



BRITISH SOCIETY OF  
GASTROENTEROLOGY

# NewWave

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**The Official e-Newsletter of the  
Association of GI Physiologists**

## **AGIP Council 2024**

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## **Welcome**

Welcome to the **October 2024** edition of NewWave!  
If you have any relevant articles or papers that you would like  
to be included in future editions, please email  
[gemma.norris@sthk.nhs.uk](mailto:gemma.norris@sthk.nhs.uk)

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**October 2024**

## From the Editor

Hello and welcome to the Autumn issue of NewWave! I hope you have all been keeping well and enjoying the shift into the darker nights and chilly mornings!

It's already time to start thinking about the BSG Live' 25 Conference, which is due to take place next year in Glasgow, in June! The application process for submitting abstracts and posters opens soon, and the window remains open for a relatively short period. See [Page 3](#) for further details, including the important deadline dates!



The AGIP Council has been working on some new ways to enable you to connect. Further details, on how to reach out via the new AGIP email account, and LinkedIn page, as well as through the AGIP Website, can be accessed on [Page 4](#).

There have been some recent changes to the AGIP Council, and on [Page 5](#), Gianni Raise introduces himself as the Council's new IQIPS Representative. I'm sure he will be a great addition to the committee!

Moving on to our feature articles, on [Page 6](#), Ismail Miah has kindly provided the abstract that he and his team had accepted for the BSG Live' 24 Conference in June. The abstract highlights the importance of adjunctive physiology testing in patients with ineffective oesophageal motility and absent contractility, in the context of assessing pre-operative suitability.

On [Page 8](#), Dr Lauren Brunskill details her own experience, as a patient in GI Physiology. Lauren works as a Clinical Scientist, and has suffered chronically with symptoms of acid reflux, experiencing gastroscopies, manometries, ambulatory 24hr pH studies and most recently, a wireless pH capsule. Lauren has also previously undergone antireflux surgery, although unfortunately experienced a recurrence of symptoms. This piece offers quite a unique perspective on the investigations that we perform in GI Physiology, by viewing the patient experience through the lens of an experienced Clinical Scientist. It makes for a very interesting read!

Finally, on [Page 11](#), I have put together some information, about a Healthcare Science Marketplace Day that was recently put on at Mersey & West Lancs Teaching Hospitals. The event was aimed at raising the profile of HCS careers, to both staff, and high school students. The event provided some great insights into the various roles that exist within the NHS, outside of those that are already well known, and it was a really enjoyable event to be a part of.

Once again, I would like to thank the colleagues who took the time to put articles together and share them with us. For contributions to future issues, in the form of articles, announcements or important news, please don't hesitate to get in touch ([gemma.norris@sthk.nhs.uk](mailto:gemma.norris@sthk.nhs.uk)). Happy Reading!

*Gemma Norris*

## Upcoming Events: 2024/2025

|                       |                                                                                                           |
|-----------------------|-----------------------------------------------------------------------------------------------------------|
| <b>November 2024</b>  | The European Foregut Society 4th Annual Meeting<br>London<br>4th—7th November 2024<br><a href="#">EFS</a> |
| <b>December 2024</b>  | BSG Campus 2024<br>Online<br>2nd—5th December 2024<br><a href="#">BSG</a>                                 |
| <b>June 2025</b>      | BSG Live' 25<br>Glasgow<br>23rd—26th June 2025<br>Await further details regarding registration            |
| <b>September 2025</b> | ESNM NeuroGASTRO 2025<br>London<br>4th—6th September 2025<br><a href="#">ESNM</a>                         |

## A Call for Posters and Abstracts: BSG Live' 25

BSG Live' 25 will be taking place from Monday 23rd – Thursday 26th June 2025 at the SEC in Glasgow! This annual conference is a great opportunity to connect with colleagues, and to access four days of high quality, educational material. BSG Live' 24 was a brilliant event, and it was great to see GI Physiology represented so well amongst the abstracts and posters!

For those interested in sharing their work at the next event, the application process for abstract/poster submissions opens on Monday 2nd December 2024, and closes on Friday 24th January 2025. Keep an eye on the [BSG Live website](#) for further information and more detailed submission guidelines. Don't miss this opportunity to share the valuable work being carried out in GI Physiology, and help to further raise the profile of our services!

Remember, AGIP will be providing bursaries of up to £500 to support conference attendance, and priority will be given to AGIP members who have had an abstract/poster accepted. Good luck, and we look forward to seeing your contributions!

**Save the date**

**BSG LIVE'25**

**Dates: 23rd – 26th June 2025**

**Venue: SEC Glasgow**

# AGIP News

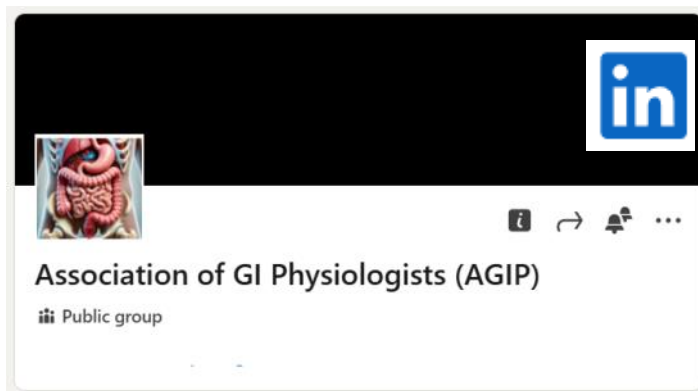
## Updated AGIP Contact Information

The AGIP Council is excited to announce a couple of new ways to stay connected! With the aim of making it quicker and easier for your GI Physiology queries to be addressed, we now have a new, dedicated email address. This account will be closely monitored by the BSG team, ensuring that all queries are promptly assessed and directed to the most appropriate member of the AGIP Council, who will then be able to assist. This approach will allow us to handle queries more efficiently, provide timely responses and improve the overall channels of communication.



Please feel free to reach out to us directly at [AGIP@bsg.org.uk](mailto:AGIP@bsg.org.uk) and we'll get back to you as quickly as possible.

In addition to our new email address, the AGIP Council is thrilled to expand our online presence with the launch of our very first social media platform. Our LinkedIn page is designed as a professional space for members to engage with AGIP and stay informed on the latest developments in GI Physiology. Follow us to be among the first to hear about upcoming events, important news and join in with professional discussions. You can find, and connect with us at: [Association of GI Physiologists \(AGIP\) | Groups | LinkedIn](#).



Finally, our website remains an essential hub for all things GI Physiology, serving as a comprehensive resource for documentation, professional guidance, and educational support. We are continuously updating this platform with the latest documents, training materials, and guidelines to support GI physiology practitioners at all career stages. In addition, you can find key resources on accreditation processes, guidance on equivalence standards, and of course, your quarterly edition of NewWave!

### AGIP – Association of GI Physiologists

The Association of Gastrointestinal Physiologists (AGIP) is an Associate group within the British Society of Gastroenterology, inaugurated in 1991.

AGIP has established the Accredited Scientific Practice (ASP) programme which enables employers to develop bespoke short courses to meet the training needs of its Healthcare Science workforce. AGIP is also a member and active participant of the Professional Bodies Council, Academy of Healthcare Science which aims for a clear 'One Voice' to represent the majority of over 65,000 people working in the profession of Healthcare Science across the UK.

We look forward to connecting with you, and hope that these new channels make it easier than ever to stay informed and engaged with AGIP.

## Introducing AGIP's Latest Committee Member: Gianni Raise, IQIPS Representative

### IQIPS Representative

Gianni Raise, Clinical Scientist at Sheffield Hospital

Hi, my name is Gianni and I have recently been appointed as the IQIPS Representative for AGIP. First of all, thank you for the opportunity; I am looking forward to working with everyone involved in AGIP. My academic journey started with a BSc in Sport and Exercise Science (2:1) which I completed in 2019,. It was during my final year that I became aware of the Scientist training programme (STP) following a talk from a guest speaker, and knew that this was what I wanted to do.

After a failed 1<sup>st</sup> application onto the STP, I started an MSc in Cardiac Rehabilitation which I completed in 2020. I then reapplied to the STP and successfully gained a place at Sheffield Teaching Hospitals in Gastrointestinal Physiology. I completed the STP a year ago and during my final year, set up the NEY GI Working group which has since had 4 successful meetings (meeting biannually). I have always enjoyed discussions around progression and the development of practice, so I was keen to get involved with all the good work going on at IQIPS and the AGIP Council currently.

I work at Sheffield Teaching Hospitals in GI Physiology and Urology (one day a week performing Urodynamics). My professional interests are in lower GI bowel management/ biofeedback and upper GI physiology. I am half Italian and stereotypically my personal interests are in sports and cooking. I am a keen football fan, player and shirt collector, and have a close attachment to my air fryer. Since lockdown, I have enjoyed running and I am currently training for the 2025 London Marathon.



# Clinical Communication of Physiology with Surgeons

**BSG Live' 24 Poster Presentation by Ismail Miah, Clinical Scientist**  
Guy's and St Thomas' NHS Foundation Trust

**Abstract:** Clinical Communication of Physiology with Surgeons

**Authors:** Ismail Miah, Terry Wong, James Gossage, Sebastian Zeki, Jafar Jafari.



**Introduction:** Clinical Scientists and Gastroenterologists predominantly perform the preoperative oesophageal physiology investigations and may report ineffective oesophageal motility (IOM) and absent contractility (AC). Although such findings pose risks of postsurgical dysphagia, adjunctive physiology tests (APT) may influence the surgical decision making, which this paper will discuss.

**Method** Patients with IOM and AC undertook APT (multiple water swallows [MWS] +/- solid bolus swallows) prospectively to the standard water swallows. Peristalsis of the oesophageal smooth muscle were gauged by the Distal Contractile Integral (DCI).

**Results** IOM (F: M=86:34, median age 52 years) and AC (F:M=59:56, median age 56 years) were prevalent respectively in 44.4% and 3.83% of the cases. MWS augmented the oesophageal DCI in 73 patients with IOM (60.8%) by average ratio factor of 2.2 (95% CI=1.8–2.5) which pose low risk of dysphagia from floppy Nissen fundoplication (fNF). The oesophageal contractile mean wave amplitude (MWA) in IOM patients was 40.8mmHg (95%CI=38.5–43.1mmHg) with 46 patients (38.3%) posing low risk of postsurgical dysphagia with magnetic sphincter augmentation (MSA). 90 patients (75%) were suitable to at least one form of antireflux surgery (ARS) while 44 patients (36.7%) were suitable for fNF (but not MSA) and 17 patients (14.2%) were suitable for MSA (but not fNF).

APT invoked peristalsis in 43 patients with AC (37.4%) which pose low risk of dysphagia for fNF (solid bolus invoking effective peristalsis was greater by 3.2 folds to MWS [ $p=0.0004$ ]). In 72 patients with failed APT, 6 patients (8.3%) showed remaining motility on dry swallows (DCI>100) and 29 patients (40.2%) demonstrated peristaltic remnants on standard swallows and/or adjunctive tests (DCI<100). 37 patients (32.2%) had absolute AC with 21/37 patients (56.7%) had achalasia on oesophageal transit testing. Absolute AC in 9 patients originate from connective tissue disorder, history of atresia and tracheoesophageal fistula surgery.

**Conclusion:** APT outcome presented surgical viability in majority of patients with IOM and AC. In IOM, augmentation of the smooth muscle contractility or adequate MWA posed low risk of postsurgical dysphagia and suitable ARS could be advised.

APT in patients with AC demonstrated remaining neuromuscular functioning in the oesophageal body in one patient cohort who were suitable for ARS while a second cohort with absolute AC were suitable for surgical myotomy.

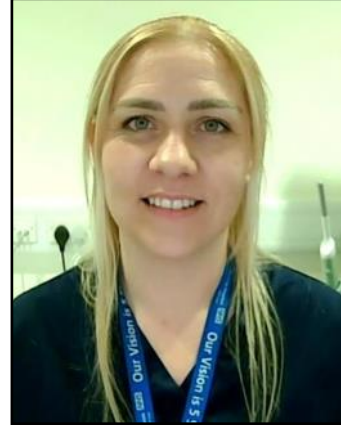
Patients' demonstrating peristaltic remnants should be trialled with prokinetic therapy and reassess for peristaltic recovery or the progression of complete diminishment of peristalsis on follow-up studies. Thereby, appropriate surgical pathway can be suggested.

# pH Monitoring: Insights from a Patient vs Physiologist's Perspective

**Dr Lauren Brunskill, Clinical Scientist**

Mersey and West Lances Teaching Hospitals NHS Trust

Having experience of GI physiology investigations as a patient, as a physiologist, and as a physiologist who becomes a patient, I wanted to provide some insight into my perspectives on GI Physiology investigations; specifically reflux monitoring.



## **Background**

I have always suffered with dyspepsia since my teens and have been on numerous PPI's over the years. I had several OGDs performed between 2003 and 2009 which were always macroscopically normal. Endoscopic examinations showed no evidence of a hiatus hernia, or of oesophageal mucosal damage to indicate signs of acid reflux, yet I was constantly experiencing reflux. Initially, I responded well to Lansoprazole, however as time went on, and frequency of my reflux symptoms increased, along with the volume of refluxate produced. Ultimately, I was referred for a laparoscopic Nissen Fundoplication, and had this procedure performed in early 2010, aged 22. Following the surgery, there was an instant cessation of my symptoms, and that was that, or so I thought.

Pre-operatively, in 2009, I had been referred for oesophageal manometry and 24hr pH testing. The manometry was normal, however the pH study (which was performed off PPIs, and without impedance), did demonstrate excessive reflux, in relation to both the number of acidic reflux episodes, and the duration of reflux events, whilst supine. At this time, I was not a physiologist, just a patient with no prior knowledge of these investigations. My experience of conventional manometry (8 channel pull through) was great, although the physiologist doing the study probably thought I swallowed too much. I also found the 24-hour pH study to be easier than expected and other than a runny nose I experienced minimal discomfort or inconvenience.

In 2014, I noticed a mild and gradual return of my reflux symptoms. At this point, I was a 2<sup>nd</sup> year STP trainee, and had some knowledge of the investigations I had been referred for, although had not performed them myself as of yet. Advances in technology meant that now, high resolution manometry was available, and this was performed, demonstrating OGJ outflow obstruction. A repeat 24hr pH study demonstrated a borderline-abnormal amount of reflux. I was never given the reports but instead, informed of the outcome by my consultant. Again, I found the 24-hour pH testing to be relatively easy. There was some minor discomfort, but I was glad to have gained insight into the experience of a patient, and knew that it would serve to improve my practice, both from a practical and communicative point of view.

## **Currently**

Fast forward to current day, I have been a qualified clinical scientist for several years. I have moved Trusts and have once again become a patient, due to a further worsening in my symptoms. At this rate, I fear every physiologist in the North West is going to have shoved a tube into me. Symptomatically, I have noticed a change and have now developed intermittent dysphagia and prolonged periods of chest pain, with conventional

24-hour pH impedance was performed OFF PPI therapy, and demonstrated normal oesophageal acid exposure and significant symptom association, providing a diagnosis of reflux hypersensitivity as per the Lyon Consensus 2.0. Whilst a little frustrating, this did not come as a shock to me, as I had an exceptionally good day with regards to my symptoms on the day of testing, having had only a few reflux episodes—which I reported accurately.

### **Catheter Based Recording**

Having experienced both standalone pH monitoring and pH impedance, I did find the impedance catheter to be more uncomfortable than the previous 24-hour pH investigations, especially within the throat. I noticed that I found it more comfortable when the catheter was secured close to my nostril, which seemed to decrease the amount of movement and irritation I experienced overall. This was in comparison to it being attached further away from my nostril for one study, and taped to the end of my nose for another. This is a practice I now use with my patients to minimise the discomfort they may experience and to make the investigation easier to tolerate. Initially, the 24-hour catheters feel like a relief, after experiencing the larger manometry catheter just prior. The first hour or two are the most difficult from a tolerance point of view, as the sensations of movement on swallowing feel so alien. As more time passes, I did become used to this feeling and felt more settled within the test as a result.

Eating and drinking were not an issue with the wired catheter in situ overall, although I feel as though I ate and drank differently/less than I usually would. This is something that patients usually state also, and so I was aware of this at the time.

As someone who moves a lot during sleep, I was conscious about damaging the catheter (resulting in an incomplete study), wrapping myself up in it and even rolling over onto the recording box. Previously, 24-hour catheters had always caused a blocked nose, which resulted in disturbed sleep due to dryness felt within the nose and throat due to breathing through my mouth. I did find this to be quite painful when I was awoken to the sensation. I was keen to remove the catheter the following morning as soon as possible! As a physiologist, I was torn between relieving the discomfort, and ensuring I had an investigation of appropriate length. I was feeling quite sorry for myself and for my patients at this point. This was now the 5<sup>th</sup> catheter based 24-hour monitoring I had experienced, and I found it to be the most unpleasant by far, despite having very few dyspeptic symptoms.

### **Wireless pH**

I was apprehensive about having an alpha study. I did not like the idea of experiencing another gastroscopy, and I was worried that I would be able to feel the device in my oesophagus constantly or have pain for the duration of the recording. I was also apprehensive as suction from the endoscope stack was being used and not a typical stand-alone suction pump, so naturally it felt a bit experimental (although this had been successfully used previously at other hospitals).

I was not worried about what the study may show and was hopeful that it would give a true representation of my symptoms due to the increased study length. I understood the procedure and what would be required afterwards, and to be honest was secretly looking forward to the rest of the afternoon and following morning off work to recover from the sedation. As per the guidance, I was given dual sedation to ensure cooperation and from what I was told, this was extremely effective. I only recall slight discomfort/retching for a few seconds at one stage (I am told this was when the scope was initially inserted) then I woke up in recovery. My OGD at this point showed patchy gastritis only. Successful placement of the capsule was confirmed 6 cm above the LOS.

At rest, I was unable to feel the presence of any sort of foreign body within my oesophagus. When eating, I was unaware of the device unless I was eating larger mouthfuls or dry foods – in this case I just had to make sure I chewed my food properly to avoid discomfort, however any discomfort experienced quickly passed. Sleeping was easier than my experience of catheter-based monitoring as I was able to place the recording box next to my bed and not worry about displacement or rolling onto the device. Showering was also not an issue, and I was able to leave the recording box in the bedroom. This made living with the device (especially at work) much easier. If I had a traditional catheter-based investigation, I would have needed to take time off work or modified my activities to be within a non-patient facing role. Instead, I was able to continue with my professional responsibilities as normal, and was able to place the box in the drawer under my desk with the knowledge that data was not going to be missed.

From a physiologist's perspective, I did experience a little confusion regarding the values displayed on screen, particularly on the first day of the investigation. The displayed pH readings, often did not correlate with the symptoms I was experiencing at the time. For example, when I knew I had an acidic reflux event the pH would seemingly not change. When I had heartburn for a short period, the displayed pH did not represent this. At another time, the pH remained  $<4.0$  long after my reflux symptom had passed. This prompted me to briefly believe that the device had experienced early detachment and was sat within my stomach. Early (and delayed) detachment is as a known risk of the procedure.

I decided to test the device by drinking water, followed by a small drink of squash, however the pH did not change to reflect these meals. Confused, I contacted the team at Synmed who confirmed that there can be a lag in the data recorded and displayed. This information was somewhat a relief as I didn't want to have to repeat the procedure, purely due to the inconvenience of stopping PPI medication and having to rearrange the investigation. It also meant that I could easily put the study out of my mind and would not have an over investment in the pH being displayed. The rest of the study was performed ensuring I adhered to the rules avoiding acidic drinks, alcohol, and fizzy pop etc. I did however have a few moments where I wondered if when I pressed the symptom button if this would be associated with the display pH or the actual pH being measured at the time, but decided only time would tell.

The pH being visible in this instance could be something that causes confusion with knowledgeable patients. During the study I did not adhere to the diary sheet as directed but used the buttons to report meal, position, and symptoms. This is the same approach I took with the catheter-based method as it avoided the need to carry paper and pen with me. The study ended with an alert from the recording box, however I could have happily continued to wear the equipment for longer. I was satisfied that I had experienced some reflux and heartburn symptoms that were typical for me on a day-to-day basis.

## **Conclusion**

As someone who has good experience of upper GI investigations as both a patient and HCP I was impressed with the comfort and ease of the wireless monitoring system. The prolonged study enabled my reflux to be correctly quantified and identified an elevated acid exposure time with significant symptom association on several of the days. It makes me wonder how patient outcomes could potentially change if this was the first pH-based recording patients received with typical dyspepsia symptoms. It enabled me to behave as I typically would, eating, drinking, and exercising as normal. As someone who has suffered with dyspeptic symptoms for a long time, the prolonged recording of the wireless system not only enabled demonstration of my symptoms, but changed my previous diagnosis from reflux hypersensitivity, to significant acid reflux, and this had significant implications from both a treatment, and also from a psychological perspective.

# The Healthcare Science Marketplace Day

by Gemma Norris, Clinical Scientist

Mersey & West Lancs Teaching Hospitals NHS Trust

Each year, Mersey & West Lancs Teaching Hospitals hosts the Healthcare Science Marketplace Day. This event is aimed at raising awareness of the variety of scientific careers that are available within the NHS. Healthcare scientists are integral to the diagnosis, treatment and management of disease, and this event provided a unique platform to showcase the various specialisms that exist within the Trust. The event involved the setup of 9 stalls, each providing information and resources relating to a different HCS specialism.



The event was open to both staff members within the Trust, who attended in the morning, and Year 10 students from several local high schools, who attended in the afternoon. The morning session provided an excellent opportunity for colleagues to learn about the different healthcare science roles within the Trust, and the range of services which are offered under the scientific umbrella. This session provided us with a chance to engage with colleagues who might not be familiar with the specifics of our services, and to promote networking and collaboration.

During the afternoon session, the students were eager to learn about the different potential career paths that exist within healthcare science. They moved around the stalls in 10-minute intervals, engaging with the different interactive displays, asking questions, and gaining hands-on experience with some of the diagnostic equipment. Each stall had prepared a question for the students to answer, and those who successfully answered all the questions correctly, were entered into a draw to win a box of chocolates.

The stalls included representatives from the following healthcare science specialisms:

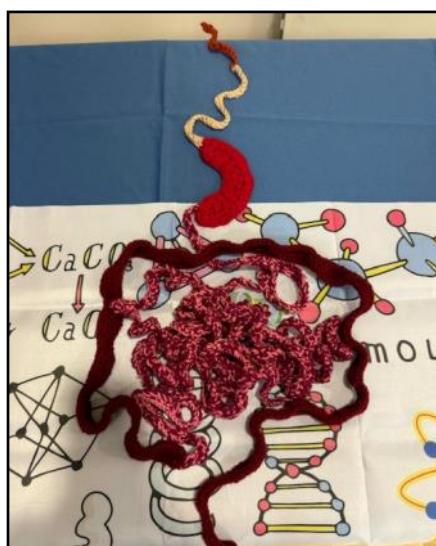
- Stall 1: Gastrointestinal Physiology
- Stall 2: Reconstructive Sciences
- Stall 3: Patient Experience
- Stall 4: Cardiology Resus
- Stall 5: Resus
- Stall 6: Respiratory
- Stall 7: EDI + Careers service
- Stall 8: Microbiology
- Stall 9: Cellular Pathology



There was an energetic atmosphere throughout the day, and both students and staff members engaged extremely well. As a smaller specialism within the Trust, I felt quite strongly about trying to ensure that the GI Physiology display was memorable, and so wanted to promote features that were interactive, eye catching and interesting. The stall included two model stomachs, which allowed the students to understand a little more about gastric anatomy. I encouraged them to handle the models and ask questions, which led to some great discussions about digestion and the importance of the GI tract. It was refreshing to see the students so engaged, and this highlighted how effective hands-on learning can be in making medical concepts more approachable and digestible (pun intended) for a younger audience.



A big hit was our crocheted GI tract, which was created by my very talented colleague, Lauren. The crochet gut was made to scale, and when I asked students to guess the average length of the GI tract, a common misconception was that the gut was the same length as a football field. This led well into discussions relating to the intestinal villi and the importance of increasing surface area. To demonstrate the actual length of the GI tract, the students rolled out the crochet gut, walking right across the room to fully lay out the 9m structure. The students seemed to really enjoy this part of the day and were all impressed by the size of their digestive systems! This activity also served as a great icebreaker and helped the students to feel more at ease and confident to ask questions.



The students also enjoyed looking at the manometry catheters, asking questions about what all of the wires were for and bending them to assess their flexibility. I explained the role that the catheters have in physiological investigations, and whilst many of the students didn't like the idea of a transnasal intubation, they did seem to find the description of a manometry test quite fascinating, and discussions relating to the importance of technology within diagnostics, followed.

One part of the display that really caught the students' attention, were the printed endoscopy images of the upper GI tract. Some of the students were quite shocked by the fact it is possible to see the inside of the GI tract using cameras, whilst a couple found the pictures a little difficult to look at. Following discussions surrounding the images, I played them some clips of small bowel capsule endoscopy procedures and asked them to shout out when they thought they saw something abnormal on the videos. The students responded really well to the positive feedback given after they had successfully identified the abnormality, and I had hoped this exercise would serve to elicit a little of the excitement that comes along with working in diagnostics.

The display also included a calibrated pH box with a single channel pH catheter attached, and buffer tubes containing buffers at pH 7, pH 4 and water. The students moved the catheter into each of the buffers and described to me what happened to the pH with each one. This led into a discussion about the importance of gastric acidity, how pH would differ within the oesophagus and how we use these measurements when assessing acid reflux.

Finally, the last part of the display related to the Capsule Sponge device. Examples of a sponge, as well as an example of a non-dissolved capsule were shown to the students, and they were given the opportunity to feel the abrasive nature of the sponge, assess the length of the string and examine the capsule. This discussion led to some interesting, and rather amusing reactions – a sort of mix of intrigue and horror, when I described the process for retrieving the device. This led nicely into a discussion with the students about the invasive nature of many of the procedures that we perform in GI Physiology, and how additional characteristics, such as empathy and good communication skills are also essential to the role of a Clinical Scientist in GI Physiology.



Participation in this event took a lot of careful planning. It was Einstein who said that “if you can’t explain something simply, you don’t know it well enough” and discussing technical diagnostic procedures with high school children certainly required an alteration in my usual approaches when explaining tests to patients. Maintaining interactive elements was important when considering how the stall could best capture the students’ interests and imaginations, and allowing them to really explore the different physiological investigations, really maintained engagement. Chatting with the students after the event, many advised that they didn’t yet know what direction they wanted to take their careers in, and this further highlighted how important events like this are in terms of raising awareness of the different opportunities that exist within healthcare science.

Overall, the Healthcare Science Marketplace day was a huge success, and this sentiment was echoed by my HCS colleagues on the other stalls, as well as by the teachers and students in attendance. We provided the students with feedback forms, to gauge their opinions relating to the relevance of the information provided, appropriateness of the level of scientific detail, and the overall value of the session. The feedback will be collated and used to guide and improve next year’s event, and in GI Physiology, we have already started brainstorming ideas for our next display!

Engaging with schools for workshops, or other types of work experience, can be extremely valuable and is something that I would really recommend becoming involved with, if the opportunity presents. Increasing our visibility raises the awareness of GI Physiology, and this, in turn, encourages more students to consider healthcare science within their career options. Events such as the Marketplace Day, not only provide students with a practical insight into what we do on a day to day basis, but also demonstrates the impact that healthcare science can have on patient care. There is no doubt that this event was enjoyed by the students, and staff alike, and we are already looking forward to putting the event together again, next year.



### **Are you attending a conference / event?**

NewWave is always looking for reviews of GI Physiology events and meetings. If you have an event coming up and would like to submit a review (or advertise it in our next issue), please contact [Gemma Norris](mailto:gemma.norris@sthk.nhs.uk) ([gemma.norris@sthk.nhs.uk](mailto:gemma.norris@sthk.nhs.uk))

**The next issue of New Wave will be published in January 2025**

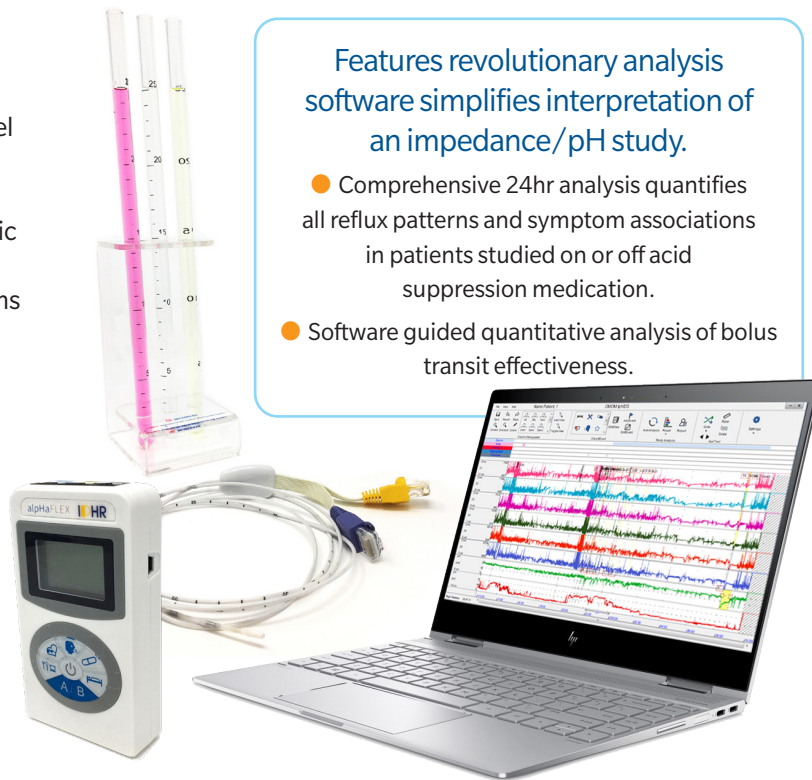
# INTRODUCING A NEW CATHETER BASED IMPEDANCE/PH MONITORING SYSTEM



The alpHaFLEX catheter based Impedance/pH Monitoring System combines the very latest in sensor and data visualisation technologies to bring an unprecedented level of accuracy and simplicity to oesophageal reflux monitoring. Traditional pH recording only records acidic pH reflux episodes. Impedance/pH detects both acidic and non-acidic reflux episodes. Combined Impedance pH recording is clinically useful in the evaluation of symptoms under PPI therapy, as well as for hoarseness, unexplained cough and applications of particular interest.

## Advantages offered by the alpHaFLEX System include:

- Combined pH-impedance system: Enables you to reliably distinguish between acid and non-acid episodes.
- Small lightweight but powerful recorder with large, easy to understand controls for ease of patient use.
- A range of Adult and Paediatric Catheters available.



## Features revolutionary analysis software simplifies interpretation of an impedance/pH study.

- Comprehensive 24hr analysis quantifies all reflux patterns and symptom associations in patients studied on or off acid suppression medication.
- Software guided quantitative analysis of bolus transit effectiveness.