Issue 2

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the Insider

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Since 1985, GastroIntestinal Endoscopy (GIE) has provided an efficient 'Open Access' service for colonoscopy and upper gastrointestinal endoscopy.

GIE provides an enviable level of medical experience. Our eight Gastroenterologists possess a broad base of clinical expertise in their varied speciality areas of interests. Currently, GIE operates an 'Open Access' service from four centres:

- **Chermside Day Hospital** – owned and operated by nine Gastroenterologists, five Urolgogists and two Anaesthetists;
- **Brisbane Endoscopy Services** – a Day Endoscopy Centre located at the McCullough Centre, Sunnybank which is owned and operated by the GIE partners;
- **Wesley Hospital** at Auchenflower;
- **North West Private Hospital** at Everton Park.

GastroIntestinal Endoscopy

1300 4 GASTRO (Ph: 1300 4 427876)
www.gastros.com.au

GIE makes some changes

In keeping with our high quality and professional standards of care, GIE have made some recent changes to our practice for the benefit of our referring practitioners and patients.

Phones

GIE has a new phone number for patients to call wishing to make an appointment for their gastrointestinal procedures – **1300 4 GASTRO (Ph: 1300 4 427876)**

When a patient makes a call to this 1300 4 GASTRO number, they will be directed to their choice of procedural location.

However, the hospital-specific phone numbers (*refer to the back of this newsletter*) still apply and you and your patients are more than welcome to call those numbers if you prefer. GIE is striving to make the booking process easier for patients by providing this new 1300 4 GASTRO phone number.

New Electronic referral forms *(saved as: GASTRO (GIE) REFERRAL)*

GIE have developed a new electronic referral form for Medical Director and PractiX programs.

Over the past month, GIE has been busily importing this template (where applicable) into most of the Northside General Practices. For the MD users, you will find this template imported into ***letter writer/user defined/ saved as: GASTRO (GIE) REFERRAL***. Once you have entered the required patient information into the referral as prompted, you only need to print it, sign it and then give this referral to the patient to bring along to GIE.

In November, GIE will be visiting the Southside and Western suburbs to assist in the importing of this template. If you want GIE to import a template or if you have a different program to MD and PractiX, please call Jenny Kilby (Medical Liaison) for assistance on 0401 712 990 or email jakilby@bigpond.com

Alternatively, and until GIE have our own website (which is currently under construction), log on to **www.gppartners.com.au/page/resources**. At the bottom of the page under 'templates' you will find the GIE referral templates and the instructions required to import the forms into your clinical software. Please remember to save the template to a folder or to your desktop. DO NOT OPEN IN MS WORD.

New A5 referral pads

GIE has also created a new A5 paper referral pad for those who prefer a printed version.

Again, Jenny Kilby can deliver these, or you are welcome to call one of our centres *(refer to the back of this newsletter)* for some referral pads to be sent to your practice.

Medical Objects

By end November, GIE will have installed Medical Objects, to enable you to receive our encrypted electronic procedural reports into your clinical program. Please notify GIE if you do not receive your reports electronically and it is your wish to do so.

Southside consultations

A reminder to the Southside GPs that Dr Andrew Bryant and Dr Roderick Roberts will provide private consultation sessions at Brisbane Endoscopy Services at Sunnybank.

In this issue

Chermside Day Hospital officially opens

GIE is pleased to announce that on 3rd September 2008, Chermside Day Hospital became a fully operational and accredited Day Hospital.

On 9th September, Chermside Day Hospital welcomed the Hon. Wayne Swan MP and other dignitaries to view the premises at the official opening of the building.

Since Chermside Day Hospital's first operating day, GIE has seen a growing number of patients requesting procedures to be performed here. GIE will continue to provide an efficient service for colonoscopy and upper gastrointestinal endoscopy from this Day Hospital. For all GIE appointments for Chermside Day Hospital call **1300 4 GASTRO**.

Equally, the Gastroenterologists will provide procedural and in some cases consultation services for their private practice patients at Chermside Day Hospital. For private practice appointments, refer to the back of this newsletter for the Gastroenterologists' contact details.

The Urology partners are also providing day case procedural and consultation services from Chermside Day Hospital. For appointments, please call their individual private practice.

Left to right: Dr Roderick Roberts, Treasurer Wayne Swan MP, Anaesthetist Danielle Moses and General Manager Franz Nohreiter.

Antibiotic prophylaxis for endoscopic procedures

By Dr Alistair Cowen

Dramatic changes in recommendations for antibiotic prophylaxis in cardiac patients undergoing a wide variety of medical, surgical and dental procedures have recently been made. The American Heart Association, the American Dental Association, the British Society for Antimicrobial Chemotherapy, the National Institute for Heath and Clinical Excellence (NICE) and Therapeutic Guidelines Australia – prevention of Endocarditis, have all issued new guidelines during 2007–2008.

In general, they have all greatly reduced the indications for which antibiotic prophylaxis is recommended. The NICE guidelines are at the extreme end of the spectrum recommending no antibiotic prophylaxis for any cardiac condition regardless of the procedure being undertaken. Most would regard this position as extreme.

I have defined as **high risk** those conditions where the American Heart Association and the Therapeutic Guidelines Australia recommend antibiotic prophylaxis for Dental and Gastrointestinal procedures. In addition some cardiac conditions previously defined as **high** or **moderate risk** are listed as optional for antibiotic prophylaxis. Also listed as **low risk** are some conditions previously recommended as requiring antibiotic prophylaxis where it is now general agreement that prophylaxis is not required unless other specific co-morbidities are present.

Antibiotic prophylaxis is recommended or considered optional for a variety of non cardiac increased risk clinical disorders. These include patients with severely compromised immune status, indwelling vascular devices and recent joint replacement.

High risk patients as defined by the American Heart Association:

- Prior infective endocarditis;
- Prosthetic cardiac valves;
- Unrepaired cyanotic congenital heart defects, including palliative shunts and conduits;
- Congenital heart defects completely repaired with prosthetic material or a device, whether placed by surgery or by catheter intervention, during the first 6 months after the procedure;
- Repaired congenital defects with residual defects at the site or adjacent to the site of a prosthetic patch or prosthetic device;
- Cardiac transplant recipients with cardiac valvular disease;
- Rheumatic heart disease in Indigenous Australians.

Moderate risk cardiac conditions as defined in some other guidelines:

- Clinically significant aortic stenosis / incompetence;
- Clinically significant mitral stenosis / incompetence;
- Cardiac stents within six months of placement.

Other conditions for which antibiotic prophylaxis may be considered:

- Severely immune compromised e.g. lymphoma, chemotherapy, myeloid dysplasia, advanced malignancy, neutropenia, advanced hepatic or renal failure;
- Indwelling venous access devices e.g. portacaths, ventriculo-peritoneal shunts;
- Artificial joints within six months of insertion.

Low risk conditions where antibiotic prophylaxis is not now recommended

- Bicuspid aortic valve;
- Minimal valvular disease including mitral valve prolapsed;
- Previous rheumatic heart disease in non Indigenous Australians;
- Joint replacements longer than six months.

Please note that oral antibiotic prophylaxis commencing the day before an endoscopic procedure is NEVER recommended and has the potential to encourage colonization with resistant organisms. Antibiotic prophylaxis should be intravenous and given immediately before the commencement of the procedure.

Dr Alistair Cowen

Frequently asked questions

Dr Alistair Cowen, Gastroenterologist, responds to FAQs

Q. What is the protocol for blood thinning medications now? Is it OK to leave the patient on Aspirin now?

A. Blood thinning agents may greatly increase the risk of serious haemorrhage following polypectomy. This is a complex problem where the risks of post-polypectomy haemorrhage must be balanced against the risks of stopping or modifying anticoagulant or antithrombotic therapy. Frequently there is NO simple and safe solution.

Our Policy is:

Aspirin poses minimal, if any, increased risk of post-polypectomy haemorrhage. If taken simply as a lifestyle measure it should be ceased 10 days before colonoscopy. If taken for a genuine medical indication (e.g. TIA, AF) then should be continued unaltered. Note that aspirin effects continue for 7–10 days after therapy is stopped. Stopping aspirin a few days before colonoscopy is pointless.

Anticoagulants (COUMADIN, MAREVAN [WARFARIN], CLEXANE, DINDEVAN) are usually prescribed for serious medical conditions and stopping treatment may pose serious risks. If therapy can be stopped safely or colonoscopy deferred (e.g. a six month course of anticoagulants following DVT) then this is appropriate. Where there are risks in ceasing therapy the patient is ***unsuitable for open access colonoscopy*** unless the referring doctor is prepared to take full responsibility for stopping anticoagulants. If not, the endoscopist should discuss risks with the initiating therapist e.g. some cardiologists feel anticoagulants can be temporarily ceased for particular artificial aortic valves but not for others, and certainly not for artificial mitral valves. The endoscopist then has the legal responsibility to ensure that the patient understands fully the risks of any modification of the anticoagulant therapy, the risks of polypectomy on whatever modified regime is undertaken, or alternatively the risks of not removing polyps if found.

NB: if anticoagulants are ceased then a Prothrombin Time and INR must be done the day before colonoscopy.

Antithrombotic Agents (AGGRASTAT, ARIXTA, ASASANTIN, ISCOVER, PERSANTIN, PLAVIX, REOPRO, THROMBOTROL, TICLID, TILODENE). The bleeding risks of antithrombotic agents are commonly underestimated. At least from a gastrointestinal point of view these agents pose a greater risk than anticoagulants. There is no way of reversing them and once haemorrhage starts it may not stop until the blood which has been affected has been replaced i.e. transfusion of some litres. A minimum of 7 days off these drugs is required for coagulation to return to normal. There appears to be a rapidly increasing use of these drugs for relatively minor indications e.g. previous history of myocardial infarction. Where the drug can be safely stopped for a ***minimum of 7 days*** before colonoscopy then open access colonoscopy can be undertaken. Where there is considered to be serious risk of stopping the drug, then patients are again unsuitable for open access colonoscopy and the same process described for anticoagulants needs to be followed.

Options where Anticoagulants-Antithrombotics cannot be ceased.

Continue therapy
In high risk patients it may be best to undertake diagnostic colonoscopy while the patient continues on their normal therapy. If polyps are found they cannot be removed and the patient will have to have a repeat colonoscopy or surgical intervention if a high risk polypoid lesion is found. In some instances the least risky course may be simple surveillance of small polyps.

Modify therapy
This could include:

- Aspirin alone
- Daily Clexane
- Twice daily Clexane
- Twice daily Heparin s/c.

Q. Concerns have been expressed that GPs might be liable in some way for complications of procedures booked through the Open Access system.

A. It is patently ridiculous to expect that a GP should know all the complications and their incidence for the possibly thousands of procedures that a Specialist may undertake on the patient that you have referred. The GP does have an ordinary duty of care such that if he or she referred a 98 year old patient with severe heart disease and advanced emphysema for a screening colonoscopy, he might be held to have some responsibility for inappropriate referral. We are the supposed experts and it is our duty of care to explain the procedure, its risk and benefits and alternative investigations and treatments to the patient. Our specifically trained nurses do this and the patient receives all of this information in a written form at least three clear days before colonoscopy. Further the patient is clearly advised in writing that if they want to discuss all possible complications, then they are not suitable for the open access and should seek a formal consultation before proceeding. You might attract some liability only if you refuse to refer the patient for a consultation despite their express concerns and wishes.

Q. When does a Gastroenterologist take biopsies for enzyme assays? The GPs know that the Gastroenterologist will biopsy for ceoliac disease, but what about the enzyme assays, lactose/maltose etc?

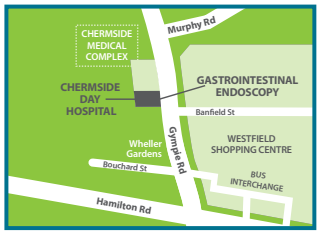
A. We do small bowel biopsies on request but also if anything in the symptoms listed on the referral or during our brief pre procedure talk to the patient suggests malabsorption. In general we only do Enzyme Assays on request. This is a debatable area. Some feel Enzyme Assays are of little value in adults for malabsorption screening and that lactose intolerance in Caucasian adults is mainly a clinical diagnosis. Others apparently find a much wider use.

If you require an electronic referral form or the A5 referral pads, please contact one of our four practice locations below.

GastroIntestinal Endoscopy

GIE practice locations and contact details

For all appointments, call 1300 4 GASTRO (Ph: 1300 4 427876)



Chermside Day Hospital

Chermside Medical Complex
Level 1, 956 Gympie Road
Chermside QLD 4032

Phone: 07 3120 3408
07 3120 3444

Fax: 07 3120 3443

Brisbane Endoscopy Services

Suite 16–18 McCullough Centre
259 McCullough Street
Sunnybank QLD 4109

Phone: 07 3344 1844
07 3344 1422

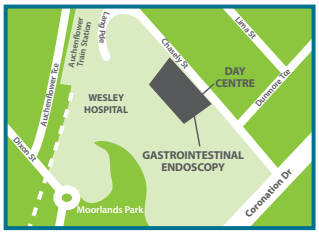
Fax: 07 3344 2739

North West Private Hospital

Endoscopy Unit
137 Flockton Street
Everton Park QLD 4053

Phone: 07 3353 3322

Fax: 07 3353 9325



Wesley Hospital

3rd Floor, Day Centre
451 Coronation Drive
Auchenflower QLD 4066

Phone: 07 3870 3799

Fax: 07 3870 5069

Private practice locations, contact details and special interests

Dr Andrew Bryant MB BS FRACP Dip Av Med (Otago) **Main Rooms:** Level 2, 33 North St, Spring Hill QLD 4000 **T: 3831 7238** F: 3831 7261	**SI:** Endoscopy, endoscopic mucosal resection, advanced polypectomy and hepatology **C:** Spring Hill, Sunnybank, North West Ramsay Place and Prince Charles Hospital Private Practice Clinic
Dr Alistair Cowen MB BS (Hons) MD FRACP **Does NOT Privately consult.** **Open Access procedures only** **T: 3353 3322** F: 3350 4143	**P:** North West Private Hospital, Holy Spirit Northside, Wesley, Sunnybank, Chermside Day Hospital
Dr Benedict Devereaux MB BS MPhil FACG FRACP **Main Rooms:** Holy Spirit Northside Hospital Level 1, Medical Centre, 627 Rode Rd, Chermside QLD 4032 **T: 3861 4866** F: 3861 4897	**SI:** Gastroenterology, ERCP, EUS, therapeutic endoscopy, IBD and polyp surveillance **C:** Holy Spirit Northside, Manor Apartments – City, Chermside Day Hospital
Dr Michael Miros MB BS (1st Class Hons Qld) FRACP **Main Rooms:** 66 Bryants Rd, Loganholme QLD 4129 **T: 3801 5200** F: 3801 5212	**SI:** Barrett's oesophagus, gastric intestinal metaplasia, polyp surveillance, capsule endoscopy **C:** Loganholme (Limited consulting – endoluminal gastroenterology only)
Dr Roderick Roberts MB BS FRACP AGAF **Main Rooms:** Level 2, Suite 62, Ballow Chambers 121 Wickham Terrace, Brisbane QLD 4000 **T: 3831 2704** F: 3835 1069	**SI:** IBD, coeliac disease, drug induced liver disease and polyp surveillance **C:** Wickham Terrace, Sunnybank North West Ramsay Place, Chermside Day Hospital
Dr William Robinson MB BS FRACP **Main Rooms:** Level 4, Suite 85, Sandford Jackson Building 30 Chasley St, Auchenflower QLD 4066 **T: 3870 7433** F: 3870 7466	**SI:** Gastroenterology and parental nutrition **C:** Wesley Hospital and Strathpine Specialist Centre
Dr Neville Sandford BSc (Med) MB BS (1st Class Hons) FRACP AGAF **Main Rooms:** Brisbane Clinic, 79 Wickham Tce, Brisbane QLD 4000 **T: 3270 4593** F: 3270 4588	**SI:** Gastroenterology and hepatitis treatment **C:** Wickham Terrace, North West Specialist Centre
Dr Patrick Walsh BSc MB ChB FRACP **Main Rooms:** Holy Spirit Northside Hospital Level 1, Medical Centre, 627 Rode Rd, Chermside QLD 4032 **T: 3861 4866** F: 3861 4897	**SI:** Gastrointestinal malignancy, endoscopic ultrasounds, advanced polypectomy, polyp surveillance **C:** Holy Spirit Northside, St Andrew's Hospital

SI: Special Interests C: Consults P: Procedures