



## European Society of Gastrointestinal Endoscopy

### ***Travelling tutor report, Belgrade, Serbia.***

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The following is a short recap of the activities, experiences and thoughts following the five day trip to Belgrade/Serbia

The trip was organized in conjunction with the faculty of the recent Category B meeting in Belgrade, November 2005, and with Boston Scientific, who generously supported the activity on a pure cost basis. Mr Carter from Boston Scientific was present during the first two days, their regional manager and local representatives were partly present throughout the week, without interfering with the clinical activities in any way. On the contrary, repeated discussions with them were very helpful in understanding various mechanisms of the region.

I travelled together with one of my most experienced nurses, Gudrun Jonasdottir. All activities were done together. Most were also combined doctor/nurse activities, because Serbian nurses spoke almost exclusively the local language.

#### **June 4 (Sunday)**

Arrival at 2PM. Lunch with Boston Scientific. Rest. Planning meeting with Manolovic/Doder/Carter/Jonasdottir at 6PM. Informal dinner.

#### **June 5 (Monday)**

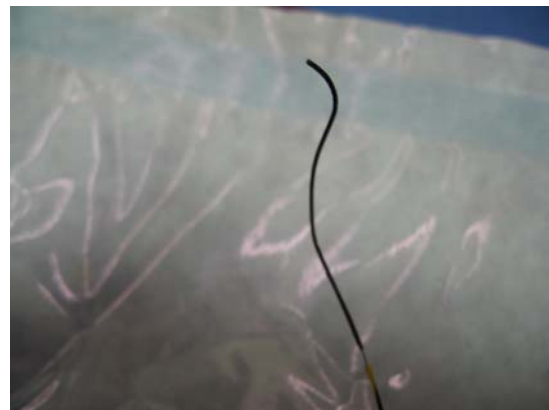
Start-up 0815 at Military Academy hospital

Planning meeting with clinical group, English presentation of individual difficult patient cases for discussion, format similar to workshops. Moderately active discussion, more "What to do, professor...?". Still reasonable session, good opportunity for general clinical advice, also on the non-endoscopic cases, and indications. In general high level of interest to intervene (too high?) Three selected for procedures.

Case 1: 7cm pseudocyst with mild bulging into the stomach, totally asymptomatic patient. EUS performed, assessment showed good position and conditions for stent drainage, but the only available equipment was an EUS needle. Apparently planned for procedure, but without any of the equipment necessary at hand. Still almost had to be restrained physically from doing the puncture.. Decided on conservative approach and check-up in 6 months, if growth or symptoms plan for new procedure with equipment available.

Case 2; ERCP – recurrent pancreatitis in young lady. ? Divisum (no indication thereof, no MRCP done). Proved to be divisum, minor papilla cannulation, wire and ept. No 5Fr stents available, will with EPT alone. Nice case. Assistance from local nurse. The papillotome was angled and twisted, and the wire (their only wire) was totally crooked.

Case 3: ERCP – dilation of biliary and pancreatic duct, question of pan stone. Previous EPT done, but fibrotic and narrow, Bile duct also narrow through the pan head. Pan duct dilated all the way down. Performed extension of EPT of the pancreas, (maybe not done at all?). No stent.



After this we observed one EUS, two uppers, two colonoscopies. These were performed very nicely and efficiently. Good EUS equipment – radial and therapeutic sector scanner. Finish at 5:15PM

**Accessories:** Minimal amount of ERCP accessories, all reprocessed (no sterilization), just enzymatic cleaning and disinfection with Cidex. Endoscopes well cleaned, Olympus ETD3, 2 machines in regular use.

**Cleaning:** All equipment was opened repeatedly, dropped on the floor, sat on.... Wires and papillotomes were severely damaged, and hardly usable. The handling during and before the procedure probably the main risk factor, not the fact that the equipment was reprocessed. On the other hand: Sterile gloves and multiple syringes for water and contrast.

Radiologist and anaesthesiologist present for the procedure, but not involved, and not very enthusiastic. Both contributed to significant delay between procedures, while the logistics for uppers/colons apparently worked very well. Deep sedation for ERCP and colons.

**Documentation:** No nurse documentation. The endoscopists write the report right away, electronic but non-structured, primarily as a typewriter function. No image documentation.



## June 6 (Tuesday)

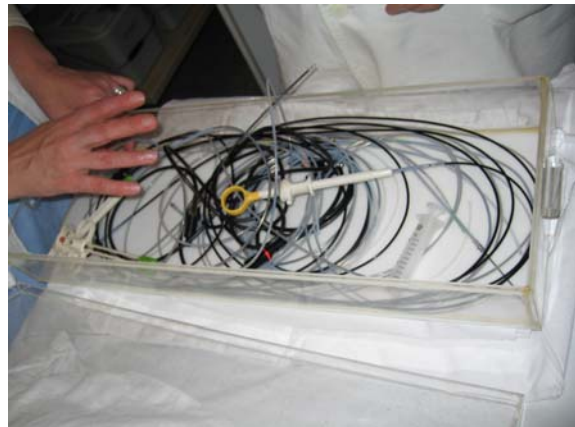
Starting 0830 at the **Zemon clinical center**, oldest hospital in the Balkans. Meeting the director of Internal medicine, then clinical meeting with the GI doctors, discussions of three cases, all colonoscopy with polyps. Very instructive cases, good discussions on piecemeal resections and saline injection/non-resection. Everybody present for procedures for discussions. Two dedicated nurses, recently recruited but very interested. Chief of endoscopy recently appointed (2 months ago), just establishing the unit.

Had 4 Excera II units, 4 more in storage! – but all accessories fit in a tiny tray. Planning to get this, but at present a huge discrepancy between endoscopes and accessories. Also, ERCP lab was 40 years old, no digital (in preparation..) One ERCP case as well, pre- cholecystectomy, suspicion of stone.

**Cleaning:** Just brief bath disinfection between patients, “manual” machine at the end of the day, not between cases. Due to time constraints (?). Probably more to gain on nurse training.

**Sedation:** None for uppers and routine colonoscopy, high tolerance for patient intolerance. Good rooms.

**Documentation:** Manual reporting with manual typewriter. No nurse documentation.



## June 7 (Wednesday)

Starting 0830 at **Clinical Center of Belgrade**, the largest hospital by far with Professor Buljagic. Demonstration of GI facility, and participation in one ERCP. Apparently large volumes, but during demonstration, the majority of the best equipment was out of order, so only fiber for EGD and only a single small channel endoscope for ERCP. Dedicated radiologist with her own screen behind the back of Dr. Buljagic (“this is my screen, he has his own..”)

Same struggle for accessories, while the access to equipment obviously is easier. Large number of doctors (political reasons?). Still building after many years, finished signposts, but reality slightly different. Same thing with some of the endoscopy equipment.

One Belimed washing machine, but stuck in an off-track room, not connected to water. Capsule endoscopy in same room. Funding for 30 per year. Planning to get DBE (?)



Then return to Military medical academy, two interesting ERCP cases after discussion. One dilated bile duct and elevated bilirubin without explanation, reportedly 3 previous EPT: Minimal EPT opening, huge bile duct and a 20mm stone in the hilum, crushed and removed after a reasonable EPT.

The other patient with ? left lobe stricture and unexplained pain, scheduled for cholecystectomy. Normal findings.

Peek into storage room with 100 Olympus cannulation catheters and some similar collections of single items.

Afternoon observation of std procedures (Dr. Doder etc). Nurse pushing endoscope, even for uppers. Saline injection for rectal polyp, nice technique, but no removal of pieces for histology. Full colonoscopy: Very quick retraction. Good routine for equipment cleaning in this department.

### June 8 (Thursday)

Starting 0845 at **City hospital**. Smaller hospital size than Zemon, also university hospital. 3 endoscopists, another 4-5 combined gastroenterologists. 3 dedicated nurses. Good endoscopy racks, washing machine (one operational another etd3 in the box). All very well organized, and nice location. 4 cases done together with the group, including an indurated polyp, with chromo, saline injection, decided for surgery.

Same situation with accessories. We used a totally faulty, taped injection needle although there were more on the shelf. Very nice tone, good collaboration, also visit from another hospital doctors that were not visited, excellent discussions.

Digital recording of endoscopy footage, but no systematic use, no still picture imaging. Lack of printer ink... A lot of the money from remuneration from clinical studies (IBD) that was specifically allocated back to the endoscopy department.



## June 9 (Friday)

Pickup 0745 at hotel to Military academy. Talk with journalists from two major newspapers, (not TV as announced..) Meeting with invitees from Belgrade, most attendees from the academy total 50 or so, also nurses. Four lectures including two by me (endotherapy of chronic pancreatitis and the future of endoscopy). Nice discussions, but few active participants (language problems.)

After this nice reception with discussions. Decision to organize accessory shipment to Belgrade for distribution until they have access to this thru normal channels. Motivate engagement in the EU society, travel, and also apply for travel grants and more courses.



## Main conclusions

- This trip gives a totally different impression of the LOCAL situation than the live demo courses.
- The two activities have complementary roles, and do not exclude each other. Moreover, travelling tutoring at a live demo course location offered many advantages, particularly awareness of what this was / who I was and some familiarity to the region. Thus, one from the course faculty would be a good traveller candidate.
- This trip had the combined virtue of teaching (lots of small-scale discussions on individual cases as well as other topics), demonstrations of endoscopic techniques, and improved understanding from the ESGE side of the needs of a society (for which the live courses are not so good). Finally, it was a good way to make the ESGE better known to the endoscopic society, including the grants- and other educational activities. The reception of our team was uniformly warmly welcoming and we truly felt this was a much-awaited visit at all the hospitals. The one hospital in Belgrade city that was not visited felt accordingly left out (but we had discussions with their doctors)
- The ESGE has a major role to play in directing the activities in developing societies like the Serbian (and probably other countries in former Yugoslavia as well.
- The discrepancy between plans, promises, "almost in place solutions" etc and the actual situation is more obvious on a travel like this.
- The sponsors must realize the long term benefit of this hardly any short term sales based on this trip, but Boston appeared content, particularly because there seems to be money in the system, but at present it is being spent very haphazardly – decisions not being made on purchases by the endoscopists, but primarily on a political level.
- Bringing a nurse: Good, and nice, but there is a major problem of the language, difficult to communicate directly. Maybe the output would be similar without a nurse companion (?)

Oslo, June 20, 2006

Lars Aabakken