

CISGNA Scope Scoop

Volume 4, Issue 2

May 2004



Calendar of Events

May 14-19, 2004

SGNA 31st Annual Course
Dallas, TX

May 15, 2004

Certification Exam (RN Exam only)
Dallas, TX
(at Annual Course)
Pittsburgh PA
(additional test site)

May 31, 2004

Deadline for submitting for recertification by contact hours

August 14, 2004

Deadline for application for October 2004 exam

October 15-17, 2004

12'th Annual Multi-Regional Conference
Madison, WI

October 16, 2004

GI Update
Bloomington, IL

October 17, 2004

Certification Exam (RN and LPN/LVN exams)
Madison, WI

October 22-23, 2004

SGNA Leadership Conference

October 31, 2003

Deadline for submitting for recertification by contact hours

President's Message

As I've been thinking about what to say to ya'll, I've become speechless. There is a lot to say and I am not sure how to say its. As the CISGNA President, I have been contemplating this year's SGNA theme, "Reaching Out: SGNA Grows It's Legacy". "Reaching Out" makes me think of hugs. I love to reach out and give hugs and I love to get hugs but it means more than that. It means attending and helping plan dinner conferences, Regional and Multi-Regional conferences, and the Annual course and then reaching out to someone I don't know and making them feel at home. You just never know. The nurse I meet today might just be our next CISGNA President!

Second, I have been reflecting on how "SGNA Grows It's Legacy". Our legacy grows because of each

GI professional who is willing to "plant a seed". We plant seeds by encouraging each other to attend SGNA events and to become involved. The current SGNA President, Jo Harbaugh, is part of CISGNA. Jo, Malham, a past CISGNA President, now serves on the SGNA Educational Committee and assists with review and updating the Core Curriculum. Lorelee Kelsey, also a former CISGNA President (who took me to my first fall CISGNA meeting), is on the SGNA Practice Committee and assists with writing and updating position statements and guidelines. Lorelee and our current President-Elect, Annett Schmit are presently working on the Multi-Regional Planning Committee and planning this fall's Multi-Regional Conference in Madison, WI. Our region and the SGNA Legacy will keep on growing as

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CISGNA 2003-2004 Executive Board Members

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The CISGNA Executive
Board Members
invite assistance with committee
work and suggestions from the
membership.
Please e-mail us at

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long as we each keep planting the seeds.

My first goal is to encourage CISGNA membership to all GI professionals. A second goal to encourage more LPNs to become involved and to take the Certification Exam. There are many LPNs who would like to be involved and just need someone to encourage them and plant the seed.

We had 96 attendees at the "Voices in GI" Spring Conference in Champaign. A new Core Curriculum was won by one of our CISGNA members and one of the 5 new members that day won a SGNA gift certificate. I want to give a special thanks to CISGNA and the Carle Special Procedures staff for a great conference.

Please reach out and find you place within this great organization, whether in a small or big way. You can help the legacy grow. Positions that will be available in CISGNA this fall include Treasurer, Newsletter Editor, and President Elect.

Get your boots on and hold on to your hat! We are going to Dallas in May and I hope to see you there and reach out and hug you. Happy trails to you till we meet again, my friends.

Respectfully,
Alice Day, LPN
CISGNA President

Meet the 2003-2004 CISGNA Executive Board



Alice Day, LPN **President**

Alice has been an LPN since 1974 and has worked in Tennessee, Texas, and Oklahoma. Since moving to Illinois she has been working at Carle Hospital in Urbana, first in the Carle Clinic Neuro Department and then in Home Care with Alpha and at the Carle Arbour's Alzheimer's Unit. Since July 1999, she has been working in the Carle Foundation Special Procedures GI lab and has been actively involved in CISGNA. In March 2000 she pre-

sented a travel poster for Colon Cancer Awareness. In 2000, she served as Co-Editor of the CISGNA Newsletter with Michele Lawhead and then served as President-Elect in 2003. She has been fortunate to be able to attend the SGNA Annual Course in 2002 and 2003 and plans to be in Dallas in 2004. While at Carle, she has also been awarded the "Friends of Nursing" award.



Annett Schmit RN
President-Elect

Annett graduated from Parkland College in 1992. For 10 years she worked as a cardiac nurse on the Telemetry Unit at Carle Hospital. Then, in July 2002, she joined the Specials Procedure/GI Lab at

Carle. She immediately became active in SGNA, serving on the CISGNA Communications Committee and on the "Voices in GI" CISGNA Spring Conference planning committee for the last 3 years. While on the Communications Committee, she kept the CISGNA display board updated. Annett has also been on the Multi-Regional planning committee both in 2003 and 2004. In the fall of 2003, Annett attended the Leadership conference. She comments, "Leadership conference really opened my eyes to what SGNA had to offer. I feel that with support from home office and area members, being an executive board member was a natural progression to professional accountability."



Kay Marvin, BSN, CGRN
Past-President

Kay graduated from Marycrest College in 1971. In 1982, she joined the Out-patient Medical/Endoscopy staff at BroMenn Healthcare in Normal, IL. She obtained GI certification in 2001.

Kay comments, "GI has changed dramatically in the past 20 years, especially in the technology and treatment. SGNA helps us network and remain abreast of all these advances. It has truly developed into a very exciting specialty."



Deb Jaskowiak, RN, CGRN
Secretary

Deb graduated from St. Joseph's Nursing School in Joliet, IL in 1980. Her nursing experience includes oncology, medical/surgical, obstetrics, and mental health. She has worked in a GI office setting for the last 5 years and received GI certification in 2002. She enjoys the networking opportunities SGNA offers, especially at the annual course.



Elaine Otto, RN
Treasurer

Elaine received her nursing education at Parkland College in Champaign, IL. After working for a number of years in Ophthalmology at the Gailey Eye Clinic in Bloomington,

she became part of the gastroenterology team at BroMenn Healthcare 7 years ago. She has enjoyed her tenure as CISGNA treasurer. While serving in this office, she has converted the CISGNA books to a Quicken program from a ledger system. She is also working hard on getting a new edition of the CISGNA cookbook ready for print.



Sonia Vercler, RN, CGRN
Newsletter Editor

Sonia graduated in 1977 from Mennonite School of Nursing in Bloomington. For 13 years, she worked at St. James Hospital in Pontiac. In 1990, she

joined the Out-Patient Medical staff at BroMenn Healthcare. At present, she is working in the Same Day Services Department at BroMenn, which includes inpatient endoscopy. Sonia received her GI certification in 1995. Although she has not yet attended an annual course, she has been able to renew certification by contact hours by taking advantage of the regional and multi-regional offerings.

New Universal
Colorectal Cancer
Symbol



March was Colorectal Cancer Awareness month.

On March 1, 2004, the new nationally accepted symbol for colorectal cancer was unveiled by the National Colorectal Cancer Roundtable (NCCRT). This new symbol, the **blue** star, represents unity within the colorectal field and is a symbol of the common commitment to beating the nation's 4th most common cancer and the second leading cause of cancer death. SGNA is proud to be a member of the NCCRT which was established in 1997 by the American Cancer Society and the Centers for Disease Control and Prevention. It's mission is to reduce incidence and mortality from colon cancer by achieving screening rates for colorectal cancer that are equal to screening rates for other cancers.

The U.S. Preventative Service Task Force (USPSTF) **strongly recommends** screening at age 50 for men and women of average risk for colon cancer. Screening options include home fecal occult blood test (FOBT), flexible sigmoidoscopy, combination of FOBT and flexible sigmoidoscopy, colonoscopy and double-contrast barium enema. According to the USPSTF, there is insufficient data to determine which screening strategy is best in terms of the balance of benefits and harms or cost effectiveness.

"Voices in GI" Spring Conference Recap

The Carle Hospital Special Procedures/GI lab hosted a very successful CISGNA Spring Conference in Urbana on February 27-28, 2004 in Urbana. 96 attendees enjoyed dinner and 2 speakers on Friday evening and then 7 speakers on Saturday. The topics were quite varied and yet all pertinent to GI nursing. Thanks to Carle Hospital staff and the planning committee for all the work you did!

Compassionate Care: Keeping our Attitude Right in a Cynical World

Christopher Poor, M.D., Ph D.

Dr. Poor encouraged all health-care workers to "Remember the person." He shared personal stories illustrating how we can watch for the moments when we can truly make a difference. By "remembering the person" we can provide better quality care and also receive the blessing of job satisfaction.

The Joy of Nursing

Lynne C. Barnes, B.S., O.T., M.P.A.

Lynne reminded all of how fortunate we are to have chosen nursing as a profession. We are privileged to share with patients the highs and lows of life and can truly contribute to the health, wellness, and independence of others. Being a nurse allows to add meaning to our patient's lives and to daily make a difference. She offered many good suggestions to help us always see the joy of nursing. Following are just a few:

- Take pride in what you do and who you work for.
- Find a bigger reason to work, rather than the work itself.
- Affirm others.....
- Assume people like you.
- Allow yourself to feel the "fire in the belly"...loving your job may not be cool but it is healthy.
- Look for the fun.

-Do little things well.

As Charles Swindoll says, "Know who you are...Like who you are.....And be who you are."

Challenges in Management of Hepatitis C **Andrew Batey, M.D.**

Hepatitis C is a major health problem in the U.S. and world-wide. At present in the U.S., 4 million persons have been exposed to HCV and 2.7 million persons are chronically infected. Worldwide, there are 3-4 million new cases each year. Chronic hepatitis is a leading cause of cirrhosis in the U.S., causing 10,000-20,000 deaths/year. It is associated with an increased risk of liver cancer and is the most common reason for liver transplantation in the U.S.

Antibody tests are the most reliable way to diagnose hepatitis C. The anti-hepatitis C antibody (ELISA) has a 95-99% sensitivity and can be detected on the average 12 weeks after infection. The RIBA antibody test (recombinant immunoblot assay) is useful in distinguishing between false positive anti-HCV tests and resolved infections. It is important to remember that the anti-HCV test will remain positive life-long, even if the disease is eradicated.

Liver function tests (ALT) are elevated when there is some degree of hepatocellular injury but they do not provide information as to the cause of injury. In chronic HCV, the ALT will spike off and on throughout life.

HCV RNA tests (virologic tests) provide a viral count. The viral count is indicative of infection but the level is not predictive of the natural history of the disease. The viral count is useful in determining who will respond to treatment. A patient with a viral count less than 2,000,000 copies/ml is likely to respond well to treatment.

The Standard of Care for HCV treatment is a combination therapy of Pegylated Interferon and Ribavirin. The goal is a sustained viral response which is a prolonged inability to detect any virus. HCV RNA below limits of detection six months after termination of treat-

ment is considered “CURE” (SVR). HCV RNA tests are able to detect levels as low as 50-100 copies/ml. New therapies are continually being investigated. It is likely that in the future HCV will be treated with a cocktail of medicines that will increase the SVR rate beyond the present 50%.

Gastric MALT Lymphoma:
Not your Average Shake

Gary R. Griglione, M.D.

MALT (Mucosa-Associated Lymphoid Tissue) is a non-Hodgkin’s lymphoma arising in the stomach. Although there are areas of organized lymph tissues in the GI tract (such as Peyer’s patches in the small bowel), the stomach normally has no organized lymph tissue. 90% of stomach cancers are adenocarcinomas (glandular carcinoma), 8% are Non-Hodgkins lymphoma (MALT) and 2% are stromal tumors (GIST). Presently, there are 8 cancers known to be linked to infectious agents and MALT is one of them. MALT is a malignancy caused by chronic H. Pylori infection.

The peak incidence of MALT occurs between 50 and 60 years and occurs equally in males and females. Symptoms include a vague dyspepsia, abdominal pain, early satiety, nausea, weight loss and possibly a GI bleed. Because of the possibility of MALT, it is important to examine patients with these symptoms endoscopically rather than treating empirically. When examined endoscopically, 40% of MALT patients have a mass, 40% have an ulcer, and 20% show a nodular, thickened stomach lining.

Fortunately, MALT is an indolent, slow-growing malignancy. At diagnosis, 70% are Stage I, limited to the mucosa. 85-90% of Stage I are cured with only eradication of H. pylori. If the MALT persists despite H. pylori eradication, then they are treated with chemo/radiation. When Stage I is treated with radiation/chemo, the 10 year survival rate is 80%. Stage II-IV MALT is treated with radiation/chemo or gastrectomy and cure rates are 50%.

Caring for Women with IBD (Crohn’s and Ulcerative Colitis)

Sunanda V. Kane, M.D., MSPH

It is not unusual to see a fluctuation in IBD symptoms in association with the menstrual cycle. Some of the reported symptoms may not be due to a change in IBD activity but simply may reflect “normal” cyclical bowel patterns related to the menstrual cycle. Osteoporosis is a special concern for women with IBD. First, Crohn’s disease is associated with a higher risk for osteoporosis. Also, steroids which are often used in the treatment of IBD, can induce osteoporosis. All menopausal women with IBD should be considered for hormone replacement therapy. HRT is beneficial for IBD related osteoporosis and can also benefit those with coronary artery disease. In women with high risk for breast cancer, the benefits must be carefully compared to the risks.

There are now 2 studies which specifically address the affect of smoking on Crohn’s. Smoking has been shown to hasten the onset of the disease, increase the need for immunomodulator therapy, and increase the likelihood of a recurrence of the disease after undergoing surgery.

Studies show conflicting data on the relationship of IBD to fertility. It has been clearly shown that the goal must be to establish a remission before conception and then to maintain the remission during the pregnancy. The greatest risk to the pregnancy is active disease, not IBD therapies. There does not appear to be an increased risk for congenital abnormalities. Birth rates do tend to be lower in Crohn’s disease. There have been studies on the safety of mesalamine, sulfasalazine, corticosteroids, and immunomodulators during pregnancy and breastfeeding. Active disease does negatively affect pregnancy outcome.

Bake, Stuff, and Sew: The Home Economics of Endoluminal Reflux Therapy

Michael D. Brown, M.D.

There are presently several endoscopic anti-reflux procedures (EARPs) being used to treat GERD symptoms. These include Enteryx, Stretta, EndoCinch and Plicator procedures. Although these procedures are promising, further long term follow is needed with placebo control groups to evaluate their benefit. Better definition of the patients appropriate for these procedures is also needed. EARPs do not appear to be the final answer for GERD. Presently, these procedures cannot guarantee that the patient will be able to stop their GERD medications. PPIs will continue to be first in the line of treatment of GERD.

Test Your GI Knowledge

**Source: Lecture “To Squeeze or Not to Squeeze”, Anorectal Manometry Overview
Corrine Pavesic, R.N., C.G.R.N.**



1. The RAIR study is used to:
 - a. Assess the severity of Ulcerative Colitis in the rectum
 - b. Determine the cause of anal pain
 - c. Screen for Hirschsprung’s disease
 - d. Assist with differential diagnosis between ulcerative colitis and Crohn’s disease.
2. The Sensation Study assesses rectal sensation thresholds. Both decreases and increases in the sensation thresh-

old increase the risk of fecal incontinence. Increased sensation thresholds are common in:

- a. Irritable bowel syndrome
- b. Diabetes
- c. Crohn’s disease
- d. Ulcerative Colitis

3. Hirschsprung’s Disease is named after Harold Hirschsprung, a Dutch physician who first described it in 1886 after caring for 2 boys who were unable to have spontaneous bowel movements. Hirschsprung’s Disease is caused by”

- a. Excessive number of nerve cells (ganglia) in rectum causing rectal spasm and inability to pass stool.
- b. Congenital narrowing of areas in the colon, causing interference with peristalsis and severe constipation.
- c. Is an inherited colon wall weakness leading to overdilatation of the colon.
- d. Aganglionic segments of the bowel including the internal anal sphincter, preventing relaxation and thus preventing peristalsis and passage of stool

-
4. Hirschsprung's Disease is a genetic disorder. Each of the following statements is true except:
 - a. Hirschsprung's disease results in persistent diarrhea with urgency and incontinence.
 - b. Treatment requires surgery to remove the affected portion of bowel.
 - c. Anal manometry demonstrates a tonically contracted external anal sphincter.
 - d. Hirschsprung's disease is relatively rare, occurring in one in every 5000 births.
 5. The Resting Study provides information about all of the following except:
 - a. Anal sphincter symmetry
 - b. Anal sphincter competency
 - c. Anal sphincter length
 - d. Rectal Compliance.

Abdominal Trauma: How Much Do You Know?

Source: Abdominal Trauma: Direct and Indirect Insults

Mary Beth Voights, R.N., M.S.N., TPN

1. Which one of the following statements about abdominal trauma is NOT true?
 - a. Intra-abdominal injury rarely reflects isolated single organ or single system injury.
 - b. Penetrating abdominal injuries are more common in urban areas and blunt abdominal injuries are more common in rural areas.
 - c. Penetrating abdominal injuries are more likely to cause solid organ injury (spleen, liver, kidney) than blunt abdominal injuries.
 - d. Gunshot wounds, stab wounds, and impalement are examples of penetrating abdominal injuries.
2. Blunt abdominal injuries (crushing or compressive injuries) are difficult to assess by physical assessment. CT scan or Ultrasonography must be utilized to assess degree of injury and amount of internal bleeding.
 - a. True
 - b. False
3. Abdominal Compartment Syndrome is also known as:
 - a. Gut bacterial translocation
 - b. Ileus
 - c. Acute Abdomen Syndrome
 - d. Intra-abdominal hypertension
4. It is theorized that a poorly perfused and/or unused gut atrophies, allowing for translocation of GI tract normal flora into the lymph system and then into the portal system, causing bacteremia and sepsis. This syndrome is known as:
 - a. Abdominal compartment syndrome.
 - b. Acute acalculous cholecystitis
 - c. Gut bacterial translocation
 - d. Bowel perforation

5. To prevent but bacterial translocation:
- Allow the gut to rest by keeping patient NPO and administering TPN for nutrition
 - Begin enteral feedings early
 - Administer IV PPIs to prevent ulcers
 - Maintain long term NG tube to low intermittent suction while allowing abdominal injuries to heal.

CISGNA News Bits...

Successful Dinner Conference

A dinner conference was held at Tater's in Decatur on Tuesday, March 23. It was sponsored by Todd Powell from **Schering Pharmaceuticals** and arranged by Kristy Harner of **Internal Medicine Subspecialty Associates** in Decatur. Peggy Wellman gave a very informative presentation on the "Management of Hepatitis C". Approximately 20 GI-related health care professionals attended.

Thank You
To Jo Malham!

Jo Malham wrote the 5'th chapter of the new edition of the SGNA Core Curriculum.

The Core Curriculum is a valuable tool in our daily practice and also when preparing for the certification exam. Thank you, Jo!

Congratulations!

Conference attendees who are SGNA members were eligible to participate in a drawing for the new Core Curriculum at the Spring Conference. The lucky winner was Mary Lyn Schultz, BSN, CGRN from the Chicago Region.



Kay Marvin, CISGNA Past-President presents Mary Lyn Schultz, RN, CGRN, with a copy of the new SGNA Core Curriculum.

Cookbook Update...



Cookbook committee members are busy sorting recipes for the CISGNA Cookbook. Ideas for the cover and recipes are still welcome.

Please send to:

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Answers to Test Your GI Knowledge:

1.C 2.B 3.D 4.A 5.D

Answers to "Abdominal Trauma:
How Much Do You Know"

1.C 2.A 3.D 4.C 5.B

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