

INCORPORATING THE
WESTMEAD ENDOSCOPY
SYMPOSIUM NURSES'
WORKSHOP
WEDNESDAY
24TH FEBRUARY, 2016

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CONFERENCE PROGRAM & SYLLABUS






SIES 2016 **9TH SYDNEY** **INTERNATIONAL** **ENDOSCOPY** **SYMPOSIUM**

**THURSDAY 25TH &
FRIDAY 26TH FEBRUARY**
HILTON SYDNEY, AUSTRALIA

TOPICS INCLUDE

- Colonoscopy
 - Approach to serrated polyps, serrated dysplasia and neoplasia in 2016
 - Best practice polypectomy
 - New methods in advanced tissue resection: EMR and ESD
 - Enhanced imaging and optical diagnosis
- GI stricture management
- Palliation of malignant luminal obstruction
- ERCP: complex and basic therapeutics
- Direct cholangioscopy
- Balloon enteroscopy
- Treatment of achalasia including POEM
- Endoscopic treatment of perforations and fistulas
- Endoscopic ultrasound
- Barrett's Oesophagus
 - Detection of inconspicuous neoplasia and dysplasia
 - Endoscopic treatment for dysplasia and early cancer in 2016

SIES INTERNATIONAL FACULTY

-  Dr Peter Cotton, South Carolina
-  Dr Emad El-Omar, Aberdeen
-  Dr Greg Haber, New York
-  Dr Oliver Pech, Regensburg
-  Dr Kazuki Sumiyama, Tokyo



Health
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SIES 2017 - Wednesday 15, Thursday 16 and Friday 17 March, 2017

FOUR POINTS BY SHERATON SYDNEY, DARLING HARBOUR

MARCH 2017						
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NEW VENUE





WELCOME



Dear Colleagues and Friends

It is my great pleasure to welcome you to the Sydney International Endoscopy Symposium, our 9th Annual Westmead Endoscopy meeting. We will again aim to provide a comprehensive demonstration of diagnostic and therapeutic endoscopy. Your support and enthusiasm has been overwhelming and this year will be our largest and I believe our most successful event yet.

We are delighted to welcome five truly outstanding clinicians from abroad; Peter Cotton, Emad El-Omar, Gregory Haber, Oliver Pech and Kazuki Sumiyama as our expert faculty. All of them are leaders on the international stage having made numerous outstanding contributions to the practice of Gastroenterology and Endoscopy over the last ten to twenty years.

The Symposium's content has been carefully designed to facilitate discussion. Please utilise the Symposium App or Twitter via your mobile phone to relay your questions through the chairs to our proceduralists. This is a unique feature that will enhance the interaction between the expert faculty and the audience. 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 interrupting 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 2016
Director of Gastrointestinal Endoscopy,
Westmead Hospital, Sydney

WELCOME TO NURSES



It is a great pleasure to welcome you to the 9th Annual 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. An interesting topic on the agenda is the Mini Symposium "When things are not/may not go well and how to avoid, anticipate and respond" to situations in the scope room with a team of doctors and nurses on the panel. Michael Bourke's sharing on what makes a successful endoscopy team will be exciting!!

We are delighted to have a large and diverse group of fantastic speakers on our programme including Nick Burgess, David Tate, Golo Ahlenstiel, Vu Kwan, Michael Bourke and our 2016 international speaker Ulrike Beilenhoff from Germany.

We have kept the very popular demonstration stations again this year and you will have hands-on opportunities with the latest devices in therapeutic endoscopy and fantastic talks by the two great presenters.

The Symposium is also an avenue for networking and interaction amongst the great nursing minds in gastroenterology and endoscopy, offering updates and sharing and learning fresh tips and tricks to promote the specialisation in this specialty.

All nurses are encouraged to attend the following 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, which demonstrate the skills and wisdom of the internationally renowned guest faculty. CPD 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 2016

INTERNATIONAL FACULTY



PROFESSOR PETER COTTON

Professor of Medicine, Digestive Disease Center, Medical University of South Carolina Charleston, SC, USA

Peter Cotton graduated in 1963 from Cambridge University and St Thomas Hospital Medical School (London). He developed the Endoscopy Laboratory at St Thomas' Hospital whilst still officially in training, brought ERCP back from Japan in 1971 and named it in 1972. He joined the faculty of the Middlesex Hospital and Medical School (London) as Director of Gastroenterology, where he developed a new department integrating medical and surgical gastroenterology. His group pioneered many diagnostic and therapeutic endoscopy procedures, particularly ERCP (sphincterotomy and stenting) and was active in teaching. He attracted postgraduates from many countries, held numerous teaching courses, and pioneered live CCTV workshops.

Dr Cotton left England in 1986 to become Professor of Medicine and Chief of Endoscopy at Duke University, Durham, North Carolina, USA. He developed a state of the art endoscopy center. He maintained his interests in teaching (mainly through live video courses), new techniques, and careful outcome evaluation. He moved to Charleston, South Carolina in 1994 to initiate the Digestive Disease Center at the Medical University of South Carolina (MUSC). The center provides a multidisciplinary environment in which to provide patient-friendly, cost-effective care, and to pursue the research and teaching necessary to enhance it. Dr Cotton retired from active clinical practice in 2011, and remains at MUSC doing research and teaching. He recently completed a major sham controlled study of sphincterotomy in patients with suspected sphincter of Oddi dysfunction, with game-changing results.

Dr Cotton has been active in many National and International organizations, and has given invited lectures and demonstrations in over 50 countries. His bibliography includes more than 900 medical publications. "Practical Gastrointestinal Endoscopy" (co-authored by Christopher Williams) is the standard teaching text, currently in its 7th Edition, and has been translated into eight languages. He also recently published his "endoscopic memoirs" called "The tunnel at the end of the light", and a series of award-winning illustrated books for children about Fred the friendly snake.

Peter and Marion Cotton live happily on Dewees Island, South Carolina. They enjoy family, friends, travel, wildlife and golf.

More information and signed and personalized copies of Peter Cotton's Memoirs can be found at www.petercottontales.com.

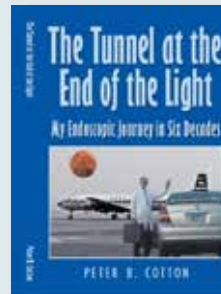


PROFESSOR EMAD M EL-OMAR

Chair in Gastroenterology (Clinical), Aberdeen University Scotland

Professor Emad El-Omar graduated with BSc (Hons) and MB ChB from Glasgow University, Scotland, in 1988. He trained in General Internal Medicine and Gastroenterology in Glasgow and gained dual accreditation in both in 1997. In 1995 he was awarded the degree of MD with honours and Bellahouston Medal, for his work on the effect of *H. pylori* infection on gastric acid secretion in man. In 1997, Professor El-Omar moved to the USA spending time in the Division of Infectious Diseases at Vanderbilt University School of Medicine, Nashville, Tennessee, followed by two years at the Division of Cancer Epidemiology and Genetics, National Cancer Institute, NIH, Bethesda, Maryland. In July 2000, Professor El-Omar took up the newly created Chair of Gastroenterology at Aberdeen University, Scotland. He is also an Honorary Consultant Physician with the NHS Grampian. Professor El-Omar is the Academic Development Coordinator for the School of Medicine and Dentistry, a role that allows him to mentor a large number of outstanding young clinician scientists and medical students. He is the Editor in Chief of the journal Gut. In March 2016, Professor El-Omar will take up the Chair of Medicine at St George & Sutherland Clinical School, University of New South Wales, Sydney, Australia. His main research interests are in the role of microbially-induced inflammation in GI cancer and inflammatory bowel disease. His group has strong collaborations with national groups within the UK and international groups in the US, Europe, Asia and Australia.

PETER COTTON'S MEMOIRS



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 17. *The king arrived for his ERCP eventually at 10 pm with a retinue of princes. He cut short my usual discussion of informed consent with a gesture of trust that I found rather menacing, backed up as it was by a rippling of Korans around the procedure room...*

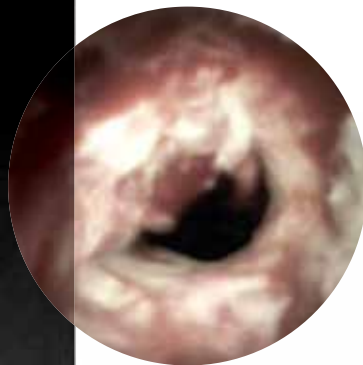
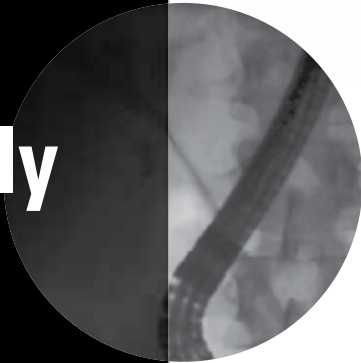
From chapter 18. *On September 11, we were dozing in Delta 11 at 30,000 feet over the Atlantic...*

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

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ENDO-322520-AA July 2015

INTERNATIONAL FACULTY CONTINUED



PROFESSOR GREGORY HABER

**Director of Gastroenterology,
Lenox Hill Hospital New York,
USA**

Dr Gregory Haber graduated from the University of Toronto and did post graduate research in bile acid metabolism at the University Of Bristol, England, having received a grant from the Medical Research Council of Canada. Two years later he returned to the University of Toronto, as a faculty member in the Division of Gastroenterology.

He served on the staff of The Wellesley Hospital and St Michael's Hospital, University of Toronto, for 20 years, and in 2005 became the Director, Division of Gastroenterology and The Center of Advanced Therapeutic Endoscopy at Lenox Hill Hospital in New York.

One of the world's foremost experts on the treatment of digestive diseases, he has published over 50 peer-reviewed articles. His research has been funded by numerous peer-reviewed agencies, and the pharmaceutical and medical device industries. Dr. Haber has spoken as invited faculty at over 300 scientific meetings. He was an associate editor of "Gastrointestinal Endoscopy" for eight years, as well as a member of the board of the Journals "Endoscopy" and "Techniques in Gastrointestinal Endoscopy".

He was the recipient of the prestigious Master of Endoscopy Award of the ASGE given to only one member annually, presented at the Cystal Awards at DDW, 2008.

His current research interests span a broad area of therapeutic endoscopy interests. These include ERCP access methods (pancreatography, choledochoscopy, altered anatomy), endoscopic submucosal dissection, POEM, endoscopic suturing and endotherapy for gastroesophageal reflux, as well as double balloon endoscopy for small bowel and pancreaticobiliary disease.



PROFESSOR OLIVER PECH

**Head of Gastroenterology and
Interventional Endoscopy,
St John of God Hospital
Regensburg, Germany**

Dr Oliver Pech graduated from the University of Erlangen and started his GI training and training in advanced interventional endoscopy with Professor Christian Ell at HSK Wiesbaden, Germany. He became a faculty member and Head of Endoscopy at HSK Wiesbaden. In 2012 Dr Pech became Head of Gastroenterology and Interventional Endoscopy at St. John of God Hospital, Regensburg, Germany – a tertiary teaching hospital of the University of Regensburg.

Dr Pech is an internationally renowned expert in interventional endoscopy and one of the world wide leading experts in endoscopic diagnosis and treatment of early Barrett's neoplasia. He published more than 50 original articles, co-authored several guidelines and is frequently invited as a speaker and as an expert endoscopist on national and international conferences. Dr Pech is associate editor for the UEG Journal and editorial board member at Endoscopy and Clinical Gastroenterology and Hepatology.

Currently his research focus is on endoscopic diagnosis and treatment of early GI neoplasias, EMR, ESD, POEM, ERCP with cholangioscopy and endosonography.



PROFESSOR KAZUKI SUMIYAMA

**Director, Department of
Endoscopy, Jikei University
School of Medicine Tokyo,
Japan**

Dr Sumiyama graduated from the Jikei University School of Medicine in 1998. He completed a two year-residency at Jikei University Hospital in 2000. He received a PhD degree from Jikei University Graduate School of Medicine in 2003. He has been promoting a series of both basic and clinical research projects in the gastrointestinal endoscopy field as a primary investigator. He has been the director and the professor of department of Endoscopy at Jikei University since 2015. He was also a former post-doctoral fellow at the Mayo Clinic College of Medicine (2005-7) and achieved a lot of internationally recognised developmental researches for novel endoscopic therapies including Submucosal Endoscopy, NOTES and Full thickness resection. He was awarded many academic honors in his career as an endoscopist. He has published 158 papers (71 of them in English) and 243 abstracts and also invited by academic societies 83 times for lectures or live demonstrations so far.

The attendance of the international faculty has been graciously supported by our Platinum Sponsors

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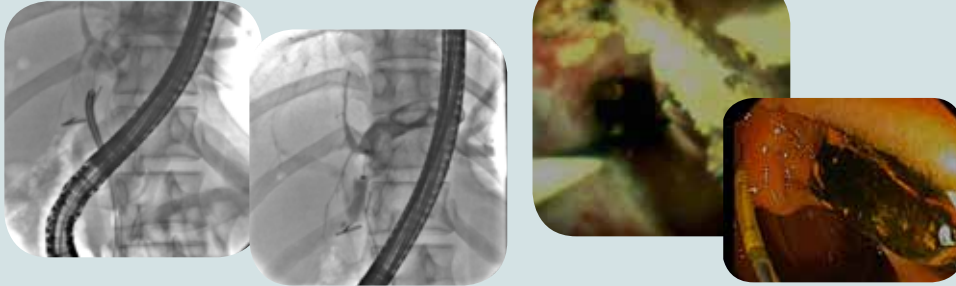
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NURSES' WORKSHOP PROGRAM

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SYDNEY INTERNATIONAL ENDOSCOPY SYMPOSIUM 2016 NURSES' WORKSHOP

This program is endorsed by the Westmead Hospital and 7 CPD points are awarded



The attendance of Ulrike Beilenhoff RN has been graciously supported by



0730	Registration opens		
0830 - 0845	Welcome note Mary Bong RN and Kate Hackett, Acting Director of Nursing, Westmead Hospital		
SECTION 1 – Facilitator: Robyn Brown RN			
0845 - 0915	<i>What makes a successful Endoscopy team and how do we achieve this?</i> – Prof Michael Bourke		
0915 - 0945	<i>Colonoscopy practice: Adenoma detection and basic polypectomy principles</i> – Dr David Tate		
0945 - 1015	<i>Portal hypertension and its complications</i> – Prof Golo Ahlenstiel		
1015 - 1045	<i>Endoscopic practices and reprocessing: The European perspective (including CRE)</i> – Ulrike Beilenhoff RN, International Speaker (Germany)		
1045 - 1115	Morning tea and trade displays ('Special dietary' platters will be placed next to the App Concierge)		
SECTION 2 – Workshop Demonstrations and Talks – Facilitator: Mary Bong RN			
1115 - 1330	Demonstration 1 CBD Stones and Endoscopes <i>Mary Bong RN</i>	Demonstration 2 Endoscopic Therapies <i>Janice Waru RN</i>	Talks Didactic Lectures <i>Dr Vu Kwan</i>
40 mins at each station	Booth 1 <i>Management of large CBD stones - therapeutic pathways</i> Judith Tighe-Foster RN, Marriam Khilwati RN & Dr Farzan Bahin	Booth 1 <i>Management of portal hypertension-Sengstaken, band ligation and histoacryl</i> Prof Golo Ahlenstiel, Sandra Ko RN & Nicky Stojanovic RN	Talk 1 <i>Interpreting basic GI radiology</i> Dr Vu Kwan
	Booth 2 <i>Endoscopes – How they work? Cleaning, maintenance and safety</i> Robyn Brown CNE, Zion Siu RN & Jeneviah Junio RN	Booth 2 <i>Colon polypectomy: tips and tricks to optimise outcomes</i> Dr Nicholas Burgess, Betty Lo RN, Dr David Tate & Stephanie Henshaw RN	Talk 2 <i>Australian reprocessing update</i> Di Jones RN
1330 - 1430	Lunch and trade displays ('Special dietary' platters will be placed next to the App Concierge)		
SECTION 3 – Facilitator: Judith Tighe-Foster RN			
1430 - 1445	Quiz – Betty Lo RN		
1445 - 1505	<i>Endoscopy nurse education program and initiatives</i> – Ulrike Beilenhoff RN, International Speaker (Germany)		
1505 - 1545	<i>Mini Symposium: When things are not /may not go well: avoiding, anticipating and responding</i> – Dr Farzan Bahin, Dr Nicholas Burgess, Judith Tighe-Foster RN, Sandra Ko RN, Janice Waru RN and Stephanie Henshaw RN		
1545 - 1600	Quiz prizes, presentations and surprises		
1600 - 1605	Closing remarks and thank you		
1605 - 1620	Afternoon tea and trade displays ('Special dietary' platters will be placed next to the App Concierge)		

SYMPOSIUM PROGRAM

DAY ONE – THURSDAY 25TH FEBRUARY 2016

0730	Registration opens
0830-0835	Official conference open and welcome – Prof Michael Bourke
	MINI SYMPOSIUM: UPDATE IN COLONIC POLYPECTOMY
0835-0855	<i>Polypectomy: Ensuring safe and complete resection</i> – Prof Greg Haber
0855-0915	<i>Serrated lesions 2016: Detection, misconceptions, characterisation and resection</i> – A/Prof Raj Singh
0915-1030	LIVE ENDOSCOPY 1 including clinical update 1: <i>ESGE polypectomy guideline highlights; what we know and what we really don't</i> – Dr Nick Burgess CHAIRS – Golo Ahlenstiel, David Hewitt, Andrew Taylor
1030-1100	Morning tea ('Special dietary' platters will be placed next to the App Concierge)
1100-1300	LIVE ENDOSCOPY 2 including clinical update 2: <i>Achalasia 2016: Chicago and beyond</i> – Dr Vincent Ho CHAIRS – Nghi Phung, Alan Moss, Sina Alexander
1300-1400	Lunch ('Special dietary' platters will be placed next to the App Concierge)
1400-1530	LIVE ENDOSCOPY 3 CHAIRS – Thao Lam, Bronte Holt, Peter Tagkalidis
1530-1600	Afternoon tea ('Special dietary' platters will be placed next to the App Concierge)
1600-1625	<i>Endoscopic treatment of early Barrett's Neoplasia: what we know and what we don't ...but should</i> – Prof Oliver Pech
1625-1635	DISCUSSION
1635-1700	General endoscopy quiz – Dr Farzan Bahin
1700	CLOSE
1700-1800	EXPERTS ON THE SPOT: MINI-SYMPOSIUM <i>Endoscopy and litigation in 2016: case based discussions</i> – Prof Peter Cotton, Prof Greg Haber
1830 –1845	Coaches depart promptly for Symposium Reception
1845 –2045	Official Symposium Reception – Sydney Opera House 'Opera Point Marquee'

*Coaches will depart the Hilton Sydney from 6.30pm sharp (one-way transfer), alternatively, you can make your own way to the venue, allow approximately 20 minutes from the Hilton Sydney.

SYMPOSIUM RECEPTION

Venue: Sydney Opera House, 'Opera Point Marquee'

Date: Thursday 25th February, 6:45pm – 8:45pm

Cost: \$ 85 per delegate

Inclusions: Fine food and drinks for 2 hours, one-way coach transfers and stunning views!

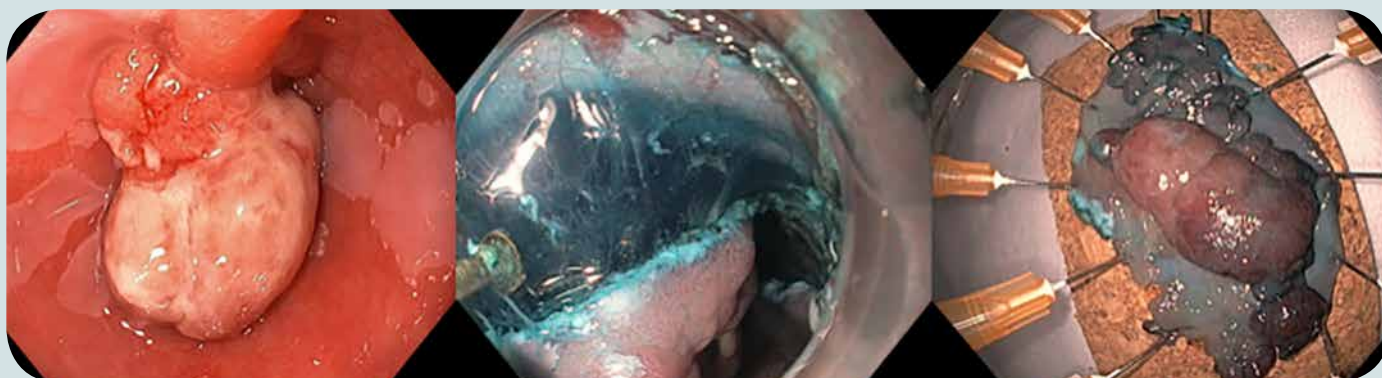
Located on the picturesque Sydney Harbour foreshore, the Opera Point Marquee offers a magnificent vantage point to enjoy one of the world's most famous views.



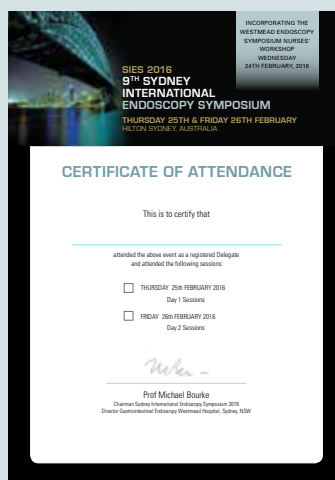


DAY TWO – FRIDAY 26TH FEBRUARY 2016

0730	Registration opens
0830 - 0900	<i>Next generation endoluminal interventions (ESD, submucosal endoscopy, and full thickness resection)</i> – Prof Kazuki Sumiyama
0900 - 1030	LIVE ENDOSCOPY 4 including clinical update 3: <i>Pancreatic cystic lesions, new surveillance guidelines, new controversies</i> – Dr Vu Kwan CHAIRS – Vu Kwan, Milan Bassan, Paul Edwards
1030 - 1100	Morning tea ('Special dietary' platters will be placed next to the App Concierge)
1100 - 1300	LIVE ENDOSCOPY 5 including clinical update 4: <i>Barrett's Oesophagus Australian clinical practice guidelines. What all Endoscopists should know</i> – Dr Eric Lee CHAIRS – David Van der Poorten, Gregor Brown, Darren Pavey
1300 - 1400	Lunch ('Special dietary' platters will be placed next to the App Concierge)
1400 - 1530	LIVE ENDOSCOPY 6 CHAIRS – Rita Lin, Nick Tutticci, David Ruppin
1530 - 1600	Afternoon tea ('Special dietary' platters will be placed next to the App Concierge)
1600 - 1630	The Peter Gillespie Lecture: <i>Gastrointestinal neoplasia and the microbiome</i> – Prof Emad El-Omar
1630 - 1645	Quiz answers and awards for the winners – Dr Farzan Bahin
1645 - 1700	Summary and meeting close – Prof Michael Bourke



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



CERTIFICATES OF ATTENDANCE

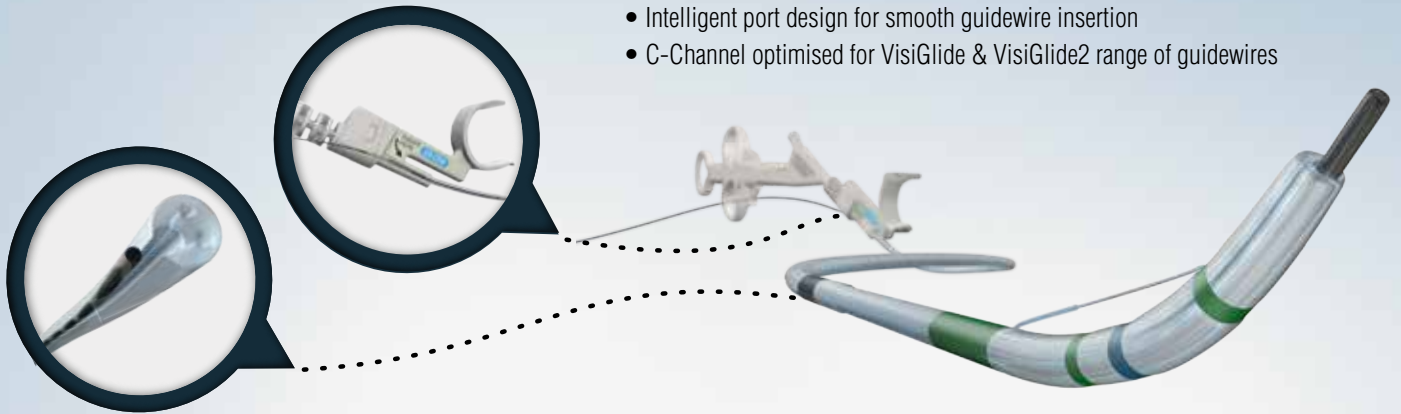
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These will be sent via email after the Symposium.

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ABSTRACTS AND CONFERENCE NOTES

ABSTRACTS AND CONFERENCE NOTES

ESGE polypectomy guideline highlights; what we know and what we really don't

Dr Nicholas Burgess, Consultant Gastroenterologist, Westmead Hospital

In 2015 the ESGE commissioned a working group to produce society guidelines on colonoscopic polypectomy. This group examined the existing evidence surrounding polypectomy and composed practice recommendations based on this. The evidence base for the technical aspects of polypectomy continues to grow, however there remain significant deficits where further research is required. An abbreviated summary is below.

Diminutive Polypectomy

All polyps should be resected except for diminutive (size ≤ 5 mm) hyperplastic rectal and recto-sigmoid polyps. In expert centres, where optical diagnosis may be made with a high degree of confidence, a resect and discard strategy may be considered for diminutive polyps. Cold snare polypectomy is the preferred technique for removal of diminutive polyps. This technique has high rates of complete resection, adequate tissue sampling for histology and low complication rates. The use of cold biopsy forceps (CBF) excision is discouraged due to high rates of incomplete resection. In the case of a 1-3 mm sized polyps where cold snare resection is technically difficult or not possible, CBF (preferably jumbo forceps) may be used. The use of hot biopsy forceps is not recommended due to high rates of incomplete resection, inadequate tissue sampling for histology and unacceptably high risks of adverse events in comparison to snare excision (deep thermal injury and delayed bleeding).

Snare Polypectomy

Snare polypectomy is recommended for sessile polyps 6-9 mm. The use of biopsy forceps for polypectomy should be avoided due to high rates of incomplete resection. Cold snare polypectomy for sessile polyps 6-9 mm in size is thought to have an excellent safety profile, although evidence comparing efficacy with hot snare polypectomy is lacking.

For polyps 10-19mm in size, hot snare resection (with or without submucosal injection) is recommended. Areas at greater risk for deep thermal injury, such as the right colon, may benefit from submucosal injection prior to hot snare resection. In certain situations, there may be a role for cold snare polypectomy to reduce the risk of deep mural injury, but further studies are needed.

Pedunculated Polyps

Hot snare polypectomy is recommended for pedunculated polyps. To prevent bleeding, dilute adrenaline injection and/or mechanical haemostasis in pedunculated colorectal polyps with head ≥ 2 cm or a stalk ≥ 1 cm in diameter should be performed.

EMR of large sessile or laterally spreading lesions ≥ 20 mm

Large (≥ 20 mm) sessile and laterally spreading or complex polyps, should be removed by an appropriately trained and experienced endoscopist, in an appropriately resourced endoscopy center. Complex lesions may include large pedunculated polyps,

lesions in difficult locations (periappendiceal, ileocaecal valve, ano-rectal junction, behind haustral folds) and lesions which have been previously attempted.

Lesions at high risk of submucosal invasive cancer

The majority of colonic and rectal superficial lesions can be effectively removed in a curative way by standard polypectomy and/or by EMR however, en-bloc resection techniques such as en-bloc EMR, ESD or surgery should be the techniques of choice in cases of suspected superficial invasive carcinoma. ESD can be considered for removal of colonic and rectal lesions with high suspicion of superficial submucosal invasion and which otherwise cannot be removed en-bloc by standard polypectomy or EMR. Advanced endoscopic imaging should be used to identify the potential presence of superficial submucosal invasion. Features may include an area of demarcated depression with disruption or absence of pit pattern (with or without magnifying chromoendoscopy (Kudo Vi-low)) or disrupted vascular features (NBI Sano IIIA). Lesions with endoscopic imaging characteristics consistent with deep submucosal invasion should not be considered for endoscopic treatment and should be referred for surgery. Lesions without characteristics of deep submucosal invasion should not proceed to surgery without consultation with an expert endoscopy centre

Colonic Tattooing

Lesions that may require localization at future endoscopic or surgical procedures should be tattooed during colonoscopy. A sterile carbon particle suspension should be used ≥ 3 cm distal (anal side) to the lesion. Endoscopic and surgical team members should agree on a standardized location of tattoo injection at their institution.

Endoscopic Mucosal Resection (EMR)

Careful lesion assessment is essential prior to EMR of sessile or laterally spreading lesions ≥ 20 mm to identify features suggestive of poor outcome. Features associated with incomplete resection or recurrence include size >40 mm, ileo-caecal valve location, prior failed attempts at resection, and SMSA level 4. The submucosal injectate for EMR should be a solution that is more viscous than normal saline and whose safety has been proven, including succinylated gelatin, hydroxyethyl starch or glycerol, since their use is associated with superior technical outcomes and reduced procedural time. A biologically inert blue dye such as indigo carmine be incorporated into the submucosal injection solution to facilitate identification of fluid cushion extent, lesion margins and deep mural injury. Perforation related to en-bloc resection increases with increasing lesion size, so en-bloc EMR should be limited to lesions ≤ 20 mm in the colon and ≤ 25 mm in the rectum. Complete snare resection should be the aim of any EMR, because adjunctive thermal ablative techniques (e.g. argon plasma coagulation) are associated with higher adenoma recurrence. Where complete snare excision cannot be achieved, the optimal method for removal of residual adenoma requires further study. Adjuvant thermal ablation of complete EMR resection margins to prevent recurrence requires further study.



When a lesion appears suitable for EMR, but does not lift with submucosal injection, referral should be made to an expert endoscopist in a tertiary centre. Successful EMR should be defined endoscopically by the absence of neoplastic tissue at the completion of the procedure. Endoscopic cure for lesions resected by EMR should be confirmed at surveillance colonoscopy by advanced endoscopic imaging and systematic biopsy. Suspected residual or recurrent adenoma identified at surveillance colonoscopy is snare resected within the same procedure. Where snare resection is not possible, ablation may be performed.

Electrosurgery

The optimum electrosurgical settings for EMR require further research. Observational studies suggest microprocessor controlled electrosurgical generators should be used for polypectomy as they have a low rate of associated complications. Low power coagulation current should be avoided because of the increased risk of delayed bleeding. Pure cutting current for pedunculated polypectomy should be avoided because of an increased risk of immediate bleeding. CO₂ insufflation during colonoscopy and polypectomy is recommended. The optimum snare type is undefined so further research is required.

Polyp Histology and Processing

To reduce confusion, polypectomy specimens should be placed in separate containers, one for each lesion and these should be carefully labelled. Local factors may play a role in whether this is feasible. Fixation should be by buffered 10% formalin. The pathologist should measure the size of each specimen in millimetres. Large (≥ 20 mm) sessile lesions removed en-bloc, or lesions suspicious for submucosal invasion removed piecemeal, should be pinned to cork to optimize histological assessment. The specimens should be sliced and totally embedded, allowing the identification of the deep and lateral margins. Adenomas should be classified as low-grade or high-grade according to the WHO classification. Sessile serrated adenomas/polyps (SSA/P) should be reported as containing cytological dysplasia where present.

Where submucosal invasion is present, the depth of invasion should be measured and reported, in addition to other risk factors, such as poor differentiation, lymphovascular invasion and tumour budding. The distance to the deep/vertical and to the lateral/horizontal resection margin should be measured and reported. A second histopathologist opinion may be warranted when reviewing high risk features. All cases of T1 colorectal cancer should be discussed at a multidisciplinary meeting.

Adverse Events

Intra-procedural bleeding (IPB) is defined as bleeding during the procedure that persists for more than 60 seconds or requires endoscopic intervention. Endoscopic coagulation (snare tip soft coagulation or coagulating forceps) or mechanical therapy, with or without the combined use of dilute adrenaline injection can be used for control. Post-procedural bleeding is defined as bleeding occurring after the procedure, up to 30 days post-polypectomy, that results in an unplanned medical presentation. No studies have definitively shown that routine endoscopic clip closure or

other methods of prophylaxis to prevent delayed bleeding for sessile polyps are effective. There may be a role for mechanical prophylaxis (e.g. clip closure of the mucosal defect) in certain high risk cases after polypectomy or EMR. This decision must be individualised based on the patient's risk factors.

Patients admitted to hospital with delayed bleeding who are haemodynamically stable, without ongoing bleeding, may be initially managed conservatively. If intervention is required, colonoscopy is recommended as the first line investigation, however unstable patients may require angioembolization or surgery.

Post-polypectomy coagulation syndrome or transmural burn syndrome, is defined as the development of abdominal pain, fever, leucocytosis, and peritoneal inflammation in the absence of perforation (free peritoneal or retroperitoneal air in the plain abdominal film or the CT scan) that occurs after colonoscopic polypectomy with electrocoagulation

Careful inspection of the post resection mucosal defect to identify features of, or risk factors for, impending perforation is suggested. Where these risk factors are identified, clip closure should be performed.

This summary reflects recommendations generated by the ESGE polypectomy working group. Statements in the final ESGE guideline contain levels of evidence according to the GRADE guidelines. Statements have also been categorised as Strong or Weak recommendations. The recommendation strength generally reflects the certainty of the evidence used to support the guideline, however where there is little evidence but a recommendation is strongly supported by expert opinion or for safety reasons, then this is typically given a strong recommendation. There remain several areas where polypectomy practice requires more research. This emerging data will shape the guidelines of the future and should encourage safer and more effective endoscopic resection.

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ABSTRACTS AND CONFERENCE NOTES CONTINUED

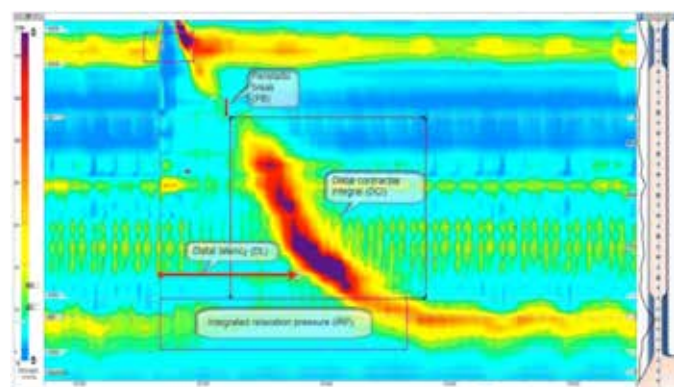
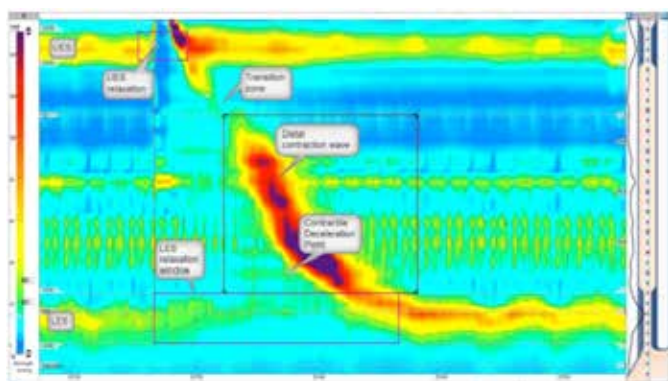
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Achalasia 2016: Chicago and beyond

Dr Vincent Ho, School of Medicine, Western Sydney University

High resolution oesophageal manometry is able to impart novel morphological information in addition to metrics. This has revolutionised the diagnostic and management approach to oesophageal motility disorders.

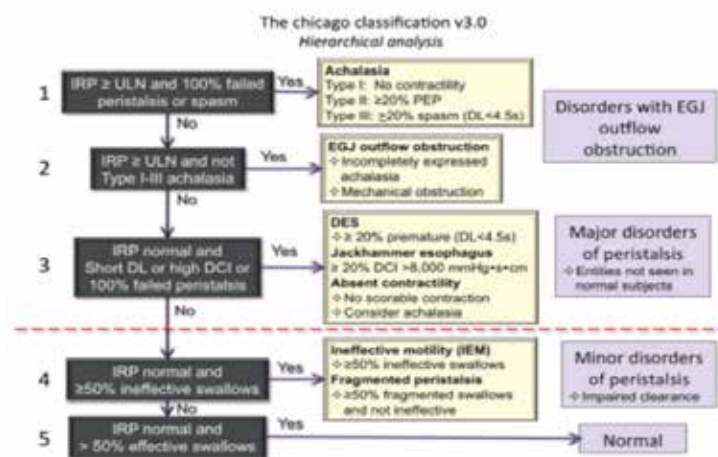


Key Chicago Classification Terms

- Contractile Deceleration Point (CDP) = Transition from peristaltic propagation to late phase of oesophageal emptying (proceeds much more slowly)
- Integrated relaxation pressure (IRP) = mean of the lowest oesophagogastric junction pressure over 4 seconds measured in the 10 second window after deglutitive UES relaxation
- Distal contractile integral (DCI) = volume (amplitude × duration × length) from proximal to distal pressure troughs
- Distal latency (DL) = interval between UES relaxation and the CDP
- Peristaltic breaks = gaps of the peristaltic contraction between the UES and oesophagogastric junction
- Pan-oesophageal pressurisation (PEP) = uniform pressurisation of >30 mmHg extending from the UES to the oesophagogastric junction

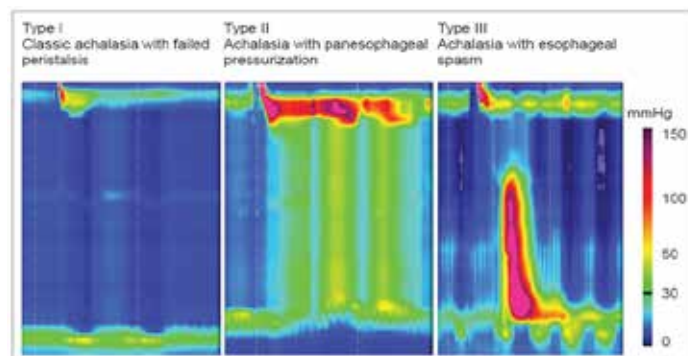
Chicago Classification Version 3

CC version 3 utilizes a hierarchical approach, sequentially prioritising: (i) disorders of oesophagogastric junction outflow, (ii) other major disorders of peristalsis, and (iii) minor disorders of peristalsis.



PEP = panesophageal pressurisation

Achalasia manometric subtypes



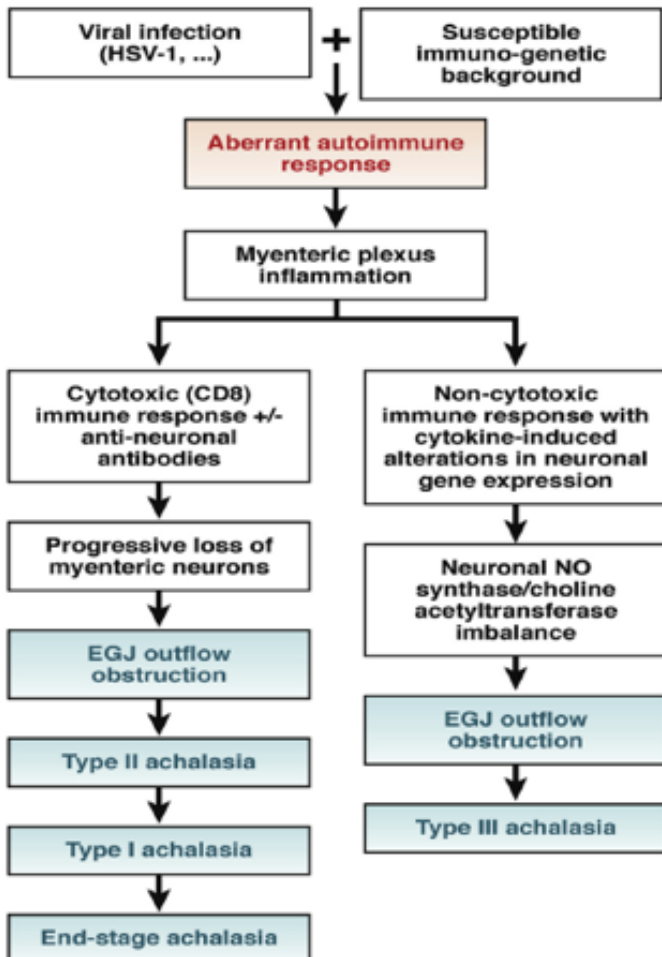
ABSTRACTS AND CONFERENCE NOTES CONTINUED

Summary of studies showing different treatment results based on achalasia subclassification

Author	Subtype and response rate	Treatment	Follow up	Definition of successful outcome
Lee 2013 [4]	N=41 Type I 10/16 (63%) Type II 14/20 (70%) Type III 5/5 (100%)	PD HM CCB	Median 22 months	Eckardt score ≤ 3
Rohoff 2013 [30]	N=176 Type I 36/44 (81%) Type II 110/114 (96%) Type III 12/18 (66%)	PD HM	Minimum 2 years	Eckardt score ≤ 3
Pratrap 2011 [29]	N=45 Type I 14/22 (63%) Type II 18/20 (90%) Type III 1/3 (33%)	PD	Mean 6 months	Symptomatic relief requiring no further intervention up to 6 months after single intervention
Salvador 2010 [28]	N=246 Type I 82/96 (85%) Type II 121/127 (95%) Type III 16/23 (70%)	HM	Median 31 months	Postoperative symptom score > than the 10th percentile of the pre-operative score (i.e. >7)
Pandolfino 2008 [3]	N=83 Type I 7/16 (56%) Type II 38/46 (96%) Type III 2/21 (29%)	BOTOX HM	Mean 19 months	Documented subjective improvement after last intervention. No recommended repeat intervention for >12 months

PD, pneumatic dilation; HM, Heller myotomy; BOTOX, botulinum toxin injection; CCB, Calcium channel blocker

Achalasia pathophysiology revised



Achalasia subgroup	LES		Distal (smooth muscle) esophagus		
	Inhibitory	Excitatory	Circular muscle inhibitory	Circular muscle excitatory	Longitudinal muscle excitatory
Type I (classic)	--	--	--	--	-- to -
Type II (with compression)	-	- to ++	-	-	+ to ++
Type III (spastic)	-	+ to ++	-	+ to ++	+ to ++
EGJ outflow obstruction ^a	-	- to ++	- to +	- to ++	+ to ++

NOTE. ++, accentuation; +, preservation; -, reduction; --, elimination.

Novel treatments – Per oral endoscopic myotomy (POEM)

Short and accumulating long term data (subjective clinical response and objective measurements) support the use of POEM for the treatment of achalasia. Key advantages of POEM include the lack of scarring and myotomy extension to the proximal oesophageal body. Postoperative reflux complications need to be considered and monitored. Emerging data supports the use of POEM for spastic oesophageal disorders refractory to medical therapy.



Long term efficacy data for POEM (from published studies in the order of a long follow-up duration)

	Total subject number	Follow-up (months)	Clinical success	Eckardt score (before/after)	LES pressure (mmHg) (before/after)	Clinical GERD (symptomatic or PPI use)
Inoue et al ³⁸	500	Over 36	88.5% (54/61)	6.0/1.7	28.7/14.0	21.3%
Hu et al ⁴⁰	32 (Sigmoid type)	30 (median)	96.8%	7.8/1.4	37.9/12.9	25.8%
Chen et al ⁴¹	26 (pediatric patients)	24.6 (mean)	100%	8.3/0.7	31.6/12.9	19.2%
Sharata et al ³⁶	75	20.1 (mean)	97%	6/1	22.2/11.7	19.1%
Minami et al ⁴²	28	16 (median)	100%	6.7/0.7	71.2/21	21.4%
Teitelbaum et al ¹⁹	41	15 (median)	92%	7/1	28/11	15%
Von Renteln et al ³⁹	70	12 (median)	82.4%	6.9/1	27.6/8.9	29%

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Endoscopic treatment of early Barrett's Neoplasia: what we know and what we don't ... but should

Prof. Oliver Pech, MD, PhD

Endoscopic treatment of high-grade dysplasia and intramucosal adenocarcinoma (IMC) in Barrett's esophagus has become the treatment of choice in the last decade. This is one of the major success stories of gastrointestinal endoscopy in recent years. Twenty years ago every patient with HGD and IMC had to undergo radical esophageal resection in order to get cured. This was associated with substantial mortality and morbidity. The mortality rates decreased to 1-3% in expert centers but the rate of relevant complications after esophageal resection is still as high as 30-50%.

Today all early neoplastic lesion are usually resected by EMR – either with the Inoue cap or with the multiband ligation device. The long-term results of EMR are excellent and EMR is the standard of care. Endoscopic submucosal dissection is a method to remove a neoplastic lesion en bloc but it is very demanding, time consuming and goes along with a high complication rate. Studies have been shown that ESD in Barrett's neoplasia is not superior to piece meal EMR and therefore is not recommended.

For many years recurrence and metachronous neoplasia was the major problem of endoscopic therapy of early Barrett's neoplasia. Therefore, ablation of the remaining Barrett's epithelium after successful resection of the neoplastic lesion became an essential part of endoscopic treatment and is nowadays recommended in every guideline.

There are different methods available to remove the remaining Barrett's mucosa. In our center we have successfully used Argon-Plasma-Coagulation for many years and this method has been shown in a prospective randomized study to significantly reduce the neoplastic recurrence rate. The downside of APC is the inhomogenous ablation, the high operator dependency and a relatively high complication rate.

Other groups investigated the complete radical resection of the whole Barrett's esophagus with piece-meal-EMR. The long-term results regarding complete remission and recurrence rates were very good but this strategy is associated with a very high stricture rate of up to 88%.

Radiofrequency ablation (RFA) seems to be the most effective and safe method to eradicate the metaplastic mucosa. Several high quality studies have proven its efficacy and safety. A recent European prospective multicenter study with 132 patients with high-grade dysplasia and early Barrett's cancer reported a complete remission rate of neoplasia in 98% and of intestinal metaplasia of 93%. Because of those excellent results RFA is the method of choice for ablation and is recommended in all guidelines. The major disadvantages of the method are the high costs.

Other new ablation techniques like cryoablation and hybrid-argon-plasma-coagulation have entered the arena but have to be investigated in prospective studies.

A new indication for endoscopic treatment is Barrett's low-grade dysplasia (LGD). Recent studies have shown that the conversion rate of LGD to HGIN and mucosal Barrett's cancer is 9.1% per patient year. However, this accounts for those LGD that were confirmed by a panel of expert pathologists. Amazingly, in one large series from Amsterdam 73% of 293 LGD patients were downstaged to non-dysplastic Barrett's epithelium after review of the histopathologic slides. Because of this high progression rate of "real" LGD a prospective randomized multicenter study was conducted to compare follow-up with RFA in patients with confirmed LGD. The results of this study with 136 patients showed a progression to HGD and mucosal Barrett's cancer in the RFA arm of 1.5% compared to 25% in the control group. Because of this significant finding the recommendation for patients with LGD changed from surveillance every 6 months to RFA treatment in many guidelines.

It is well known that infiltration of a Barrett's cancer into the submucosa is associated with an increased rate of lymph node metastasis. However, there seems to be a subgroup of patients with incipient infiltration of the submucosal layer up to 500µm (pT1sm1) without high risk features (no lymphovascular invasion, no poor differentiation, lesions size <20mm) with a very low risk for lymph node metastasis. A recent study from the Wiesbaden group reported a risk of 1.5% in 67 patients with "low risk" T1sm1 Barrett's cancer. This risk is lower than the usual mortality rate of esophagectomy in high-volume centers and therefore those patients can be offered endoscopic treatment instead of surgery. Whether there is also a subgroup of patients with deeper infiltration that can be treated endoscopically is subject of further research.

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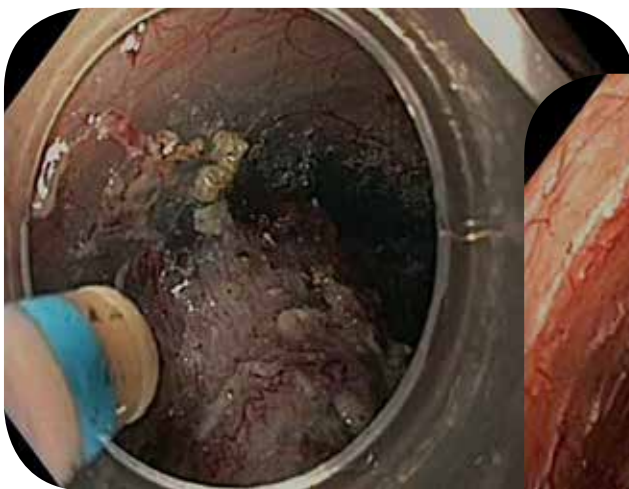
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Next generation endoluminal interventions (ESD, submucosal endoscopy, and full thickness resection)

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Tissue sampling is one of most important roles in endoscopy. Since the development of polypectomy as a minimally invasive therapeutic option for neoplastic lesions alternative to surgery, the technology for endoscopic tissue sampling has been steadily evolving to sample larger specimens from superficial layers of the gut wall. Endoscopic submucosal dissection eventually eliminated the size limitation of tumor size could be endoscopically resected en bloc in a minimally invasive manner and greatly improved radical resection rate of tumors. The concept of submucosal endoscopy has spread rapidly around the world as POEM procedure has been accepted as a therapeutic option for achalasia. Also, a series of preliminary clinical experiences of novel tissue apposition devices demonstrated that the technical feasibility of endoscopic full thickness resection. However, a hybrid approach through collaboration with laparoscopic surgeons is still more commonly performed than the pure endoluminal approach, and it seems to be more reasonable at the present stage.

These latest technological advances show us that the working space for flexible endoscopy is no longer restricted within the gut lumen. We have already embarked on a new frontier for endoscopic interventions.



CALL FOR ABSTRACTS

A prospective randomized trial comparing EUS guided ERCP without fluoroscopy with standard ERCP in common bile duct stone removal

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Background: Our pilot study showed EUS guided ERCP without fluoroscopy (EGEWF) in common bile duct stone (CBDS) was feasible. The efficacy of EGEWF compared with standard ERCP was assessed.

Aims: To compare the efficacy and safety of EGEWF with ERCP in CBDS removal.

Methods: Patients with CBDS ≤ 10 mm, no CBD stricture and no distal CBD narrowing were randomized to EGEWF (group A) or ERCP (group B). In EGEWF, bile aspiration was used to verify bile duct cannulation followed by sphincterotomy. CBDSs were removed by a balloon till the number matched the number detected by EUS. Stone clearance was confirmed by fluoroscopy. In ERCP, standard ERCP was performed. The procedure time, fluoroscopy time, and complications were recorded.

Results: 92 were enrolled from May 2013 till December 2015. 44 (20 male, 24 female) were in group A and 48 (17 male, 31 female) were in group B. The demographic data, stone size and stone number were similar between the 2 groups. Cannulation was successful in 43 of 44 in group A and 48 of 48 in group B ($p = 1.00$). Stone clearance was significantly lower in group A than in group B (38 of 44 (86.4%) vs 48 of 48 (100%), $p = 0.00$). The procedure time was similar in both groups (18.7 ± 13.4 vs 19.7 ± 20.8 minutes, $p = 0.78$). The fluoroscopy time was significantly shorter in group A than B (2.18 ± 1.87 vs 7.05 ± 9.01 minutes, $p = 0.00$). 12 complications occurred, 5 in group A and 7 in group B ($p=0.64$).

Conclusion: EGEWF has similar success cannulation rate, lower stone removal rate but shorter fluoroscopy time compared with ERCP.

Optical Diagnosis of Diminutive Colorectal Polyps by Non-Academic General Gastroenterologists using Non-Magnifying Narrow Band Imaging (NBI): A Prospective Study

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Background: Optical diagnosis for managing diminutive polyps (DPs), as proposed by the American Society of Gastrointestinal Endoscopy (ASGE) Preservation and Incorporation of Valuable Endoscopic Innovations (PIVI) can reduce healthcare costs substantially. We assessed the optical diagnosis performance of non-academic self-trained NBI-novice gastroenterologists.

Methods: Seven NBI-novice general gastroenterologists across 2 district non-academic hospitals underwent standardized ex-vivo training using still images and the ASGE's online educational video "Optical Diagnosis for colorectal polyps (OLV004)". An in-vivo NBI self-training on optical diagnosis of DPs was performed to ensure competency prior to starting the study. We used the NBI International Colorectal Endoscopic (NICE) classification. Level of confidence and assignment of surveillance intervals were documented.

Results: A total of 343 DPs were analyzed; 193 (56.6%) adenomas, 148 (43.4%) hyperplastic. Overall 297 polyps were predicted with high confidence (87.1%). There were 145 rectosigmoid polyps. (42.5%, 105 hyperplastic and 40 adenomas) of which 123 (84.8%) were predicted with high confidence. The results are presented in Table 1, with rectosigmoid polyp results tabulated separately to assess against the "diagnose-and-leave" ASGE PIVI strategy. Overall, ASGE PIVI thresholds have been achieved. However, two endoscopists had a NPV $<90\%$ and two had $<90\%$ accuracy. Conversely, two endoscopists achieved a NPV and accuracy of $\geq 95\%$. Optical diagnosis was globally better when predicted with high confidence (OR 5.3, 95% CI 2.5-11.3; $p < 0.001$). Agreement in assignment of surveillance intervals with high confidence was 98.3%.

Conclusions: NBI-novice gastroenterologists in non-tertiary institutions can meet and exceed the ASGE PIVI thresholds. Furthermore, the study demonstrated very high levels of accuracy for some individual endoscopists, while identifying others who may benefit from further targeted training. Hence there is significant potential in non-expert centres for future cost savings.



Table 1: Components of validated NBI polyp classification for high-confidence predictions

	Polyps diagnosed (n=297)	Rectosigmoid polyps diagnosed (n=123)
	% (95% CI or p-value)	% (95% CI or p-value)
Prevalence of adenoma	58 (52-63)	28 (20-36.4)
Correlation of diagnostic methods	83.5 (p<0.0001)	76.7 (p<0.0001)
Accuracy (ROC area)	91.7 (88.5-94.9)	89.6 (83.4-95.9)
Sensitivity	93.0 (88-96)	88.2 (72.5-96.7)
Specificity	90.5 (84-95)	91.0 (83.1-96.0)
NPV	90.5 (84-95)	95.3 (88.4-98.7)
Agreement (kappa)	91.9 (p<0.0001)	90.2 (p<0.0001)

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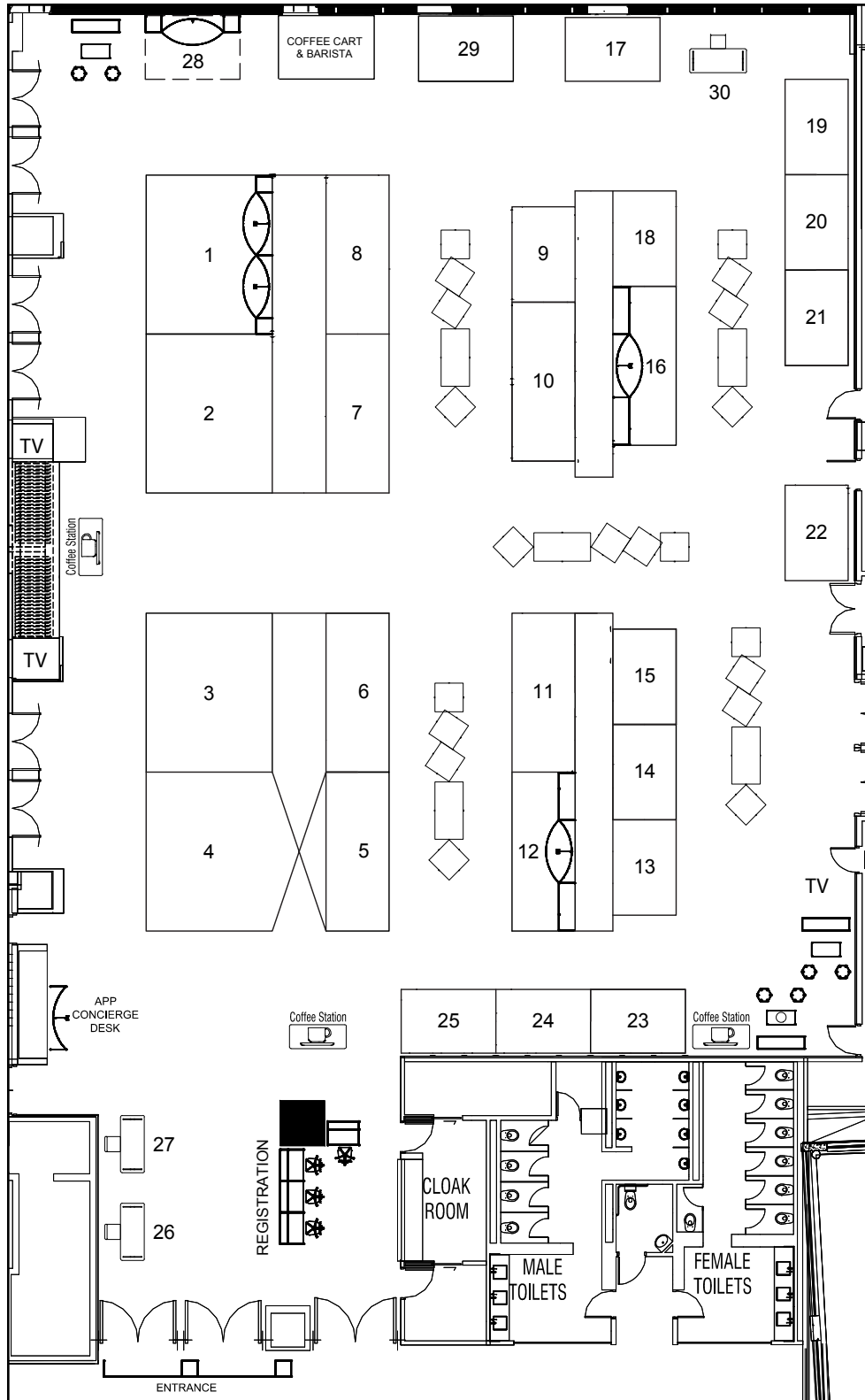


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