aga American Gastroenterological Association

Official newspaper of the AGA Institute

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GI&Hepatology News

June 2023

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AGA

At DDW® in May, outgoing AGA President Dr. John Carethers addressed AGA achievements made over 125 years. Pictured at left is President-Elect Dr. Barbara Jung who began her tenure in May.

The AGA's future

BY NEIL OSTERWEIL
MDedge News

AT DDW 2023

CHICAGO – Since its founding 125 years ago, the American Gastroenterological Association (AGA) has gone from a small organization in which gastroenterology wasn't even a known medical specialty, to an organization that grants millions of dollars in research funding each year.

Congratulating the organization on its 125th anniversary, AGA President John M. Carethers, MD, AGAF, reflected on its history and outlined many accomplishments and challenges. He spoke with optimism about gastroenterology's future during his presidential address on May 8 at the annual Digestive Disease Week® (DDW) meeting in Chicago.

"I congratulate the AGA on its quasquicentennial, or 125th anniversary," said Dr. Carethers, who is distinguished professor of medicine and vice chancellor for health sciences at the University of California, San Diego.

The AGA was founded in 1897 by Detroit-based physician Charles Aaron, MD. His passion was gastroenterology, but at that point, it wasn't an established medical discipline. Dr. Aaron, Max Einhorn, MD,

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CRC screening grows in Medicaid expansion states

BY NEIL OSTERWEIL
MDedge News

AT DDW 2023

CHICAGO – Improving access to preventive health care services, such as colorectal cancer screening, for the poor and uninsured has led to better health outcomes, shows a study presented on May 6 in Chicago at the annual Digestive Disease Week® meeting.

Researchers from the University of California, Los Angeles reported that states with expanded Medicaid coverage had significantly higher rates of colorectal cancer (CRC) screening than states where officials refused federal support for Medicaid expansion.

Led by Megan R. McLeod, MD, an internal medicine resident at UCLA, researchers compared CRC screening rates in states that did not adopt Medicaid expansion in 2021, with screening rates in states that invested Medicaid expansion into 1,284 Federally Qualified Health Centers (FQHC), which are nonprofit health centers or clinics that serve medically underserved areas and populations.

In this study, 76% of these centers were in states that accepted Medicaid expansion. The median colorectal cancer screening rate was 42.1% in Medicaid expansion states, compared with

See **Medicaid** · *page 11*

First oral *C. diff* recurrence pill OK'd

BY JENNIE SMITH
MDedge News

The recent approval of the first oral fecal-derived microbiota therapy to prevent the recurrence of *Clostridioides difficile* (*C. diff*) infection in patients was welcome news for physicians who've struggled under the weight of having too few treatment options for the prevention of *C. diff* recurrence.

The product, developed by Massachusetts-based Seres Therepeutics and marketed as Vowst, was approved by the Food and Drug Administration on April 26. It is approved for use in adults who have already been treated with antibiotics for a recurrent infection with *C. diff* bacteria.

This is the first oral treatment for the prevention of

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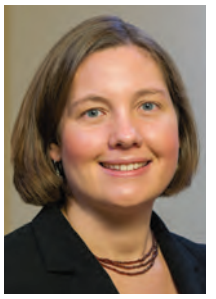
LETTER FROM THE EDITOR

The power of mentorship

In a 2018 JAMA Viewpoint, Dr. Vineet Chopra, a former colleague of mine from the University of Michigan (now chair of medicine at the University of Colorado) and colleagues wrote about four archetypes of mentorship: mentor, coach, sponsor, and connector. While we are products of our hard work, passion, and perseverance, none of us would be where we are today without a larger community of individuals who helped us along the way in both large and small ways.



Dr. Adams

"DDW serves as an annual reminder of the power of mentorship in building and sustaining careers."
— Dr. Adams

For me, DDW serves as an annual reminder of the power of mentorship in building and sustaining careers. Each May, trainees and early career faculty present their projects in oral or poster sessions cheered on by their research mentors. Senior thought leaders offer career advice and guidance to more junior colleagues through structured sessions or informal conversations and facilitate introductions to new collaborators. Department chairs, division chiefs, and senior practice leaders take time to reconnect with their early mentors who believed in their potential and provided them with opportunities to take their careers to new heights. And, we see the incredible payoff of programs like AGA's FORWARD Program and the Future Leaders Program in serving as springboards for career advancement and in creating powerful role models and mentors for the future.

This year's AGA presidential leadership transition served as a particularly poignant example of the power of mentorship as incoming AGA President Dr. Barbara Jung succeeded one of her early mentors, outgoing AGA President Dr. John Carethers, in this prestigious role. I hope you'll join me in reflecting on the tremendous impact that mentors, coaches, sponsors, and connectors have had on your career, and continue to pay it forward to the next generation.

In this month's issue, we feature several stories from DDW 2023, including summaries of the AGA presidential address and a study evaluating the impact of state Medicaid expansion on uptake of CRC screening in safety net practices. From AGA's flagship journals, we highlight a propensity-matched cohort study assessing the impact of pancreatic cancer surveillance of high-risk patients on important clinical outcomes and a new AGA CPU on the management of extra-esophageal GERD. In this month's AGA Policy and Advocacy column, Dr. Amit Patel and Dr. Rotonya Carr review the results of a recent membership survey on policy priorities and outline the many ways you can get involved in advocacy efforts. Finally, our Member Spotlight column celebrates gastroenterologist and humanitarian Kadirawel Iswara, MD, recipient of this year's AGA's Distinguished Clinician Award in Private Practice, who is a cherished mentor to many prominent members of our field.

Megan A. Adams, MD, JD, MSc
Editor-in-Chief

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Member SPOTLIGHT

Brooklyn gastroenterologist: Good listening skills make a doctor a better teacher, person

BY JENNIFER LUBELL
MDedge News

The accomplishments of Kadirawel Iswara, MD, go far beyond gastroenterology—they include humanitarian pursuits.

After the 2004 Indian Ocean earthquake and tsunami, he traveled to his home country of Sri Lanka to help people who were in need and to establish an orphanage. He has applied his skills as a gastroenterologist in the U.S. military and the New York City Police Department.

When dealing with patients and colleagues, he offers this simple pearl of advice: Listen and then listen some more.

He was in New York during the 9/11 terrorist attacks. To this day, he treats patients with residual gastrointestinal problems and precancerous changes associated with 9/11. "I'm involved in screening those people who were the first responders referred by the NYPD," he says.

This year, Dr. Iswara earned the Distinguished Clinician Award in Private Practice from the American Gastroenterological Association. "He puts his patients first in every endeavor and every question that he asks with regard to research and education is linked to the ultimate measuring stick of improving patient care," the AGA stated in its announcement of the award.

When dealing with patients and colleagues, he offers this simple pearl of advice: Listen and then listen some more.

"Once you listen more, you can find out their issues much more in depth, and you can give a satisfying answer to them and their problems. Listening is a kindness and a compassionate thing. It not only makes you become a better teacher, but a better person," said Dr. Iswara, an attending gastroenterologist at Maimonides Medical Center, Brooklyn, N.Y.

In this interview, he talks about his GI beginnings, his role as a mentor, and why he always starts the day with a prayer. He also shares a time management habit from his military days that gives him energy.

Q: What gives you joy in your practice?

Dr. Iswara: My colleagues, coworkers, fellows, and patients. The patients are No. 1. As I walk into my practice area or in the hospital, there is a sense of inner happiness in my mind to see the smiles of patients and the greetings I get from patients and all the coworkers. But I also see smiling patients with anxiety in their face, trying to get my attention to take care of them.

After I see the patient, I change to a different mode—a kind of a professional mode to give the best to the people whom I'm caring for and who are trusting me with their lives.

One thing I do in my mind before I even start the day, I do a silent prayer to guide me, to give compassionate care and safe care [that] I will not harm anyone who is depending on my care.

"Listening is a kindness and a compassionate thing. It not only makes you become a better teacher, but a better person."
— Dr. Iswara

Q: Who was your mentor?

Dr. Iswara: I was lucky enough to have been trained by Baroukh El Kodsi, MD, at Maimonides Medical Center. He recently passed away and was a legend in Brooklyn. I was his first-generation trainee, and I was able to pass on my skills to my trainees. Now, so many people who are in Brooklyn were trained by me. So, it's kind of growth by generations.

When I finished training with Dr. Kodsi, he hired me as an associate director of the GI department at Maimonides. I became the program director, then division chief, then I became a director of advanced endoscopy. All these gastroenterology procedures started after 1975 while I was doing the training, so I was one of the pioneers to bring all this new technology to our hospital. I'm still involved in fellowship education.

Q: Can we talk more about your accomplishments? Perhaps you can discuss your AGA award and what you received it for.

Dr. Iswara: I'm humbled and honored by this role, and I'll be forever grateful to AGA for this prestigious honor in the late stage of my career.

I have been a continuous AGA member for the last 45 years. I probably have one of the longest durations of being an actively practicing gastroenterologist in Brooklyn. I've also done academic work, teaching so many young gastroenterologists, motivating several of them to become leading gastroenterologists.

Q: If you could describe a scene of your vision for the future, what would it be in terms of how gastroenterology is practiced?

Dr. Iswara: I'd like to see the newer generation practice more of a clinical medicine than technical medicine. Sometimes when I see the young people, they sit in front of the computer more than talking and touching the patient. There has to be some sort of a balance where the newer people should be taught more bedside personal care, touching the patient, looking at the patient's face. They are kind of under pressure to write longer notes than to examine the patient, so I think this has to change.

Q: Describe how you would spend a free Saturday afternoon.

Dr. Iswara: When I was in the military, I was told that to prevent battle fatigue you had to take a rest. I really try to take a rest almost 2 hours every day in the daytime. This rejuvenates me.


Dr. Kadirawel Iswara

We live in New York, and I love to go to shows, especially magic shows. I love magic and illusion.

On free Saturday evenings, I also spend time with my grandchildren in the city, watching them in their baseball, soccer, swimming, and other activities. I love to spend time with them. ■

Lightning round

Texting or talking?
Texting

Favorite city in the U.S. besides the one you live?
Naples, Fla.

Favorite breakfast?
Pancakes

Dark Chocolate or milk chocolate?
Cadbury from England

Last movie you watched?
"To Sir, With Love"

A distinct and potentially deadly cause of gastric polyposis

What's your diagnosis?

BY JAD ABIMANSOUR, MD, TSUNG-TEH WU, MD, PHD, AND SETH SWEETSER, MD

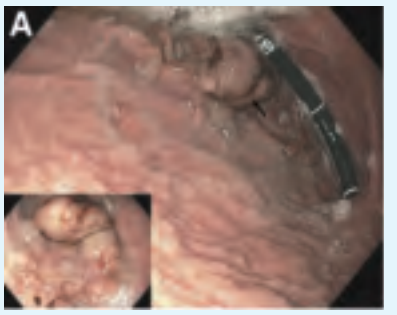
A 72-year-old man with compensated cirrhosis owing to autoimmune hepatitis presented for evaluation of an indeterminate gastric lesion found during an otherwise normal endoscopic retrograde cholangiopancreatography performed for incidental ductal dilation seen on cross-sectional imaging. He did not endorse any abdominal pain, dyspepsia, or weight loss and was not on a proton pump inhibitor. Family history was notable for a daughter diagnosed with metastatic gastric adenocarcinoma at the age of 44 years.

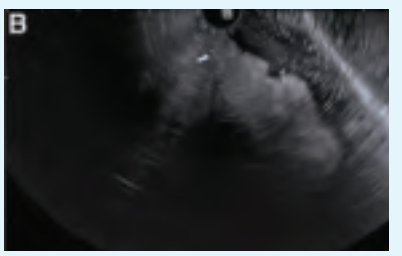
Upper endoscopy showed innumerable sessile polyps of variable size carpeting the gastric body and fundus (Figure A) with a large, mound-like mass lesion in the fundus (Figure A, arrow and inset). Echoendoscopy revealed a hypoechoic, noncircumferential mass restricted to the mucosal surface with well-defined borders (Figure B, arrow).

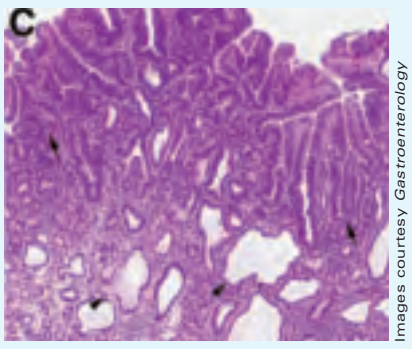
A technically challenging, piecemeal endoscopic mucosal resection was performed. The patient also underwent a colonoscopy that was unremarkable. Pathology of the gastric lesion was consistent with a fundic gland polyp (Figure C, arrowheads) containing low-grade and high-grade dysplasia (Figure C, arrows).

What is the most likely diagnosis?

See page 22 for answers.







Images courtesy *Gastroenterology*

Test your knowledge

View more clinical challenges on *GI & Hepatology News* at https://rb.gy/zezb0

AGA Research Foundation awards $2.66M

The American Gastroenterological Association is proud to announce the 71 recipients selected to receive research funding through its annual AGA Research Foundation Awards Program. The program serves as a catalyst for discovery and career growth among the most promising researchers in gastroenterology and hepatology.

"This year's recipients are determined to make an impact on digestive health care through their research," said Michael Camilleri, MD, AGAF, chair, AGA Research Foundation. "We are honored to support these talented individuals at a critical stage in their careers and research projects. We look forward to seeing their great accomplishments."


Dr. Camilleri

Treatment options for digestive diseases begin with vigorous research. The AGA Research Foundation supports medical investigators as they advance the understanding of gastrointestinal and liver conditions. The AGA Research Awards Program is made possible thanks to generous donors and funders. Learn more about the AGA Research Foundation at foundation.gastro.org.

Here are this year's award recipients:


AGA Institute

This year the AGA Research Foundation granted awards to 71 physicians and researchers.

Research Scholar Awards

AGA Research Scholar Award
- Alexander Nguyen, MD, PhD, The Regent of the University of California, Los Angeles
- Jeffrey W. Patterson-Fortin, MD, PhD, Dana-Farber Cancer Institute, Boston
- Sean Spencer, MD, PhD, Stanford Medicine, Calif.
- Ken Y. Hui, MD, PhD, Johns Hopkins University School of Medicine, Baltimore

AGA-Gastric Cancer Foundation Ben Feinstein Memorial Research Scholar Award in Gastric Cancer
- Martina Molgora, PhD, Washington University School of Medicine, St. Louis

AGA-Takeda Pharmaceuticals Research Scholar Award in Inflammatory Bowel Disease
- Brooke R. Druliner, PhD, Mayo Clinic, Rochester, Minn.

Specialty Awards

AGA-Caroline Craig Augustyn & Damian Augustyn Award in Digestive Cancer
- Simon Schwörer, PhD, University of Chicago

AGA-R. Robert & Sally Funderburg Research Award in Gastric Cancer
- Bryson W. Katona, MD, PhD, University of Pennsylvania Perelman School of Medicine, Philadelphia

AGA-Amgen Fellowship-to-Faculty Transition Award
- Cynthia Hsu, MD, PhD, University of California, San Diego

AGA-Bristol Myers Squibb Fellowship-to-Faculty Transition Award
- Siyan Cao, MD, PhD, Washington University in St. Louis
- Amit Ringel, MD, Brigham and Women's Hospital, Boston

Pilot Awards

AGA Pilot Research Award in Digestive Disease Health Disparities
- Sharad Wadhwani, MD, MPH, University of California, San Francisco

AGA Pilot Research Award in Health Disparities
- Enrique Soto Pérez de Celis, MD, PhD, MS, Instituto Nacional de Ciencias Médicas y Nutrición Salvador Zubirán

AGA Pilot Research Award
- Diana L. Snyder, MD, Mayo Clinic, Rochester, Minn.
- Michael Li, MD, MPH, University of California, San Francisco
- Patricia Bloom, MD, University of Michigan, Ann Arbor
- Edward Barnes, MD, MPH, University of North Carolina School of Medicine, Chapel Hill

AGA-Amgen Pilot Research Award in Digestive Disease Health Disparities
- Laura Targownik, MD, MSHS, University of Toronto/Mount Sinai Hospital

Undergraduate Research Awards

AGA-Aman Armaan Ahmed Family Summer Undergraduate Research Award
- Gwyneth Garramone, Loyola Marymount University, Los Angeles
- Ella McLaren, University of California, San Diego
- Nathan Moy, University of Southern California, Los Angeles
- Hussein Elfayoumy, Johns Hopkins University, Baltimore
- Isabelle Garcia-Fischer, Tufts University, Medford, Mass.
- Lidia Appell, University of New Mexico, Albuquerque
- Katherine Burkman, Duke University, Durham, N.C.
- Alexa Boylan, Spelman College, Atlanta

AGA-Dr. Harvey Young Education and Development Foundation's Young Guts Scholar Program
- Lucy Zhao, Massachusetts Institute of Technology Koch Institute for Integrative Cancer Research, Cambridge
- Andrew Tran, Duke University, Durham, N.C. Carolina
- Sohaib Hassan, Rutgers University – Verzi Lab, New Brunswick, N.J.
- Varun Ponnusamy, University of Michigan Medical School, Ann Arbor
- Daniella Montalvo, University of Miami, Coral Gables, Fla.
- Sara Chough, Columbia University Irving Medical Center, N.Y.

Abstract Awards

Fellow Abstract Awards
- David Flores Marin, MD, Beth Israel Deaconess Medical Center, Boston
- Jesse Platt, MD, PhD, Massachusetts General Hospital, Boston
- Devika Gandhi, MD, Loma Linda University, Calif.
- Amanda Krause, MD, University of California, San Diego
- Cynthia Tsay, MD, Mphil, Johns Hopkins Hospital, Baltimore
- Suha Abushamma, MD, Cleveland Clinic Foundation, Ohio
- Md Obaidul Islam, PhD, University of Miami, Coral Gables, Fla.
- Sakteesh Gurunathan, MD, New York University School of Medicine
- Aaron Yeoh, MD, Stanford Hospital & Clinics, Calif.
- Yang Xiao, PhD, Mayo Clinic, Rochester, Minn.
- Jacques Gonzales, PhD, MS, Michigan State University, East Lansing
- Kai Wang, MD, PhD, Harvard T.H. Chan School of Public Health, Cambridge, Mass.

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- Hoyeol Kim, PhD, Cedars Sinai Medical Center, N.Y.
- Babajide Ojo, PhD, MS, Stanford University, Calif.

AGA Fellow Abstract of the Year Award

- Stefania Tocci, PhD, MS, University of Massachusetts, Cambridge

Student Abstract Awards

- Pritha Chatterjee, MS, University of California, Riverside
- Ela Contreras Panta, Vanderbilt University, Nashville, Tenn.
- Mihir Shah, MD, MBBS, John H. Stroger Hospital of Cook County, Chicago
- Yuhan Fu, DO, Metrohealth Medical Center, Cleveland
- Raissa Nana Sede Mbakop, MD, Piedmont Athens Regional Medical Center, Ga.
- Eleazar Montalvan-Sanchez, MD, Indiana University School of Medicine, Bloomington
- Sarang Gupta, MD, St. Michael's Hospital, Toronto
- Daniel Kim, Harvard Medical School, Cambridge, Mass.
- Hannah Hrncir, Emory University, Decatur, Ga.
- Zarwa Saqib, McMaster University, Hamilton, Ontario
- Ying Zhu, MD, PhD, University of Michigan, Ann Arbor
- Lizeth Cifuentes, MD, University of Pittsburgh Medical Center, Penn.
- Sharvani Dhandibhotla, MBBS, MS, Massachusetts General Hospital, Boston
- Lauren Lynch, Baylor College of Medicine, Houston, Texas

AGA Student Abstract of the Year Award

- Gabrielle Waclawik, MD, MPH, University of Wisconsin, Madison

AGA Abstract Award for Health Disparities Research

- Soyoun Min, PhD, Lerner Research Institute (fellow), Cleveland
- Xiaobei Zhang, PhD , David Geffen School of Medicine at University of California, Los Angeles (fellow)
- Matthew Zhao, David Geffen School of Medicine at University of California, Los Angeles (student)
- Hannah Fiske, MD, Brown University/Rhode Island Hospital (student), Providence

AGA-APFED Abstract Award in Eosinophilic GI Diseases

- Matthew Buendia, MD, Vanderbilt University Medical Center – Monroe Carell Jr. Children's Hospital, Nashville, Tenn.
- Alexandra L. Strauss, MD, University of Pennsylvania Health System, Philadelphia
- Mira Yang, Northwestern Feinberg School of Medicine, Chicago

AGA-Moti L. & Kamla Rustgi International Travel Award

- Aviv Pudipeddi, MBBS, Concord Repatriation General Hospital, Sydney, Australia
- Dianqin Sun, MBBS, Mmed, Erasmus University Medical Center, Rotterdam, Netherlands

AGA POLICY & ADVOCACY

Membership priorities shape the AGA advocacy agenda

BY AMIT PATEL, MD, AND ROTONYA CARR, MD

The AGA Government Affairs Committee and staff recently published in *Gastroenterology* the results from an AGA membership survey on policy priorities and how members can contribute to AGA advocacy efforts.[1] Here, we present key highlights from the survey findings and share opportunities for members to engage in GI advocacy.

AGA advocacy has contributed to significant recent successes that include lowering the average risk of colorectal cancer screening age from 50 to 45 years, phasing out cost-sharing burdens associated with polypectomy at screening colonoscopy, encouraging federal support to focus on GI cancer disparities, ensuring coverage for telehealth services, expanding colonoscopy coverage after positive noninvasive colorectal cancer screening tests, and mitigating scheduled cuts in Medicare reimbursement for GI services.

Despite these important successes, the GI community faces significant challenges that include persisting GI health disparities; declines in reimbursement and increased prior authorization burdens for GI procedures and clinic visits, limited research funding to address the burden of GI disease, climate change, provider burnout, and increasing administrative burdens (such as insurance prior authorizations and step therapy policies.

The AGA sought to better understand policy priorities of the GI community by disseminating a 34-question policy priority survey to AGA members in December 2022. 251 members responded to the survey with career stage and primary practice setting varying among respondents. The AGA vetted and selected 10 health policy issues of highest interest with 95% of survey respondents agreeing these 10 selected topics covered the top priority issues impacting gastroenterology.

From these 10 policy issues, members were asked to identify the top 5 issues that AGA advocacy efforts should address.

The issues most frequently identified included reducing administrative burdens and patient delays in care because of increased prior authorizations (78%), ensuring fair reimbursement for GI providers (68%), reducing insurance-initiated switching of patient treatments for nonmedical reasons (58%), maintaining coverage of video and telephone evaluation and management visits (55%), and reducing delays in clinical care resulting from step therapy protocols (53%).

Other important issues included ensuring patients with pre-existing conditions have access to essential benefits and quality specialty care (43%); protecting providers from medical licensing restrictions and liability to deliver care across state lines (35%); addressing Medicare Quality Payment Program reporting requirements and lack of specialty advanced payment models (27%); increasing funding for GI health disparities (24%); and, increasing federal research funding to ensure greater opportunities for diverse early career investigators (20%).

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TABLE. American Gastroenterological Association advocacy

AGA advocacy activities	Features	Where to learn more
Educational resources and programming	Modules and guides	AGA University (agau.gastro.org), Digestive Diseases Week
AGA Washington Insider	Monthly e-newsletter	AGA members can sign up at advocacy@gastro.org
Communication with elected officials	Pre-formatted/templated e-mails, in-district meetings	AGA Advocacy Action Center (gastro.quorum.us/AGAactioncenter); AGA staff at agaadvocacy@gastro.org
AGA Advocacy Days	Meetings with congressional offices	Gastro.org/advocacy-and-policy/get-involved/aga-advocacy-day
AGA Congressional Advocates Program	Mentoring by AGA staff, developing relationships with lawmaker's offices	Gastro.org/advocacy-and-policy/congressional-advocates-program
AGA Political Action Committee	Support candidates who protect the GI community	Gastro.org/advocacy-and-policy/aga-pac
AGA Government Affairs Committee	Operationalize AGA advocacy efforts in line with AGA strategic priorities	Gastro.org/committees/government-affairs-committee

Source: *Gastroenterology*

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Most problematic burdens

Survey respondents identified insurer prior authorization and step therapy burdens as especially problematic. 93% of respondents described the impact of prior authorization on their practices as "significantly burdensome" (61%) or "somewhat burdensome" (32%).

About 95% noted that prior authorization restrictions have impacted patient access to clinically appropriate treatments and patient clinical outcomes "significantly" (56%) or "somewhat" (39%) negatively. 84% described the burdens associated with prior authorization policies as having increased "significantly" (60%) or "somewhat" (24%) over the last 5 years.

Likewise, step therapy protocols were perceived by 84% of respondents as burdensome; by 88% as negatively impactful on patient access to clinically appropriate treatments; and, by 88% as negatively impactful on patient clinical outcomes.

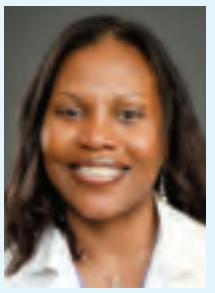
About 84% of respondents noted increases in the frequency of nonmedical switching and dosing restrictions over the last 5 years, with 90% perceiving negative impacts on patient clinical outcomes. 73% of respondents reported increased burdens associated with compliance in the Medicare Quality Payment Program over the last 5 years.

AGA's advocacy work

About 76% of respondents were interested in learning more about the AGA's advocacy work. We presented some of the various opportunities and resources for members to engage with and contribute to AGA advocacy efforts. Based on the tremendous efforts and dedication of AGA staff, some of these opportunities include educational modules on AGA University, DDW programming, the AGA Washington Insider monthly policy newsletter, preformatted communications available through the AGA Advocacy Action Center, participation in AGA Advocacy Days or the AGA Congressional Advocates Program, service on the AGA Government Affairs Committee, and/or contributing to the AGA Political Action Committee.

Overall, the survey respondents illustrate the diversity and enthusiasm of AGA membership. Importantly, 95% of AGA members responding to the survey agreed these 10 selected policy issues are inclusive of the current top priority issues of the GI community. Amidst an ever-shifting health care landscape, we—the AGA community—must remain vigilant and adaptable to best address expected and unexpected changes and challenges to our patients and colleagues. In this respect, we should encourage constructive communication and dialogue among AGA membership, leadership, other issue stakeholders, government representatives and entities, and payers. ■

Dr. Patel



Dr. Carr

Amit Patel, MD, is a gastroenterologist and associate professor of medicine at Duke University and the Durham Veterans Affairs Medical Center, both in Durham, N.C. He serves on the editorial review board of Gastroenterology. Rotonya McCants Carr, MD, is the Cyrus E. Rubin Chair and division head of gastroenterology at the University of Washington, Seattle. Both Dr. Patel and Dr. Carr serve on the AGA Government Affairs Committee. The contents of this article do not represent the views of the Department of Veterans Affairs.

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MDEDGE NEWS

➤ NEWS

CRC screening rates improve

Medicaid *from page 1*

36.5% in nonexpansion states.

"The impact of being uninsured on CRC screening participation was profound in nonexpansion states," said Dr. McLeod, who will be a UCLA gastroenterology fellow this year.

The study adds to a growing body of evidence that shows Medicaid expansion, which increases access to health care services to previously uninsured or underinsured patients, can improve health outcomes and may reduce racial and economic disparities.

For example, a 2019 study based on electronic health record data presented at the annual meeting of the American Society of Clinical Oncology, showed that after Medicaid expansion, racial differences in timely cancer treatment effectively disappeared. Before Medicaid expansion, Black patients were 4.8% less likely than White patients to receive timely cancer treatment, which is defined as treatment starting within 30 days of the diagnosis of an advanced or metastatic solid tumor. After Medicaid expansion, however, the difference between the racial groups dwindled to 0.8% and was no longer statistically significant.

Researchers at Weill Cornell Medical Center in New York reported in 2020 at the annual meeting of the American Association for the Study of Liver Diseases, that 1 year after Medicaid expansion began on Jan. 1, 2014, the rate of liver-related mortality began to decline in 18 states with expanded coverage, whereas the rate of liver-related deaths continued to climb in 14 states that did not expand Medicaid.

Dr. McLeod

The U.S. Health Resources and Services Administration funds FQHC that serve nearly 29 million patients throughout the country, including a large proportion whose care is covered by Medicaid. Among patients cared for in these centers, one in three have incomes below the federal poverty line, and one in five are uninsured.

Screening rates compared

Dr. McLeod and colleagues sought to determine whether Medicaid expansion would have an effect on CRC screening rates at FQHC centers. The final analysis included 6,940,879 patients (between 50 and 74 years), of whom 1.7% were unhoused and 17.6% were uninsured.

Medicaid expansion status appeared to have a direct impact on whether screenings were even offered to patients. Centers in rural areas and those with a high proportion of uninsured patients were found to have significantly higher odds for doing fewer CRC screenings. In Medicaid expansion states, CRC screening rates were significantly lower for patients who were male, Black, Hispanic, had low income, were unhoused, or were uninsured.

The study was internally supported. Dr. McLeod reported no conflicts of interest.

DDW is sponsored by the AASLD, AGA, American Society for Gastrointestinal Endoscopy (ASGE) and The Society for Surgery of the Alimentary Tract (SSAT). ■

Diagnosing exocrine pancreatic insufficiency

BY CAROLYN CRIST
MDedge News

FROM GASTRO HEP ADVANCES

Based on discussions during PancreasFest 2021, a group of experts and key opinion leaders have proposed a new definition of exocrine pancreatic insufficiency (EPI) and best practices for diagnosis and management, according to a recent report in Gastro Hep Advances (2022 Nov 14. doi: 10.1016/j.gastha.2022.11.008).

Due to its complex and individualized nature, EPI requires multidisciplinary approaches to therapy, as well as better pancreas function tests and biomarkers for diagnosis and treatment, wrote researchers who were led by David C. Whitcomb, MD, PhD, AGAF, emeritus professor of medicine in the division of gastroenterology, hepatology and nutrition at the University of Pittsburgh.


Dr. Whitcomb

"This condition remains challenging even to define, and serious limitations in diagnostic testing and therapeutic options lead to clinical confusion and frequently less than optimal patient management," the authors wrote.

EPI is clinically defined as inadequate delivery of pancreatic digestive enzymes to meet nutritional needs, which is typically based on a physician's assessment of a patient's maldigestion. However, there's not a universally accepted definition or a precise threshold of reduced pancreatic digestive enzymes that indicates "pancreatic insufficiency" in an individual patient.

Current guidelines don't clearly outline the role of pancreatic function tests, the effects of different metabolic needs and nutrition intake, the timing of pancreatic enzyme replacement therapy (PERT), or the best practices for monitoring or titrating multiple therapies.

In response, Dr. Whitcomb and colleagues proposed a new mechanistic definition of EPI, including the disorder's physiologic effects and impact on health. First, they said, EPI is a disorder caused by failure of the pancreas to deliver a minimum or threshold level of specific pancreatic digestive enzymes to the intestine in concert with ingested nutrients, followed by enzymatic digestion of individual meals over time to meet certain nutritional and metabolic needs. In addition, the disorder is characterized by variable deficiencies in micronutrients and macronutrients, especially essential fats and fat-soluble vitamins, as well as gastrointestinal symptoms of nutrient maldigestion.

The threshold for EPI should consider the nutritional needs of the patient, dietary intake, residual exocrine pancreas function, and the absorptive capacity of the intestine based on anatomy, mucosal function, motility, inflammation, the microbiome, and physiological adaptation, the authors wrote.

Due to challenges in diagnosing EPI and its common chronic symptoms such as abdominal pain, bloating, and diarrhea, several conditions may mimic EPI, be present concomitantly with EPI, or hinder PERT response. These include celiac disease, small intestinal bacterial overgrowth, disaccharidase deficiencies, inflammatory bowel disease (IBD), bile acid diarrhea, giardiasis, diabetes mellitus, and functional conditions such as irritable bowel syndrome. These conditions should be considered to address underlying pathology and PERT diagnostic challenges.

Although there is consensus that exocrine pancreatic function testing (PFT) is important to diagnosis EPI, no optimal test exists, and pancreatic function is only one aspect of digestion and absorption that should be considered. PFT may be needed to make an objective EPI diagnosis related to acute pancreatitis, pancreatic cancer, pancreatic resection, gastric resection, cystic fibrosis, or IBD. Direct or indirect PFTs may be used, which typically differs by center.

"The medical community still awaits a clinically useful pancreas function test that is easy to perform, well tolerated by patients, and allows personalized dosing of PERT," the authors wrote.

After diagnosis, a general assessment should include information about symptoms, nutritional status, medications, diet, and lifestyle. This information can be used for a multifaceted treatment approach, with a focus on lifestyle changes, concomitant disease treatment, optimized diet, dietary supplements, and PERT administration.

PERT remains a mainstay of EPI treatment and has shown improvements in steatorrhea, postprandial bloating and pain, nutrition, and unexplained weight loss. The Food and Drug Administration has approved several formulations in different strengths. The typical starting dose is based on age and weight, which is derived from guidelines for EPI treatment in patients with cystic fibrosis. However, the recommendations don't consider many of the variables discussed above and simply provide an estimate for the average subject with severe EPI, so the dose should be titrated as needed based on age, weight, symptoms, and the holistic management plan.

For optimal results, regular follow-up is necessary to monitor compliance and treatment response. A reduction in symptoms can serve as a reliable indicator of effective EPI management, particularly weight stabilization, improved steatorrhea and diarrhea, and reduced postprandial bloating, pain, and flatulence. Physicians may provide patients with tracking tools to record their PERT compliance, symptom frequency, and lifestyle changes.

For patients with persistent concerns, PERT can be increased as needed. Although many PERT formulations are enteric coated, a proton pump inhibitor or H2 receptor agonist may improve their effectiveness. If EPI symptoms persist

Continued on following page

Recognition of recent advances and unaddressed gaps can clarify key issues around exocrine pancreatic insufficiency (EPI).

The loss of pancreatic digestive enzymes and bicarbonate is caused by exocrine pancreatic and proximal small intestine disease. EPI's clinical impact has been expanded by reports that 30% of subjects can develop EPI after a bout of acute pancreatitis. Diagnosing and treating EPI challenges both clinicians and investigators.


Dr. Gorelick

The contribution on EPI by Whitcomb and colleagues provides state-of-the-art content relating to diagnosing EPI, and in assessing its metabolic impact, enzyme replacement, nutritional considerations, and the effectiveness of therapy.

Though the diagnosis and treatment of EPI have been examined for over 50 years, a consensus for either is still needed. Assessment of EPI with luminal tube tests and endoscopic collections of pancreatic secretion are the most accurate, but they are invasive, limited in availability, and time-consuming. Indirect assays of intestinal activities of pancreatic enzymes by the hydrolysis of substrates or stool excretion are frequently used to diagnose EPI. However, they need to be more insensitive and specific to meet clinical and investigative needs.

Indeed, all tests of exocrine secretion are surrogates of unclear value for the critical endpoint of EPI, its nutritional impact. An unmet need is the development of nutritional standards for assessing EPI and measures for the adequacy of pancreatic enzyme replacement therapy. In this context, a patient's diet, and other factors, such as the intestinal microbiome, can affect pancreatic digestive enzyme activity and must be considered in designing the best EPI treatments. The summary concludes with a thoughtful and valuable road map for moving forward.

Fred Sanford Gorelick, MD, is the Henry J. and Joan W. Binder Professor of Medicine (Digestive Diseases) and of Cell Biology for Yale School of Medicine, New Haven, Conn. He also serves as director of the Yale School of Medicine NIH T32-funded research track in gastroenterology; and as deputy director of Yale School of Medicine MD-PhD program.

Potential conflicts: Dr. Gorelick serves as chair of NIH NIDDK DSMB for Stent vs. Indomethacin for Preventing Post-ERCP Pancreatitis (SVI) study. He also holds grants for research on mechanisms of acute pancreatitis from the U.S. Department of Veterans Affairs and the Department of Defense.

High-risk PDAC benefits from surveillance

BY JIM KLING
MDedge News

FROM GASTROENTEROLOGY

Individuals who are carriers of germline pathogenic variants in susceptibility genes for pancreatic ductal adenocarcinoma (PDAC), or have a strong family history of PDAC, benefit from having annual MRIs, shows a new study published in Gastroenterology (2023 Mar 6. doi: 10.1053/j.gastro.2023.02.032).

While other studies have shown potential benefit in screening high-risk individuals, "a concern is that in absence of sufficiently large control groups with unscreened controls," the outcomes may be influenced by lead-time bias. The current study is the first to address that important limitation.

The study, which was led by Derk C.F. Klatte, MD, of the department of gastroenterology and hepatology at Leiden University Medical Center, the Netherlands, included 43,762 patients from the Netherlands Cancer Registry who were diagnosed with PDAC between January 2000 and December 2020. Using a 1:5 ratio, researchers matched 31 patients who were diagnosed in the pancreatic cancer surveillance cohort against 155 patients in the non-surveillance group.

"We show that surveillance for PDAC in high-risk individuals results in significant earlier detection, increased resectability, and improved survival as compared with average-risk individuals diagnosed with PDAC not under surveillance. This reaffirms that pancreatic surveillance for certain high-risk individuals is beneficial and could have a meaningful impact on disease course," the authors wrote.

PDAC has the worst outcomes among all cancers and is on pace to become the second-leading cause of cancer-related mortality. By the time a tumor is detected, it is usually unresectable or has developed distant metastases. In principle, early detection could improve outcomes, but there is no test that is adequate for population wide screening. Surveillance must therefore concentrate on individuals deemed to be at heightened risk. Prospective studies have shown a benefit of pancreatic cancer screening in patients who are at high-risk. Such studies may be misleading, however, due to the potential for lead-time bias. This can occur when a condition is detected at an earlier time than it would have been identified based on clinical signs, as usually occurs in unscreened populations, and this asymptomatic lag time between diagnosis and initial symptoms does not get incorporated into a survival analysis. The result can be an artificially longer survival time following diagnosis in the screened population.

Dr. Klatte

"...surveillance for PDAC in high-risk individuals results in significant earlier detection, increased resectability, and improved survival..." — Klatte et al.

Guidelines from the International Cancer of the Pancreas Screening consortium, the American Society for Gastrointestinal Endoscopy, and American Society of Clinical Oncology recommend surveillance in high-risk cases.

In this study, researchers conducted a propensity score match cohort analysis of patients from the general population with primary PDAC who were diagnosed outside of a screening program, with carriers of a germline CDKN2A/p16 mutation who were diagnosed after surveillance.

The surveillance group received a stage 1 diagnosis in 38.7% of cases, versus 5.8% of those outside of surveillance (OR, 0.09; 95% CI, 0.04-0.19). Surgical resection occurred in 71.0% of surveillance patients, versus 18.7% of non-surveillance patients (OR, 10.62; 95% CI, 4.56-26.63), and stage 4 diagnoses were much more common in the non-surveillance population (61.3% versus 9.7%). Among the patients who did not undergo surveillance, 61.3% were diagnosed with stage 4 disease compared with 9.7% of those in the surveillance group.

The 5-year survival rate (unadjusted for lead-time) in the surveillance group was 32.4% and 4.3% in the non-surveillance group. The median overall survival was 26.8 months in the surveillance group compared with 5.2 months in the non-surveillance group, (hazard ratio, 0.22; 95% CI, 0.14-0.36). The mortality rate per 100 person-years was 114.5 (95% CI, 96.2–135.3) in non-surveillance patients and 21.9 (95% CI, 13.4–33.8) in surveillance patients.

Despite the apparent benefit of screening, there is room for improvement. "Although the outcomes presented here are encouraging and endorse our earlier findings, a significant proportion of surveillance patients (61%) still had poor outcomes because of diagnosis in a late stage (T2–4N0M0 and nodal or distant metastatic PDAC), with a 5-year survival of 16%," the authors wrote.

The study received no funding and the authors declared no conflicts. ■

Continued from previous page

despite increased doses, other causes of malabsorption should be considered, such as the concomitant conditions mentioned above.

"As EPI escalates, a lower fat diet may become necessary to alleviate distressing gastrointestinal symptoms," the authors wrote. "A close working relationship between the treating provider and the [registered dietician] is crucial so that barriers to optimum nutrient assimilation can be identified, communicated, and overcome. Frequent monitoring of the nutritional state with therapy is also imperative."

PancreasFest 2021 received no specific funding for this event. The authors declared grant support, adviser roles, and speaking honoraria from several pharmaceutical and medical device companies and health care foundations, including the National Pancreas Foundation. ■

AGA Clinical Practice Update

Extraesophageal gastroesophageal reflux disease

BY JIM KLING
MDedge News

Extraesophageal reflux (EER) symptoms are a subset of gastroesophageal reflux disease (GERD) that can be difficult to diagnose because of its heterogeneous nature and symptoms that overlap with other conditions.

That puts the onus on physicians to take all symptoms into account and work across disciplines to diagnose, manage, and treat the condition, according to a new clinical practice update from the American Gastroenterological Association, which was published in Clinical Gastroenterology and Hepatology (2023 Apr 14. doi: 10.1016/j.cgh.2023.01.040).

GERD is becoming increasingly common, which in turn has led to greater awareness and consideration of EER symptoms. EER symptoms can present a challenge because they may vary considerably and are not unique to GERD. The symptoms often do not respond well to proton pump inhibitor (PPI) therapy.

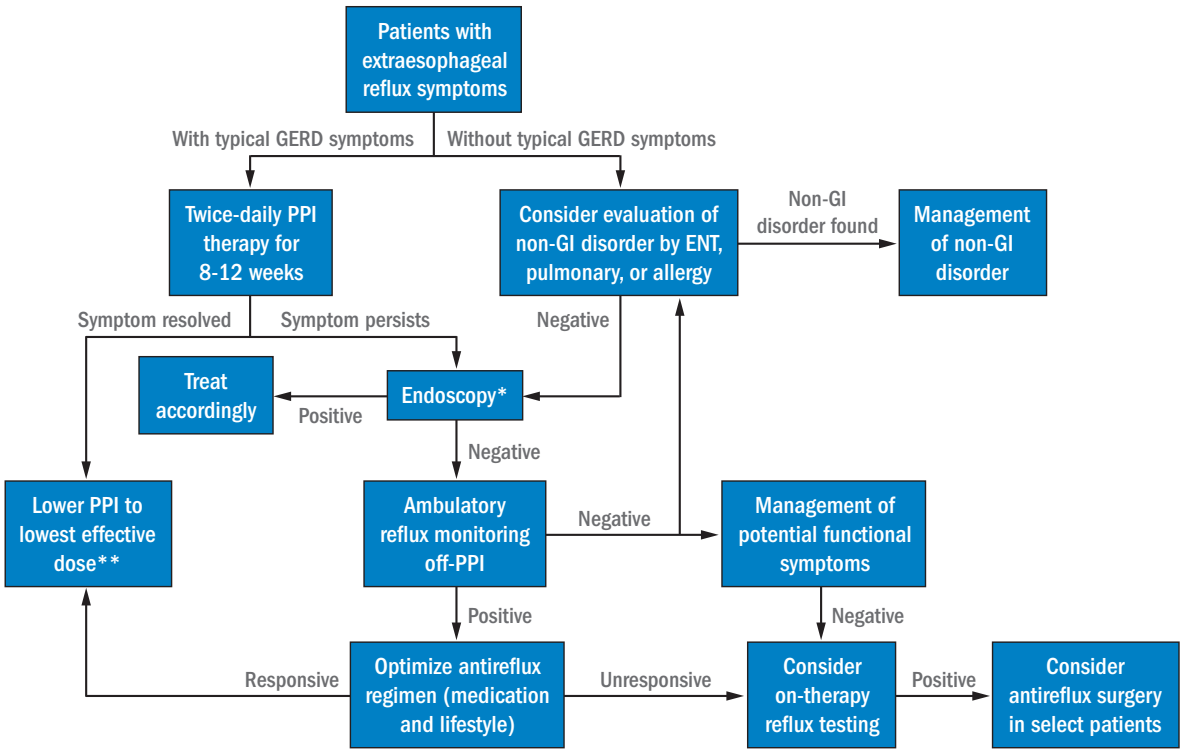

Dr. Chen

EER symptoms can include cough, laryngeal hoarseness, dysphonia, pulmonary fibrosis, asthma, dental erosions/caries, sinus disease, ear disease, postnasal drip, and throat clearing. Some patients with EER symptoms do not report heartburn or regurgitation, which leaves it up to the physician to determine if acid reflux is present and contributing to symptoms.

"The concept of extraesophageal symptoms secondary to GERD is complex and often controversial, leading to diagnostic and therapeutic challenges. Several extraesophageal symptoms have been associated with GERD, although the strength of evidence to support a causal relation varies," wrote the authors, who were led by Joan W. Chen, MD, a gastroenterologist with the University of Michigan, Ann Arbor.

There is also debate over whether fluid refluxate is the source of damage that causes EER symptoms, and if so, whether it is sufficient that the fluid be acidic or that pepsin be present, or if the cause is related to neurogenic signaling and resulting inflammation. Because of these questions, a PPI trial will not necessarily provide insight into the role of acid reflux in EER symptoms.

To guide physicians in diagnosing and managing EER symptoms, the authors created 10 advice statements based on a review of the published literature and expert opinion.



*Look for evidence of GERD-related injury or complications and rule out alternative esophageal diseases
**Consider endoscopy and reflux monitoring to support long-term use of PPI

Source: Clin Gastroenterol Hepatol. 2023 Apr 14. doi: 10.1016/j.cgh.2023.01.040

Best practice advice 1: The authors emphasized that gastroenterologists need to be aware of the potential extraesophageal symptoms of GERD. They should inquire with GERD patients to determine if laryngitis, chronic cough, asthma, and dental erosions are present.

Best practice advice 2: Consider a multidisciplinary approach to EER manifestations. Cases may require input from non-GI specialties. Tests performed by other specialists, such as bronchoscopy, thoracic imaging, or laryngoscopy, should be taken into account, since patients will also seek out multiple specialists to address their symptoms.

Best practice advice 3: There is no specific diagnostic test available to determine if GER is the cause of EER symptoms. Instead, physicians should interpret patient symptoms, response to GER therapy, and input from endoscopy and reflux tests.

Best practice advice 4: Rather than subject the patient to the cost and potential for even rare adverse events of a PPI trial, physicians should first consider conducting reflux testing. A PPI trial has clinical value but is insufficient on its own to help diagnose or manage EER. Initial single-dose PPI trial, titrating up to twice daily in those with typical GERD symptoms, is reasonable.

Best practice advice 5: The inconsistent therapeutic response to PPI therapy means that positive effects of PPI therapy on EER symptoms can't confirm a GERD diagnosis because a placebo effect may be involved, and because symptom improvement can occur through mechanisms other than acid suppression. A meta-analysis found that a PPI trial has a sensitivity of 71%-78% and a specificity of 41%-54% with typical symptoms of heartburn and regurgitation. "Considering the greater variation expected with PPI response for extraesophageal symptoms, the diagnostic performance of empiric PPI trial for a diagnosis of EER would be anticipated to be substantially lower," the authors wrote.

Best practice advice 6: When EER symptoms related to GERD are suspected and a PPI trial of up to 12 weeks does not lead to adequate improvement, the physician should consider testing for pathologic GER. Additional trials employing other PPIs are unlikely to succeed.

Best practice advice 7: Initial testing to evaluate for reflux should be tailored to patients' clinical presentation. Potential methods to evaluate reflux include upper endoscopy and ambulatory reflux monitoring studies of acid suppressive therapy, which can assist with a GERD diagnosis, particularly when nonerosive reflux is present.

Best practice advice 8: About 50%-60% of patients with EER symptoms will not have GERD. Testing can be considered for those with an established objective diagnosis of GERD who do not respond well to high doses of acid suppression. Cost-effectiveness studies have confirmed the value of starting with ambulatory reflux monitoring, which can include a catheter-based pH sensor, pH impedance, or wireless pH capsule.

Ambulatory esophageal pH monitoring can

Continued on following page

Psyllium fiber may shield against colitis

BY JIM KLING
MDedge News

FROM CELLULAR AND MOLECULAR GASTROENTEROLOGY AND HEPATOLOGY

Psyllium fiber offered protection against colitis in mice models through its effect on bile acid metabolism, which in turn reduces proinflammatory signaling through activation of the farnesoid X receptor (FXR), shows a study recently published in Cellular and Molecular Gastroenterology and Hepatology (2023 Feb 23. doi: 10.1016/j.jcmgh.2023.02.007).

"Our results support the notion that pharmacologic FXR activation might be useful in managing IBD [inflammatory bowel disease], and thus, further investigation of its mechanisms of action are warranted," wrote the authors, led by Andrew Gewirtz, of the Center for Inflammation, Immunity and Infection, Institute for Biomedical Sciences, Georgia State University, Atlanta.

"These results indicate that psyllium's protection against colitis involves its ability to increase circulating bile acid levels, thus activiting FXR signalling."
— Gewirtz et al.

Dietary fiber has long been understood to be a key component to a healthy diet by promoting intestinal and metabolic health, but it is unclear whether dietary fiber benefits IBD, specifically Crohn's disease and ulcerative colitis, and if so, what fiber types are best for these conditions. Some studies have suggested an association between fiber-rich diets and reduced incidence of IBD, but some IBD patients experience intolerance to fiber-rich foods and associated fiber-rich foods with disease flares. In mouse models with colitis, semi-purified fibers have been associated with both the easing and exacerbation of IBD symptoms, with soluble/fermentable fibers like inulin and pectin generally worsening colitis.

The study had two goals: Identify specific fibers that might ameliorate two models of experimental colitis in mice models and to better understand the mechanism by which fiber(s) might suppress inflammation.

Mice were fed high-fiber grain-based chow or diets enriched with semi-purified fibers that included inulin, cellulose, pectin, glucomannan, and psyllium, but only psyllium, a semi-soluble derived from Plantago seeds, improved colitis, and metabolic syndrome. The other fibers often protected against obesity but worsened colitis.


Dr. Gewirtz

Consuming diets enriched with psyllium were found to "markedly" protected against both dextran sulfate sodium– and T-cell transfer–induced colitis. The protection was independent of fermentation and occurred in animals with minimal microbiota. The animals had increased expression of genes that influence bile acid secretion, and the researchers noted increased levels of both fecal and serum bile acid.

The increased serum levels prompted the researchers to investigate psyllium's role in signaling activation through bile acid receptors, especially FXR. An FXR agonist also reduced colitis severity, while an FXR antagonist worsened it. FXR-deficient mice gained little benefit from psyllium supplementation, further suggesting that FXR mediates psyllium's effect.

All soluble fibers impacted gut microbiota composition, but none more than psyllium which protected mice from developing dextran sulfate sodium colitis. While other soluble fibers increased in the abundance of bacteria (that is, fecal/luminal bacterial density), psyllium decreased in this area, which may explain why some fermentable fibers, including inulin, exacerbate colitis.

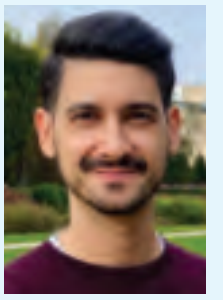
"These results indicate that psyllium's protection against colitis involves its ability to increase circulating bile acid levels, thus activating FXR signaling," the authors wrote.

Researchers found some evidence that prolonged psyllium supplementation could lead to mild elevations in AST and ALT, suggesting that the ability of psyllium to chelate BA could lead to lipid deficiency, especially in the presence of a low-fat diet.

"We suggest that future studies of psyllium in humans measure serum BA and consider roles for FXR activation in mediating impacts of this fiber," the authors wrote.

The study was supported by the National Institutes of Health and the Crohn's and Colitis Foundation. The authors disclosed no conflicts. ■

Consumption of dietary fibers can promote general health in most people, but is reported to be difficult to tolerate, and even deleterious, in patients suffering from inflammatory bowel disease. Given the broad structural and biochemical diversity of fibers, their mechanisms of action remain to be fully explored.


Dr. Corrêa

In a recent study published in Cellular and Molecular Gastroenterology and Hepatology, Bretin et al. highlight how psyllium, a semi-soluble fiber derived from Plantago seeds, can protect mice against both obesity and colitis—a unique feature when compared to other common fibers, such as pectin and inulin, which can also prevent obesity but, in contrast, exacerbate colon inflammation.

Interestingly, although psyllium intake affected the composition of the gut microbiota, its beneficial effects seemed to be partially microbiota independent. In fact, psyllium contributed to colitis protection by inducing an increase in the luminal concentration of bile acids which, in turn, activated the bile acid sensor FXR, thereby suppressing inflammation. Nonetheless, how psyllium elevates bile acids, which FXR-expressing cell types are involved, and why other fibers can also alter bile acids levels without achieving the same effects, remain outstanding questions.

This study illustrates the need to assess individually the role of different fibers to provide practitioners with the rationale for optimizing diet in IBD and possible personalized access to fiber health benefits.

Renan Oliveira Corrêa, PhD, is postdoctoral researcher and Nadine Cerf-Bensussan, MD, PhD, is Inserm Research Director and head of the laboratory of intestinal immunity at the IMAGINE Institute and Université Paris Cité. They have no conflicts of interest.

Continued from previous page

also assist in making a GERD diagnosis, but it does not indicate whether GERD may be contributing to EER symptoms.

"Whichever the reflux testing modality, the strongest confidence for EER is achieved after ambulatory reflux testing showing pathologic acid exposure and a positive symptom-reflux association for EER symptoms," the authors wrote. They also pointed out that ambulatory reflux monitoring in EER patients should be done in the absence of acid suppression unless there is already objective evidence for the presence of GERD.

Best practice advice 9: Aside from acid suppression, EER symptoms can also be managed through other means, including lifestyle modifications, such as eating avoidance prior to lying down, elevation of the head of the bed, sleeping on the left side, and weight loss. Or, alginate containing antacids, external upper esophageal sphincter compression device, cognitive behavioral therapy, and neuromodulators.

Best practice advice 10: In cases where the EER patient has objectively defined evidence of GERD, physicians should employ shared decision-making before considering anti-reflux surgery. If the patient did not respond to PPI therapy, this predicts a lack of response to anti-reflux surgery.

All four authors reported financial ties to multiple pharmaceutical companies. ■

Dr. Carethers outlines AGA goals

AGA *from page 1*

and 8 other colleagues formed the American Gastroenterological Association. Today, with nearly 16,000 members, the organization has become a driving force in improving the care of patients with gastrointestinal conditions.

Among AGA's accomplishments since its founding: In 1940, the American Board of Internal Medicine certified gastroenterology as a subspecialty. Three years later, the first issue of Gastroenterology, the AGA's flagship journal, was published. And, in 1971, the very first Digestive Disease Week® meeting took place.

In terms of medical advances that have been made since those early years, the list is vast: From the description of ileitis in 1932 by Burril B. Crohn, MD, in 1932 to the discovery of the hepatitis B surface antigen in 1965 and the more recent discovery of germline mutations in DNA mismatch repair genes as a cause of Lynch syndrome.

Dr. Carethers outlined goals for the future, including building a leadership team that is "reflective of our practice here in the United States," Dr. Carethers said. Creating a culturally and gender diverse leadership team will only strengthen the organization and the practice of gastroenterology. The AGA's first female president, Sarah Jordan, MD, was named in 1942, and since then, the AGA has been led by women and men from different ethnic backgrounds, including himself as AGA's first president of African American heritage.

The AGA is committed to a number of diversity and equity objectives, including the AGA Equity Project, an initiative launched in 2020 with the goal of achieving equity and eradicate disparities in digestive diseases (with a focus on justice and equity), research and funding, workforce and leadership, recognition of the achievements of people of color, unconscious bias, and engagement with early career members.

"I am not only excited about the diversity and equity objectives within our specialty, but also the innovation," Dr. Carethers said.

Securing funding for early-stage innovations in medicine can be difficult across medical disciplines, including gastroenterology. So, last year, the AGA, with Varia Ventures, launched the GI Opportunity Fund 1 to support early-stage GI-based companies. The goal is to raise $25 million for the initial fund. Through the AGA's Center for GI Innovation and Technology and the AGA Tech Summit, early-stage companies may have new funding opportunities.

And, through the AGA Research Foundation, the organization will continue to support clinical research. Last year, $2.6 million in grants were awarded to investigators.

Dr. Carethers is a board director at Avantor, a life sciences supply company.

DDW is sponsored by the American Gastroenterological Association, the American Association for the Study of Liver Diseases, the American Society for Gastrointestinal Endoscopy, and the Society for Surgery of the Alimentary Tract. ■

AGA

This year, the AGA welcomes a new president, Dr. Barbara Jung of the University of Washington, Seattle. Dr. John Carethers, vice chancellor of Health Sciences at UC San Diego, completed his term in May.

CLINICAL CHALLENGES AND IMAGES

The diagnosis

Continued from page 8.

Answer: Gastric adenocarcinoma and proximal polyposis of the stomach syndrome

Fundic gland polyps (FGPs) are the most common gastric polyps and when occurring in the sporadic setting are typically benign; however, FGPs that occur in gastrointestinal polyposis syndromes such as familial adenomatosis polyposis can progress to adenocarcinoma and require surveillance. It is important to distinguish sporadic versus syndromic fundic gland polyposis. Gastric adenocarcinoma and proximal polyposis of the stomach is a recently described condition that significantly increases the risk of developing invasive gastric adenocarcinoma from FGPs. Diagnostic criteria include (1) gastric polyposis restricted to the body and fundus with no small bowel or colonic involvement, (2) >100 gastric polyps or >30 polyps in a first-degree relative, (3) histology consistent with FGP with areas of dysplasia, (4) a family history consistent with an autosomal-dominant pattern of inheritance, and (5) exclusion of other syndromes and proton pump inhibitor use.[1]

Unlike familial adenomatosis polyposis, the polyposis is restricted to the oxyntic mucosa of the gastric body and fundus with sparing of the gastric antrum, small bowel, and colon. The genetic basis of the disease has been attributed to a point mutation in the APC gene promotor IB region leading to a loss of tumor suppressor function.[2] Typical histology shows large FGPs with areas of low-grade and high-grade dysplasia, as seen in our patient.

There are few data on the natural history of gastric adenocarcinoma and proximal polyposis of the stomach, but effective surveillance is limited by the degree of polyposis. There are multiple reports of hidden adenocarcinoma on surgically resected specimens, as well as rapid progression to metastatic adenocarcinoma despite adequate diagnosis and surveillance.[1,3] Total gastrectomy should be offered to patients who are surgical candidates. Our patient underwent genetic testing that revealed a point mutation in the APC promotor IB. He declined surgical intervention and opted for surveillance endoscopy every 6 months.

This quiz was originally published in Gastroenterology. https://doi.org/10.1053/j.gastro.2022.04.036

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Recurrence prevention in *C. diff*

C. diff *from page 1*

C. diff recurrence and is designed to be delivered in four capsules taken daily for 3 days.

Gastroenterologist Phillip I. Tarr, MD, division chief of gastroenterology at Washington University, St. Louis, and chair of the American Gastroenterological Association Center for Gut Microbiome Research and Education, said that prevention of recurrent *C. diff* infection "remains challenging," and that Vowst "provides the first FDA-approved, orally administered microbiome therapeutic with which to achieve this goal. This advance also makes us optimistic we might soon be able to prevent other disorders by managing gut microbial communities."

Vowst, which could cost $20,000 per course, is the second therapy derived from human stool to be approved for the indication in less than 6 months. In December, the FDA approved Rebyota (Ferring), a rectally delivered treatment that also uses microbes from donor feces.

C. diff infection can be aggravated by an alteration of normal gut flora associated with antibiotics treatment, leading to cycles of repeated infections. Infection can produce diarrhea, abdominal pain, fever, and severe morbidity. In the United States, an estimated 15,000- 30,000 deaths per year are linked to *C. diff*.

Therapies transplanting fecal microbiota from donors have been used since the 1950s as treatments for recurrent *C. diff* infection, and in the past decade, as stool banks recruiting screened donors have made fecal microbiota transplants, or FMT, standard of care. However, only in recent years have fecal-derived therapies become subject to standardized safety and efficacy testing. Both the current FDA-approved products, Rebyota and Vowst, were shown in randomized controlled trials to reduce recurrence of *C. diff* infection, compared with placebo. In a phase 3 clinical trial of Rebyota (n = 262) in antibiotic-treated patients, one rectally administered dose reduced recurrence of *C. diff* infection by 70.6% at 8 weeks, compared with 57.5% for placebo. A phase 3 study of Vowst (n = 281) showed recurrence in treated subjects to be 12.4% at 8 weeks, compared with nearly 40% of those receiving placebo (relative risk, 0.32; 95% confidence interval, 0.18-0.58; *P* less than .001).

Vowst is manufactured with purified bacterial spores derived from donor feces, not whole stool. Vowst could still potentially introduce infectious agents or allergens.

Dr. Allegretti disclosed consulting work for Seres Therapeutics, Ferring, and other manufacturers. ■

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