

7th

Sydney International Endoscopy Symposium

Wednesday
5th March

2014

Hilton Sydney, Australia

NURSES' WORKSHOP PROGRAM AND SYLLABUS

INTERNATIONAL KEYNOTE SPEAKER



Maria Cirocco RN, GI Research Manager,
St Michael's Hospital, Toronto, Canada

SPECIAL THANKS TO



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SIES Sydney International
Endoscopy Symposium



NURSES' WORKSHOP 2014



It is a great pleasure to welcome you to the 7th Sydney International Endoscopy Symposium Nurses' Workshop. The Westmead Endoscopy team has prepared another fabulous and stimulating array of talks and demonstrations which will enhance your understanding of Gastrointestinal Endoscopy.

We are delighted to have a large and diverse group of fabulous speakers on our programme including Farzan Bahin, David van der Poorten, Vu Kwan, Sandra Ko, Michael Bourke and our 2012 international speaker Maria Cirocco.

We have continued with the very popular demonstration stations this year and you will have hands-on opportunities with the latest devices in therapeutic endoscopy.

The Symposium is also an avenue for networking and interaction amongst the great nursing minds in Endoscopy, offering updates and learning fresh tips and tricks to promote gastrointestinal endoscopy nursing.

Nurses are encouraged to attend the two full days live high quality transmission from the Westmead Endoscopy Suite to the Hilton Sydney Hotel which will showcase the latest development with interesting and challenging cases that demonstrate 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 Westmead Endoscopy Symposium 2014



I am very proud to support Westmead Nurses in showcasing their talents and contribution to gastrointestinal endoscopy. Now is the time to broaden our thinking, to evolve by harnessing new ideas and new technology, to provide the best possible care for our patients, every time.

It gives me great pleasure that Westmead Nursing is at the forefront of delivering the best care to our patients and we continue to engage other health care professionals to strive for best practice.

I am looking forward to listening to the nursing presentation and watching live the telecast from Westmead Hospital.

I hope you enjoy the two day conference not only for the educational benefits but also the opportunity to network with other health care professionals to maintain a strong culture of sharing knowledge and collaborative learning.

Yours sincerely

Ms Joanne Edwards
Director of Nursing & Midwifery
Westmead Hospital

DEMONSTRATION STATIONS

what you need to know!

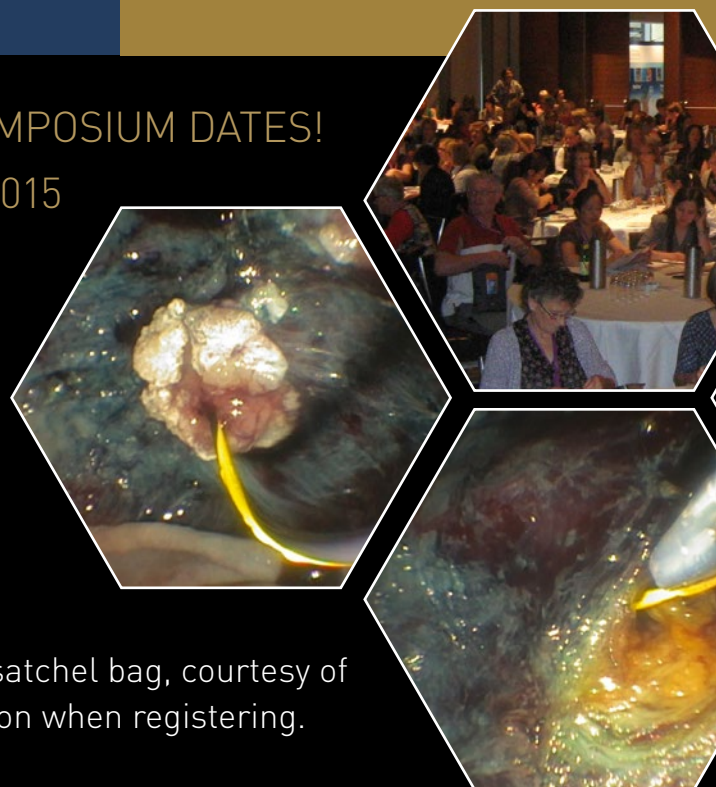
- * There will be 3 Workshop Demonstration Stations to visit and these will be located in different areas within level 3. One will remain in the main auditorium, and two will be based in the adjoining room.
- * For each Workshop Demonstration Station, you will be required to break into smaller groups to view the various Demonstrations.
- * Your name badge will be colour coded (**yellow, green or blue**) to represent the group you have been allocated to. The yellow group will start at Demonstration Station 1, the green group will start at Demonstration Station 2, and the blue group will start at Demonstration Talk 3 (in the main auditorium). Groups will then be rotated after 40 minutes.
- * In each demonstration station there will be 4 booths, and 10 minutes is allocated per booth.
- * Please follow the Facilitator's (Westmead Hospital staff) instructions when moving from booth to booth.
- Demonstrators will be equipped with microphones and be situated on podiums to ensure you can hear and see what is being presented.

MARK YOUR DIARY NOW, NEXT YEAR'S SYMPOSIUM DATES!

WEDNESDAY 4TH - FRIDAY 6TH MARCH, 2015

MARCH 2015

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				



Each delegate will receive a stylish satchel bag, courtesy of Cook Medical – available for collection when registering.

NURSES' WORKSHOP PROGRAM

Kindly supported by



SYDNEY INTERNATIONAL ENDOSCOPY SYMPOSIUM 2014 NURSES' WORKSHOP

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

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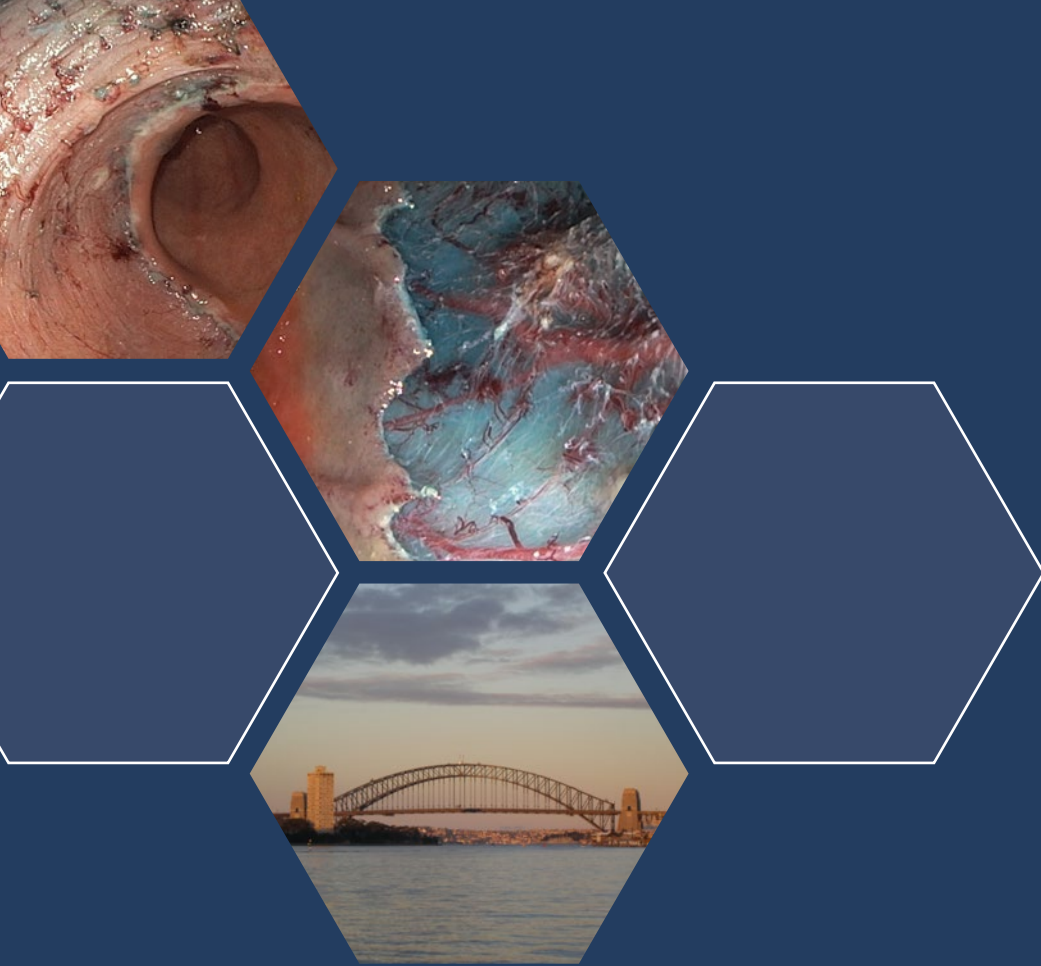


The attendance of Maria Cirocco has been graciously supported by



NURSES' WORKSHOP - WEDNESDAY 5TH MARCH 2014

0730	REGISTRATION OPENS		
0830 - 0845	Welcome Note – Mary Bong RN and Joanne Edwards DON Westmead Hospital		
SECTION 1 - Facilitator: Robyn Brown			
0845 - 0910	<i>Managing polypectomy complications: bleeding, perforation and others</i> - Prof Michael Bourke		
0915 - 0940	<i>Barrett's: What's the fuss about diagnosis and treatment in 2014?</i> - Dr Farzan Bahin		
0945 - 1010	<i>The importance of nursing admission and assessment in the Day Surgery setting</i> - Sandra Ko RN		
1015 - 1040	<i>Infection control: Where to now?</i> - Maria Cirocco		
1045 - 1115	Morning Tea and Trade Displays		
SECTION 2 – Workshop Demonstrations & Presentations – Facilitator: Mary Bong			
1115 - 1330	DEMONSTRATION 1 <i>Tools for managing polypectomy complications</i> Co-ordinator – Robyn Brown	DEMONSTRATION 2 <i>Principles, safe and effective use of endoscopic devices</i> Co-ordinator - Jeneviah Junio	DEMONSTRATION TALK 3 <i>What's new in 2014</i> Co-ordinator - Janice Waru
	BOOTH 1 <i>Deployment of clips</i> Nicky Stojanovic and Co. Reps	BOOTH 1 <i>ERCP Stone retrieval and crushings</i> Judy Tighe-Foster and Co. Rep	TALK 1 <i>Principles of intraductal stone crushers</i> Amelia Tighe
	BOOTH 2 <i>Coagulation devices</i> Rebecca Sonson & Polly Leong	BOOTH 2 <i>EUS FNA needle techniques</i> Sandra Ko	TALK 2 <i>EUS images interpretations</i> Vu Kwan
	BOOTH 3 <i>Recipes</i> Mariam Khilwati <i>Ovesco Clips</i> Stephanie Henshaw and Co. Rep	BOOTH 3 <i>Barrett's Therapy</i> Helna Lindhout and Vanessa McArdle-Gorman	TALK 3 <i>Interpretation of GI Radiological images</i> Dr Farzan Bahin
	BOOTH 4 <i>Snares and Diathermy settings</i> Zion Siu and Co. Rep	BOOTH 4 <i>Achalasia Dilatation</i> Betty Lo and Alison Bannister	TALK 4 <i>Highlighting biofilms in endoscope reprocessing</i> Greg Whiteley
1330 - 1430	Lunch and Trade Displays		
SECTION 3 - Facilitator: Judy Tighe-Foster			
1430 - 1445	Quiz - Zion Siu RN		
1445 - 1510	<i>"Trap that polyp" How and Why?</i> - Maria Cirocco <i>What happens when it goes to the lab?</i> - Dr Farzan Bahin		
1515 - 1540	<i>Hard to swallow (Achalasia)</i> - Dr David van der Poorten		
1545 - 1600	Open forum: Question time – Di Jones and Debbie McQueen		
1600 - 1615	Quiz prizes, presentations and surprises		
1615 - 1620	Closing remarks and thank you		
1630	Afternoon Tea and Trade Displays		



SPEAKER BIOS AND WORKSHOP ABSTRACTS

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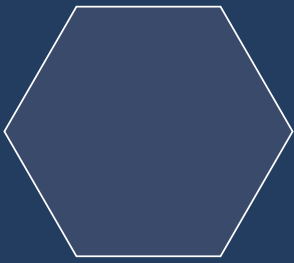
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SPEAKER BIOS



PROF MICHAEL BOURKE MD, PHD

Professor Michael Bourke is Clinical Professor of Medicine, University of Sydney and Director of Gastrointestinal Endoscopy at Westmead Hospital. He is Co-editor of the journal Endoscopy. He is the convenor of the Sydney International Endoscopy Symposium, now in its 7th year with a delegation of more than 600 registrants and Australia's second largest gastroenterology meeting.

His clinical and research interests encompass many different facets of diagnostic and interventional endoscopy. Endoscopic resection for advanced mucosal neoplasia at all sites in the gastrointestinal tract has been a focus. Patients referred to Westmead with early Barrett's neoplasia, duodenal and ampullary lesions, and large sessile polyps or laterally spreading tumours of the colon are invited to participate in prospective studies and randomised trials designed to validate, assess and enhance the safety and efficacy of endoscopic resection for advanced mucosal neoplasia.

Work in the animal laboratory augments the clinical research. He is also active in ERCP research. Original research is published regularly in the leading international journals in Gastroenterology and Endoscopy.



DR FARZAN BAHIN

Dr Farzan Bahin is a gastroenterology advanced trainee and research fellow at the Endoscopy Unit, Westmead Hospital. He is currently undertaking his PhD in the endoscopic evaluation and management of pre-malignant lesions of the gastrointestinal tract, including Barrett's oesophagus and advanced colonic mucosal neoplasia. He has a strong interest in research and teaching of all aspects of gastroenterology and hepatology.



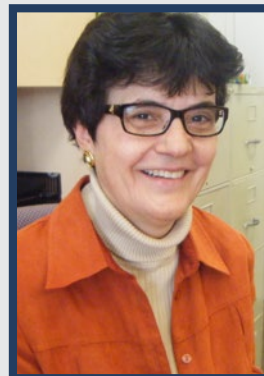
SANDRA KO

Sandra Ko is a registered nurse who has worked at Westmead Endoscopy for nearly 8 years. She previously worked at Concord Hospital Endoscopy for 6 years. Sandra is COGEN credentialed and an active GENCA member on the NSW Committee.

Her interests are in interventional endoscopy such as ERCP, EUS, EMR and ESD. She has also been to Japan to watch ESD being performed.

Sandra attended the World Congress of Gastroenterology last year in Shanghai where she gave a talk on "Polyp Assessment for Nurses".

Sandra has an active role in the new reporting system and paperless data capturing system.



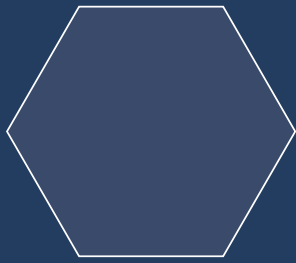
MARIA CIROCCO

Maria is currently employed as the GI Research Manager at St. Michael's Hospital in Toronto, Canada.

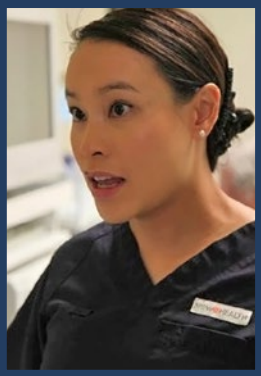
Maria Cirocco received her Nursing Diploma and Bachelor of Science in Nursing at Ryerson Polytechnical Institute in 1978 and 1988. She received a Master of Arts, Ed. from Central Michigan University in 2003.

Maria's professional affiliations include:

- Involved with CSGNA since its formation, have served as secretary, president and on various committees
- Participated in the certification process by serving as a member of the Competencies committee and the Exam committee
- Obtained Canadian certification in Gastroenterology in 2004
- Served as speaker at various conferences
- Served on the first SIGNEA executive committee as treasurer
- Long standing Member of SGNA
- Long standing member of the Registered Nurses Association of Ontario and served as chapter president.



SPEAKER BIOS



DR VU KWAN

Vu Kwan is a staff specialist in Gastroenterology at Westmead Hospital.

She is delighted to be participating in the important Nurses Symposium at this meeting once again.

Notes



DR DAVID VAN DER POORTEN BSC (MED) MBBS FRACP PHD

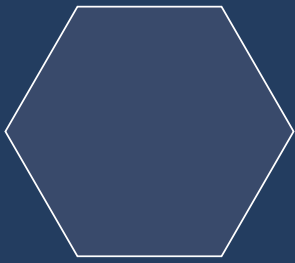
**Staff Specialist Westmead Hospital
Senior Lecturer Sydney University**

Dr David van der Poorten is a Staff Specialist Gastroenterologist at Westmead Public Hospital and a Clinical Senior Lecturer in medicine at the University of Sydney. He is a Consultant Gastroenterologist at Norwest Private as well as Westmead Private and Strathfield Private hospitals. He is a fellow

of the Royal Australasian College of Physicians and an active member of the Gastroenterological Society of Australia.

A graduate of the University of New South Wales, Dr van der Poorten underwent Gastroenterology training at Concord and Westmead Hospitals Sydney, before undertaking a PhD in advanced Hepatology through the Storr Liver Unit at Westmead Hospital under Professor Jacob George. He has published widely in the medical literature and is a reviewer for high ranking journals in his field including Gastroenterology, Hepatology, Journal of Hepatology, World Journal of Gastroenterology and the Medical Journal of Australia.

Dr van der Poorten's practice encompasses all aspects of Gastroenterology and Liver disease but he has a particular interest in colorectal cancer screening, the management of fatty liver disease and NASH, inflammatory bowel disease, drug-resistant helicobacter infection and therapeutic endoscopy.



Barrett's: What's the fuss about diagnosis and treatment in 2014?

DR FARZAN BAHIN

Barrett's oesophagus (BO) is an acquired condition whereby a malignancy predisposing metaplastic columnar epithelium replaces the usual oesophageal squamous epithelium. Endoscopists have a significant role in managing BO. Systemic biopsy protocols have facilitated the diagnosis of this condition. Advancements in endoscopy technology have improved dysplasia detection and subsequent surveillance and treatment outcomes. Treatment for dysplastic BO and early oesophageal cancer has changed from being surgical to organ-sparing endoscopic therapy. A multimodal treatment approach combining endoscopic resection (EMR, ESD) of visible or raised lesions with ablation techniques (RFA, PDT, Cryotherapy) for flat dysplastic mucosa, followed by long-term surveillance improves the outcomes of BO. Important questions remain including the optimal surveillance protocols, endoscopic treatment approach. Shared decision making between the patient and physician, as well a strong working relation between endoscopists and endoscopy team members is important for all aspects of the detection and treatment algorithm of BO.

The Importance of Nursing Admission and Assessment in the Day Surgery setting

SANDRA KO

A thorough Nursing Admission and Assessment is essential for the provision of high quality nursing care as it details the needs of the patient's health situation.

Nurses begin their assessment when they bring the patient from the waiting room to the interview room or bed. When the nurse greets and introduces themselves they can ascertain whether the patient can understand basic English? Are they quite rotund or very frail and skinny. Does the patient have mobility issues? And also some insight into the patient's psychological state. When nurses have this intuition they can arrange interpreters, gather mechanical lifters, perform a pressure area assessment or arrange a pre-medication for the patient.

The nurse also begins the discharge planning during the admission process as the patient requires continuity of care when they are discharged post sedation/anaesthetic. This provides the patient with the optimal level of care.

Infection control: Where to now?

MARIA CIROCCO

The face of infection prevention and control is evolving; however basic principles never go out of style. Hospital acquired infections are of concern for both our patients and those of us caring for them.

Although the reported infection transmission in endoscopy is low is very low, (Public Health Agency of Canada pg 12) it is recognized that endoscopy related infection may occur from patient to patient due to contaminated endoscopic equipment or from patient to personnel and vice versa related mostly to breaches in accepted standards.

This aim of this presentation is to provide a brief overview of where we are today in relation to endoscope reprocessing; hand hygiene; personal protective equipment; environmental considerations and future challenges

Reference

Public Health Agency of Canada. *Infection Prevention and Control Guideline for Flexible Gastrointestinal Endoscopy and Flexible Bronchoscopy.*

<http://www.phac-aspc.gc.ca/nois-sinp/guide/endo/pdf/endo-eng.pdf> (Accessed January 15, 2013)



Principles of intraductal stone crushers

AMELIA TIGHE
BSC (HONS) HEALTH SPORTS SCIENCE

Gallstones in Australia accompany a lifetime risk of 14-20%, and are formed when cholesterol, calcium bilirubinate and calcium carbonate are out of balance in the gallbladder. Some of the risk factors associated with their formation are being over 40 years of age, female, overweight, fair complexion and fertile (pre-menopausal).

When the stones obstruct bile flow serious complications may develop such as cholecystitis (inflammation of the gallbladder), acute cholangitis (inflammation of the bile duct) or pancreatitis (inflammation of the pancreas). Patients are generally asymptomatic but may experience fever, abdominal pain or jaundice. Stones vary from small (5mm) to extremely large (>3cm) and from 1 to numerous.

Gallstones can occur anywhere within the biliary tract, including the gallbladder and the common bile duct (CBD). The most common disorder of the biliary tract is known as cholelithiasis (stones in the gall bladder). When the stones are confined to the gallbladder they can be surgically removed via cholecystectomy. If the stones migrate into the ducts, the condition is referred to as choledocholithiasis (stones in the bile duct), in which case an Endoscopic Retrograde Cholangiopancreatography (ERCP) needs to be performed.

Endoscopic sphincterotomy is an established method for the removal of CBD stones. This procedure has been shown to be safe (<10% complication rate) and effective in 80%-90% of patients. Stones <1 cm in diameter can be extracted using a basket or balloon catheter whereas large (>2 cm) stones require some form of lithotripsy (mechanical crushing) to facilitate duct clearance.

Interpretation of GI Radiological images

DR FARZAN BAHIN

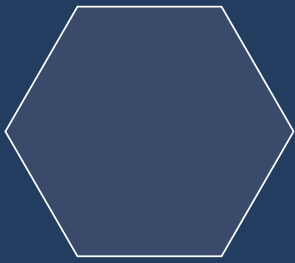
In addition to a good clinical history and physical examination, imaging of the gastrointestinal tract plays a significant role in the diagnosis and management of a multitude of gastroenterology and hepatology conditions. The endoscopist and health practitioner nowadays has a multitude of imaging options available including plain x rays, fluoroscopy, ultrasound, CT, MRI and PET scans. In addition imaging guided procedures such as percutaneous guided cholangiography or gastrostomy insertions are in routine practice at experienced centres. Endoscopy team members benefit from a basic understanding of these modalities as these help inform diagnosis and therapy decision making for the patient. This session will give an overview of common and evolving imaging techniques when dealing with clinical and endoscopic problems.

Highlighting biofilms in endoscope reprocessing

GREG WHITELEY

This brief session will outline the key issues in cleaning validation for endoscopes, including the need to understand the nature and persistence of biofilms on endoscopes and the dry surface biofilms that may be present on surrounding objects and surfaces. The latest evidence on cleaning claims and biofilms will be reviewed (both Australia and the USA), and evidence on the need to maintain strict aseptic practice will be discussed. The role of High Level Disinfection and poor evidence in relation to false claims of bacterial resistance will also be covered.





“Trap that polyp:” How and Why?

MARIA CIROCCO

Colorectal cancer is the third most common cancer, with an estimated 1.4 million new cases diagnosed worldwide in 2012. (http://www.wcrf.org/cancer_statistics/data_specific_cancers/colorectal_cancer_statistics.php)

Improvements in endoscopic technology, in conjunction with parallel improvements in endoscopic devices, and the ability to perform complex endoscopic interventions have revolutionized therapeutic options for patients and shifted care away from traditional surgery. Early detection greatly increases the chances of successful endoscopic treatment and it is accepted that the removal of adenomas can prevent colon cancer. The aim of endoscopic screening and surveillance is to detect adenomatous polyps and early cancers, which can be treated endoscopically, before progression to invasive cancer.

Once a lesion is removed, retrieval of the tissue sample is paramount to ensure patients are staged appropriately, that endoscopic treatment was sufficient for the lesion removed and to determine appropriate follow up.

This presentation will focus on some of the tools available to the GI Nurse, to “trap” the specimen so that appropriate pathological diagnosis can be achieved.

What happens when it goes to the lab?

DR FARZAN BAHIN

Our understanding of colonic polyp biology and subsequent treatment decision making has evolved significantly over the past decades. All aspects of polyp management are as important as each other - from polyp detection to resection, from retrieval to transporting and processing; and finally from histological assessment and communication of the histological information. In this session we will outline how all those steps occur in routine clinical practice and are intrinsically linked to each other.

Hard to swallow (Achalasia)

DR DAVID VAN DER POORTEN
BSC (MED) MBBS FRACP PHD

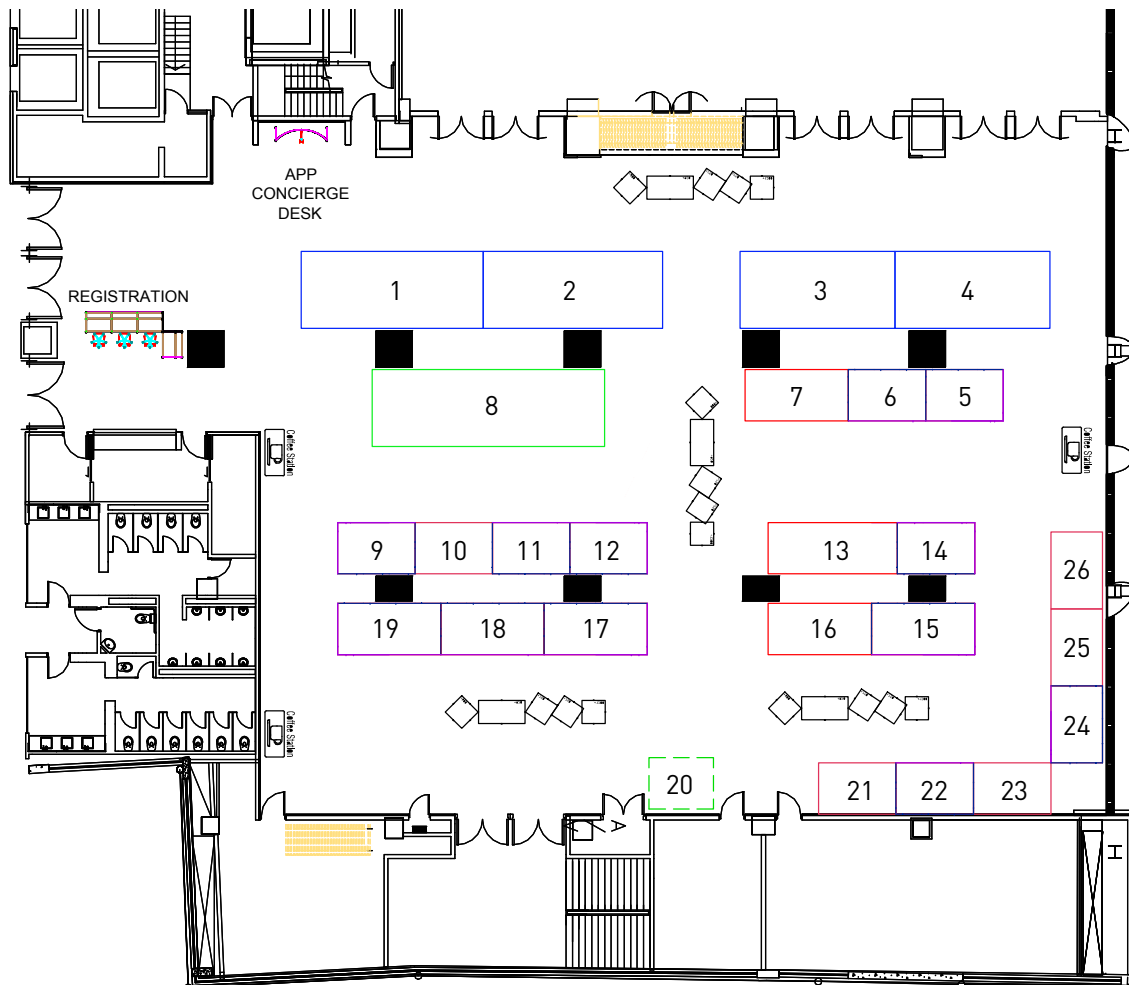
Achalasia is a rare motility disorder of the oesophagus that causes progressive dysphagia for both liquids and solids. The aetiology of Achalasia is unknown, but may be due to viral or autoimmune factors. The disease results in degeneration of the myenteric nerve plexus within the oesophageal wall, leading to loss of oesophageal peristalsis and failure of relaxation of the lower oesophageal sphincter.

Diagnosis is based on a high index of suspicion in a patient with dysphagia where other causes have been excluded. Endoscopy is important to assess for a malignant lesion but rarely is able to establish the diagnosis. Barium swallow typically shows a dilated “birds beak” oesophagus, but can be normal. Manometry is the gold standard and demonstrates aperistalsis of the oesophagus with a hypertonic lower oesophageal sphincter that fails to relax. There are 3 subtypes based on manometry findings with type 2 having the best response to therapy.

Treatment options for Achalasia include Pneumatic balloon dilation, laparoscopic myotomy, injection of Botox or novel endoscopic myotomy techniques (POEM). Balloon dilation and surgical myotomy are the preferred options and appear to be equally effective. Dilation tends to be safer and can be performed as an outpatient procedure. Botox injection is safe and effective, but needs to be repeated frequently.

Long-term complications of the condition include aspiration pneumonia, mega-oesophagus and oesophageal cancer. Overall life expectancy, however, is not reduced.

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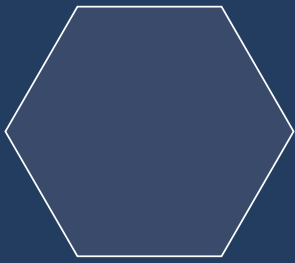
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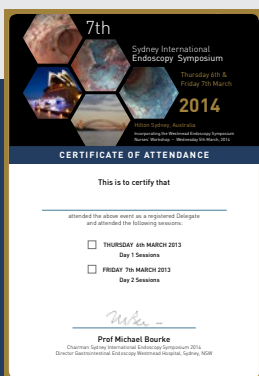
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Westmead Department of Anaesthetics – Prof Peter Klineberg and Dr Susan Voss



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