures, radiation strictures and those from endoscopic mucosal resection can be treated with good medium to long term results with covered SEMS. (Lakhtakia, GIE 2007, Eloubeidi, GIE 2008) (Fig 1) There is also emerging literature to support the use of oesophageal stents in post operative fistulous disease, acute leaks and tears, as in Boerhaaves syndrome. (Swinnen, GIE, 2011) Recently available OVESCO, over the scope (OTS) clips may allow single step fistula closure and avoid the need for stent removal once a fistula is healed. (Surace, GIE, 2011)

Biliary leaks and fistulae have been treated endoscopically with plastic stents very successfully. However benign biliary strictures, such as those seen following liver transplantation, biliary surgery or chronic pancreatitis have usually involved a program of repeated multiple biliary stents and dilations over a period of 12 months or more to prevent relapse. (Costamagna, GIE, 2001, Draganov, GIE 2002) Newer removable, covered metal stents may be an appropriate alternative thus avoiding the need for recurrent intervention and morbidity. (Kahelah, GI Endoscopy 2008), Costamagna, GIE, 2008, Poley GIE, 2011, Kasher, GIE 2011)

Endoscopic removal of SEMS for benign conditions may be complicated by incomplete removal, fracturing of the stent and even perforation despite use of double channel endoscopes with two 'rat tooth' forceps or by inversion of stents. (Hirdes, Endoscopy, 2011). Hyperplastic ingrowth may be overcome by placement of a second internal stent to allow tissue necrosis and then reattempt removal. (Evrard, GIE, 2004, Swinnen, GIE, 2011).

Polydioxinol biodegradable (BD) stents have now been used in the oesophagus, (Vandenplas, Endoscopy 2009), biliary tree (Petrtýl, Endoscopy 2010) and colon (Toth, Endoscopy, 2011, Rejchrt, Endoscopy 2011). They potentially offer the advantage of avoiding reintervention for removal. When they stay in place long enough for 'remodelling' they may allow improved long term control. However severe hyperplastic ingrowth (Hair, Endoscopy 2010, Orive, Endoscopy 2010, Holt, JGH 2010) and recurrent strictures may still occur in a sizable proportion of recipients.

My aim is to present the data on these new and emerging therapies as they apply to a wide variety of diseases and indications in most parts of the gastrointestinal tract.

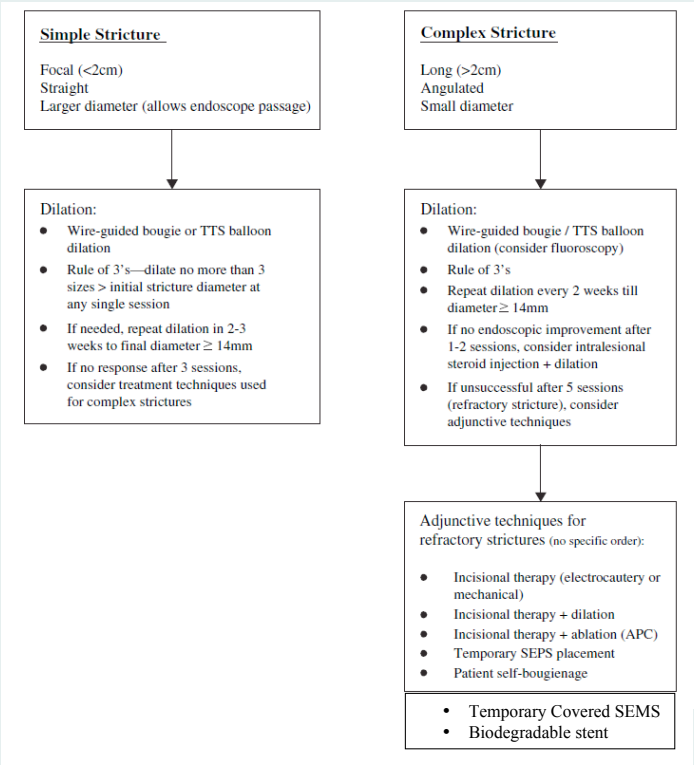


Fig 1: Algorithm for management of Refractory Benign Oesophageal strictures (adapted from Shah, GIE, 2006)

Early gastric cancer in the West: Are we missing it?... Whom to target and how to detect and evaluate

Mitsuhiro Fujishiro

Department of Endoscopy and Endoscopic Surgery, Graduate School of Medicine, The University of Tokyo

I live in a country where both of incidence and mortality of gastric cancers are extremely high in comparison with those in the West. The main reason must be a high prevalence of H.pylori infection. However, tremendous efforts to overcome gastric cancer deaths by introduction of mass screening (barium meal) in general population over 40 y.o. have resulted in steep reduction of the mortality year by year. Additionally, because individuals with H.pylori infection are rapidly decreasing in younger generation, we estimate that an incidence of gastric cancer must become quite similar with that in the West in the near future.

When the incidence is low (in case of the West), an efficient screening scheme "from serological diagnosis by pepsinogen level and H.pylori antibody status to endoscopy for high-risk individuals" (not "from barium meal to endoscopy") should be adopted considering cost-effectiveness and risks & benefits. Although white-light endoscopy is still a gold standard to detect early gastric cancer (EGC), autofluorescence imaging (AFI) may help to detect suspicious lesions with low specificity. In terms of characterization after detection of the suspicious lesions, narrow band imaging (NBI) with magnification is commonly used in advanced institutions in Japan to evaluate them without taking biopsy or chromoendoscopy with indigocarmine.

Are they missing an EGC in the West? This is a very difficult question. My answer is "maybe Yes"! However, in order to detect it, the national strategy to pick up high-risk individuals by serum samples must be necessary beforehand, because detection of EGC in the West is like detection of a missing coin in a wide stadium. The next step may be to train endoscopists who are familiar with high-definition magnifying endoscopes equipped with AFI and NBI. In this step, experiences and accumulated knowledge of our Japanese endoscopists will contribute a lot.

THE PETER GILLESPIE LECTURE

New therapies in interventional endoscopy: Where are we and where to?

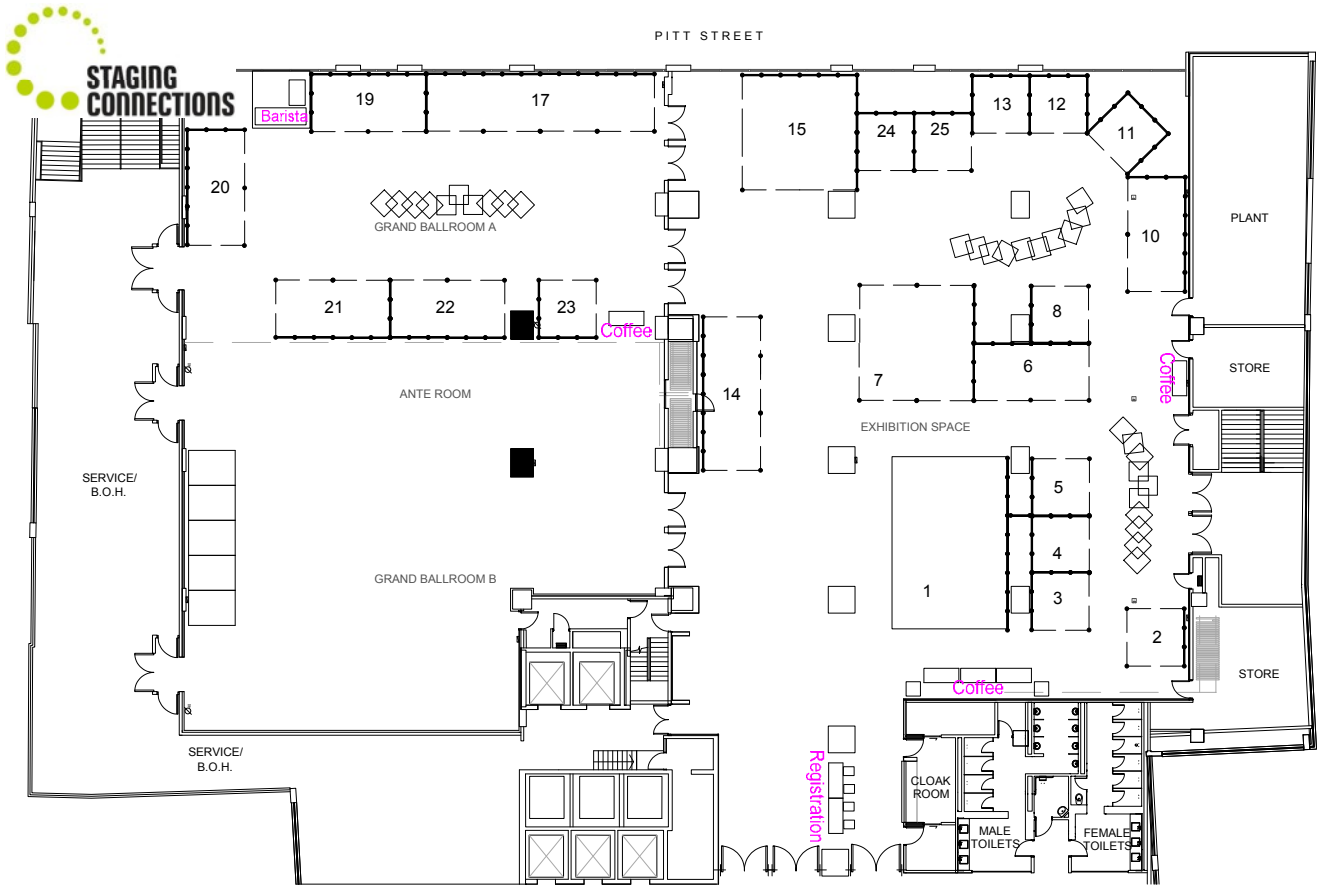
Jacques Deviere, MD, PhD

Department of Gastroenterology, Hepatopancreatology and Digestive Oncology, Erasme Hospital, Université Libre de Bruxelles Brussels, Belgium

Since the first flexible endoscopy performed in 1958, endoscopy and endotherapy have dramatically changed the diagnosis and the outcome of patients having GI diseases. It is hard to believe that 40 years ago patients with gallstone pancreatitis or acute cholangitis had a mortality far above 30% and that many patients were dying from peptic ulcer disease or uncontrolled variceal bleeding. The joined development of early diagnosis and technical sophistication has allowed not only to decrease the mortality from GI cancer thanks to early detection but also to develop new therapies for early GI cancer. Nowadays, probably more than 50% of the cancers of the GI tract are treated by an endoluminal route without the need for open surgery. Therapeutic endoscopy has reached targets which are located outside the GI tract not only in the biliopancreatic ducts but also, with the development of therapeutic endoscopic ultrasound, located in any areas around the upper GI tract. Pancreatic and biliary diseases, followed by post-surgical complications, have taken the most benefit of this development but, outside of their work of "plumbers", therapeutic endocopists have also become interventional oncologists, interventional radiologists and are even thinking about becoming real surgeons with the recent development of NOTES. The new therapies in interventional endoscopy have prompted the need for close coworking between all the practitioners who are caring about the same patients including obviously gastroenterologists and GI surgeons, but also radiologists, anesthesiologists and pathologists. The management of obesity, the pandemy of the 21st century, is a typical example of such developments where the interventional endoscopist initially developed techniques to treat complications of surgery, dramatically reducing the morbidity of severe complications occurring after bariatric procedures but also developed some specific treatment for primary treatment of morbid or non morbid obesity. The next steps in this area will be dealing with the treatment of type II diabetes where recent developments have shown encouraging results.

The future of interventional endoscopy will be dealing with competitive techniques which will probably dramatically reduce the number of procedures performed for simple diagnosis using an endoscope. The mass screening might be performed mainly using non invasive techniques while endoscopy will focuse on immediate histological diagnosis and treatment which will progressively replace many of the currently available functional surgical procedures. Whatever the cases, it will profoundly alter our way of managing the patients, rendering mandatory the multidisciplinary approach performed in dedicated centers by people having had the proper training. The common gall will be to reduce morbidity for screening, early diagnosis and treatment while improving the outcome in this multidisciplinary setting. By the way, it will become one of the areas where practitioners could enjoy the most while doing innovations.

TRADE FLOOR PLAN



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