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June 2024 ▪ Volume 9, Issue 5

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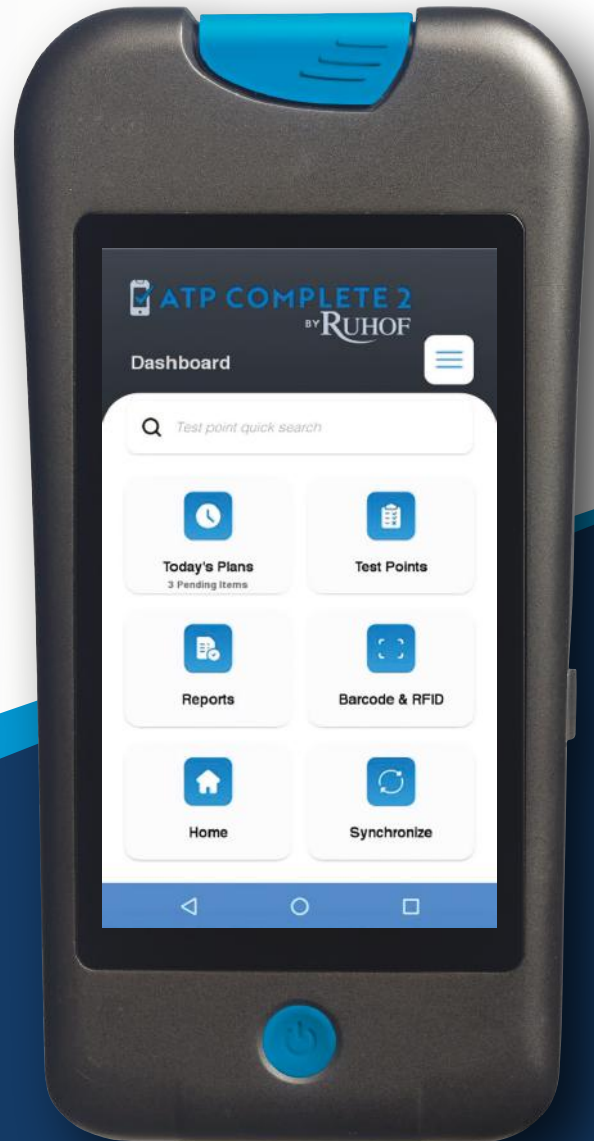
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Contents

June 2024 • Volume 9, Issue 5

Departments

6 Editor's Letter

Shining Star

Do You Have a Fantastic Colleague?

By Michelle Beaver

8 All Stars

Arapahoe Endoscopy Center

Encouraging Respect Between Team Members

By Madison Knutson

10 Tech Talk

A Call for Certification

It's Time to Invest in Flexible-Endoscope Reprocessing Personnel

By Nancy Chobin, RN, AAS, ACSP, CSPM, CFER

14 After Care

A 'Gentle Sort of Ruthlessness'

Take Responsibility for the Third One-Third of Your Life

By Patricia Raymond, MD, FACP (retired)

Features

18 Inflammation and Celiac Disease

Have We Had It Backward?

By Lisa Hewitt, MA

28 Critical Work

The Cleaning and Disinfection of Flexible and Semi-Flexible Endoscopes

By Janet Pate, JD, MHA, BSN, RN

34 News

Popular Obesity Drugs May Lead to Medical-Procedure Complications

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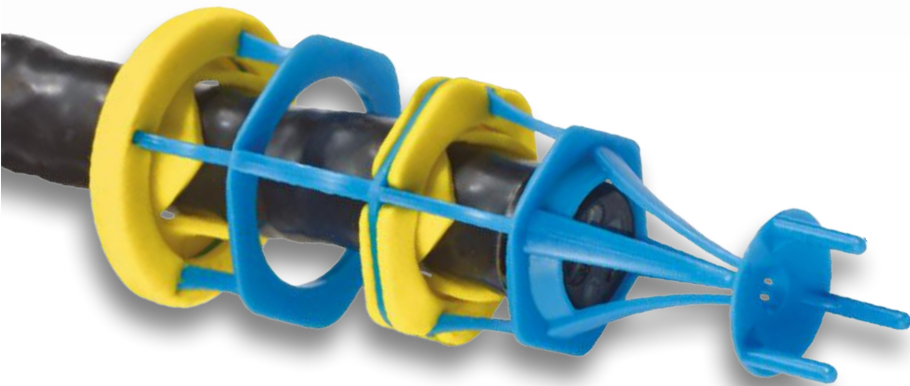
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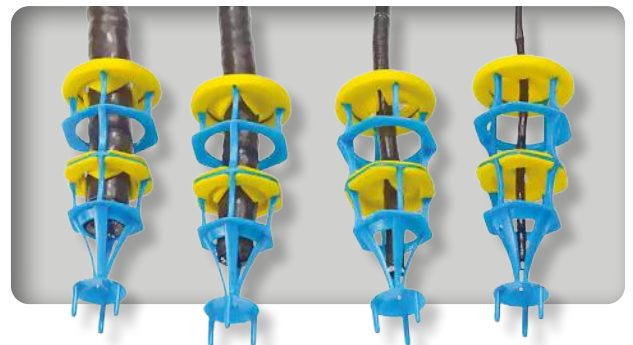


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Shining Star

Do You Have a Fantastic Colleague?

Over the years you've probably noticed that our magazine always includes a feature about a great endoscopy team. This section is called All Stars. We've recently increased the prominence of this section by moving it toward the front of the magazine. Over the years we've highlighted hundreds of teams (if you include the precursor to EndoPro, which was called EndoNurse). In addition to this much-loved staple, we're now widening the honor landscape by also including features about individuals.

The section will still be called All Stars, but sometimes we will feature a single individual, as opposed to a team.

Does anyone come to mind for you? Have you ever, or do you now, work with a person who shines as exemplary? Someone who goes above and beyond, who has a teachable attitude, who shares their knowledge, who does their best to help patients and teammates? Perhaps this person has overcome difficult odds to get where they are and inspires others.

Perhaps this person is you!

If you'd like to nominate an endoscopy professional who stands out as exceptional, simply send me an email at Michelle.Beaver@endopromag.com and write a paragraph or so about what makes this individual great. If the person meets our criteria, someone from our team will reach out with more information. We make the process quick and easy, because healthcare professionals are busy enough as is.

This process is the same for our All Star teams too, so feel free to nominate a whole group. These features give new ideas to your peers across the country, affirm effective things they're already doing, and provide inspiration.

It's been a pleasure over the years to learn about the wonderful teams who are providing efficacious and kind care to endoscopy patients everywhere. Now it will be a pleasure to learn about the individuals who set an example for their teams. Thanks for all you do!

Michelle Beaver

Want to nominate an exceptional endoscopy professional or a team? The process is easy! Simply send an email to Michelle.Beaver@endopromag.com with a paragraph about why a certain endoscopy individual or team is great.



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References: 1. Al-Haddad MA, et al. *Endoscopy*. 2015;47(2):136-142. 2. Farrell J, et al. *Gastrointest Endosc*. 2019;89(4):832-841.e2. 3. Data on file. Interpace Diagnostics.

All Stars

It's your time to shine!

Arapahoe Endoscopy Center Encouraging Respect Between Team Members

By Madison Knutson



The first team priority for the Arapahoe Endoscopy Center, located in Littleton, Colorado, is respect.

According to Director of Nursing Kris O'Brien, the team is a family. They bond by keeping in touch with each other and understanding what is going on in other team-members' lives. O'Brien said the respect that the team has grown for each other is essential to their work in the clinic, and that other clinics should adopt that philosophy, too.

"We have people who are single parents, have kids with disabilities, are caring for elderly parents, are raising their grandchildren, etc.," O'Brien said. "There has to be respect from each person, including management."

Arapahoe Endoscopy Center offers procedures such as colonoscopy, upper endoscopy, hemorrhoid banding and flex sigmoidoscopy. These services are supported by three procedure rooms. There are typically between nine and 10 registered nurses, three or four techs, three doctors and three or four certified registered nurse anesthetists on the team each day.

According to O'Brien, the team typically treats 30 to 40 cases a day. They pride themselves on their same-day endoscopic surgical services, which allow patients to receive a procedure and return home in a matter of a few hours.

The Arapahoe center was one of 470 endoscopy clinics featured in Newsweek's "America's Best Ambulatory Surgery

Centers 2022." There were some 5,000 ambulatory surgery centers in the U.S. that year.

The center was also featured on the 2023 and 2024 lists—one of about 500 endoscopy clinics chosen.

The Arapahoe team experienced a challenge to their group dynamic when an administrator did not work well with the team and disrespected staff members. After working with the administrator for one and a half years, the person was removed from the position. O'Brien said the team is working to rebuild the group's family dynamic since the member's departure. Arapahoe is still looking for a new administrator, and O'Brien said she has involved staff members in the decision-making process.

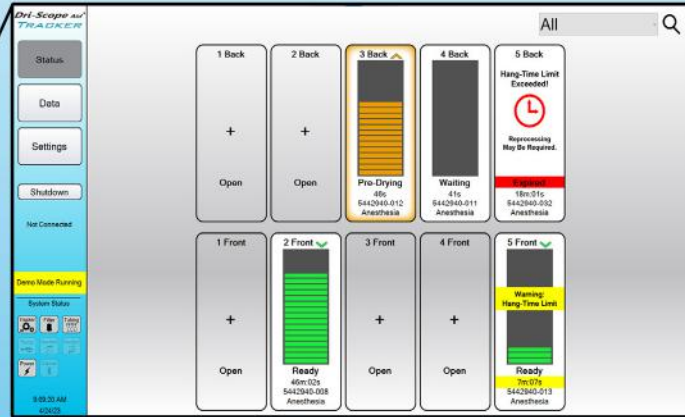
Arapahoe technician Marla Brown applauds the team at the clinic and their unique approach to teamwork.

"Our specific dynamic doesn't exist anywhere I have ever worked. We are fun and energetic, and experts in many fields," Brown said. "We all come from different backgrounds including ER, ICU, NICU, etc. We have a staff age range of in our 20s to in our 70s, and everyone works together and respects each other."

Madison Knutson is a student at Arizona State University pursuing a bachelor's degree in journalism and mass communication. She works as a producer for the Alaska Teen Media Institute and is a deejay for Blaze Radio at ASU.

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A Call for Certification

It's Time to Invest in Flexible-Endoscope Reprocessing Personnel

By Nancy Chobin, RN, AAS, ACSP, CSPM, CFER



Flexible-endoscope reprocessing personnel perform essential duties, including cleaning, disinfecting, and possibly packaging and sterilizing reusable medical and surgical devices for the safe and effective care of patients. Obviously, in so doing, they can affect patient outcomes.

In today's healthcare environment there is a decreased financial reimbursement to healthcare facilities. Endoscopes are expensive, so facilities may have limited inventory, yet the facility is under pressure to book as many cases as possible. To add to the problem, we have much more sophisticated surgical equipment necessary to support advanced procedures. Facilities are adding surgeons and GI procedure rooms. To retain the physicians who practice at the facility, employers need to satisfy them in terms of service and available equipment—yet still need to maintain quality and patient safety and avoid waste and losses. Not an easy task.

Flexible endoscopes are a valuable diagnostic and therapeutic tool. Their design is complex, making cleaning and reprocessing protocols critical. In addition, we are dealing with microbes that are more resistant than ever.

Microorganisms can be spread from patient to patient via contaminated or improperly processed flexible and semi-rigid endoscopes, or due to malfunctioning equipment. In addition, microorganisms may be transmitted from patients to endoscopy personnel and/or from endoscopy personnel to patients. If endoscopes are not rinsed properly, chemical residues used during the procedure or the reprocessing

can remain on devices, which can subsequently cause toxic reactions in patients.

In addition, we need to be aware of the quality of water used for cleaning and rinsing endoscopes and devices. As we learn more about the various steps involved with processing endoscopes and the factors that can negatively impact the final outcome, manufacturers' instructions for use (IFU) will continue to be a major patient-safety factor.

Educational Programs

We must provide basic knowledge to reprocessing personnel. This is key to competent performance. Education is the first step to providing an awareness of the standards and guidelines that affect endoscope processing. The education/training can be offered in a formal or informal setting. However, successful completion of an educational program does not ensure competency; education should be coupled with experience.

AAMI's ST-91 document, "Flexible and Semi-Rigid Endoscope Processing in Healthcare Facilities (2021)," states: "Policies and procedures for endoscope processing, which includes processes for monitoring adherence to the policies and procedures and a chain of accountability, should include guidelines for:

- a) delineating procedures for processing of endoscopes and endoscope accessories

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b) confirming that current versions of the manufacturer's written IFU for the endoscope models and automated endoscope reprocessors (AERs) used at the facility are readily available to processing personnel

NOTE—Processing personnel should inform manufacturers, as well as the FDA if applicable, if the IFU seem unclear or inadequate.

c) confirming that facility processing procedures do not conflict with the written IFU of the manufacturers of the endoscopes, AERs, cleaning solutions, liquid chemical sterilants, or high-level disinfectants

d) verifying that processing personnel comply with processing procedures”

The policies and procedures that direct the reprocessing methods should be readily available to the reprocessing staff in the area(s) where the cleaning, disinfection, packaging or sterilization take place. The policies should be reviewed routinely and as standards and guidelines are developed, updated or published.

Unless there are clearly defined policies and procedures (which should be based on ST-91, since this is a national standard), and compliance with stated policies is monitored, facilities may continue to face problems with breaches in protocols. In addition, a copy of the processing policies should be readily available in the processing area for staff reference.

Certification

Before being assigned to processing endoscopes without supervision, personnel should be thoroughly trained, with competencies verified. AAMI ST-91 states, “All personnel performing processing of endoscopes should be certified in flexible endoscope processing within two years of employment and should maintain that certification throughout their employment.” At a minimum, personnel should complete a certification exam.

For endoscopy personnel who take an endoscopy course, it is important to note that professional certification is not about gaining a certificate after the completion of a training course. Certification can more accurately be described as a form of standardization, because it is based on a predetermined level of competence as established by a credentialing body. Therefore, the course is Step 1 and certification is Step 2. A course by itself is not enough.

An accredited certification program means the certification program has been reviewed and accredited by the National Commission for Certifying Agencies (NCCA). It provides consensus data on what flexible endoscope reprocessors need to know and be able to do. The knowledge and skills are identified through a Job Analysis of the profession which determines the critical knowledge and skills needed for competent performance (NCCA).

Benefits to Certification

These include:

- a more productive and highly trained workforce for employers
- prestige for the individual and a competitive advantage over non-certified individuals in the same field
- certification can be used as basis for career ladder to offer employees professional growth
- enhanced employment opportunities
- assists employers in making better-informed hiring decisions
- assists consumers in making informed decisions about qualified providers
- protects the general public from incompetent and unfit practitioners
- establishes a professional standard for individuals in a particular field

Knowledge and skills have grown dramatically for personnel who process flexible and semi-rigid endoscopes. These individuals should be recognized as professionals who are an integral part of the medical/surgical team. They should be properly trained, and their competency verified through a legally defensible certification process.

The cost for certification is small when compared to the benefits of:

- improved work performance
- improved self-esteem
- successful patient outcomes
- employee satisfaction
- increased patient and employee safety

The time is now. Don't fear certification—embrace it!

Nancy Chobin, RN, AAS, ACSP, CSPM, CFER, is the president and CEO of Sterile Processing University, LLC, an on-line education and continuing-education website (www.spdceus.com). Chobin is a member of AAMI, AORN, SGNA and OSAP. She serves on numerous AAMI standards committees and served as co-chair of the Endoscope Document Committee from 2012 to 2018. Chobin has lectured extensively in the United States; Latin, Central and South America; Mexico; and in Asia and Europe. She has co-authored three textbooks on sterile processing and flexible endoscope processing activities. Reach her at Nancy@SPDCEUS.com.

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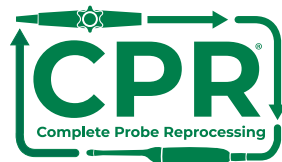
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A ‘Gentle Sort of Ruthlessness’

Take Responsibility for the Third One-Third of Your Life

By Patricia Raymond, MD, FACP (retired)



*You must allow yourself
to outgrow and depart
from certain eras of your life
with a gentle sort of ruthlessness.*

~ Katy Maxwell, girl of the earth

We may have met.

Since about 2009, I'd frequently been honored to be a speaker at both national and regional SGNA meetings, singing gastrointestinal pop music parodies at the end of my presentations. I'd performed nationally as my alter ego, the Divine Ms. Butt Meddler, extolling the virtues of colorectal cancer screening in jokes, song and story—for an example, search “(Lookin’ Up My) Back Door.” I hosted a regional NPR-affiliate health call-in show, “House Calls,” for several years. I've practiced local gastroenterology for 30 years and was a community faculty member of the nearby medical school, helping to train the residents.

Then came COVID-19.

I think I contracted COVID in early 2020; we had no testing then, but I had the diagnostic signs like “COVID toes” (objectively fascinating geographic vasculitis), dyspnea, tachycardia, proximal muscle weakness, pedal edema, and

orthostatic hypotension. I just couldn't get better, needing to lean against the endoscopy stretcher to carry out my procedures, seeing my “office” patients via video at home, and needing to climb my desk from the chair to make it up to a standing position.

I retired from GI in January 2021.

Yes, I likely acquired long COVID-19, an entity affecting up to 19% of COVID patients, according to the CDC, and a syndrome we are still discovering. Remember the time it took to understand the multitude of exposure effects of Agent Orange?

The greatest wealth is health. ~ Virgil

Well, thank goodness I'm a doctor, and to appropriate words from the lead character from Andy Weir's book, “The Martian,” I chose to “science the sh*t out of it.” However, my long-COVID journey isn't the actual topic for this article; an offshoot of my self-serving post-retirement investigation led me to examine what we know about aging and how to mitigate the effects, or even—in what bears resemblance to an amped-up infomercial or obnoxious Facebook ad—to reverse it.

You might believe that I have won the genetic lotto; Dad died not of genetic predispositions, but of causes attributable to cigarette use (laryngeal cancer,

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cardiovascular disease, COPD). Mom, at 90, is thriving and doing exercise classes and vigorous daily beach walks to “keep her juices flowing.” Unfortunately for me, only 10%–25% of longevity is due to genetics, so I cannot rest on Mom’s laurels and maternal mitochondria.

Or perhaps that’s actually fortunate for all of us: That means that 75%–90% of your own longevity, that third one-third of your life, lies in your hands, and it can be modified. And likely not by consuming Cindy C’s non-rotting melons from the south of France.

Eat food, not too much, mostly plants. ~ Michael Pollan

It’s clear that diet plays an essential role. In 2008, anecdotal yet scientific writer Dan Buettner looked at lifestyle and community, diet, and activity levels in the ten world regions of highest longevity in his acclaimed book, “The Blue Zones.” In one of the earliest supports for our potential mastery over what was inferred to be an inevitable aging process, he found essentially what you’d now expect, and I encourage you to read his now 15-year-old book, and pivot to embrace an improved (even ~gasp~vegan) diet, cultivate strong social support, and increase natural activity levels. There is additional anecdotal and scientific support for almost all Buettner’s findings.

In case you are wondering, the exceptions are moderate alcohol intake and naps, although naps of greater than an hour cut your longevity. My retired, loves-a-good-afternoon-nap-cuddled-with-kitties self is grumbling, yet taking notice.

If we knew what diseases we were at risk for, what choices would we make? ~ Leroy Hood, M.D., PhD

Were you aware that medicine as we have practiced it is in the throes of an extensive makeover, and not by our insurance foes? Leroy Hood, M.D., PhD—an inventor who is also fundamental for our understanding of the human genome through his work on DNA sequencers—has now turned his innovative sights on what is known as “systems medicine.” Using data analysis and genetic testing, Dr. Hood advocates for “**P4**” Medicine: medical care that is **p**redictive, **p**reventive, **p**ersonalized and **p**articipatory.

You may have already inadvertently joined Dr. Hood’s movement, “the quantified self,” which enlists digital devices to self-monitor parameters such as weight, activity, sleep and diet—perhaps a Bluetooth-enabled scale, a Fitbit or Apple Watch, a diet-tracking app, or even an Oura Ring to monitor sleep patterns. What devices might you use to add data as well as participation to your daily wellness decisions? The goal is to convert reactive sick care into proactive wellness care using personalized tools and gaining patient participation. How might you choose to participate?

You don’t have to be sick to get better. ~ Hale Irwin

A plethora of aging research involves the length of the telomeres, the endcaps on your DNA that directly correlate with diseases of age. Telomeres are like the plastic tips on your shoelaces (BTW, their name is an “aglet”) that prevent the laces from unraveling; long telomeres are great, and short or absent telomeres, not so much. As expected, factors that reliably shorten your telomeres include obesity, smoking, alcohol, low sleep, refined grains, saturated fats, processed meats, poultry intake, and sugar-sweetened beverages. But telomeres can be lengthened too!

You can lengthen your telomeres with exercise, a plant-based diet, an anti-inflammatory diet, increased dietary fiber, green tea, and the dreaded cooked kale. If that final one left you lamenting, find a way. As little as five days of daily kale showed measurable increased telomerase activity which restores base pairs to your DNA aglets.

Do something today your future self will thank you for. ~ Unknown

If you want to learn more—a whole lot more—I would be remiss if I didn’t point your attention to Nutrition Facts’ Dr. Michael Greger’s 640-page (and 1.68-pound) opus, “How Not to Age: The Scientific Approach to Getting Healthier as You Get Older,” released in late 2023. This dad-joke replete, joyous anti-aging guide is brimming with practical techniques to improve you—and your family’s, friends’ and innocent bystanders’—aging process. Even my mom, who has successfully progressed to 90, is not immune to my urgings—she’s added the (albeit poorly named) spermidine (aka, wheat germ) to her diet to enhance autophagy of damaged or diseased cells.

So, let’s look at your third one-third—your first third being your childhood and education, your second third being your adulthood and career. Will you permit your third one-third to be hampered with aging and chronic disease, or will you choose diet and lifestyle changes that will keep your juices flowing?

I closed each House Calls broadcast with:

It’s your life
It’s your health.
And it’s your choice.

We are not aging. We are ripening to perfection. ~ Auntie Acid

Patricia Raymond, M.D., FACC, is a retired gastroenterologist and educator savoring the third one-third of her life in coastal Virginia. She completed her gastroenterology fellowship at the Medical College of Virginia oh, so long ago, and after a 30-year gastro practice in southeastern Virginia and thriving professional speaker and broadcast career, is a popular provider of second opinions in gastroenterology for 2nd MD, now educating people one by one. You will likely find her in her greenhouse or gardens, either propagating fig trees or growing much of her vegan diet organically with donated rabbit poo.

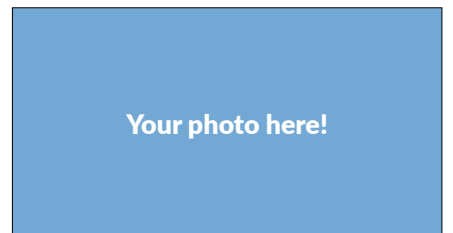
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We'd like to honor you, the endoscopy professional. From doctors and technicians to nurses and office managers, we love showcasing you and giving you the space to share your struggles and success.

Why? It helps teams connect across the country, it gives our readers ideas on how to excel, and enhances pride in what you do. (And who doesn't like to thump their chest?)

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Don't delay! Nominate today!

Inflammation and Celiac Disease

Have We Had It Backward?

By Lisa Hewitt, MA

Celiac disease (CD) can blindside, and it can sneak. I found out the hard way: After a particularly grueling workout, I felt a soft puff of pain in my right elbow. Rest and ice didn't help; avoiding exercise gave no improvement. This was back in the mid-1990s, when CD wasn't well known, and I went through four doctors before one mentioned that I might be having an allergic reaction. Testing confirmed allergies to wheat, rye and barley, and he recommended I remove those foods from my diet. Easier said than done, but I switched my allegiance to rice, found a tasteless form of gluten-free bread and tearfully said goodbye to bagels and thick-crust pizza.

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I didn't even know the disease existed until several years later when a nurse looked askance at my chart and said, "Allergies to all that? Have you been tested for Celiac?" By then, of course, a diagnostic test would have proven nothing: I'd been gluten-free for years and my villi were doing happy dances.

Eating gluten-free (GF) became a fad in the 2010s. A plethora of books touted the benefits of a gluten-free or wheat-free diet, and film stars and influencers became the diet's most ardent supporters. Everyone, it seemed, was talking about gluten and the benefits of doing without. This was a mixed blessing for those of us with CD: On one hand, it was great to have more gluten-free options in the grocery store, and to be able to talk intelligently with wait staffers at restaurants about our dietary needs. On the other hand, it became tiresome to explain that no, I wasn't following a fad diet, and yes, I could get seriously sick from just a speck of plain flour. Restaurants have since starred their GF offerings with a caveat: "Our kitchen is not gluten-free. If you have Celiac disease, proceed with caution." Or "We cannot guarantee gluten-free."

Not helpful. We're back to square one.

What is Celiac Disease?

If you work in gastroenterology, you've long been familiar with the malady I found troubling and frightening. The Celiac Disease Foundation describes it as a "serious autoimmune disease that occurs in genetically predisposed people where the ingestion of gluten leads to damage in the small intestine."

Gluten itself isn't the issue. It's the body's immune system that's the problem, overreacting to a dose of gluten like a cat jumping away from a thunderclap. According to the Mayo Clinic, "Over time, this reaction damages your small intestine's lining and prevents it from absorbing nutrients, a condition called malabsorption."

Malabsorption may sound fairly benevolent, but it isn't. Untreated, CD can wreak havoc with the body, inducing diarrhea, gas, bloating, constipation, vomiting and other gastrointestinal symptoms. This can lead to weight loss, anemia, tooth damage, and irritability. In infants, the disease can cause failure to thrive; in kids, it can lead to short stature and delayed puberty.



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People who have untreated Celiac can be diagnosed with osteoporosis, mouth ulcers, fatigue, joint pain, hyposplenism, and elevated liver enzymes.

Symptoms vary. Cramping and diarrhea after eating may be only the most common giveaways. According to Meghan Donnelly, senior manager of nutrition services at Schär, Inc.—a well-known manufacturer of gluten-free products—unexplained nutritional deficiencies can be a big hint. “I’ve had a lot of people tell me they had iron deficiency anemia, and that was the red flag that made the doctor order another test. Symptoms can even be things like fatigue and having poor energy levels. You wouldn’t necessarily associate those with Celiac disease in the absence of a nutrient deficiency, but they often are present.

“A lot of people get what we call neuropathy, which is like tingling of the nerves, especially in the extremities. A lot of people get headaches, migraines. There are skin manifestations of celiac disease. Some people get what is called dermatitis herpetiformis, which is a skin rash. Some people experience fertility issues. Irregular menstruation, poor growth, unexplained weight changes—there’s so many.”

Worse, sufferers can develop neurological problems, including learning disabilities, ADHD, lack of muscle coordination and seizures. Nervous-system injury can lead to numbness in the extremities, balance problems, and cognitive impairment.

Possibly worst of all, the chronic inflammation associated with CD can cause such damage to the intestinal T-cells that their beneficial disease-fighting capabilities are reduced or lost—permanently.

This is far more than a stomachache.

What Causes Celiac Disease?

Short answer: We don’t know.

CD has a genetic component, which means it runs in families; when I chatted with a gastroenterologist about the disease and discovered I was way past the point of testing, she recommended a genetic screening, which did return the gene marker for CD. Sometimes the engine that fires up the disease is stress: People have developed the disease after contracting a virus or an intestinal infection, having surgery, getting pregnant, or even going through a stressful period.

In the journal of the MDPI (Multidisciplinary Digital Publishing Institute), Barone, et al., write, “Patients at risk of CD are those subjects that have a genetic risk defined as the presence of HLA DQ2 or 8 and are first-degree relatives (sons or daughters, sisters or brothers) of a CD patient.”

And CD piggybacks. You’re at higher risk if you have Type 1 diabetes; Addison’s disease; Down syndrome, Turner syndrome or William syndrome; autoimmune thyroid disease; or microscopic colitis. In addition, researchers at the University of Colorado Anschutz Medical Campus discovered that autoimmune diseases like Celiac travel in packs. If you have one autoimmune disease, you’re at higher risk for getting another. This turns out to also be true for me: In addition to CD, I have rosacea. (I’ll stop there, thank you.) Head researcher Nirmal Banda, PhD, professor in the division of rheumatology, says people like me should be vigilant about monitoring symptoms to avoid developing another disease.



"I believe because of our changing environment we are seeing a growth in autoimmune diseases," he said in an interview with Science Daily.

Khan and Wang agree. They write in the journal *Frontiers in Immunology*, "Strong evidence exists linking environmental agents, including solvents, crystalline silica, mercury, pesticides, Pesticides, and cigarette smoking with the development of various ADs. However, significant knowledge gaps remain regarding potential cellular, molecular, and immunological mechanisms by which environmental agents contribute to the disease pathogenesis."

And sometimes CD just doesn't stop. Refractory Celiac Disease is like pouring a whole tanker's worth of gasoline on CD's little campfire: Even eliminating gluten from the diet doesn't stop the symptoms and inflammation in Refractory CD patients. The National Organization for Rare Disorders (NORD) states on its website that Refractory CD is "resistant or unresponsive to at least 12 months of treatment with a strict gluten-free diet."

The diagnosis, NORD says, is "made by exclusion:" eliminating the possibility of other culprits like Crohn's disease, intestinal lymphoma, small intestinal bacterial overgrowth (SIBO) or hypogammaglobulinemia.

While only 1%-2% of CD patients will develop RCD, and the vast percentage of those are over the age of 50, the symptoms can be more severe and more disabling. NORD says, "In Celiac disease, T-cells that recognize gluten proteins are activated and proliferate. When gluten is removed from the diet, these T-cells become inactive and the intestinal damage heals. In

Refractory Celiac Disease, intestinal T-cells are activated without gluten stimulation and intestinal injury persists despite the removal of dietary gluten."

The link between RCD and enteropathy-associated T-cell lymphoma, or EATL, is a great reason to keep awareness of this nasty rare disease in your mental filing cabinet. Almost always a product of CD, EATL nominally shows up in the small intestine, although it's been known to present in other sites. NORD writes, "The most common location is the jejunum, and the lymphoma presents as single or multiple tumors or as a diffusely infiltrating intestinal malignancy. EATL typically presents with tumor involvement of the middle or lower thirds of the small intestine leading to obstruction (blockage), bleeding, and pain from ulcer formation or perforation (puncture)."

The Chicken or the Egg?

Researchers have long known that inflammation is part of the Celiac mix. But what they're looking into now is whether inflammation contributes to the disease. Barone, et al., write, "A central role in the pathogenesis of CD is played by the HLA-restricted gliadin-specific intestinal T-cell response generated in a pro-inflammatory environment. The mechanisms that generate this pro-inflammatory environment in CD is now starting to be addressed."

One of the theories is that some cells are genetically more "fragile," predisposing them to an inflammatory trigger that renders them vulnerable. The authors cite beta-cell fragility as an example; beta cells are the underlying cause of Type 1 and Type 2 diabetes.



More Than Just GF

While Schär is best known for its gluten-free breads and other products, it also has created the Dr. Schär Institute, a resource for healthcare professionals that is dedicated to gluten-free and metabolic nutrition. In addition to its gluten-free products, it also creates nutrition for those with chronic kidney disease as well as those who can't process conventional fats.

Donnelly said part of her job is to help train providers. "We have continuing-education programs for Celiac disease that are primarily targeted for dietitians, but we do training programs all the time for all types of providers. The website has a lot of great training—webinars and education and I am always willing to give a training. I do this all the time, especially with different dietician groups, especially with retail dietitians, dietitians who work in grocery stores, just so people can understand the gluten-free diet better. I understand that not everyone has access to a dietitian. But if you're a healthcare provider, we want to get you set up with the resources for the gluten-free diet. I'm always willing to share and send [materials] out and host trainings."

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They write, "A central role in the pathogenesis of CD is played by the HLA (human leukocyte antigen)-restricted gliadin-specific intestinal T-cell response." But why is the response pro-inflammatory instead of regulatory? "The answer partially comes from studies conducted in mice that demonstrated that mucosal inflammation due to reovirus infection may disrupt oral tolerance by suppressing regulatory T-cell conversion and by promoting Th1 immunity against gliadin, indicating that in an inflamed environment enriched in cytokines, such as IL-15 or type I interferons, T-cells tend to acquire a pro-inflammatory phenotype. Many mice-based studies as well as epidemiological data have suggested viral infections as one of such factors."

So what causes the inflammation that kicks off the CD response? Recent literature posits that the causes could be a Heinz-57 mix of external environmental factors, including the previously cited viral infection, a Western diet, and other inflammatory agents, combined with endogenous predisposition that makes the cells more vulnerable to pro-inflammatory stimuli.

Khan and Wang discuss the influence of environmental toxicants in autoimmune diseases. "It is well-accepted that both genetic and environmental factors influence the pathogenesis of ADs [autoimmune diseases]," they write. Citing mercury, pesticides, pristane, silica, smoking and trichloroethene as some of the worst offenders, they also discuss how these toxins affect the gut microbiome, and how this subsequently contributes to disease pathogenesis.

The enemy is without and within.

Celiac and the Gut Microbiome

It stands to reason that a patient with CD might be more susceptible to having a less-healthy gut microbiome, and the research bears that out. Marasco, et al., found that "In fact, patients with Celiac disease have a reduction in beneficial species and an increase in those potentially pathogenic as compared to healthy subjects. This dysbiosis is reduced, but might still remain, after a gluten-free diet. Thus, gut microbiota could play a significant role in the pathogenesis of Celiac disease, as described by studies which link dysbiosis with the inflammatory milieu in Celiac patients."

Khan and Wang agree. They write how "human microbiome changes could be a significant contributory factor in autoimmunity as an altered microbial composition can induce inflammation and loss of immune tolerance. The composition and stability of gut microbiome not only help with the nutrient absorption but also regulate mucosal immune system, therefore, dysbiosis can result in multiple ADs."

A healthy gut microbiome is critical to avoiding "inflammaging," or long-term inflammation, which can lead to increased risk for a host of diseases, including heart disease, cancer, and Type 2 diabetes. This is tough enough for the young and healthy, but older patients are increasingly at higher risk for inflammaging.



The immune system generally does an effective job at managing inflammation. The innate part of the immune system zeroes in on infection or injury, deploying inflammation as necessary to facilitate the healing process. The adaptive immune system is the body's "memory," keeping a record of the host of nasties that have crossed the threshold and sending out a response when one is detected. When we're

young, it's easy for these two parts of our immune system to work together; but as we age, the body finds it harder to keep them in balance.

This is why diet is so important, writes Jefferson Adams on the Celiac.com website: "Historically, research has focused on the T-cell response in Celiac disease, but there is growing recognition of the importance of the

pre-inflammatory state. Modulating this state with a Mediterranean-type diet or preventing intestinal viral infections could have a significant impact on the onset of Celiac disease, and could be easier to manage than the more complex autoimmune response."

It isn't just CD development that might be influenced by this approach. Adams states that inflammatory bowel diseases and diabetes might also be delayed or derailed by early intervention in the inflammation process.

A Future Cure?

While currently the only help for CD sufferers is faithful adherence to a GF diet, help is coming. Researchers at Columbia University are testing more than a dozen drugs to help mitigate or eliminate the worst effects of gluten. Latiglutenase contains enzymes that help break down gluten in the stomach, according to an online article published by Columbia University Irving Medical Center. Larazotide works to protect the small intestine. And a yet-unnamed "known as PRG-015 is meant to dampen the body's inflammatory response upon exposure to small amounts of gluten."

A second category of drugs is meant to re-educate the patient's immune system, eliminating gluten as a threat. Columbia is currently recruiting trial subjects for these potential treatments.

Celiac disease can be a conundrum. With its shifting symptoms and potentially deadly pathology, it can present challenges to the most experienced GI professional. But thanks to ongoing research and dedicated clinicians, CD sufferers like me can look forward to a future of good health with the disease under control, and the possibility of a cure on the horizon.

And hopefully, someday, deep-dish pizza.

Lisa Hewitt, MA, senior editor at EndoPro Magazine, has had a long career as an editor, writer and designer, with an emphasis on medical content.



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Critical Work

The Cleaning and Disinfection of Flexible and Semi-Flexible Endoscopes

By Janet Pate, JD, MHA, BSN, RN

The cleaning and disinfection of flexible and semi-flexible endoscopes is critical for providing safe patient care in healthcare organizations. Cross contamination has been a growing concern. It's vital for healthcare providers and techs to strictly follow standards, guidelines and manufacturer instructions for use (IFU). Not doing so could result in serious harm to the patient.

Patients have experienced illnesses or adverse outcomes resulting from cross contamination during scope procedures. Healthcare facilities must make cleaning and disinfection of scopes a priority and ensure the cleaning methods meet standards provided by the American National Standards Institute and the Association for the Advancement of Medical Instrumentation, ANSI/AAMI ST91:2021.

When developing a program to effectively clean, disinfect, store and transport scopes, many factors should be included:

- design and construction of space that allows personnel adequate space and equipment to perform cleaning and disinfection
- development of cleaning and disinfection policies and procedures based on the most current guidelines
- employment of adequate personnel to perform the functions
- training and education of personnel
- development of a process for point-of-use treatment
- development of a safe transportation process for taking the contaminated scope to the reprocessing area
- obtaining the correct equipment, chemicals and water
- development of a scope-decontamination process
- development of a process to transport the clean/sterile scope to the scope storage room and ultimately the procedure room
- providing appropriate storage for the scopes





Design and Construction

The Facilities Guidelines Institute (FGI) should be utilized for design and construction of the endoscopy suite, and the cleaning, disinfection and sterilization processing department. The guidelines give direction on the space needed, as well as airflow and design. Design of the cleaning, disinfection and sterilization area should address placement and type of equipment to ensure the workflow is conducive for cleaning scopes without cross contamination. Appropriate water quality for the operation of machines must be addressed. A separate decontamination area with a closing, pass-through window is ideal. It is very important to include infection prevention in the design phase of these areas.

Policies and Procedures

Excellent resources for use in policy development include the American National Standard Institute (ANSI), ANSI/AAMI ST91:2021, American Society for Operating Room Nurses (AORN), American Society of Gastroenterology Nurses and Associates (SGNA), American Society for Gastrointestinal Endoscopy (ASGE), and the Association of Professionals in Infection Control and Epidemiology (APIC). The policies should also be based on the manufacturer's instructions for use (IFU) for each type of scope that will be used. Topics to include are point-of-use treatment, transportation, processing, cleaning verification and storage.

Personnel

The personnel hired to work in the scope processing area are vital to the success of the department. There must be an adequate number of employees to ensure sufficient time for the cleaning and disinfection process. Employees should not be rushed to process scopes, as this may compromise cleaning. They must have the time to carefully leak-test, inspect, and manually clean and decontaminate each scope.

Education and Training

Employees in the cleaning and disinfecting area must be highly trained and educated. To ensure appropriate cleaning, the employees must be familiar with all aspects of the cleaning process, the equipment, and the IFU for the scopes. Employees should be trained upon employment and retrained at least annually, demonstrating competency for each scope. If changes occur with equipment or cleaning standards, if new scopes are purchased, or if updated IFU are published, employees must also be trained at that time. Records should also be kept for employee training. Adequate training and education will be beneficial in the production of disinfected or sterilized scopes. Many organizations now require certification for employees who work in the cleaning and processing department.

Point-of-Use Treatment

Upon the completion of the endoscopy procedure, point-of-use treatment should be performed as soon as possible to ensure bioburden doesn't dry on the scope. This should

be done following the manufacturer's IFU for the scope used. It is important to record the time the procedure was completed to ensure the cleaning process was initiated within an acceptable time frame recommended by the manufacturer and guidelines.

Transportation of Contaminated Scopes

Contaminated scopes must be transported to the decontamination area in a manner to prevent harm/contamination of others or the environment. Contaminated scopes should be transported from the point of use to the decontamination area for manual cleaning in a closed, leakproof, puncture-resistant container. The container must be labeled "biohazard." Some organizations choose to use a closed cart for transportation, and this must also be labeled "biohazard." The container/cart must be cleaned before returning to a clean storage area.

Equipment, Chemicals and Water Quality

The equipment used in the decontamination area must be suitable for cleaning scopes. Automated endoscope reprocessors (AERs) are often used for high-level disinfection. Certain scopes may be sterilized, and the equipment to do so must be purchased. The IFU detail the cleaning process and must be followed. The equipment and process are defined by the type of scope being cleaned.

Appropriate water quality must be provided in the cleaning area. Ensure rinsing is adequate to remove all cleaners and detergents prior to high-level disinfection or sterilization. The water must meet the requirements of the equipment being used.

Scope Decontamination

Scopes that arrive in the decontamination area typically have already received point-of-use treatment. The scope then must be leak-tested prior to the manual cleaning process. Once the scope passes the leak test, the manual cleaning process may begin.

Equipment used in the decontamination area must be clean and suitable for cleaning the scopes. Clean water should also be used for each scope. The cleaning equipment and process is defined by the type of scope. Manufacturers' IFU may be different for various scopes.

Technicians should submerge the scope into a cleaning solution as indicated by the manufacturer's IFU. The appropriate cleaning chemicals must be used, and the concentration of the chemicals used is determined by the chemical manufacturer. The appropriate dilution of the chemical affects the cleaning properties and the integrity of the scope. The parts should be removed and cleaned per IFU and stored with the scope. All visible blood and body fluids must be removed. All ports, channels, elevators and crevices must be thoroughly cleaned. The scope must then be thoroughly rinsed to ensure there is no chemical residue remaining before processing.

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ANSI/AAMI ST:91 2021 provides standards for reprocessing scopes. They also identify high-risk scopes and the appropriate procedure for cleaning, disinfection/sterilization, and cleaning verification for those scopes. These standards must be followed.

Transportation of Clean/Sterile Scopes

Care should be taken during transportation of clean or sterile scopes to ensure there is no contamination of the scope prior to use. Ideally, the sterile scope should be placed in a clean or sterile container for transportation to a clean storage cabinet and patient procedure room. Scopes can easily be contaminated if they come into contact with equipment, doors, or the floor. If this occurs, the affected scope must be returned to decontamination and the entire cleaning process must be repeated. A different (sterile) scope must be used for the procedure.

Scope Storage

Disinfected scopes typically are stored outside the procedure area in a scope cabinet in a clean room with positive airflow. The scope must dry completely before being placed into the scope storage cabinet. Scope cabinets are available for purchase that facilitate drying; other scope cabinets contain HEPA filters. There currently is no mandated timeframe in which a scope should be reprocessed if it not used. Many facilities reprocess the scopes if they are not used in a month, or 30 days; this is determined by organizational policy, manufacturer's IFU, or guidelines. If there is a chance that a scope has been contaminated or the cleanliness has been compromised, the scope should be reprocessed before use.

Patient safety must be the ultimate priority for any healthcare organization. There are numerous opportunities for patients to experience adverse outcomes while receiving care. The development of organizational policies and procedures based on current standards and guidelines is imperative. It is the responsibility of the healthcare organization to take measures to ensure patients receive safe, high-quality care. A collaborative approach with key organizational leaders and infection prevention experts is beneficial to ensure patients receive high-quality, safe care: in every hospital, every time.

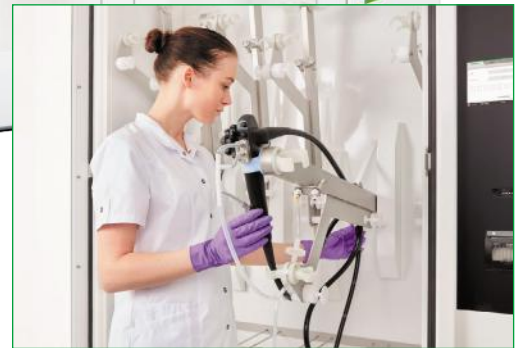
Janet Pate, JD, MHA, BSN, RN, is a nurse consultant and educator for the Ruhof Corporation. She has 28 years of experience as the director of ambulatory environment of care and safety, including 20 years as ambulatory director of infection prevention and 10 years as ambulatory director of central processing. She is also a licensed attorney in Alabama.

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Popular Obesity Drugs May Lead to Medical-Procedure Complications

Cedars-Sinai Investigators Find Popular Weight-Loss Drugs Are Associated With Risk of Aspiration Pneumonia Following Endoscopy

New research from Cedars-Sinai suggests people who are scheduled for certain medical procedures should stop taking popular weight-loss drugs in the days or weeks prior in order to avoid complications.

Ali Rezaie, M.D., found that glucagon-like peptide-1 receptor agonists (GLP-1RAs)—medications like Ozempic and Wegovy that are used to treat diabetes and obesity—are associated with an increased risk of aspiration pneumonia following endoscopy. The large, population-based study is published in the leading peer-reviewed journal *Gastroenterology*.

Aspiration pneumonia is caused by inhaling foreign materials—including food in the stomach, or secretions from the mouth and nose—into the lungs. Endoscopy is a medical procedure in which a physician puts a tubelike scope down a patient's throat and into the body to look inside.

One way the new obesity medications work is by slowing digestion so people feel full longer, causing them to eat less. This also means that food sits in the stomach longer. As a result, the stomach may not empty completely during the usual duration of fasting recommended ahead of a surgical procedure to decrease risk of aspiration, explained the study's corresponding author, Ali Rezaie,

M.D., medical director of the GI Motility Program and director of bioinformatics at the MAST Program at Cedars-Sinai.

“Aspiration during or after endoscopy can be devastating,” Rezaie said. “If significant, it can lead to respiratory failure, ICU admission and even death. Even mild cases may require close monitoring, respiratory support and medications, including antibiotics. It is important we take all possible precautions to prevent aspiration from occurring.”

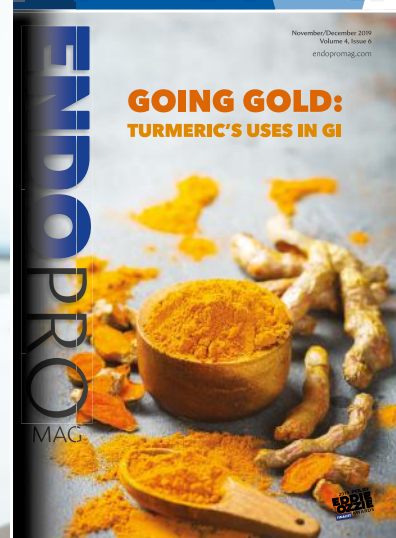
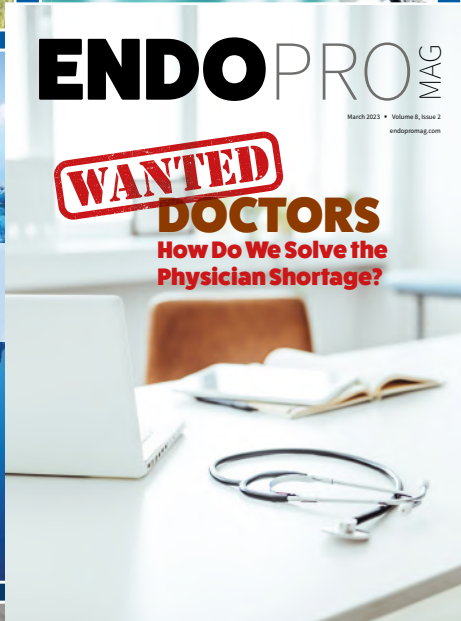
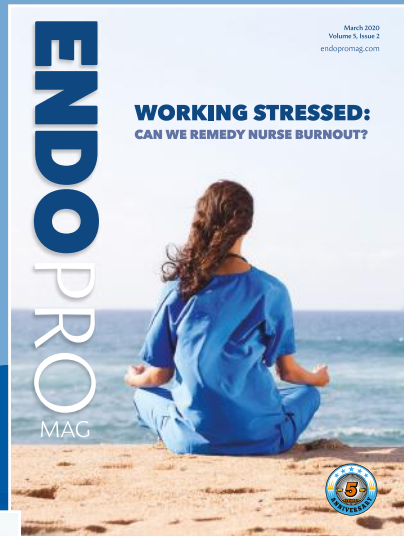
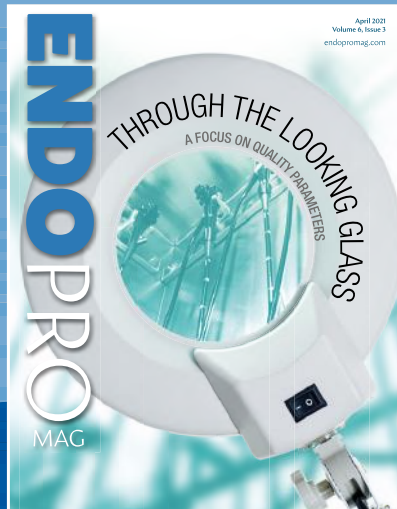
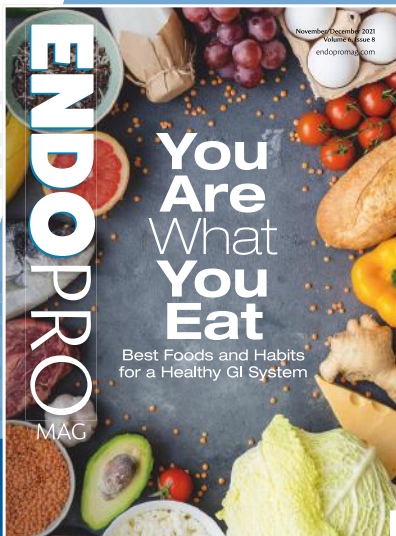
The study analyzed data from nearly 1 million de-identified U.S. patients who underwent upper or lower endoscopy procedures between January 2018 and December 2020. Patients who were prescribed GLP-1RA medications had a 33% higher chance of experiencing aspiration pneumonia than those who did not take these medications before the procedure. This comparison also considered other variables that could influence the outcome, in order to ensure a fair comparison between the two groups.

“When we apply this risk to the more than 20 million endoscopies performed in the U.S. each year, there may actually be a large number of cases where aspiration could be avoided if the patient safely stops their GLP-1RA medication in advance,” Rezaie said.

“The results of this study could change clinical practice,” said Yee Hui Yeo, M.D., first author of the study and a clinical fellow in the Karsh Division of Gastroenterology and Hepatology at Cedars-Sinai. “Patients taking these medications who are scheduled to undergo a procedure should communicate with their healthcare team well in advance to avoid unnecessary and unwanted complications.”



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