

2 February, 2026

Nathalie Kamel

Managing Director

Lakeshore General Hospital Foundation

Dear Madame Kamel:

We are pleased to discuss an exciting opportunity to introduce a new medical service at Lakeshore. Our gastroenterology service has a shared goal with the foundation to provide state of the art care to our patients close to home.

We have been fortunate to recently welcome Dr. Davide Maggio as the fourth member of our department, joining Drs. Nadeem Ahmed, Rehan Kazmi and Kosta Hnaris. Dr. Ahmed currently serves as the CIUSSS service chief, and Dr. Kazmi serves as the Lakeshore Site Chief.

Dr. Maggio worked at Hopital Santa Cabrini since 2013 and had been the GI service chief since 2015. After completing his undergraduate, medical and postgraduate training at McGill, he completed an additional biliary fellowship at McGill. Although he was primarily based at Santa Cabrini, he was also cross appointed at Hopital Maisonneuve-Rosemont, where he had a biliary practice performing ERCP and therapeutic endoscopy including luminal stenting (colonic and gastroduodenal).

Until now, our GI service has relied on our clinical corridor to MUHC to provide expertise in biliary disease. This means that patients typically are transferred by ambulance to have the specialized procedure of ERCP performed at either the Glen or MGH sites.

We would like to propose the development of a biliary and gastroenterology therapeutics service at Lakeshore. We would like to explain why we believe that with Dr. Maggio's arrival we are well positioned to provide this innovation for the first time to our growing patient population.

To better understand the rationale for this proposal we would like to elaborate on the following factors:

1. What is ERCP
2. Indications and benefits to Lakeshore
3. Why provide this service at Lakeshore
4. Opportunity to collaborate with the interventional radiology service for manpower and procedural space
5. Volume justification, quality parameters
6. implementation

1) What is ERCP

ERCP stands for Endoscopic Retrograde Cholangiopancreatography.

It's a specialized endoscopic procedure used to diagnose and, more importantly, treat problems of the bile ducts and pancreatic duct (**see Diagram A**)

What it looks at

- Bile ducts (from the liver and gallbladder)
- Pancreatic duct
- The ampulla of Vater (where these ducts drain into the duodenum)

How it works (step-by-step) (**see Diagram B**)

1. A side-viewing endoscope is passed through the mouth → stomach → duodenum.
2. The opening of the ducts (major papilla) is identified.
3. A small catheter is inserted into the duct.
4. Contrast dye is injected, and X-ray (fluoroscopy) is used to visualize the ducts.
5. Therapy is performed as needed.

2) Indications and benefits to Lakeshore to developing a biliary program

ERCP today is primarily a treatment tool, not just diagnostic:

- Removing bile duct stones
- Treating obstruction or narrowing (strictures)
- Placing stents for blocked ducts (e.g., cancer, scarring)
- Treating bile leaks
- Managing complications of pancreatitis
- Sphincterotomy (cutting the sphincter to allow drainage)

What it's not mainly for anymore:

- Pure diagnosis (this is now usually done with MRCP or EUS.
MRCP is an MRI procedure done at Lakeshore already, whereas EUS is done at tertiary centres such as MUHC).

Risks (important): ERCP is powerful but not benign:

- Post-ERCP pancreatitis (most common) 5%
- Bleeding 1%
- Infection (cholangitis) 1%
- Perforation <1%

Because of these risks, ERCP is done only when there's a clear therapeutic reason.

“ERCP is an advanced endoscopic procedure that combines endoscopy and X-ray to treat diseases of the bile and pancreatic ducts—most often to remove stones, relieve obstruction from stones, tumours, or other obstructive processes, or place stents to relieve potentially life-threatening obstruction.”

3) Why should we start a biliary (ERCP) program at Lakeshore?

Current state:

- All ERCP cases are transferred to a MUHC which is ~25 km away
- This creates delays, inefficiencies, and patient dissatisfaction

Proposed solution:

- Establish a local ERCP service at Lakeshore

A. Clinical Rationale (Patient-Centred)

ERCP is time-sensitive

- Cholangitis, obstructive jaundice, bile leaks, gallstone pancreatitis
- Delays increase morbidity, length of stay (LOS), ICU use, and mortality

Benefits of local ERCP

- Faster source control
- Reduced complications from delayed transfer
- Continuity of care by the same admitting team
- Improved patient and family experience (no downtown transfer)

B. Emergency Department & Hospital Flow Benefits

Current problems:

- Prolonged ED boarding while awaiting transfer
- Ambulance utilization for inter-facility transfers
- Bed block at tertiary centres
- Lost admissions and case mix

With local ERCP:

- Fewer transfers
- Shorter ED length of stay
- Faster inpatient throughput
- Reduced pressure on downtown tertiary hospitals
- Better alignment with regional care mandates

C. Financial & Strategic Advantages

Cost savings:

- Reduced ambulance transfers
- Reduced length of stay (ER, ICU and wards)
- Lab, radiology and pathology costs associated with prolonged hospitalizations

D. Strategic positioning

- Elevates hospital from “community” to advanced suburban centre
- Attracts and retains talented physicians, nurses and support staff in the clinical spheres of GI, surgery, and critical care (“I want to work in a hospital that provides innovative care”)

4. Opportunity to collaborate with other services

- Tremendous benefit to medical, surgical, oncology and critical care services
- Excellent opportunity to collaborate with diagnostic imaging service at Lakeshore
- Ongoing discussions with Dr. Fadi Aris, CIUSSS radiology service chief

Infrastructure

- Uses existing angiography suite, recovery room planning TBA
- Requires acquisition of specialized biliary equipment as follows:
- Side-viewing duodenoscopes (at least 2)
- Standard ERCP accessories

Staffing

- ERCP-trained gastroenterologists (now possible with Dr. Maggio's arrival)
- Endoscopy/radiology nurses (with ERCP training)
- Radiology technicians and nurses already present in radiology department
- On-call anesthesia support for some patients (as already done for occasional complex endoscopy patients)

Call model

- Start with:
- Weekday daytime ERCP
- Expand to urgent / on-call coverage once volume justifies

5. Volume Justification and Quality of Service

Typical suburban catchment:

- Gallstone disease is common
- Aging population
- High prevalence of biliary obstruction

Even 1–2 ERCPs/week is usually enough to:

- Justify equipment
- Maintain competency
- Prevent unnecessary transfers

“Most suburban hospitals underestimate their true ERCP volume because cases are automatically diverted. An important proportion of patients require repeat ERCPs.”

Safety

- ERCP complication rates comparable to tertiary centres when:
- Volume thresholds are met
- Clear indications and triage pathways exist

Quality framework

- Defined indications
- Post-ERCP pancreatitis prophylaxis
- Surgical backup agreement
- Clear escalation pathways

6. Implementation Roadmap (6-12 months)

Phase 1 – Planning

- In conjunction with radiology department
- Capital request

Phase 2 – Setup

- Equipment procurement (2 duodenoscopes, electrocautery unit, ERCP accessories)
- Nursing training
- Protocol development

Phase 3 – Launch

- Elective + urgent daytime ERCP
- Monitor outcomes, complications, LOS

Phase 4 – Expansion

Costs related to starting a biliary program at Lakeshore:

Approximate total cost of equipment for ERCP is \$130 000 including the following

- 2 duodenoscopes
- Endoscopy tower including processing units, video screen, water pump etc.
- Electrosurgical generator (cautery unit)

“Establishing a local ERCP program will reduce emergency transfers, improve patient outcomes, and position our hospital as a regional advanced GI care centre—using existing infrastructure with modest investment.”

We would like to thank you in advance for considering supporting our goal of establishing a biliary service at Lakeshore.

Please contact Dr. Ahmed or Dr. Kazmi for clarification on any matter discussed.

Yours sincerely,

The Lakeshore Gastroenterology Service

Nadeem Ahmed MD FRCPC

Rehan Kazmi MD FRCPC

Konstantinos Hnaris MD FRCPC

Davide Maggio MD FRCPC

Addendum

Diagram A

- anatomy of the liver, pancreas, biliary system and duodenum.

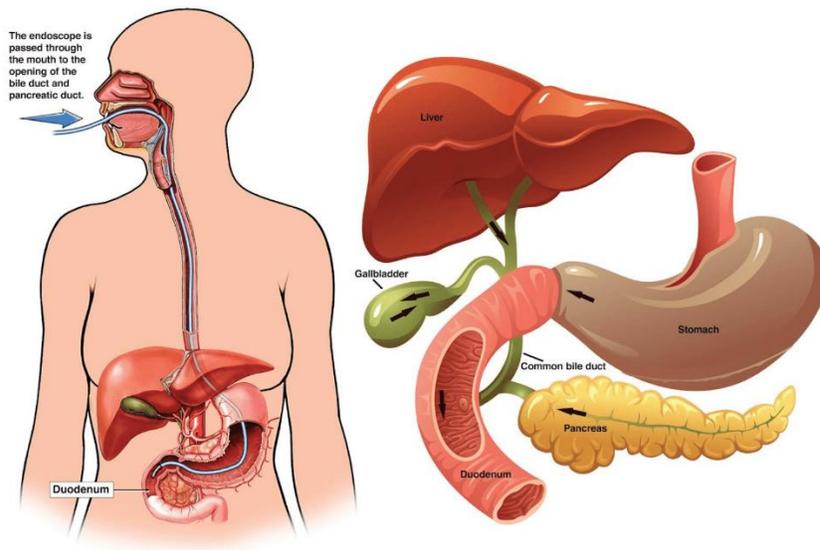


Diagram B

- Here is a more detailed picture showing the duodenoscope within the duodenum with a catheter inserted into the main bile duct in order to remove biliary stones

