AT THE FOREFRONT
UChicago Medicine

SECTION OF GASTROENTEROLOGY, HEPATOLOGY & NUTRITION

WOMEN IN DIGESTIVE DISEASES: AT THE FOREFRONT

2021 UPDATES

A VIRTUAL EVENT

CONFERENCE CO-DIRECTORS
Sonia Kupfer, MD
Sonali Paul, MD, MS
Anjana A. Pillai, MD
Vijaya Rao, MD
Helen S. Te, MD

UNIVERSITY OF CHICAGO
Center for Care and Discovery
7th Floor Boardroom
5700 S. Maryland Ave.
Chicago, IL 60637

Syllabus/Slides: https://cme.uchicago.edu/WomeninDDSyllabus2021

AT THE FOREFRONT
UChicago Medicine
Digestive Diseases Center

March 13, 2021

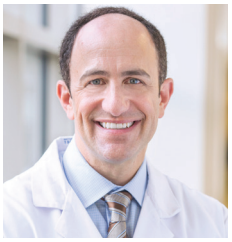
Dear Colleagues:

Welcome to the annual Women in Digestive Diseases: At the Forefront conference!

We are delighted to welcome you to the third year of this unique CME conference highlighting women's gastrointestinal and liver health issues. The Digestive Diseases Center at the University of Chicago Medicine is proud of our outstanding women physicians and scientists, and delighted that you have chosen to learn from and with them today.

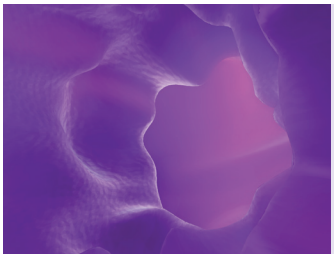
The University of Chicago Medicine is committed to identifying the needs of different populations of patients and providing the unique multidisciplinary care that they both need and deserve. Thank you for your interest and ongoing support.

Sincerely,



David T. Rubin, MD
The Joseph B. Kirsner Professor of Medicine
Chief, Section of Gastroenterology, Hepatology and Nutrition
Co-Director, Digestive Diseases Center
University of Chicago Medicine

Neil H. Hyman, MD
Professor of Surgery
Section Chief, Colon and Rectal Surgery
Co-Director, Digestive Diseases Center
University of Chicago Medicine



WOMEN IN DIGESTIVE DISEASES: UPDATES IN 2021

University of Chicago | A Virtual Event

March 13, 2021

DESCRIPTION

Women face unique challenges in the field of digestive diseases, both as patients and practitioners. This activity will address these challenges in an exciting and interactive forum. Topics include the symptoms, diagnosis, and treatment of common gastrointestinal and liver diseases that afflict women more commonly and/or differently than men as well as strategic solutions to barriers women gastroenterologists and other women providers in gastroenterology face in their career development.

TARGET AUDIENCE

This activity is designed for physicians, nurses, and other healthcare professionals interested in the treatment of women with gastrointestinal illnesses and the career development of women providers in the field of gastroenterology and medicine.

LEARNING OBJECTIVES

At the conclusion of this education activity, participants will be able to:

- *Identify the unique presentations and complications of specific gastrointestinal and liver diseases that afflict women more commonly or in different ways than men;*
- *Discuss gender-specific management strategies that address the needs of the women patients more optimally;*
- *Recognize challenges that women healthcare providers face as they navigate their professional journeys;*
- *Determine strategies that help women healthcare providers overcome barriers in the advancement of their careers and promote success in their chosen paths.*

ACCREDITATION AND CREDIT DESIGNATION

PHYSICIAN CREDIT

The University of Chicago Pritzker School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The University of Chicago Pritzker School of Medicine designates this live activity for a maximum of 5.25 A*MA PRA Category 1 Credits*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

NURSING CREDIT

University of Chicago Medicine is approved as a provider of nursing continuing professional development by the Ohio Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation. (OBN-001-91)

This live activity is designated for a maximum of 5.25 continuing nursing education units.

OTHER HEALTHCARE PROFESSIONAL CREDIT

Other healthcare professionals will receive a Certificate of Participation. For information on the applicability and acceptance of Certificates of Participation for educational activities certified for *AMA PRA Category 1 Credit*™ from organizations accredited by the ACCME, please consult your professional licensing board.

EDUCATIONAL GRANTS/COMMERCIAL SUPPORT

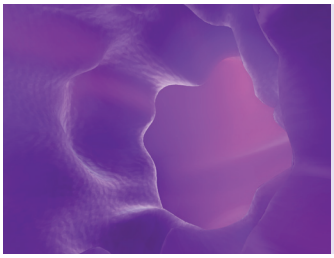
Educational grant funding has been generously provided by:

AbbVie Inc. **Boston Scientific Corporation** **Medtronic** **Salix Pharmaceuticals, Inc.**

Supported by an educational grant from **Janssen Biotech, Inc**., administered by **Janssen Scientific Affairs, LLC**.

We also thank our exhibitors:

Abbvie Exact Sciences Gilead Sciences Takeda



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DISCLOSURE DECLARATIONS

As a provider accredited by the ACCME, The University of Chicago Pritzker School of Medicine asks everyone who is in a position to control the content of an education activity to disclose all relevant financial relationships with any commercial interest. This includes any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients. The ACCME defines "relevant financial relationships" as financial relationships in any amount, occurring within the past 12 months, including financial relationships of a spouse or life partner that could create a conflict of interest. Mechanisms are in place to identify and resolve any potential conflict of interest prior to the start of the activity.

Additionally, The University of Chicago Pritzker School of Medicine requires Authors to identify investigational products or off-label uses of products regulated by the US Food and Drug Administration at first mention and where appropriate in the content.

COURSE FACULTY

The following individuals have disclosed no relevant financial relationships:

Katherine Schuver Garman, MD
Sonia Kupfer, MD
Amy Majkowski, AB
M. Ruth Mangonon-Barnes, MSN, APN, ACNS-BC, CPHQ
Vijaya Rao, MD
Carol E. Semrad, MD
Courtney Schuchmann, MS, RD, LDN
Nundhini Thakkani, MD
Ritu Verma, MD
Yalini Vigneswaran, MD, MS

Aline Charabaty Pishvaian, MD has served as a consultant for and received educational grant funding from AbbVie, Takeda, Janssen, and Pfizer. Dr. Charabaty Pishvaian has served on the advisory board of Janssen and Pfizer.

Jan Cowell, CNS, RN, MS, CWOCN has served as a speaker for Hollister and Coloplast.

Sunanda V. Kane, MD has served as a consultant for Gilead and Pfizer.

Sonali Paul, MD, MS has received research support from GENFIT, TARGET Pharmasolutions, and Intercept Pharmaceuticals.

Anjana A. Pillai, MD has served on the medical advisory board of Eisai Inc., Exelixis, and Genentech.

Uzma D. Siddiqui, MD has served as a speaker and consultant for Boston Scientific, Olympus, Medtronic, and ConMed and as a speaker for Ovesco and Pinnacle Biologics.

Helen S. Te, MD has received research funding from AbbVie.

The staff of the Center for Continuing Medical Education have no relevant financial relationships to disclose.

DISCLAIMER

The views expressed in this activity are those of the individual speaker. It should not be inferred or assumed that they are expressing the views of any pharmaceutical or product/device manufacturer, provider of commercial services, or The University of Chicago. The drug selection and dosage information presented in this activity are believed to be accurate. However, participants are urged to consult the full prescribing information on any agent(s) presented in this activity for recommended dosage, indications, contraindications, warnings, precautions, and adverse effects before prescribing any medication. This is particularly important when a drug is new or infrequently prescribed.

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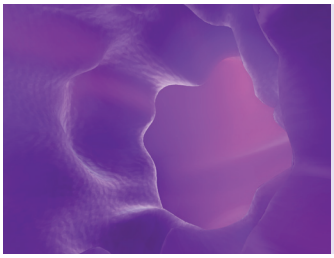
Please Note: Requests to claim *AMA PRA Category 1 Credit*™ after three months will be subject to additional fees.



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CONFERENCE SPEAKERS AND MODERATORS

GUEST SPEAKERS

Aline Charabaty, MD, AGAF, FACG

Assistant Clinical Director of Gastroenterology, Division of Gastroenterology, Johns Hopkins School of Medicine
Director of the Inflammatory Bowel Disease Center, Johns Hopkins – Sibley Memorial Hospital
Founder, @MondayNightIBD

Dr. Aline Charabaty is the Assistant Clinical Director of the Gastroenterology Division at Johns Hopkins School of Medicine and the Director of the Inflammatory Bowel Diseases (IBD) Center at John Hopkins-Sibley Memorial Hospital. She is actively involved in educational and advocacy initiatives and committees of the American Gastroenterological Association and the American College of Gastroenterology. She founded @MondayNightIBD, a twitter platform that brings clinicians together to discuss the management of complex IBD cases, for which she received the Healio Gastroenterology Disruptive Innovator Award in 2019. She has also been recognized as "Top Doctor" by her peers in *Washingtonian Magazine* and by her patients in the *Washington Consumers' CheckBook*. When she is not at work or on social media, she is running, striking a yoga pose, watching black and white movies, cooking or planning an exciting and foodie trip with her family or her girlfriends!

Katherine S. Garman, MD, MHS

Associate Professor of Medicine
Vice Chief for Research, Gastroenterology
Duke University

Dr. Katie Garman is an Associate Professor of Medicine at Duke University in the GI Division and in Duke's Molecular Physiology Institute. She serves as Vice Chief of Research in the GI Division and she co-leads Duke Cancer Institute's Cancer Risk, Detection, and Interception (CRDI) Program. She is also a fellow of the American Gastroenterological Association (AGA). As a basic and translational researcher, Katie is focused on premalignant disease in the upper GI tract and how knowledge of underlying biology can be used for cancer prevention and interception. Her lab has an active R01 on esophageal wound healing and a P20 project on disparities in gastric cancer with an emphasis on the role of H pylori infection in pre-malignant disease. In addition to the lab-based work, Katie has maintained an active interest in women's mentorship and wellness. She has been involved in research related to ergonomics at Duke and at the national level through work with the AGA. Outside the lab, Katie loves running, gardening, cooking, and spending time with her family and their animals in Hillsborough, NC.

Sunanda Kane, MD, MSPH, FACG, FACP, AGAF

Professor of Medicine
Division of Gastroenterology and Hepatology
Mayo Clinic
Rochester

Dr. Sunanda V. Kane is a Professor of Medicine at the Mayo Clinic in Rochester Minnesota. She has a busy clinical practice that reflects her expertise in inflammatory bowel disease (IBD), which is also the focus of her research work encompassing new therapies, gender-specific issues, and medication adherence. She is a prolific researcher and writer, having published over 200 original articles, reviews and book chapters; she also authored a book for patients on self-management of IBD. She is a passionate teacher, not just to students, trainees and colleagues, but also to patients in her previous role as Chair of the National Patient Education Committee for the Crohn's and Colitis Foundation. She also hit a milestone as the first female Associate Editor for Alimentary Pharmacology and Therapeutics, and she serves in editorial roles for other journals as well.

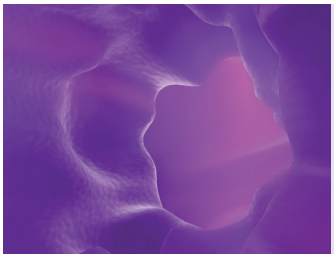
Amongst many leadership positions that she holds within Mayo Clinic is the Chair of Quality within the Division of Gastroenterology and Hepatology, but the pinnacle of Dr. Kane's leadership journey was being President of the American College of Gastroenterology in 2019-2020. She also just completed a 5-year service on the Gastroenterology Specialty Council of the American Board of Internal Medicine. To take a break from work, Dr. Kane parlays her interest in football by serving as the Commissioner of two fantasy football leagues at Mayo Clinic during the season and otherwise enjoys spending time watching Netflix while cuddling with her dog, Ted.

Nundhini Thukkani, MD

Chief, Gastroenterology and Hepatology
Northwest Permanente, PC
Founder, Ladies of the Gut Facebook Group

Dr. Nundhini Thukkani resides in Portland, Oregon where she currently serves as the Chief of Gastroenterology and Hepatology for Northwest Permanente, P.C.

Her clinical practice encompasses the breadth of general gastroenterology with a focus on inflammatory bowel diseases. She created the Ladies of the Gut, a platform for networking, community and clinical discussion in January of 2015, which currently numbers >1,000 members spanning across the globe. Members include female/identifying pediatric and adult gastroenterologists, hepatologists and pathologists specializing in gastroenterology and hepatology. Outside of work, she enjoys time with her husband and 10-year-old twins, has taken up quarantine baking, and all things Peloton. She looks forward to traveling, live music and enjoying dinners out with friends.



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Janice C. Colwell, APRN, CWOCN, FAAN

Clinical Nurse Specialist, General Surgery

Janice Colwell, RN, MS, CWOCN, FAAN is a certified nurse specialist in wound ostomy and continence care. She has been working in the field of ostomy care nursing for over 40 years. She has deep expertise in the inpatient and outpatient management of patients who are anticipating ostomy surgery or have had ostomy surgery and are working towards adapting to living with a stoma. She has published extensively and edited two books in ostomy care. She is also the editor of the ostomy section of the Journal of Wound Ostomy and Continence Nursing. She has been invited to lecture on ostomy care both nationally and internationally. She is the past president of the Wound Ostomy and Continence Nurses Society and is on the board of Friends of Ostomates Worldwide USA. Her leisure activities include spending time with her family, and she has just completed a master gardener class with hopes that she can use her new skills in her ever-changing garden.

Sonia Kupfer, MD

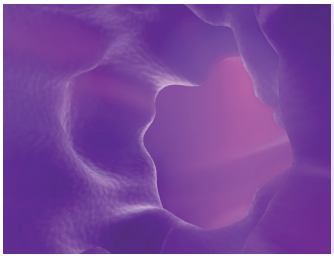
Associate Professor of Medicine
Vice-Chief, Education, Section of Gastroenterology, Hepatology, and Nutrition
Director, Gastrointestinal Cancer Risk and Prevention Clinic

Dr. Sonia Kupfer has been a faculty member in the Section of Gastroenterology, Hepatology and Nutrition for 8 years. Her clinical interests include hereditary gastrointestinal cancer syndromes and celiac disease. She launched the Gastrointestinal Cancer Risk and Prevention clinic where she works with a multi-disciplinary team to provide assessment and management for individuals at high risk for gastrointestinal cancers, such as those with Lynch syndrome, polyposis syndromes, familial pancreatic cancers and hereditary diffuse gastric cancer. In 2017, Dr. Kupfer served as the President of the Collaborative Group of the Americas on Inherited Gastrointestinal Cancer. Dr. Kupfer also leads a translational research program and is funded by the National Cancer Institute to study colonic host-environmental interactions pertaining to carcinogenesis. She has a particular interest in understanding how these interactions differ between individuals and populations in order to address cancer disparities. She is dedicated to education along the continuum of training and has been appointed as the Associate Section Chief for Education and, more recently, as Associate Director of the Physician Scientist Development Program of the Department of Medicine. Her ability to juggle all her roles is enabled by a supportive husband, an art dealer, who partners with her in raising their two children, ages 13 and 15. In the spare time that she rarely has, Dr. Kupfer practices Pilates, spins and plays the oboe.

Sonali Paul, MD

Assistant Professor of Medicine

Dr. Sonali Paul began her career in hepatology within the Section of Gastroenterology, Hepatology and Nutrition at the University of Chicago Medicine. Her clinical practice is focused on the largest epidemic in the history of hepatology – nonalcoholic fatty liver disease – and she also has an interest in immune-mediated diseases. She is board-certified in obesity medicine, and works closely with a multidisciplinary team that includes a nutritionist and an endocrinologist to provide a comprehensive approach of dietary, lifestyle and drug therapy interventions to manage fatty liver. She has a master's degree in Clinical and Translational Science, which has given her the skills to add patient outcomes research and large database research to her portfolio. Dr. Paul's home life is dedicated to raising her 6 year-old son, Raj, with her wife, Cathy, and enjoying her puggle, Milo.



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Anjana A. Pillai, MD

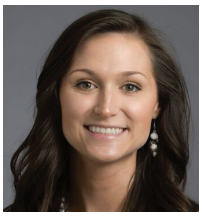
Associate Professor of Medicine
Medical Director, Liver Tumor Program
Medical Director, Living Donor Liver Transplantation

Dr. Anjana Pillai is an Associate Professor of Medicine and came to the Section of Gastroenterology, Hepatology and Nutrition of the University of Chicago Medicine in 2016. She has a strong clinical and research interests in clinical outcomes and novel therapeutic options for hepatocellular carcinoma and cholangiocarcinoma. She is the Medical Director of the Liver Tumor Program, which brings the disciplines of hepatology, hepatobiliary surgery, oncology, diagnostic and interventional radiology together to offer patients a multidisciplinary and highly innovative approach to the management of liver tumors, whether malignant or benign. She is also the Medical Director of the Living Donor Liver Transplant program, which was recently reinvigorated at the University of Chicago Medicine. She is the Program Director of the Transplant Hepatology Fellowship. To maintain her sanity, she often runs and tries to "compete" in 1-2 races every year. At home, she is fortunate enough to have a supportive husband and is the mother to two young energetic children.

Vijaya Rao, MD

Assistant Professor of Medicine
Director, Student and Resident Rotations

Dr. Vijaya Rao transitioned seamlessly from gastroenterology fellowship into the faculty at the University of Chicago Medicine in 2017. Her clinical practice includes patients with a variety of digestive diseases, with a particular interest in celiac disease. She completed an ethics fellowship at the MacLean Center for Clinical Medical Ethics and remains part of the center's faculty. As Associate Program Director for the gastroenterology fellowship program, she has implemented an ethics curriculum for the fellows. Since 2019, she has been Editor-in-Chief of The New Gastroenterologist, a publication of the American Gastroenterological Association. Outside of work, Dr. Rao is a wife and mother to an active toddler and loves cooking, yoga, traveling and tennis when she finds the time.



Courtney Schuchmann, MS, RD, LDN

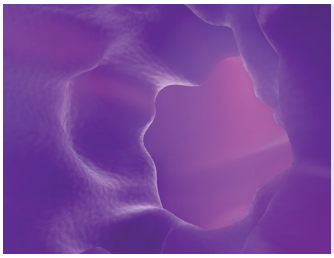
Registered Dietitian

Courtney Schuchmann , MS, RD, LDN is a registered dietitian who is the nutrition advisor for many of the clinical programs at the University of Chicago Medicine, including the Center for Celiac Disease, Center for Liver Diseases, and Center for Endoscopic Treatment of Obesity. In her role, she has an expertise on the nutritional management of celiac disease, obesity and fatty liver. However, she also provides medical nutrition therapy to other patients within the Section of Gastroenterology, Hepatology and Nutrition. Her work philosophy is to use her knowledge and expertise to help patients manage their nutrition-related diseases or to help patients address the nutritional complications resulting from their underlying gastrointestinal or hepatic disease, in order to optimize their nutritional status and improve their overall quality of life. She is an active member of the Academy of Nutrition and Dietetics as well. In her spare time, she likes to explore new restaurants, try out new recipes in the kitchen, workout and spend time traveling.

Carol E. Semrad, MD

Professor of Medicine
Director, Small Bowel Disease and Nutrition Program

Dr. Carol Semrad has led the Small Bowel Disease and Nutrition Program for the last 18 years that she has been a faculty in the Section of Gastroenterology, Hepatology, and Nutrition. She is one of the pioneers in the use of double balloon enteroscopy for diagnosis and management of small bowel diseases. Her clinical and research interests also include celiac disease and small bowel malabsorption disorders, for which she has earned an international reputation. She has also been recognized with many awards from national societies, and has been named consistently as an American Top Doctor and Chicago Magazine Top Doctor by her peers for more than 10 years. Most recently, she is the recipient of the American Society of Gastrointestinal Endoscopy Master Endoscopist Award, an attestation to her clinical and endoscopic expertise. When she can get away from work, Dr. Semrad likes music, theater and nature.



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Uzma D. Siddiqui, MD

Professor of Medicine
Associate Director, Center for Endoscopic Research and Therapeutics
Director, Endoscopic Ultrasound and Advanced Endoscopy Training Program

Dr. Uzma Siddiqui has been practicing in interventional endoscopy for 16 years, 9 of which have been at the University of Chicago Medicine. She has particular expertise in the use of endoscopic ultrasound, ERCP, and endoscopic ablative and resection techniques in the treatment of pancreatic and biliary system diseases as well as tumors of the gastrointestinal luminal tract. She is conducting clinical trials of novel therapeutic modalities for early esophageal cancer, cholangiocarcinoma, and pancreatic cancer. She also is the program director for the EUS and Advanced Endoscopic Training Program. Dr. Siddiqui has a passion for tennis and does not miss attending the US Open Tennis annually, except during a pandemic.

Helen S. Te, MD

Professor of Medicine
Medical Director, Adult Liver Transplantation

Dr. Helen S. Te has been on faculty at the University of Chicago Medicine for 21 years, and has directed the Adult Liver Transplant Program for the last 15 years. Her clinical practice consists of both general hepatology and transplant hepatology patients, and she finds patients with cirrhosis and liver transplant recipients to be the most challenging and most rewarding to care for. She uses a personalized approach and nimble innovations as the basic elements of her routine management of these patients. This strategy has earned her peer recognition with the America's Top Doctor and Chicago Magazine Top Doctor awards for the past consecutive 10 years. Beyond her professional role, Dr. Te is a wife and mother of 3 children and loves organizing travels for her extended family.

Ritu Verma, MD

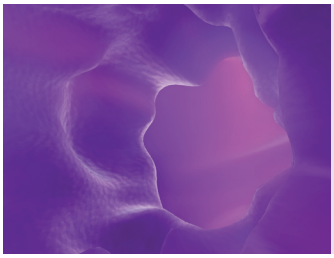
Professor of Pediatrics
Section Chief, Pediatric Gastroenterology, Hepatology & Nutrition
Medical Director, Celiac Disease Center

Dr. Ritu Verma leads the Section of Pediatric Gastroenterology, Hepatology and Nutrition at the University of Chicago Medicine. She is a leading expert in celiac disease, but she also provides compassionate, comprehensive care to children and adolescents suffering from a wide spectrum of other complex gastrointestinal conditions. She is committed to ensuring pediatric gastroenterology patients have a seamless continuum of care throughout their journey, which includes a coordinated transition from pediatric to adult gastroenterology programs. In addition to her clinical practice, Dr. Verma is passionate about creating a holistic approach to research that merges both adult and pediatric as well as basic and clinical science research in celiac disease, inflammatory bowel disease and food allergies so that all of gastroenterology is marching towards to the same goal, providing her patients with the latest therapies and access to innovative treatments. In addition to clinical care and education, her other passion is to mentor medical students, residents, fellows and faculty. She was also recently selected as the 2020 Bucksbaum Institute Master Clinician at the University of Chicago Medicine. On her leisure time, she enjoys reading and traveling, especially to the beach. She loves to spend time with her family – just hanging out, playing board games, and organizing "Family Support Groups and Education days" for various gastrointestinal diseases with help from her family! She does not like to cook and prefers to order take-out!

Yalini Vigneswaran, MD, MS

Assistant Professor of Surgery

Dr. Yalini Vigneswaran is an advanced minimally invasive gastrointestinal surgeon who specializes in esophageal and gastric disorders, including motility disorders, esophageal and gastroesophageal junction cancers, reflux disease and paraesophageal hernias as well as bariatric surgery. Additionally, Dr. Vigneswaran has surgical expertise in advanced laparoscopic and robotic-assisted techniques to approach complex gastrointestinal disorders. Dr. Vigneswaran conducts clinical and translational research and is committed to improving outcomes for patients with gastroesophageal disorders and patients undergoing bariatric surgery. She has been recognized nationally for her research and has received several awards for her work. Outside of work she enjoys traveling, golf and exploring the Chicago food scene.



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WOMEN FACULTY DIRECTORY

UNIVERSITY OF CHICAGO SECTION OF GASTROENTEROLOGY, HEPATOLOGY AND NUTRITION

Valerie Abadie, PhD

Research Assistant Professor

Research interests:
gastrointestinal immunology

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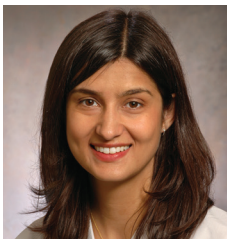

Sushila Dalal, MD

Assistant Professor of Medicine

Clinical interests:
inflammatory bowel diseases, pregnancy and inflammatory bowel diseases

Clinic locations:
Hyde Park Campus 5758 S. Maryland Ave., Chicago, IL 60637
River East 355 E. Grand Ave., Chicago, IL 60611
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Cell 847-606-6394 **Office** 773-702-4703 **Fax** 773-834-4037

Sushila.Dalal@uchospitals.edu

Nina Gupta, MD

Clinical Associate of Medicine

Clinical interests: GI cancer risk and prevention, general gastroenterology

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Bana Jabri, MD, PhD

Professor of Medicine
Sara and Harold Lincoln Thompson Professor
Vice Chair for Research (Basic Science), Department of Medicine

Research interests: gastrointestinal immunology

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900 E. 57th St. | Suite 9124 Chicago, IL 60637

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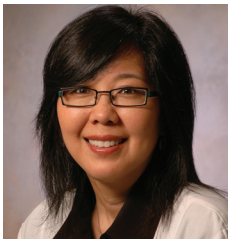

Karen E. Kim, MD

Professor of Medicine

Vice Provost for Research, University of Chicago

Director, Center for Asian Health Equity

Associate Director, Comprehensive Cancer Care Center

Clinical interests: colon cancer, health disparities, women's health

Clinic location:
Hyde Park Campus 5758 S. Maryland Ave., Chicago, IL 60637

Cell: 773-590-5522 **Office:** 773-702-3149 **Fax:** 773-702-5970

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Sonia Kupfer, MD

Associate Professor of Medicine

Vice-Chief, Education, Section of Gastroenterology, Hepatology, and Nutrition

Associate Director, Physician Scientist Development Program, Department of Medicine

Director, Gastrointestinal Cancer Risk and Prevention Clinic

Clinical interests: cancer genetics, colon cancer, hereditary syndromes, celiac disease

Clinic location:
Hyde Park Campus 5758 S. Maryland Ave., Chicago, IL 60637

Cell: 312-752-8510 **Office:** 773-702-8076 **Fax:** 773-702-2281

skupfer@medicine.bsd.uchicago.edu

Sonali Paul, MD, MS

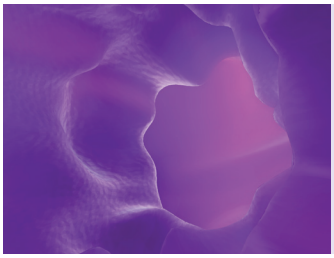
Assistant Professor of Medicine

Clinical interests: fatty liver disease, obesity, primary sclerosing cholangitis, autoimmune liver disease, liver transplant

Clinic locations:
Hyde Park Campus 5758 S. Maryland Ave., Chicago, IL 60637
Merrillville 99 E. 86th St. | Suite C, Merrillville, IN 46410

Cell: 857-383-9504 **Office:** 773-702-2395 **Fax:** 773-834-1288

spaul@medicine.bsd.uchicago.edu



WOMEN IN DIGESTIVE DISEASES: UPDATES IN 2021

University of Chicago | A Virtual Event

March 13, 2021

WOMEN FACULTY DIRECTORY

UNIVERSITY OF CHICAGO SECTION OF GASTROENTEROLOGY, HEPATOLOGY AND NUTRITION

Anjana A. Pillai, MD

Associate Professor of Medicine

Medical Director, Liver Tumor Program

Medical Director, Living Donor Liver Transplantation

Program Director, Transplant Hepatology Fellowship

Clinical interests: liver cancer, liver transplantation, liver diseasess

Clinic locations:
Hyde Park Campus 5758 S. Maryland Ave., Chicago, IL 60637
Orland Park 14290 S. La Grange Rd., Orland Park, IL 60462

Cell: 786-218-0107 **Office:** 773-834-2302 **Fax:** 773-834-1288
apillai1@medicine.bsd.uchicago.edu

Vijaya Rao, MD

Assistant Professor of Medicine

Associate Program Director, Gastroenterology Fellowship

Director, Student and Resident Rotations

Clinical interests: general gastroenterology, women's health, medical ethics

Clinic locations:
Hyde Park Campus 5758 S. Maryland Ave., Chicago, IL 60637
River East 355 E. Grand Ave., Chicago, IL 60611
Cell: 262-751-3607 **Office:** 773-702-1774 **Fax:** 773-834-4037
vijayarao@medicine.bsd.uchicago.edu

Carol E. Semrad, MD

Professor of Medicine

Director, Small Bowel Disease and Nutrition Program

Clinical interests: celiac disease, malabsorption syndromes, nutrition, small bowel enteroscopy

Clinic locations:
Hyde Park Campus 5758 S. Maryland Ave., Chicago, IL 60637
River East 355 E. Grand Ave., Chicago, IL 60611

Cell: 773-860-6561 **Office:** 733-702-6921 **Fax:** 773-834-5872
csemrad@medicine.bsd.uchicago.edu

Uzma D. Siddiqui, MD

Professor of Medicine
Associate Director, Center for Endoscopic Research and Therapeutics

Director, Endoscopic Ultrasound and Advanced Endoscopy Training Program

Clinical interests: EUS, ERCP, pancreas cancer, cholangiocarcinoma, endoscopic resection

Clinic location:
Hyde Park Campus 5758 S. Maryland Ave., Chicago, IL 60637
Office: 773-702-3329 **Fax:** 773-834-8891
usiddiqui@medicine.bsd.uchicago.edu

Helen S. Te, MD

Professor of Medicine
Medical Director, Adult Liver Transplantation

Clinical interests: liver transplantation, liver diseases, liver cancer

Clinic locations:
Hyde Park Campus 5758 S. Maryland Ave., Chicago, IL 60637
Schererville 222 Indianapolis Blvd, Schererville, IN 46375
Merrillville 99 E. 86th St. | Suite C, Merrillville, IN 46410

Cell: 773-316-4996 **Office:** 773-702-2395 **Fax:** 773-834-1288
hte@medicine.bsd.uchicago.edu

CONFERENCE AGENDA

SATURDAY, MARCH 13, 2021

8:00	**Introductory Remarks** **Vijaya Rao, MD**
	SESSION 1 Moderator: **Sonia Kupfer, MD**
8:10	**Ergonomics for Women in Endoscopy** Katie Garman, MD
8:30	**Tightening the Belt: Surgical Options for GERD** Yalini Vigneswaran, MD
8:50	**Life Goes On: Stomas in Women** Jan Colwell, RN
9:10	**Pancreatic Disorders in Women** Uzma Siddiqui, MD
9:30	**Panel Discussion** Session 1 Faculty
9:50	**BREAK**
	SESSION 2 Moderator: **Carol Semrad, MD**
10:00	**Celiac Disease—Life time perspective** Ritu Verma, MD
10:20	**Disordered Eating** Courtney Schuchmann, RD
10:40	**Medication Adherence in Inflammatory Bowel Disease** Sunanda Kane, MD
11:00	**Immune-Mediated Liver Disease in Women** Sonali Paul, MD
11:20	**Panel Discussion** Session 2 Faculty
11:50 a.m.	**LUNCH BREAK**
	SESSION 3 Moderator: **Anjana Pillai, MD**
12:15 p.m.	**KEYNOTE: Leadership in 2021 and Beyond** Sunanda Kane, MD
	HASHTAGS, HANDLES AND HEALTHCARE: **Social Media for GI Practice, Education & Career Development**
1:00	**Facebook: Ladies of the Gut** Nundhini Thukkani, MD
1:20	**Twitter: @MondayNightIBD and More** Aline Charabaty, MD
1:40	**Panel Discussion** Session 3 Faculty
1:55	**Closing Remarks** **Helen Te, MD**
	ADJOURN

Program agenda and speaker selection subject to change.

Faculty members were identified due to their expertise in topic areas as well as based on their teaching evaluations from their activities at the University of Chicago.

Introductory Remarks

Vijaya Rao, MD

AT THE FOREFRONT UChicago Medicine

Women in Digestive Diseases: Updates in 2021

March 13th, 2021

Women in Medicine & Gastroenterology

- Recent years have seen increased numbers of women in medicine, particularly in medical school matriculation
- Active women gastroenterologists remain a minority (18%)—UCM GI faculty comprised of 38% women
- Percentage of GI fellows is rising (33% in 2009 to 39% in 2019)
- Despite these advances, the COVID-19 pandemic has highlighted systemic assumptions about women that lend to further professional disadvantage

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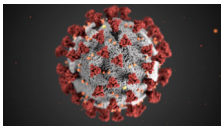
https://www.aamc.org/data-reports/students-residents/interactive-data/report-residents/2019/table-b3-number-active-residents-type-medical-school-gme-specialty-and-sex Accessed on 3/8/21

AAMC 2019 Physician Data and Specialty Report. https://www.aamc.org/data/workforce/reports/492560/1-3-chart.html. Accessed on 3/8/21

How the COVID-19 pandemic exacerbates existing inequities

- Increasing demands at home
- Compensation
- Exaggerating leadership gap
- Physical and mental health



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Journal of Hospital Medicine® Vol 15 | No 8 | August 2020

Women in the media: COVID-19 pandemic

Table 2. Distributions of Physicians and Nonphysicians With PhD Degrees on Major News Media Outlets by Gender

	No./No. total (%)[a]			
	All networks	MSNBC	CNN	Fox
Physicians (MD/DO): COVID-19 content only				
Unique speaker[b]				
Women	12/47 (25.5)	7/23 (30.4)	5/22 (22.7)	0/6 (0)
Men	35/47 (74.5)	16/23 (69.6)	17/22 (77.3)	6/6 (100)
Speaking slots[c]				
Women	17/116 (14.7)	7/33 (21.2)	10/61 (16.4)	0/22 (0)
Men	99/116 (85.3)	26/33 (78.8)	51/61 (83.6)	22/22 (100)
Total speaking time, min				
Women	65.5/423.0 (15.5)	21.5/119.5 (18.0)	44.0/241.0 (18.3)	0/62.5 (0)
Men	357.5/423.0 (84.5)	98.0/119.5 (82.0)	197.0/241.0 (81.7)	62.5/62.5 (100)
Average speaking time, mean (IQR), min				
Women	4.4 (3.0-5.0)	4.3 (4.0-4.5)	4.4 (3.0-5.0)	NA
Men	4.0 (3.0-5.0)	4.9 (4.0-5.75)	4.2 (3.0-5.5)	2.8 (2.5-3.0)
Total	4.1 (3.0-5.0)	4.8 (4.0-5.5)	4.2 (3.0-5.0)	2.8 (2.5-3.0)

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JAMA Internal Medicine January 2021 Volume 181, Number 1

Manuscript submissions by women: COVID-19 pandemic

Table. Manuscripts With Male or Female First, Last, or Corresponding Authorship Submitted to *JAMA Surgery* in April and May of 2019 and 2020[a]

Characteristic	No. (%) 2019	2020	Absolute change, %
Manuscripts, No.	366	702	NA
First author			
Female	119 (33)	205 (29)	−4
Male	247 (67)	494 (70)	3
Last author			
Female	98 (27)	148 (21)	−6
Male	267 (73)	551 (78)	5
Corresponding author			
Female	105 (29)	156 (22)	−7
Male	260 (71)	542 (77)	6

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JAMA Surgery September 2020 Volume 155, Number 9

COVID-19 Pandemic – What Can We Learn?

- Are there institutional changes adopted during COVID-19 that have the potential to reduce systemic barriers historically faced by women?
- What specific aspects of different leadership models lead to effective strategies to advance women?
- How might insights gained about work-life boundaries and mental health inform preparedness for the future and how institutions can support reductions in workload?

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https://www.insidehighered.com/news/2021/03/10/covid-19-moment-women-stem Accessed 3/10/21

Rabinowitz, LG; Rabinowitz, DG,. Women on the Frontline, Academic Medicine: February 16, 2021

Conference Co-Directors

Sonia Kupfer

Sonali Paul

Anjana Pillai

Vijaya Rao

Helen Te

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UCM Women GI Faculty

AT THE FOREFRONT UChicago Medicine

Educational Grant Support

- Abbvie
- Bausch Health
- Gilead
- Janssen
- Boston Scientific
- Medtronic

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Virtual Exhibitors

- Abbvie
- Exact Sciences
- Takeda

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7:30 a.m.	**REGISTRATION AND BREAKFAST**
8:00	**Introductory Remarks** Vijaya Rao, MD
	SESSION 1 Moderator: **Sonia Kupfer, MD**
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2:00 p.m.	**ADJOURN**

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Education Credits

- Physicians: maximum of 5.25 *AMA PRA Category 1 Credits* ™
- Nurses: CNE credits via the Ohio Nurses Association
- Other healthcare professionals: Certification of participation

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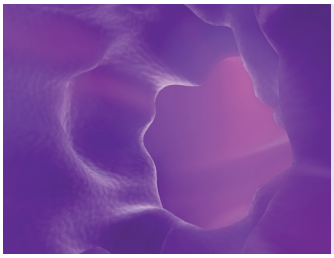
Video credit: Dr. Sharmila Sachithanandan; Women in Gastroenterology Network Asia-Pacific (WIGNAP) & Women in Endoscopy (WIE)



Ergonomics for Women in Endoscopy

Katie Garman, MD

Ergonomics for Women in Endoscopy

KATHERINE (KATIE) S. GARMAN, MD, MHS
DUKE UNIVERSITY
03/13/2021

Disclosures

I have no financial relationships to disclose.

I will not discuss off label use or investigational use in my presentation.

Learning Objectives

What you wished you learned in fellowship about ergonomics and endoscopy…

Goal: Long satisfying career spent serving patients well while preserving physician health and well-being

Challenge: Endoscopy subjects us to strain, overuse and related micro-trauma and injury

What is Ergonomics?

"Ergonomics is a multidisciplinary activity striving to assemble information on people's capacities and capabilities and to use that information in designing jobs, products, workplaces, and equipment."

Evaluates how a job can best be fit to an individual, instead of forcing an individual to fit into a job.

Reduces fatigue by designing tasks within workers' capacities

Ref: Kodak's Ergonomics Design for People at Work. 2004. Eastman Kodak Company

Why Worry About Ergonomic Issues

Scope of the Problem:

Gastroenterologists report high rates of musculoskeletal injury related to endoscopy (37-86%)

Highest rates of injury to neck, left thumb and lower back

Women are at higher risk for wrist and shoulder injuries

2016 AGA Survey – Only 4.5% of respondents reported receiving any training on ergonomics during fellowship

Historical Prevalence?

Study	Year	% Men	Prevalence of Injury
Buschbacher (ASGE)	1994	95% Men	57%
Keate (ASGE) (abstract)	2006	Not reported	78%
Hansel (Mayo)	2007	83% Men	74%
Lee (Australian) (abstract)	2007	84% Men	37%
Ridtitid (ASGE)	2015	84% Men	53%

Ref: Technical Review. Shergill et al. ASGE 2009

2016 AGA Survey – Types of Injury

Injury in Women – 85.8%

Eye Strain – 22.2%
Neck – 37.3%
Upper Back – 16.1%*
Right Shoulder – 18.5%*
Left Shoulder – 17.1%*
Right Elbow – 8.3%
Left Elbow – 6.0%
Lower Back – 34.0%
Right Wrist – 30.6%*
Left Wrist – 18.6%
Right Finger – 15.2%
Left Finger – 13.0%
Right Thumb – 26.2%*
Left Thumb – 32.7%
Feet – 21.1%

Injury in Men – 85.8%

Eye Strain – 21.5%
Neck – 35.5%
Upper Back – 8.7%
Right Shoulder – 12.3%
Left Shoulder – 11.2%
Right Elbow – 13.7%
Left Elbow – 8.7%
Lower Back – 35.0%
Right Wrist – 17.5%
Left Wrist – 15.1%
Right Finger – 12.0%
Left Finger – 12.5%
Right Thumb – 18.7%
Left Thumb – 34.9%
Feet – 15.8%

Ref: Edelman et al. Endoscopy-Related Musculoskeletal Injury in AGA Gastroenterologists in Common While Training in Ergonomics is Rare. Gastroenterology 2017;152:S217.

AGA Survey – Predictors of Injury

Injury since starting endoscopy was associated with:

Any prior injury (p-value 0.0012)
OR 2.5 (95% CI 1.43 – 4.33)

Age (older) (p-value <0.0001)
OR 1.06 (95% CI 1.03 – 1.08)

Number of half-days scoping (p-value 0.0028)
OR 1.5 (95% CI 1.15 – 1.96)

Asked to increase procedure volume (p-value 0.0015)
OR 2.45 (95% CI 1.41 – 4.28)

Ref: Edelman et al. Endoscopy-Related Musculoskeletal Injury in AGA Gastroenterologists in Common While Training in Ergonomics is Rare. Gastroenterology 2017;152:S217.

Be Aware of Risk of Prior Injury

Previous musculoskeletal injury prior to starting a career in endoscopy, is associated with increased risk for pain/injury later.

Example: Fellow with prior hand fracture, wrist or shoulder injury

Consider early consultation with a physical therapist.

Ref: Edelman et al. Endoscopy-Related Musculoskeletal Injury in AGA Gastroenterologists in Common While Training in Ergonomics is Rare. Gastroenterology 2017;152:S217.

Applying Ergonomic Principles to GI Endoscopy

Design of tools (endoscope design)

- **Minimize load**
- **Neutral postures -** Work in position of max strength
- **Appropriate for the 5th percentile female – 95th percentile male**

Design of endoscopy suite

- **Minimize static loads**
- **Neutral postures**
- **Appropriate for the 5th percentile female – 95th percentile male**
- **Rearranging/redesigning workstations**

Minimizing Force During Scope Insertion

Aim to minimize insertion forces – avoid over-reliance on torque such as "tip deflection, pulling back and suction"

Consider resting left hand on patient's hip

Hold the scope in the left hand in a neutral position (lateral)

Ref: Alexander R. Ende et al.. Dig Dis Sci (2018) 63:46–52. PMID 29147876.

Neutral Postures Maximize Force Production

Condition	% Max Grip Strength (bare-handed, 5-cm span, neutral wrist angle)
45 degrees wrist flexion	60
65 degrees wrist flexion	45
45 degrees wrist extension	75
25 degrees of radial deviation	80
40 degrees of ulnar deviation	75
Grip span of 2.5cm	40
Grip span of 11cm	45
Wearing rubber household gloves	81

Maximum grip strength decreases with non-neutral wrist postures

Ref: Kodak's Ergonomics Design for People at Work. 2004. Eastman Kodak Company

Gender, Scope Design, and Musculoskeletal Injury

Some endoscopes were designed for a 95th percentile male hand span for proper use – ideally scopes will be eventually be designed to accommodate even a 5th percentile hand size.

Women experience greater risk of right thumb, right wrist, right shoulder, pain

Consider early PT and PT evaluation could be considered as a preventive measure and certainly if you are experiencing symptoms while we await better scope design

Ref: Edelman et al. Endoscopy-Related Musculoskeletal Injury in AGA Gastroenterologists in Common While Training in Ergonomics is Rare. Gastroenterology 2017;152:S217.

Importance of Rest: Example - EGD

Assuming the force required to handle the endoscope is light or very light:

After maintaining static grasp of the endoscope for 3 min (such as during EGD) → Requires 3 minutes recovery time

7.5 min procedure → Recovery time = 45 minutes

No data to guide rest requirements for estimated force levels and average duration of colonoscopy

Could microbreaks help? Data are lacking on technique.
Opportunity to relax from static positions, increase blood flow, stretch.
Consider shaking out hands and wrists, rolling shoulders, stretching hands and fingers

Ref: Battevvi et al. Med Lav. 2009 May-Jun;100(3):171-7

AGA Survey – Room Design

How common is proper positioning of table and monitor?

89% used adjustable tables all or most of the time
(8% never used adjustable tables)

8% set the table above elbow height
(shoulder, upper back strain)

67% used an adjustable monitor or screen all or more of the time
(6% never had an adjustable monitor or screen)

41% reported having the monitor above eye level

Ref: Edelman et al. Endoscopy-Related Musculoskeletal Injury in AGA Gastroenterologists in Common While Training in Ergonomics is Rare. Gastroenterology 2017;152:S217.

Posture: Examination Table and Monitor Height

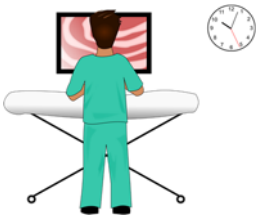
Optimal ergonomic room design associated with lack of injury

Table should be at or below elbow height (0-10 cm below the elbow)

Adjustable bed / table – height should go from 85 to 120 cm

Monitor: Viewing angle of 15 to 25 degrees below the horizon and Adjustable from 93 to 162 cm

Viewing distance of 52 to 182 cm



Ref: O'Sullivan 2002. Can J. Gastroenterology. 16: 369-74.
Shergill et al 2009. Technical Review. Ergonomics and GI Endoscopy. GIE. 70: 145-153
Singla M et al 2018. CGH. 16: 1003-1006. DOI: 10.1016/j.cgh.2018.04.019

Algorithm for Ergonomics Time-Out

Check at the start of each procedure:

Adjust monitor for endoscopist's height with goal of center of monitor at eye level or below and directly positioned in front of the endoscopist.

Adjust bed height so that table is between elbow height and 10cm below elbow height.

Use anti-fatigue floor mats for endoscopist and assisting staff.

When fluoroscopy is used, wear two-piece lead aprons.

During the procedure, strive for neutral stance and avoid contortions.

Refine endoscopic technique to minimize force during scope insertion.

Always use two or more staff to move heavy patients.

Consider micro-breaks between procedures to relieve stress and relax from static and/or strained positions.

Debate: Individual vs Scope Re-Design

According to principles of ergonomics, burden should not be on the individual but rather on environmental and equipment changes.

However, PT may be an important step, particularly for physicians who are suffering from injury now

We wanted to learn more about how PT assessment might be helpful in preventing musculoskeletal injury (all female research team)

Duke Ergonomics PT Pilot Study

Individualized Assessment and Wellness Programs to correct poor postural habits, reduce pain, and improve strength

Assessment of prior injury, baseline posture and dynamic patterns during procedures (tired posture)

Suite set-up evaluated

Each location of subjective pain evaluated for exacerbating movement patterns or loading

Ref: Markwell, SA, Garman KS, Vance IL, Patel A, Teitelman M. An individualized ergonomic wellness approach for the practicing gastroenterologist (with video). GIE 2021. PMID: 3356148

Individual Postural Assessment and Suggestions

Ref: GIE 2021. PMID: 3356148

You are consistently observed increased cervical protraction, upper thoracic flexion, and marked bilateral scapular protraction with frequent elevation/upward rotation. Your hands are often near or at midline. This shifts your center of mass anterior to your body and will likely worsen over time as the ligaments of your spine lengthen and your anterior chest wall tightens. You are not observed to move in the reverse direction. You weight shift often which is very protective!

Recommendations to posture during execution of colonoscopy
Realize this is like training for a marathon. It takes time, repetition, and commitment to make these changes and build your strength. **Commit to focusing on your posture and alignment for 2-5 minutes initially** during your procedures and progress as you are able.

Shift your pelvis while engaging your core to feel weight through arches of feet
Bring your shoulder blades together and down while lightly retracting your chin
Avoid static positioning of your hands
Retract your shoulder blades and keep equipment close to your body
Some procedures require forward leaning; lean back in between
Seek standing documentation stations and raise the monitor at your desk

Duke Ergonomics PT Pilot Study

All participants felt their wellness plan was helpful.

8/8 - Posture education and procedure suite recommendations helpful

87.5% Pictures depicting posture and movement analysis were helpful

50% of the participants found the pain education plan helpful

25% found the personalized wellness exercise instruction helpful

3/8 of the participants asked the physical therapist to return to repeat observation and intervention

Ref: Markwell, SA, Garman KS, Vance IL, Patel A, Teitelman M. An individualized ergonomic wellness approach for the practicing gastroenterologist (with video). GIE 2021. PMID: 3356148

Take Home Points (Empowerment)

Educate yourself, your colleagues and your fellows on best ergonomic practices

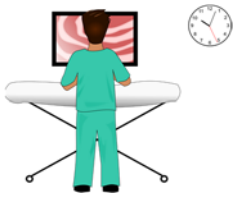
Be aware of risk related to prior injuries

Take an ergonomic time-out

Insist on an adjustable screen and set center at eye level or below and use an adjustable table

Schedule and take microbreaks and increase postural awareness, consider PT evaluation

Advocate for better scope design!



Thank you!

Knowledge Check Question 1

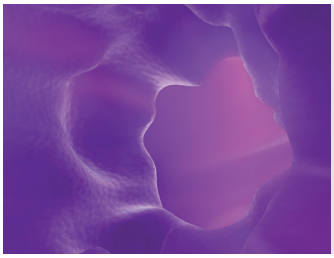
Survey based studies have demonstrated an association of endoscopist injury with the presence of all of the following risk factors except:

A. Any prior injury
B. Older age
C. Higher number of half days scoping
D. Increased procedure volume
E. Scheduled rest breaks

Knowledge Check Question 2

Suggested "Ergonomics Time Out" includes all except:

A. Adjust monitor for endoscopist's height with goal of center of monitor above eye level and to the side.
B. Adjust bed height so that table is between elbow height and 10cm below elbow height.
C. Use anti-fatigue floor mats for endoscopist and assisting staff.
D. When fluoroscopy is used, wear two-piece lead aprons.
E. During the procedure, strive for neutral stance and avoid contortions.



Tightening the Belt: Surgical Options for GERD

Yalini Vigneswaran, MD

Tightening the Belt: Surgical Options for GERD

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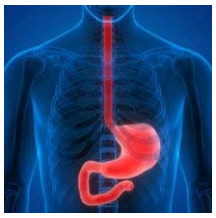

Yalini Vigneswaran, MD MPH
Assistant Professor of Surgery
Advanced GI and Bariatric Surgery

Disclosures

- I am a surgeon

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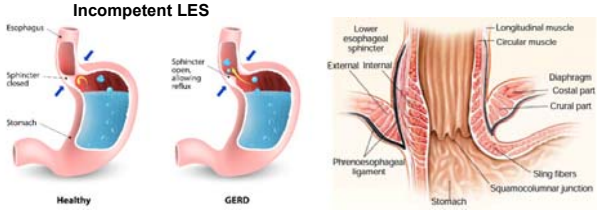
What is gastroesophageal reflux disease?

Incompetent LES



- **Up to 10% American population have daily symptoms**

AT THE FOREFRONT UChicagoMedicine

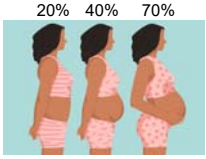
Locke GR 3rd et al. Prevalence and clinical spectrum of gastroesophageal reflux: A population-based study in Olmsted County, Minnesota. *Gastroenterology* 1997 May; 112:1448-56.

GERD in Women

- **Similar incidence of symptoms (heartburn, regurgitation, chest pain, cough)**
- **Women had a higher frequency and increased severity**

BMI >25

20% 40% 70%



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Lin M et al. Features of gastroesophageal reflux disease in women. *Am J Gastroenterol* 2004 Aug; 99:1442-7

Acid suppression has become the treatment for heartburn

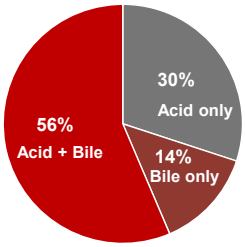
- >60 million prescriptions for treatment GERD
- 48% of all prescriptions for GI diseases
- >50% of the total cost for GI disease
- 60 billion dollars spent in last 5 years

- PPIs were the top 5 most commonly prescribed
- This excludes over the counter medications

What is refluxing?

The Impact of Reflux Composition on Mucosal Injury and Esophageal Function

Daniel S. Oh, M.D., Jeffrey A. Hagen, M.D., Martin Fein, M.D., Cedric G. Bremner, M.D., Christy M. Dunst, M.D., Steven R. DeMeester, M.D., John Lipham, M.D., Tom R. DeMeester, M.D.



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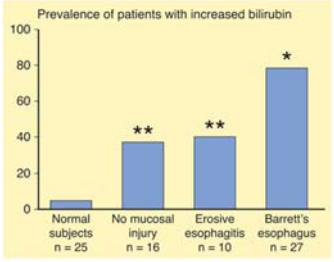
"Atypical" symptoms

Reflux Symptom Index (Measures Atypical Symptoms)
1) Hoarseness or a problem with your voice?
2) Clearing your throat?
3) Excess throat mucus or postnasal drip?
4) Difficulty swallowing food, liquids, or pills?
5) Coughing after you ate or lie down?
6) Breathing difficulties or choking episodes?
7) Troublesome or annoying cough?
8) Sensations of something sticking in your throat or lump in your throat?
9) Heartburn, chest pain, indigestion, or stomach acid coming up?
RSI TOTAL SCORE:

Acid + Bile leads to caustic injury of the esophagus



Source: Brunicardi FC, Andersen DK, Billiar TR, Dunn DL, Hunter JG, Matthews JB, Pollock RE: *Schwartz's Principles of Surgery, 9th Edition:* http://www.accessmedicine.com

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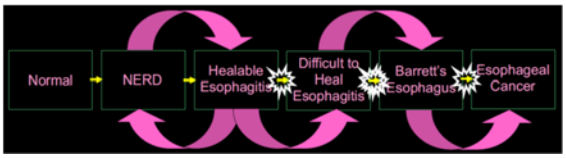
Progression of disease on PPI therapy



After 5 years: 12% of patients progress to Difficult to Heal Esophagitis.
10% of patients progress to Barrett's esophagus.

After 20 years: 43% of patients progress to Difficult to Heal Esophagitis.
28% of patients progress to Barrett's esophagus.

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P. Malfertheiner et al. Aliment Pharmacol Ther 2012; 35: 154-164
D. Falkenback et al. Scan J Gastroenterol 2009; 44: 1277-1287

9

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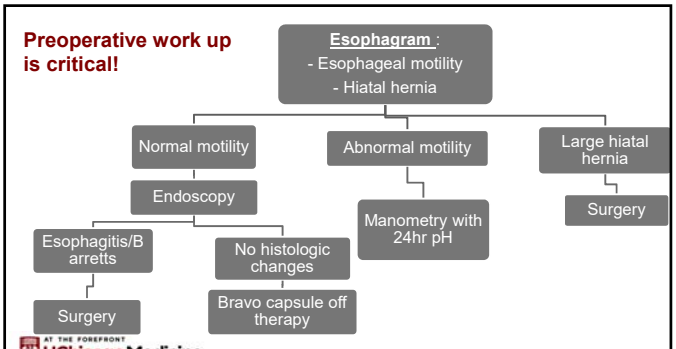
10

Preoperative work up is critical!



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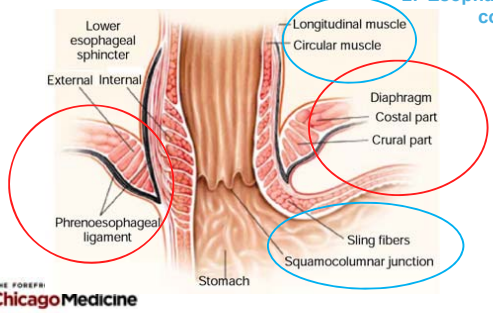
Competency of the LES

1. Crural component
2. Esophagogastric component



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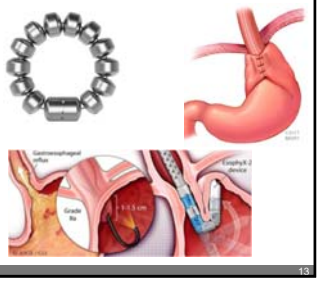
Restoring LES competency: Anti-reflux Procedures

1. Hiatal hernia repair is necessary for ALL anti-reflux procedures

2. Reconstructing the valve

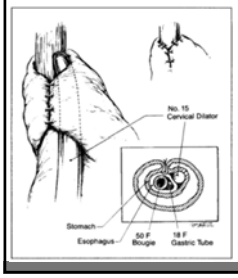


The Floppy Nissen Fundoplication

Arch Surg—Vol 120, June 1985

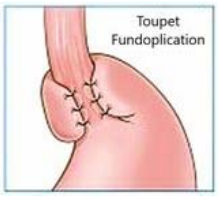
Effective Long-term Control of Pathologic Reflux

Philip E. Donahue, MD; Scott Samelson, MD; Lloyd M. Nyhus, MD; C. Thomas Bombeck, MD



360 Degree Wrap
Associated with:
- Bloating
- Gas/Bloat
- Flatulence

Partial Fundoplication
Toupet



REVIEW ARTICLE

Assessing the efficacy and safety of laparoscopic antireflux procedures for the management of gastroesophageal reflux disease: a systematic review with network meta-analysis

Alexandros Andrew[1] · David I. Watson[2] · Dimitrios Mavridis[3,4] · Nader K. Francis[5] · Stavros A. Antoniou[6,7,8]

29 RCT: 1,892 patients
- **Nissen vs partial fundoplication**
- **Equal efficacy**
- **Similar morbidity**
- **Less dysphagia**
- **Less gas/bloat**

Flatulence After Anti-reflux Treatment (FAART) Study

A. J. Cockbain[1] · R. Parameswaran[2] · D. I. Watson[2] · T. Bright[2] · S. K. Thompson[3]

N=265, 11 year median follow up

3xs more flatulence with nissen vs partial

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Magnetic Sphincter Augmentation- LINX Device

Absolute contraindications:
- **Patients requiring MRI >1.5T**
- **Allergies to nickel, stainless steel, titanium or ferrous materials**

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GIE

ORIGINAL ARTICLE

Laparoscopic magnetic sphincter augmentation versus double-dose proton pump inhibitors for management of moderate-to-severe regurgitation in GERD: a randomized controlled trial

RCT: LINX- N 50, BID PPI- N 100

- **> 50% improvement GERD HRQL**
  - 8% BID PPI group
  - 81% LINX group
- **pH normalization**
  - 58% BID PPI group
  - 91% LINX group

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Reg Bell, et al. GIE August, 2018

17

SCIENTIFIC REPORTS

OPEN Six to 12-year outcomes of magnetic sphincter augmentation for gastroesophageal reflux disease

N= 124

Mean follow up 9 years:

- **79% off ALL PPIs**
- **pH normalization >90% patients**

Risks

- **2.4 % removal after 9 years**
- **0 erosions or migrations**

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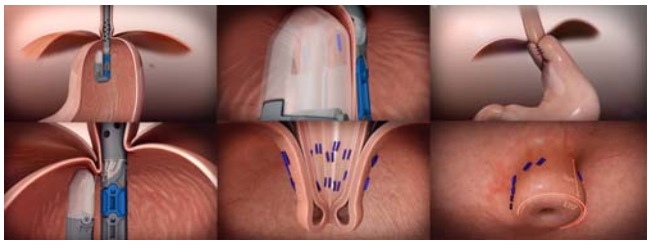
Ferrari, Bonavina Scientific Reports, August 2020

18

Combined TIF with hiatal hernia repair



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Transoral fundoplication offers durable symptom control for chronic GERD: 3-year report from the TEMPO randomized trial with a crossover arm

ORIGINAL SCIENTIFIC ARTICLE

Novel Interdisciplinary Approach to GERD: Concomitant Laparoscopic Hiatal Hernia Repair with Transoral Incisionless Fundoplication

SCIENTIFIC PAPER JSLS

pH Scores in Hiatal Repair with Transoral Incisionless Fundoplication

- **TIF is a partial fundoplication**
- **Only TIF: 40% pH normalization**
- **HH repair + TIF: 90% pH normalization**

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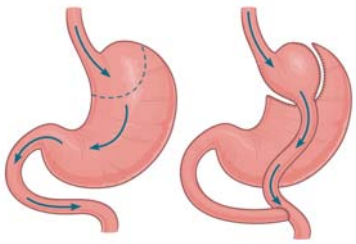
Gastric Bypass

- **Treatment for GERD:**
  1. Weight loss
  2. Divert acid, bile and volume
- **BMI >35**
- **BMI 30-35 controversial**



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Perioperative/ Postoperative protocol

Who should be offered for surgical consultation?

Any patient that wants to stop PPI use

Significant failure of LES

- **Hiatal hernia >3cm**
- **Esophagitis**
- **Regurgitation**
- **Barrett's**

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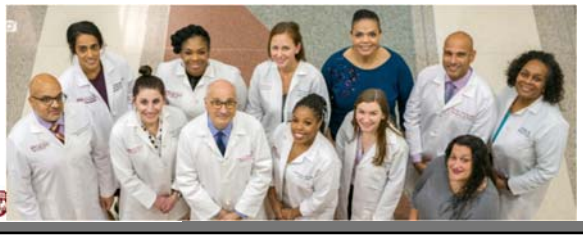

The NEW ENGLAND JOURNAL of MEDICINE

OCTOBER 17, 2019

Randomized Trial of Medical versus Surgical Treatment for Refractory Heartburn

78 With reflux-related, PPI-refractory heartburn underwent randomization (MII-pH monitoring during PPI treatment showed abnormal acid reflux, SAP >95%, or both)

(<50% improvement in total GERD-HRQL score and score ≥2 for ≥1 heartburn question)

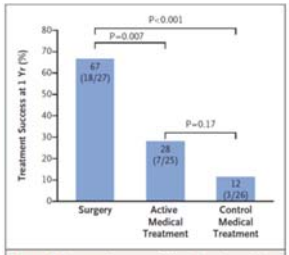

Figure 3. Treatment Success at 1 Year (Intention-to-Treat Analyses).

Treatment success was defined as an improvement (decrease) of 50% or more in the GERD-HRQL score from baseline.

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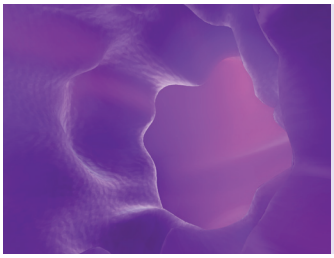

Life Goes On: Stomas in Women

Jan Colwell, RN

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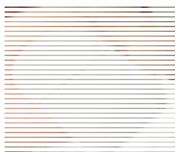
Life Goes On: Stomas in Women

Janice C. Colwell, APRN, CWOCN, FAAN
General Surgery

Background

- **Stoma is a <u>treatment</u>**
- **The treatment for a disease**
- **Etiology:**
  - Ulcerative colitis
  - Crohn's disease
  - Rectal/Colon/Bladder Cancer
  - Diverticular disease
  - Gyn/onc cancers
- **Permanent/Temporary**
- **Stomas are incontinent**
  - Ileostomy, colostomy, urostomy
- **Stomas are managed with a pouching system (in place at all times)**



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Disclosure Information

I have the following financial relationships to disclose:

- Consultant for: Speaker's Bureau for: Hollister, Coloplast and ConvaTec
- Grant/Research support from: Stealth Belt, Ostoform

I will not discuss off label use or investigational use in my presentation

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Goal

- **Consistent wear time**
  - No leakage
- **Maintain peristomal skin integrity**
- **Assist in adaptation**
  - Return to activities
    - Employment
    - Family/Friends
    - Sexuality
    - Athletics
    - Travel

<u>Control</u>

- **What we know**
  - Self efficacy positively correlated with self esteem [1]
  - Early support improves acceptance
  - Regaining control improves QOL [2]

[1] Nasiriziba F, Saati M, Hagani, S. Correlation between self-efficacy and self-esteem in patients with an intestinal stoma. British Journal of Nursing, 2020

[2] Nichols, T.R. Quality of life in persons living with an ostomy assessed using the SF36v2-Mental component summary: Vitality, social function, role-emotional, and mental health. Journal of Wound, Ostomy and Continence Nursing, 2016.

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Adjustment Issues: Fears[1-2]

- **Noise**
- **Smell**
- **Concealment**
- **Intimacy**
  - Pregnancy
- **Return to Activities**
  - Travel
  - Place in family
  - Employment
  - Swimming
  - Diet

[1] Gautam S, Poudel A. Effect of gender on psychosocial adjustment of colorectal survivors with ostomy. J Gastrointest Oncol, 2016

[2] Pittman, J., Rawl, S. M., et al. Demographic and clinical factors related to ostomy complications and quality of life in veterans with an ostomy. Journal of Wound, Ostomy and Continence Nursing, 2008.

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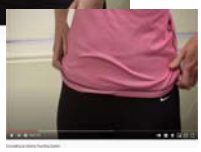
Concealment



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Other Clothing Options

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Retrieved from: https://www.wikihow.com/Dress-with-an-Ostomy

Intimacy Issues Considerations

- **Disclosure**
- **Intercourse issues**
  - Anatomical
    - Narrowing of the vagina (rectal removal, radiation)
    - Positioning may be important
    - Vagina may be dry-lubrication
  - Concealment
  - Security

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Intimacy

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Disclosure: How to Discuss with Young Children

Just do it!

Minimal info

No sensation (i.e., a hug won't hurt)

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Main Stream

aerie

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Pregnancy

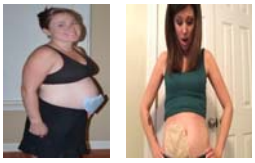
Pelvic surgery may have a slight reduction in fertility/decreased % with laparoscopic surgery

J Pouch: slightly decrease in fertility

Endometriosis association to IBD

Chemotherapy can affect fertility

Avoid C section in patient with pelvic surgery (adhesions)



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Pregnancy Considerations

The stoma enlarges with the abdomen
- Larger size in pouch

Bowel obstructions can occur
- Warning (decompression)

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What Can't a Women with a Stoma Do?

Nothing!

Swimming
Sports
Travel

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Patient Resource

United Ostomy Association

Ostomy.org

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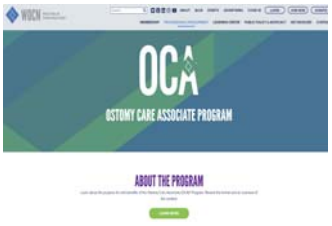
Clinician Resource

Wound Ostomy and Continence Nurse Society

Educational opportunities:
Ostomy Care Associate Program

OCAProgram@uchospitals.edu

https://cme.uchicago.edu/OCAProgram2020



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Conclusion

Stoma Clinic: resource

janice.colwell@uchospitals.edu

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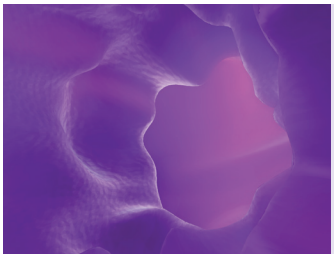


Pancreatic Disorders in Women

Uzma Siddiqui, MD

PANCREATICOBILIARY DISEASES IN WOMEN: CYSTS AND STONES

Uzma D. Siddiqui, MD
Associate Professor of Medicine
Associate Director, Center for Endoscopic Research and Therapeutics (CERT)
Director, Advanced Endoscopy Training

Disclosure

- Consultant and Speaker for: Boston Scientific, Medtronic, Olympus, ConMed
- Speaker for: Ovesco, Pinnacle Biologics

Outline

- Pancreatic cysts
  - Most common types → which ones more common in women
  - Risk for malignancy
- Gallstones
  - Risk factors
  - Associated complications

CASE

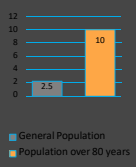
60 yo female with vague abdominal pain

NOW WHAT?

Clinical Dilemma of Pancreatic Cysts

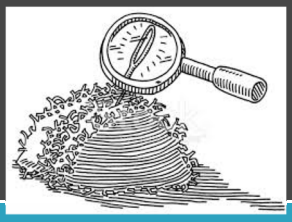
Facing the Epidemic of Pancreatic Cysts

Pancreatic cysts are increasingly found [1]

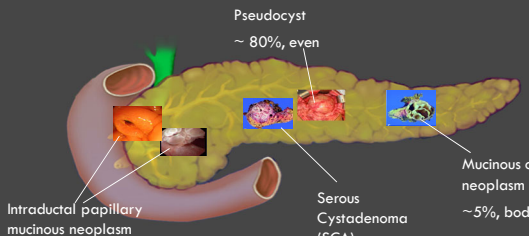


1. Gardner TB, et al., AJG, 2014
2. ACS Cancer Facts and Figures 2014

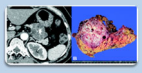
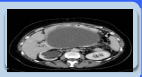
HOW DO WE IDENTIFY CYSTS WITH MALIGNANT POTENTIAL?



Most Common Cystic Lesions



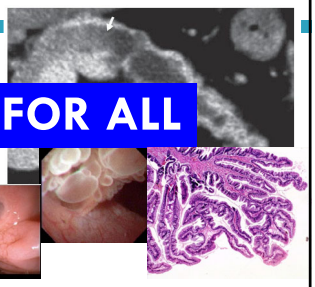
GOAL: Differentiate Types of Cysts

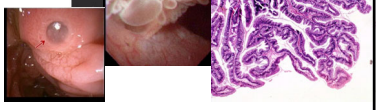
Malignant Potential		Benign	
			
Intraductal papillary mucinous neoplasm (IPMN) • Main duct • Side branch duct	Mucinous cystic neoplasm (MCN)	Serous cystadenoma (SCA)	Pseudocysts
Mucinous		Non-Mucinous	
Monitoring or Resection		No monitoring	

Main duct IPMN (Md-IPMN)

- M=F, >60yo
- Minority of all IPMNs (25%)
- Symptoms- Up to 2/3
- Location- Head
- Imaging
  - PD dilation >10m
  - "Fish mouth" ampulla
- Cytology- Mucin producing columnar epithelium
- Malignant potential
  - Most dysplastic (>80%)
  - Cancer 57-92%
  - High rate of progression

SURGERY FOR ALL





Tanaka et al., Pancreatology 2006 Belyaev et al., J Clin Gastroenterol 2008

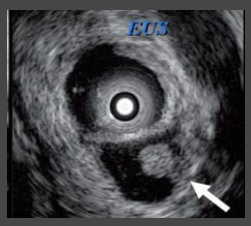
Side Branch Duct IPMN (Sb-IPMN)

- M=F, >60yo
- Majority of IPMNs (75%)
- Most asymptomatic
- Locatio
  anywhe
- Imaging
  - Norm
  - Can
- Malign
  - Slow growth
  - Annual incidence of cancer <2%

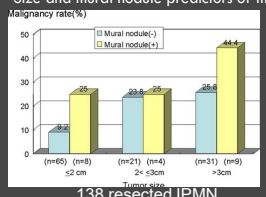
SURGERY FOR SOME

Pancreatology 2012 Belyaev et al., J Clin Gastroenterol 2008 Ringold, et al., Gastrointest Endosc 2009

EUS Predictors of Malignancy in Sb-IPMN



Size and mural nodule predictors of malignancy



138 resected IPMN

Tanaka et al., Pancreatology 2006 Jang et al., Korean J Gastro 2008

Mucinous cystic neoplasm (MCN)

- Female (95%), >40yo
- Most asymptomatic
- Location- Body/tail
- Imaging
  - Multilocular, macrocy
  - Solitary
  - No PD communicatio
- Cytology- Ovarian-type stroma
- Malignant Potential
  - 6-36% incidence of cancer

SURGERY

Oh et al, AJG 2008 Tanaka et al., Pancreatology 2006

Serous Cystadenoma (SCA)

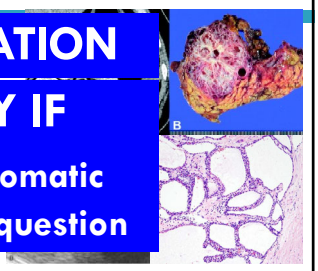
- Female >50%
- Symptoms if
- Location- Any
- Imaging
  - "Honey Comb" or
  - Central scar
  - Macrocystic/oligoc
- Cytology- Glycoge
- Malignant potentia
  - Low/none

OBSERVATION

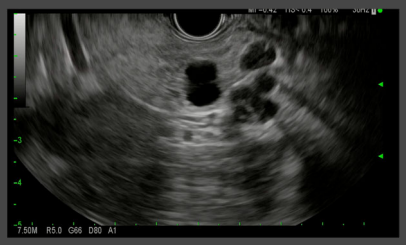
SURGERY IF

-Symptomatic

-Dx in question



Video: EUS of Serous Cystadenoma



VIDEO: EUS of Solid Pseudopapillary Neoplasm

- Young Females (20-40's)
- Rare (1% of panc neoplasms)
- Body/tail
- Tx SURGERY
- 5 year survival >95%

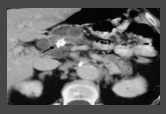
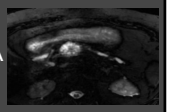
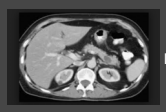
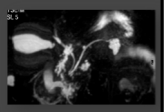
MAKING THE DIAGNOSIS

Tools

- Patient demographics and history
  - Age, gender, Hx of pancreatitis, incidental finding
- Cyst characteristics (location, size, morphology)
  - CT
  - MRI
  - Endoscopic Ultrasound (EUS)
    - Fine Needle Aspiration (FNA)

Diagnosis: CT and MRI

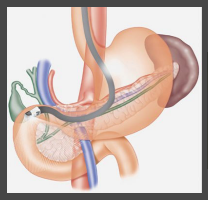
- CT and MRI
  - 40-60% accurate for predicting correct histologic diagnosis
- MRI preferred
  - Identify connection w/ pancreatic duct (PD)
  - No ionizing radiation
  - MRCP no iv contrast


SCA


IPMN


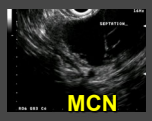
Sainani et al, Am J Roent 2009 Visser et al, Am J Roent 2007 Ogawa et al, Radiology 2008 Brenner et al, NEJM 2007

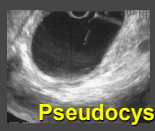
Diagnosis: EUS

- EUS advantages
  - Number and location of cysts
  - Presence and type of septations
  - Worrisome features of malignancy
    - Mural nodules
    - Associated mass
  - Fine needle aspiration (FNA)
    - Solid nodules
    - Cyst fluid
      - CEA, amylase, cytology

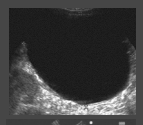


What type of cyst is it?

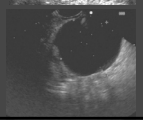




IPMN



SCA

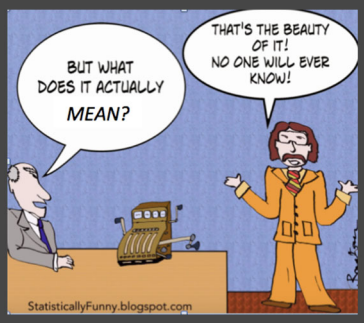


Pseudocyst

CYST GUIDELINES

Agreement Level Among Guidelines

	ACG 2018	Fukuoka 2017	AGA 2015
HIGH RISK FEATURES:			
PD dilation >5 +/- change in duct caliber	X	X	X
Solid component/nodule/mass	X	X	X
+Cytology	X	X	X
Size >3cm	X	X	X
Cyst with increased growth >3-5mm/1-2 years	X	X	
PREFERRED SURVEILLANCE TOOL:			
<1cm	MRI	CT/MRI	MRI
1-2cm	MRI	CT/MRI	MRI
2-3cm	MRI/EUS	EUS	MRI
>3cm and/or any HIGH RISK features	EUS/MRI	EUS/MRI	EUS/MRI
SURVEILLANCE CESSATION	X *if SCA		X *if stable for 5 years



Approach to Pancreatic Cysts

- Talk to your patient
  - Not surgical candidate→ Why survey at all?
  - Small cysts <1cm do not need EUS
- Interpret guidelines in context of each patient
- Sb-IPMNs most common incidental finding
  - Over-surveillance→ $$$, anxiety
- Cysts with any worrisome features or rapidly enlarging
  - ALWAYS discuss with a pancreatic surgeon

"Still, let's do an x-ray just to be sure."

Clinical Relevance of the Increasing Incidence of IPMN

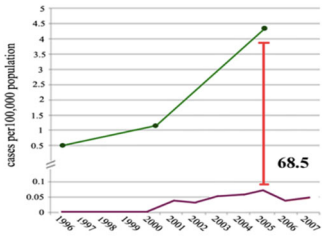


Figure 3.
Comparison of the incidence rate of total IPMN (Green) versus IPMN-related carcinoma (Violet) per 100,000 persons at risk between the years 2000 and 2005

Klibansky D, et al. Clin Gastroenterol and Hepatol. 2012

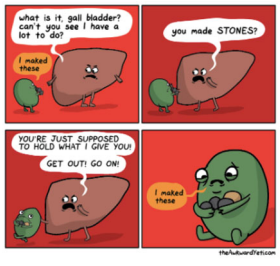
CASE

- 56yo female admitted with severe epigastric pain radiating to her back and nausea/vomiting
- Serum lipase elevated
- ABD US shows gallstones

Dx: GALLSTONE PANCREATITIS

Gallstones

- Occur in 10% US Population
- Gallbladder = bile reservoir
- Gallstones develop if bile altered
  - Too much cholesterol
  - Too much bilirubin
  - Not enough bile salts
  - Decreased gallbladder motility



Risk Factors for Gallstones

- Female
- Age (> 40)
- Pregnancy
- Obesity
- Rapid weight loss
- Prolonged fasting/TPN
- Crohn's
- Sickle cell
- Cirrhosis
- Dyslipidemia
- Family history

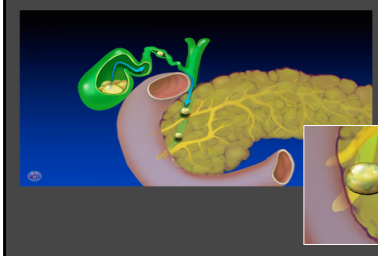
Complications of Gallstone Disease

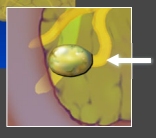
MAJORITY ARE ASYMPTOMATIC

- Biliary colic
- Cholecystitis
- CBD stones
  - Jaundice
  - Cholangitis
  - Pancreatitis
- Gallstone ileus

Gallstone Pancreatitis

3-7% of all pts with gallstones will have associated pancreatitis



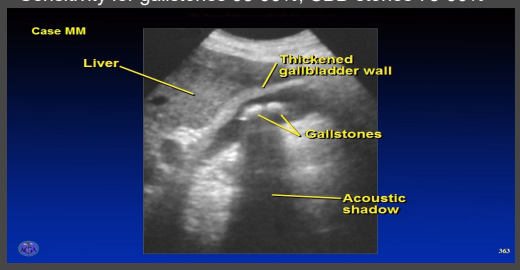


Stone obstructing both CBD and PD

MAKING THE DIAGNOSIS

ABDOMINAL US: Gallstones

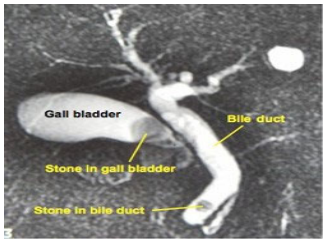
Sensitivity for gallstones 95-99%, CBD stones 75-90%



However, if abnormal LFT's then consider further bile duct imaging.

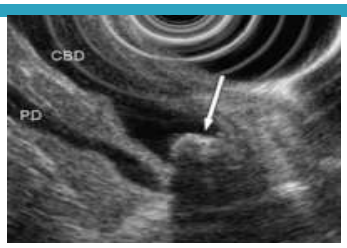
MRCP

- No iv contrast
- Highly sens/spec for CBD stone detection 90-97%
- No therapeutic potential, sensitive to motion artifact

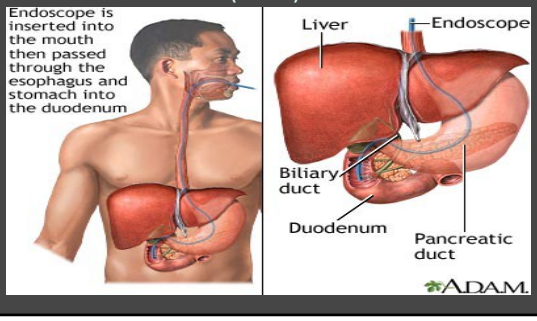


Endoscopic Ultrasound (EUS)

- Requires sedating patient
- Operator dependent
- Similarly high sens 88-97% and spec 96-100% for CBD stones compared to MRCP or ERCP
- No therapeutic potential

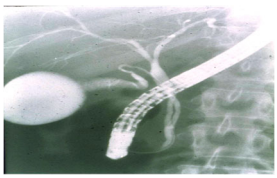


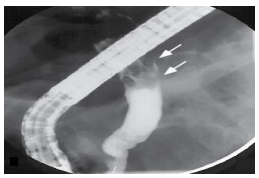
Endoscopic Retrograde CholangioPancreatography (ERCP)



ERCP Images

- Normal cholangiogram
- CBD stones





NOT A DIAGNOSTIC TEST!!!
~10% risk of causing pancreatitis

MANAGEMENT

Management

- Gallbladder
  - Cholecystectomy
  - Percutaneous cholecystostomy drain
  - ERCP with cystic duct stent
  - EUS-guided gallbladder drainage
- Bile Duct
  - ERCP
  - Percutaneous biliary drain
  - Surgical bile duct exploration

Timing of Cholecystectomy

- Elective if recurrent biliary colic
- Urgent if cholecystitis
- Timing after acute gallstone pancreatitis varies
  - Early in mild biliary pancreatitis (during index admission) to prevent recurrent biliary events
  - Later in severe pancreatitis to allow for resolution of inflammatory changes and any associated complications

van Baal MC, et al, Ann Surg 2012

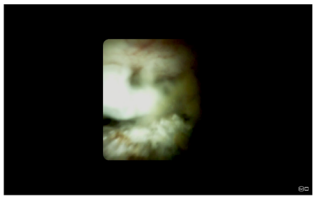
Endoscopic Therapy

"Urgent" ERCP in Acute Gallstone Pancreatitis

- Within 72 hours
  - Acute cholangitis
  - Persistent/worsening biliary obstruction (rising Dbili)
- ERCP is safe/effective either before, during, or after cholecystectomy

Ayub K, et al., Cochrane Database Syst Rev 2004

ERCP with CBD Stone Removal



Gallstones in Pregnancy

- Weight gain and hormonal changes predispose to gallstone formation
- Gallstones (3-10%) and biliary sludge (up to 30%)
- Choledocholithiasis in pregnancy is infrequent (1/1200)
  - ABD US and MRCP safe imaging modalities
- ERCP and cholecystectomy can be performed safely throughout pregnancy
  - 2nd trimester or after delivery

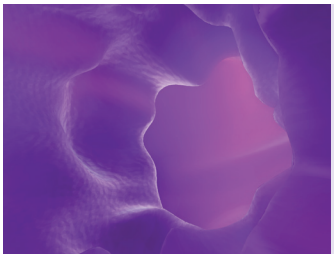
Ko CW, et al,Hepatology 2005 Oto A, et al, Br J Rad 2009

ASGE Guidelines for Endoscopy in Pregnant Patients, GIE 2012

Conclusion

- Certain pancreatic cystic lesions more common in women
  - Serous cystadenomas
  - Mucinous cystic neoplams
  - Solid pseudopapillary neoplasms
- Gallstone disease more common in women
  - Especially after age 40, if obese, or pregnant
  - Diagnostic imaging: ABD US, MRCP, EUS
  - ERCP only for therapeutic removal of CBD stones

Women In Endoscopy



Celiac Disease—Life time perspective

Ritu Verma, MD

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Comer Children's

Celiac Disease

Ritu Verma, MD

Section Chief, Gastroenterology, Hepatology, and Nutrition
Medical Director, University of Chicago Celiac Center

I have no financial relationships to disclose.

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Objectives

- Diagnostics
  - who/what/when to test?
- Disease Course
  - manifestations
  - co-morbid/associated disease
- Treatment
  - Diet
- Life stages
  - Infancy/Childhood
  - Adolescence

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Patient

- **CC:** Celiac Disease
- **HPI: 34** yo woman w/3 week old ,12 year old daughter and Mother
  - no GI symptoms
  - spontaneous conception
  - pregnancy- monitored for low fetal weight
  - spontaneous vaginal delivery
  - currently breastfeeding
- **PMH:** Celiac disease
  - dx age 20
  - presented with anemia
  - improved with Fe suppl and GFD

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Patient Cont…

- **Meds/Allergies:** Prenatal MVI
- **Family/Social Hx:** negative
  - relatives not tested
  - engaged, no tobacco, ETOH or drugs
- **ROS:** negative
- **Exam:** Height 5'1" Weight 185 lbs BMI 35 kg/m^2 Otherwise unremarkable

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20 minutes to address…….

- Is the baby going to be ok?
- When should the baby be tested?
- Should the baby stay gluten free once weaned?
- Is the baby missing anything with breastfeeding?
- Is my baby low birth weight because of celiac disease?
- How should I monitor my 13 year old?
- Should my Mom be tested?
- What blood tests should her doctor order?

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Baby Feeding Practice and Risk

- **Timing of introduction** of gluten (4 months v 6 months, 6 months v 12 months) had **no effect** on the risk of developing celiac disease at 3 years and 5 years.
- **Duration of breastfeeding** or continuation of breastfeeding at the time of gluten introduction had **no influence** on celiac disease risk at 3 years and 5 years.
- The **type** of gluten (solid food vs cereal in formula) does not affect celiac disease risk.

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Baby Feeding Practice and Risk.

- **Maternal diet** during pregnancy and lactation does not appear to affect risk of development of celiac disease.
- **Amount of gluten** in the first 5 years of life has been associated with increased risk in high risk families.
- Altered microbiome may be a trigger.
- Early life infections could be a trigger.

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Final feeding recommendations for baby?

Feeding – Nurse for as long as the mom can

Gradual Introduction of gluten around 6 months of age.

Blood work ?

- No Serology at this time – Why? No gluten in diet. Ideally should do serology between 2-3 years of age for the first time unless symptomatic prior to this. Need yearly serology ,till puberty ,as part of family screen so long as eating adequate gluten .
- Genetic Testing

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Celiac Disease Autoimmunity

The prevalence of autoimmune disorders in Celiac Disease is related to the duration of gluten exposure.

- Diagnosis before 2 years of age: **5%**
- Age 2-10 years: **17%**
- Greater than age 10 years: **24%**

Ventura et al, Gastro 1999; *Not , Diabetologia* 2001

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HLA-DQ association with CD

- DQ2 or DQ8 antigens are prerequisites for Celiac Disease
  - More than 90% of patients with CD have the DQ2
  - 8-10% of patients with CD have the DQ8
- **Not Diagnostic**: Just because you have DQ2 or DQ8 does not mean you have or will have CD.
- 40% of the population is DQ2+
- DQ typing can be used for its Negative Predictive Value.
- **If a pt is Negative for DQ2 or DQ8 it is highly unlikely that they have or will develop CD**.

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Risk Factor

- DQ2 homozygosity
  - 10% higher risk of early development of Celiac Disease in affected families
  - More often seen in girls
  - Early diagnosis -may be diagnosed before age of 3 yrs.

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What about the sibling?

- No Obvious GI or Non GI symptoms
- Growth – Height and weight 50th centile.
- He is on a regular diet.
- Has never had any screening labs.
- Large cohort study has shown that more than half of screen detected patients with celiac disease had unrecognized symptoms at diagnosis. The severity of histologic damage , antibody levels, dietary adherence and response to treatment in screen detected cases was comparable with those detected on a clinical basis

Why is it Important?

- If untreated, it poses long-term adverse health consequences including:
  - **Malabsorption**
  - Anemia
  - **Poor growth**
  - Osteopenia
  - Neurological complications
  - **Increased risk of autoimmune conditions**
  - Intestinal lymphoma

Screening Laboratory Blood Tests

- Tissue Transglutaminase (TTG) IgA
  - Cheapest and most accurate
    - 90-98% sensitivity
    - 94-97% specificity
- Deamidated Gliadin Peptide (DGP) IgG
  - Especially good for children <3 yo
    - Sensitivity of 91%
    - Specificity 98%
- Endomysial (EMA) IgA
  - More expensive & requires expert labs as can be subjective
    - 85-98% sensitivity
    - 97-100% specificity
- Antigliadin (AGA) IgA and IgG
  - Inferior accuracy & no longer recommended
    - 69-85% sensitivity
    - 73-90% specificity

https://pixabay.com/vectors/blood-sample-tube-container-32548/

Celiac Disease

- Auto-immune condition with a prevalence around 1% and growing
- Occurs in genetically susceptible individuals
- A unique autoimmune disorder because…
  - Environmental trigger (gluten) and the autoantigen (tissue-transglutaminase) are known
  - Elimination of the environmental trigger leads to an almost complete resolution of the disease
  - Permanent sensitivity to gluten

Celiac Disease

- 1 in 100 children to 1 in 80 children
- Females affected more than males
- Affects all age groups .
- Risk of Celiac disease
  - Siblings –rate of up to 5-20%
  - First Degree relatives 10%
- Seen in any Ethnic background.

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Clinical Aspects

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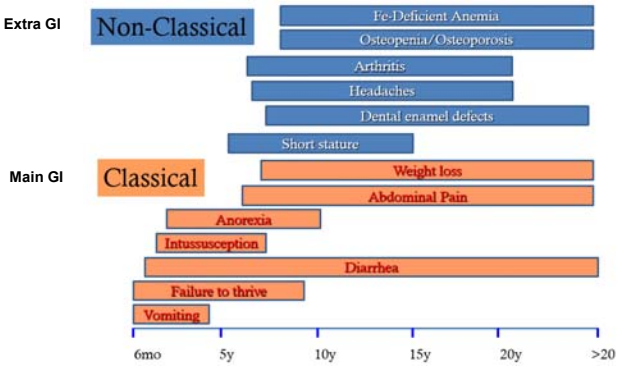
Manifestations



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Short Stature/Delayed Puberty

- Short stature in children / teens:
  - ~10% of short children and teens have evidence of celiac disease
- Delayed menarche:
  - Higher prevalence in teens with untreated Celiac Disease

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Bone Disease in Celiac Disease

- Arthritis
- Osteoporosis
- Osteopenia
- Osteomalacia
- Rickets

Neurological

- Headaches
- Peripheral Neuropathy-up to 25% of patients.
- Ataxia
- Seizures –Prevalence 4-8 %.
- Dementia
- Head MRI changes-Brain white matter different-Cognitive deficit.

Gluten Ataxia

- Prevalence -15% -40%
- <10% have GI symptoms.
- 1/3 rd have Biopsy changes.
- May have antigliadin antibodies elevated
- Elevated TG 6
- Brain Imaging –MRI –Atrophy of cerebellum
- MR Spectroscopy –abnormal indices
- Voxel based morphometry –significant grey matter loss in patients with CD
- Disability for a long time

Neurological Issues and Celiac Disease

- Maybe malabsorption of
  - Folate , Vitamin B6 ,Iron ,Magnesium,Vitamin C
- Tryptophan malabsorption and therefore less serotonin
- Could be direct Gluten sensitivity to the Nervous System .
- More research needed
- Symptoms improve once you withdraw Gluten and supplement with vitamins

Behavioral Issues and Celiac Disease

- Learning Disabilities
- ADHD
- Anxiety
- Depression
- Schizophrenia
- Autism- the gluten connection?

Dermatitis Herpetiformis

- Erythematous macule > urticarial papule > tense vesicles
- Severe pruritus
- Symmetric distribution
- 90% no GI symptoms
- 75% villous atrophy
- Gluten sensitive

Garioch JJ, et al. *Br J Dermatol*. 1994;131:822-6.
Fry L. *Baillieres Clin Gastroenterol*. 1995;9:371-93.
Reunala T, et al. *Br J Dermatol*. 1997;136-315-8.

Celiac Disease and GI comorbidity

- GERD
- Microscopic Colitis
- Pancreatic Insufficiency
- IBS
- IBD
- Liver Disease
  - "Celiac hepatitis"
  - AIH, PBC, Autoimmune cholangiopathy

Clin Gastroenterol Hepatol. 2011 Mar;9(3):214-9.
Clin Gastroenterol Hepatol. 2013 Apr;11(4):359-65.
Dig Liver Dis. 2016 Feb;48(2):112-9.
Dig Liver Dis. 2016 May;48(5):499-505.

Who Should Be Tested?

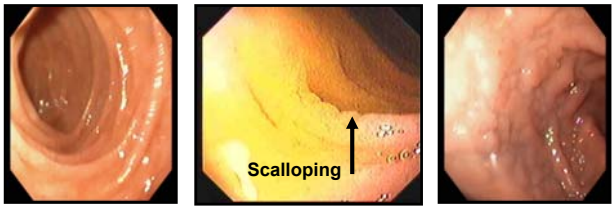
Everyone!

- Relatives
- Patients with short stature, anemia, fatigue, hypertransaminasemia
- Associated diseases
  - autoimmune disorders, Down's, IgA deficiency, neuropathies, osteoporosis, infertility

Diagnosis

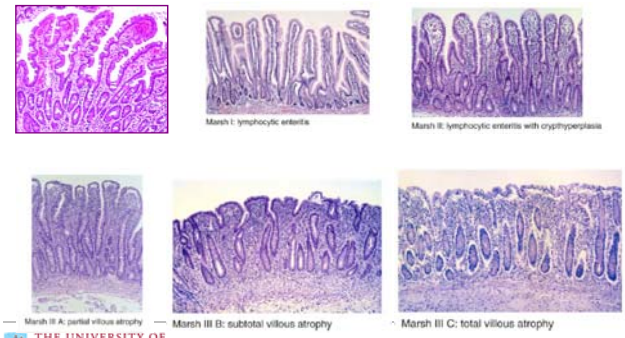
Role of Endoscopy

- To obtain a small intestinal biopsy for histologic analysis to establish the diagnosis of celiac
  - Multiple bulb and distal
- Gold standard
- Drug Trials
- More compliance?
- Re-biopsy to look for healing?

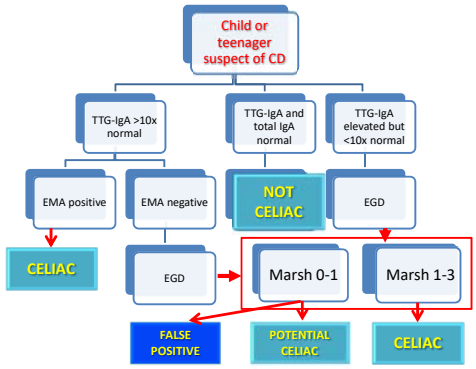


Normal Appearing **Scalloping** **Nodularity**

Marsh Grade



Simplified ESPGHAN-like diagnostic scheme



Treatment

It's a **lifelong commitment**, not just adhering to the gluten-free diet but avoiding cross-contamination as well

- Even just 50mg of gluten daily can cause mucosal damage.

- Obvious sources:
  - Bread
  - Bagels
  - Cakes
  - Cereal
  - Cookies
  - Pasta / noodles
  - Pastries / pies
  - Rolls
- Not-so obvious sources:
  - Candy
  - Communion wafers
  - Cured Pork Products
  - Drink mixes
  - Gravy
  - Imitation meat / seafood
  - Sauce
  - Self-basting turkeys
  - Soy sauce

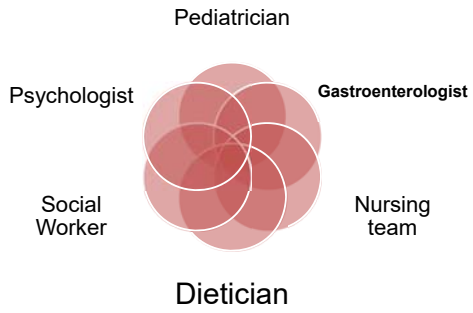
Treatment

Gluten-free diet

- no wheat, rye, and barley
- OK: **rice, corn**, millet, **potato**, buckwheat, and soybeans
- other gluten free foods:
  - fresh fish, meats, milk, cheese, fruits and veggies

Ann Med. 2013 Dec;45(8):522-31

Celiac disease- Follow up



Why Should I Follow-Up?

- Monitor Complications of Celiac disease.
- Monitor Complications of the Gluten Free Diet.
- Provide Developmentally appropriate guidance about disease and diet.
- Education directed towards Patient, Families and Providers.

Celiac Disease Follow-Up Appointment

- **Timing and Frequency**
  - No firm guidelines
- **Growth Parameter Check**
  - Height and weight trend before and after diagnosis
- **Symptom Check (GI/Non GI)**
  - Pre and post diagnosis symptoms
  - Abdominal pain
  - Constipation
  - Headaches
  - Etc.

Celiac Disease Follow-Up Appointment Continued…

- **Social History**
  - School
  - Eating out/Dual kitchens
  - Family events family events
- **Assess Diet Compliance**
  - History of any exposures to gluten and in what setting?
- **Assess knowledge of the disease and lifestyle adjustment**
- **Provide Education for**:
  - Patient (based on age group)
  - Caregiver (based on age group of child)
  - Education for siblings
- **Discuss 504 Plan**
- **Family Screening Frequency**

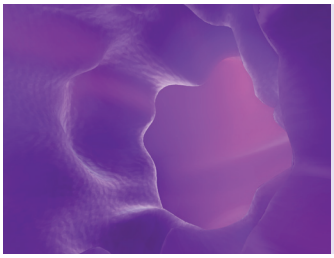
Celiac Disease Follow-Up Appointment Continued…

- Complete DEXA Scan
- **Blood Work**
  - Frequency
  - Blood Test Types (CBC, Iron, Metabolic Panel, Vitamin D, Zinc, Thyroid, Other Vitamins, Hepatitis B, Celiac Panel)
- **Genetic Testing**
- **Repeat Upper Endoscopy**

504 PLAN

- Celiac disease is a “disability” and students have a legal right to accommodation .
- Resources for schools (and health professionals) on supporting children with gluten-free diets are available at https://www.autoimmuneinstitute.org/celiac-education/managing-celiac-in-schools/

Thank You.



Disordered Eating & Gastrointestinal Disorders

Courtney Schuchmann, MS, RD, LDN
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Department of Gastroenterology

AT THE FOREFRONT UChicago Medicine

Disclosure Information

Women in Digestive Diseases
Courtney Schuchmann, MS, RD, LDN

- I have no financial relationships to disclose.
- I will not discuss off label use or investigational use in my presentation.

Eating Disorders

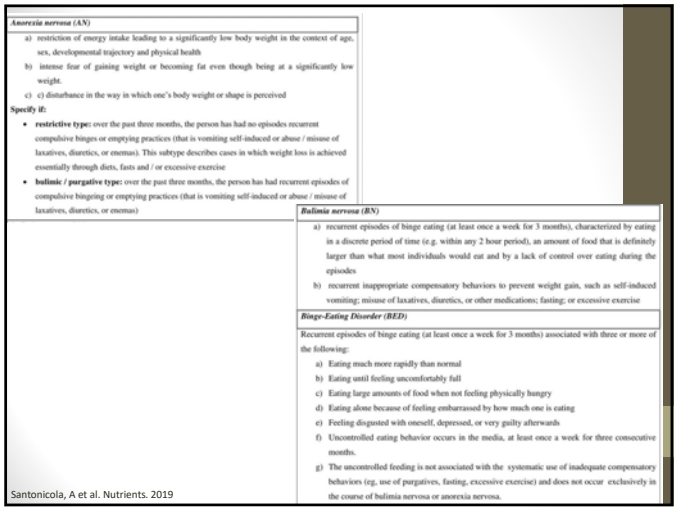
- Illnesses in which people experience severe disturbances in their eating behaviors and related thoughts and emotions.
- Prevalence:
  - 9% of the U.S. population or 28.8 million Americans
- Less than 6% are diagnosed as underweight
- Second deadliest mental illnesses (first is opioid overdose)
- 10,200 deaths/year as direct result of an ED
  - 1 death every 52 minutes
  - About 26% of people with EDs attempt suicide
- Economic cost: $64.7 billion every year

ANAD, Eating Disorder Statistics, 2020

Types of Eating Disorders

- Anorexia nervosa (AN)
- Bulimia nervosa (BN)
- Binge eating disorder (BED)
- Avoidant restrictive food intake disorder (ARFID)
  - Does not involve any distress about body shape, size, or weight
- Other Specified Feeding or Eating Disorder (OSFED)

NEDA, Information by eating disorder, 2020



***Anorexia nervosa* (AN)**

a) restriction of energy intake leading to a significantly low body weight in the context of age, sex, developmental trajectory and physical health

b) intense fear of gaining weight or becoming fat even though being at a significantly low weight.

c) c) disturbance in the way in which one's body weight or shape is perceived

Specify if:

- **restrictive type:** over the past three months, the person has had no episodes recurrent compulsive binges or emptying practices (that is vomiting self-induced or abuse / misuse of laxatives, diuretics, or enemas). This subtype describes cases in which weight loss is achieved essentially through diets, fasts and / or excessive exercise
- **bulimic / purgative type:** over the past three months, the person has had recurrent episodes of compulsive bingeing or emptying practices (that is vomiting self-induced or abuse / misuse of laxatives, diuretics, or enemas)

***Bulimia nervosa* (BN)**

a) recurrent episodes of binge eating (at least once a week for 3 months), characterized by eating in a discrete period of time (e.g. within any 2 hour period), an amount of food that is definitely larger than what most individuals would eat and by a lack of control over eating during the episodes

b) recurrent inappropriate compensatory behaviors to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise

***Binge-Eating Disorder* (BED)**

Recurrent episodes of binge eating (at least once a week for 3 months) associated with three or more of the following:

a) Eating much more rapidly than normal

b) Eating until feeling uncomfortably full

c) Eating large amounts of food when not feeling physically hungry

d) Eating alone because of feeling embarrassed by how much one is eating

e) Feeling disgusted with oneself, depressed, or very guilty afterwards

f) Uncontrolled eating behavior occurs in the media, at least once a week for three consecutive months.

g) The uncontrolled feeding is not associated with the systematic use of inadequate compensatory behaviors (eg, use of purgatives, fasting, excessive exercise) and does not occur exclusively in the course of bulimia nervosa or anorexia nervosa.

Santonicola, A et al. Nutrients. 2019

Avoidant restrictive food intake disorder (ARFID)

- An eating disturbance (e.g., concern about aversive consequences of eating) associated with at least one of the following:
  - Significant weight loss
  - Significant nutritional deficiency
  - Dependence on enteral feeding or oral nutritional supplements
  - Marked interference with psychological functioning
- The person does not have a distorted body image
- The eating disturbance is not attributable to a concurrent medical condition or another mental disorder.

American Psychiatric Association. Diagnostic and statistical manual of mental disorders, 5th ed (DSM 5)

Disordered Eating

- No specific definition or diagnostic criteria, but only a list of behaviors and attitudes
- Abnormal eating behaviors/patterns such as:
  - Meal skipping
  - Food restriction (restricting certain foods)
  - Binge eating
  - Purging (vomiting, laxative use)
  - Fasting
- Less severe and less frequent than required to meet the full criteria for the diagnosis of an ED

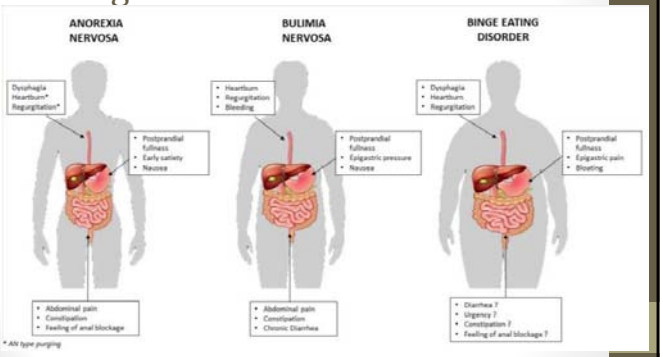
Grilo, C. (2006). Eating and weight disorders. New York: Psychology Press

Disorders of Gut-Brain Interaction and Eating Disorders

- Functional gastrointestinal disorders – now disorders of gut-brain interaction (DGBI)
  - 2016 Rome IV criteria
- FGIDs are common in patients with EDs
  - 98% of females (n=101) with AN, BN, and EDNOS met criteria for FGID
    - 52% IBS, 51% heartburn, 31% abdominal bloating, 24% constipation, 23% dyspepsia, 22% anorectal pain disorder
    - 52% satisfied the criteria for at least three FGIDs

Drossman DA, Hasler WL. Gastroenterology. 2016 May;150(6):1257-61. doi: 10.1053/j.gastro.2016.03.035. PMID: 27147121.
Boyd C et al. Scand J Gastroenterol. 2005;40(8):929-935

GI Symptoms are Common with Eating Disorders



Santonicola, A et al. Nutrients. 2019

Cause of GI Disorders in Individuals with Eating Disorders

- ED behaviors: vomiting, laxative abuse, restrictive food intake can damage GI tract
- Motility disorders can contribute to ED behaviors
  - Loss of appetite, vomiting, dysphagia, bloating, constipation
- Malnutrition → metabolic myopathy & electrolyte depletion→ impaired gastric emptying, motility, & intestinal transit

Santonicola, A et al. Nutrients. 2019
Abraham, S et al. BMC Gastroenterol. 2013
Norris ML, et al. Int J Eat Disord. 2016

GI disease/ dysfunction → Disordered Eating → Malnutrition
Celiac disease, IBD, IBS

GI disease/ dysfunction → Malnutrition → Disordered Eating
IBD, Cystic Fibrosis, T1DM/Gastroparesis

Disordered Eating → GI disease/ dysfunction → Malnutrition
Constipation, esophageal motility disorder, gastroparesis

Disordered Eating → Malnutrition → GI disease/ dysfunction
Fatty liver, villous atrophy, SMA syndrome

Treating GI disorders in Individuals with Eating Disorders

- GI symptoms and DGBI often improve with weight rehabilitation
- Medical intervention may be necessary to treat underlying GI disorder that may be causing or exacerbating ED
  - Motility agents

Disordered Eating is Common with GI Disorders

- Common with celiac disease, IBD, and IBS
- Triggers for disordered eating
  - Dietary restraint
  - GI symptoms
  - Food awareness
  - Burden of chronic illness
- Symptoms associated with foods can result in conditioned food aversions

Passananti, V et al. Gastroenterol Res Pract. 2013
Satherley, R et al. Appetite. 2014

Satherley R., Howards R., Higgs S., Disordered eating practices in gastrointestinal disorders, Appetite (2014).

ARFID is Common in Individuals with GI Disorders

- 20% of adults GI patients screen positive for ARFID
- ARFID is frequently documented in patients with DGBI
  - IBS has been associated with more GI symptoms and greater weight loss
  - Many patients are still prescribed low FODMAP diet despite being under weight or actively losing weight

Zia JK et al. Gastro. 2017; Harer KN et al. Am J Gastro. 2018; Harer KN et al. Gastro. 2019

Eating Disorders are Common in IBD

- Malabdaptive attitudes toward eating are common in IBD
  - Associated with being female, underweight, having IBD diagnosed during childhood, psychological distress and body image disturbance
- IBD symptomology may be use to potentiate weight loss
- ED in IBD is associated with morbidity and mortality

Wabich J et al. Journal of Clinical Psychology in Medical Settings. 2020
Ilzrbe L et al. Journal of Psychosomatic Research. 2017

What Should Providers Do

- Screen for disordered eating and eating disorders in patients with GI disease/disorders
- Ask patients if they have a history of disordered eating or an eating disorder
- Ask patients about specific food avoidances or eliminations
- Ask about distress related to eating, preoccupation with food, body weight
- Ask if the patient WANTS to treat their disorder with diet

Screen Tools

- There are no ED screen tools validated in GI population
- Screening tools that may be of use:
  - Nine Item Avoidant/Restrictive Food Intake Disorder Screen (NIAS)
  - SCOFF
  - Eating Attitudes Test (EAT-26).
- Dietitians can assess for red flags:
  - Limited food groups/lack of diet versatility, insufficient intake

TABLE 4 SCOFF questionnaire

1. Do you make yourself **S**ick because you feel uncomfortably full?
2. Do you worry you have lost **C**ontrol over how much you eat?
3. Have you recently lost **O**ver 1 stone (14 lb) in a 3-month period?
4. Do you believe yourself to be **F**at when others say you are too thin?
5. Would you say that **F**ood dominates your life?

Yes=1 point; score of >2 suggests AN or BN

Abbreviations: AN, anorexia nervosa; BN, bulimia nervosa
Source: Morgan JF, Reid F, Lacey JH.[21]

Morgan JF, Reid F, Lacey JH. *BMJ*. 1999;319:1467-1468.

Next Steps

- Refer to GI psychologist
  - CBT & Gut directed hypnotherapy
- Refer to a dietitian
  - Develop intervention to increase diet versatility
  - Address nutrient deficiencies/inadequacies
- Some patients may require inpatient medical stabilization or intensive outpatient eating disorder treatment

National Institute for Clinical Excellence (NICE) Guidelines for Management of Refeeding Syndrome	
Patients at risk for refeeding syndrome	
ONE or more of the following: -OR-	TWO or more of the following:
BMI < 16 kg/m^2	BMI <18.5 kg/m^2
Unintentional weight loss of >15% in the previous 3-6 months	Unintentional weight loss of >10% in the previous 3-6 months
Little or no nutritional intake for >10 days	Little or no nutritional intake for >5 days
Low levels of potassium, phosphorus, or magnesium before refeeding	History of alcohol abuse or drugs including insulin, chemotherapy, antacids, or diuretics

Summary

- Screening for ED and assessing disordered eating is important in patient with digestive disorders
  - Disordered eating is common in patients with GI disorders
- Disordered eating can advance to eating disorders
- Eating disorders can contribute to GI disorders and increase risk for malnutrition
- A multidisciplinary approach is key for these patients
  - Gastroenterologist, PCP, dietitian, GI psychologist

Questions?

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773-709-5912

AT THE FOREFRONT
UChicago Medicine

Adherence in IBD: Some Practical Thoughts from a Seasoned Clinician

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Professor of Medicine
Mayo Clinic Rochester

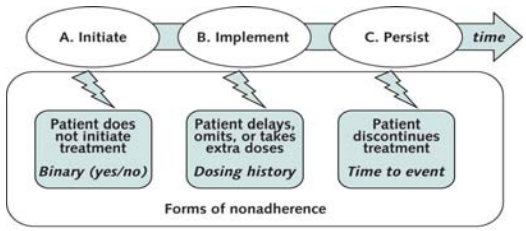
Disclosures

- Consultant: Gilead Sciences, United Health Group, TechLab, Kinetix Group
- Other: Section Editor, UptoDate

Evidence → Practice

Glasziou and Haynes ACP JC 2005

ESPACOMP Medication Adherence Reporting Guideline (EMERGE)



De Geest S. Ann Intern Med 2018; 169:30-35

MARS-5 Adherence Tool

- 112 adults with IBD in the longitudinal Manitoba Living With IBD Study
- Demographics, IBD type, surgeries, disease activity (using the Inflammatory Bowel Disease Symptom Inventory and fecal calprotectin levels), perceived stress, and medication use were collected biweekly through online surveys.
- MARS-5 scores were obtained at baseline and at 1 year. Predictors of medication adherence were assessed at both ≥90% and ≥80%.
- Participants were predominantly female (71.4%), mean age was 42.9 (SD = 12.8), and the majority (67.9%) had Crohn disease (CD).
- Almost half (46.4%) were taking more than 1 IBD medication, with thiopurines (41.9%) and biologics (36.6%) the most common.
- Only 17.9% (n = 20) were nonadherent at a level < 90%, 90% on an oral med
- MARS-5 was significantly associated with adherence based on medication monitoring data at baseline (r = 0.48) and week 52 (r = 0.57).
- Having CD (OR = 4.62; 95% confidence interval, 1.36-15.7) was the only significant predictor of adherence

Stone J. Aliment Pharmacol Thera. 2020 March 20 [Epub ahead of print] doi: 10.1093/ibd/izaa056

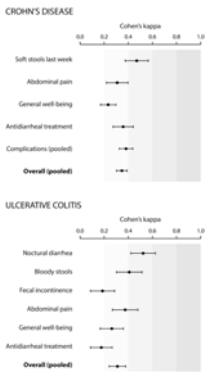
Goals for Managing Patients

- Key Concept Statements:
  - Therapeutic decisions should be categorized into those for a) induction and b) maintenance; with a goal of obtaining and maintaining a steroid-free remission
  - Control of mucosal inflammation may reduce dysplasia risk
  - Screen for co-existent anxiety and depressive disorders and, when identified, provide resources to address these conditions
  - In general, favor topical/organ selective treatments before systemic ones for UC if possible

Small Molecules vs Biologics

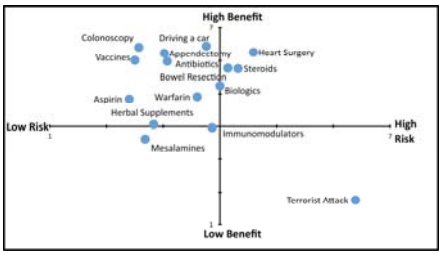
Small Molecules	Biologics
Small (single molecule)	Large (mixture)
Simple well-defined structure	Complex heterogeneous structure
Produced by chemical synthesis	Produced in a living cell culture
Non-immunogenic	Immunogenic
Oral administration	Parenteral administration

Patient/Provider Agreement on Disease Activity



Pittet V. Clinical Gastroenterology and Hepatology 2019 17, 2050-2059.e1DOI: (10.1016/j.cgh.2018.11.029)

Plot of the perceived risk of an exposure vs the benefit of the exposure.



Koliani-Pace J. Inflammatory Bowel Diseases, Volume 26, Issue 1, January 2020, Pages 141–146, https://doi.org/10.1093/ibd/izz121

Thiopurine Metabolite Monitoring in Non-Responders

Identify reasons for non-response:

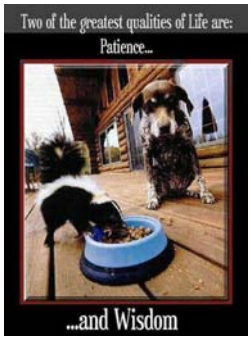
	6-TGN	6MMP
Inadequate dose	↓	↓
Non-adherence	↓↓↓	0
6-MMP shunting	↓	↑↑↑
Drug resistance	↑↑↑	↑

Adherence during pregnancy

- 230 women from Alberta CA IBD cohort
- 159/230 women were adherent during the year prior to pregnancy, 21 (13.2%; discontinued their medications during pregnancy
- Medication adherence during pregnancy differed significantly by drug class
  - Biologics (41.5%; 32.9-50.7%)
  - Thiopurines (22.9%; 16.1-31.5%; *P* = 0.006)
  - 5-aminosalicylates (35.6%; 27.4-44.8%; *P* = 0.204)
  - Women were more likely to be adherent to biologics (49.3%) than thiopurines (20.9%) (*P* = 0.014) and 5-aminosalicylates (29.9%, p = 0.030) in first and third trimesters
  - In the second trimester, adherence pattern did not significantly differ by drug class (biologics vs thiopurines: *P* = 0.348; biologics vs 5-aminosalicylate: *P* = 0.999).
  - Infants born to women with IBD were more likely to be admitted into the neonatal intensive care unit than the general obstetric population, but not significantly different between women who were adherent or not adherent to their IBD medication (adherent: RR 1.58, 95% CI 1.02, 2.27; non-adherent: RR 1.32, 95% CI 0.97, 1.81)

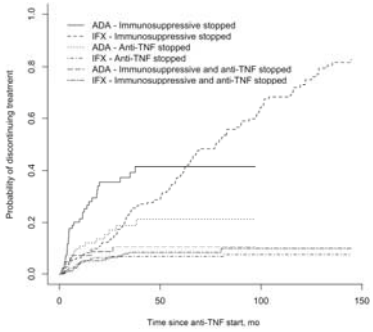
Lee S. AP&T Dec 2 2019 Epub ahead of print https://doi.org/10.1111/apt.15596

- Have someone else there if possible
- Assume your patient has read/Googled
- Consider the patient might be downplaying symptoms or isn't cognizant of them
- Be open minded about their position
- Pick your battles



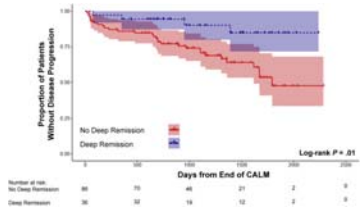
- Don't just hand them a pamphlet
- Talk in English (no terms like "mucosa")
- Use analogies/mental pictures when possible
- Talk-Ask-Talk
- This is a marathon not a sprint

Doctor Can I Stop My Medicine?
Discontinuation of immunosuppressives and anti-TNF over time



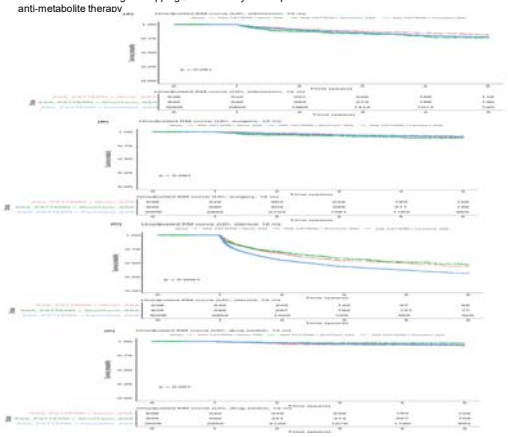
Elias E. Inflam Bowel Dis 2019 July https://doi.org/10.1093/ibd/izz148

Effect of Deep Remission on CD



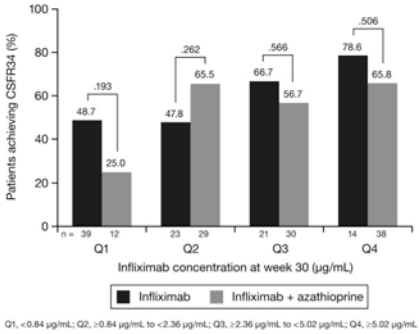
Ungaro R. Gastroenterol 2020. Volume 159, Issue 1, 139-147.

No benefit of continuing vs stopping 5-aminosalicylates in patients with ulcerative colitis escalated to anti-metabolite therapy



Singh S. Aliment Pharmacol & Thera 2020; 52(3):481-491 DOI: (10.1111/apt.15876)

Do You Really Need AZA?



Q1, <0.84 µg/mL; Q2, ≥0.84 µg/mL to <2.36 µg/mL; Q3, ≥2.36 µg/mL to <5.02 µg/mL; Q4, ≥5.02 µg/mL

Columbel JF. Clin Gastroenterol Heaptol 2019; 17(8): 1525-1532.

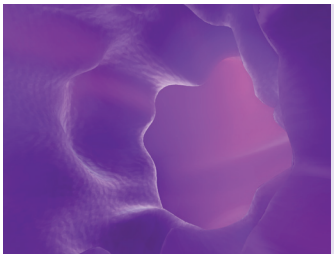
Aspirin Use Safe in IBD

- Retrospective analysis of a prospectively collected registry of patients with IBD from May 2008 to June 2015.
- Patients with daily aspirin use were matched 1:4 to controls by age, sex, disease, disease location, and presence of cardiac comorbidity.
- Patients with at least 18 months of follow-up were included in the final analysis. The primary outcomes of interest were having an IBD related hospitalization, IBD-related surgery, and requiring corticosteroids during the follow-up period
- 764 patients with IBD were included in the analysis, of which 174 patients were taking aspirin.
- There was no statistical difference in diagnosis (Crohn's disease vs ulcerative colitis), disease duration, Charlson Comorbidity Index, smoking status, medication usage, or baseline C-reactive protein between groups.
- After controlling for covariables and length of follow-up in the entire population, aspirin use was not associated with a risk of being hospitalized for an IBD-related complication (odds ratio [OR], 1.46; *P* = 0.10), corticosteroid use (OR, 0.99; *P* = 0.70), or having an IBD-related surgery (OR, 0.99; *P* = 0.96).

Patel P. Inflamm Bowel Dis March 2020 doi: 10.1093/ibd/izaa060

Choose Wisely

Negotiation at My House



Gender Differences in Autoimmune Liver Diseases

Sonali Paul, MD MS
Assistant Professor of Medicine
Center for Liver Diseases

Disclosures

- Research / grant funding from: Intercept, GENFIT, TARGET PharmaSolutions

Objectives

- Briefly review autoimmune liver diseases (PBC, PSC, AIH)
- Within thisreview, we thus aim to summarize our understanding of howsex influences the development, progression, and pathogene-sis of autoimmune liver disease

Reference

Auotimmune Hepatitis (AIH)
Primary Biliary Cholangitis (PBC)
Primary Sclerosing Cholangitis (PSC)

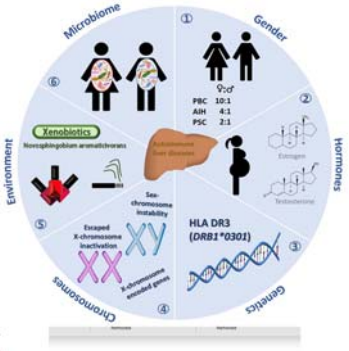
- Leading autoimmune liver disease in both males and females
- Complex, orphan disorders
- Different injury sites, pattern of inflammation, and symptoms
- Cirrhosis, portal hypertension, liver transplant

Sex Differences

- AIH & PBC have greatest female predominance among all autoimmune diseases
  - 3 to 9x ↑ in females than in males
- Impact on disease course, complications

Reference

Sex Differences



Schwinge D & Schramm C. Seminars in Immunopathology. 2019.

Autoimmune Hepatitis (AIH)

- Prevalence: 1.68 / 100,000 persons in Europe
  - Increasing prevalence over time
  - Varies by ethnicity
- Female > Male(3-4:1)
- Bimodal age distribution
  - Puberty, middle age (40-60s)

#32, #37

AIH Types

- **Type 1 (classic)**
  - Adults, adolescents
  - **+ANA and/or +ASMA (>1:320)**
  - (anti-solube liver/liver pancreas (anti-SLA/LP))
- **Type 2**
  - Infants, kids (girls)
  - (+ liver-kidney microsomes (ALKM-1))
  - (+ liver cytosol antigen (ALC-1))
  -)

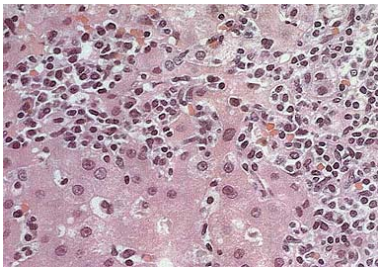
66, 119

AIH Presentation

- Most asymptomatic
- Acute liver failure (1/3 presentations)
- Some with symptoms
  - n/v, fatigue, malaise
  - Arthralgia
- Cirrhosis (1/3)
  - And its complications
- Associated with other autoimmune diseases
  - Thyroid, Celiac, RA

AIH Liver Biopsy

- Assess disease severity
- Interface hepatitis
- Plasma cell infiltrate



Krawitt EL. NEJM. 2006.

Reference

AIH Scoring System

- xxx

Diagnosis by the International Autoimmune Hepatitis Group

	Points	Parameter
Simplifie		ANA or SMA
	+1	≥1:40
	+2	≥1:80
Category	+2	LKM ≥1:40
1) AUTO ANTIBOI ANA or SMA	+2	SLA positive*
Anti-LKM-1		IgG
Anti-SLA	+1	Upper normal limit
	+2	>1.1 times upper normal limit
2) IMMUNOGLOBI		Liver histology
3) HISTOLOGY	+1	Compatible with AIH†
	+2	Typical of AIH†
4) VIRAL DISEASE	+2	Absence of viral hepatitis
DEFINITE DIAGNO		
PROBABLE DIAGN		

Adapted from Hennes et al. (Hepatology 2008;48:169-76) with permission [8].

Reference

AIH Treatment

- **Induction** (variable methods)
  - Prednisone 30mg – 60mg daily
  - Azathioprine 50mg – 2mg/kg daily (up to 200mg)
  - Wean prednisone
  - +/- budesonide
- **Maintenance** with azathioprine (2 years)
- 90% respond
  - Improvement in LFTs and IgG
  - Histological improvement lags behind (3-8 months)
  - Auto-antibodies do not parallel disease activity

AIH Other Treatments

- Mycophenolate mofetil
- Budesonide
- Cyclosporine
- Tacrolimus
- Other
  - Methotrexate
  - Infliximab
  - Rituximab

Title

- Blacks (men) more likely
  - Cirrhosis
  - Less likely to respond to treatment
  - Liver failure at presentation
  - Referred for liver transplantation
  - Higher mortality

Reference

Primary Biliary Cholangitis (PBC)

- Incidence: 1-2/100,000 per year
- Autoimmune mediated
- Involvement of **small intrahepatic bile ducts**
- Etiology
  - Genetic predisposition
  - Environmental (cosmetics, nail polish, UTIs)

Reference

PBC Natural History

- Chronic cholestatic disease
- Progressive course over many decades
- **In absence of treatment**
  - Early disease: 60% ten year survival
  - Symptomatic disease: median survival 5-8 years
- **More being recognized at earlier stages**
  - Early treatment
  - Decreasing liver transplants

Reference

PBC Diagnosis

- **Chronic cholestasis**
  - ↑ alk phos – related to histological severity
  - Mild AST/ALT elevations
- **Auto-antibodies**
  - **+ anti-mitochondrial antibody** (AMA) → M2 antibody
    - Very specific (95%)
    - 5% are AMA negative
  - ANA / ASMA found in 50%

AT THE FOREFRONT UChicago Medicine

Elevated IgM

Reference

PBC Diagnosis

- To biopsy or not to biopsy …
- Controversial

- Inflammation of interlobular and septal bile ducts
  - **"florid duct lesion"**
    - Inflammatory changes / necrosis of bile ducts
    - Lymphocytes, plasma cells, macrophages, eos
    - Can see granulomas
  - **Ductopenia** … < 50% of portal tracts containing ducts

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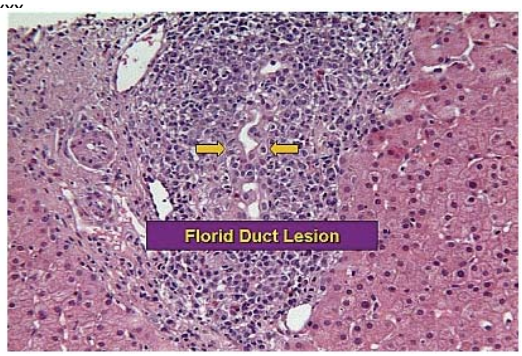
Reference

PBC Diagnosis

- [illegible]



AT [illegible] UChicago Medicine

Reference

PBC Autoimmune Associations

- **Sicca syndrome (40-65%) (prior to PBC diagnosis)**
  - Dry eyes / dry mouth
- **Scleroderma (5-15%) (prior to PBC diagnosis)**
  - Limited cutaneous scleroderma
  - CREST Syndrome
- **Rheumatoid Arthritis (5-10%)**
- **Inflammatory arthropathy (40%)**
- **Hypothyroidism (10-15%)**

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PBC Treatment

- **Ursodiol 13-15mg/kg/day**
  - Improves biochemical indices
  - Delays histologic progression
  - Improves liver transplant free survival
  - Decrease variceal formation (not bleeding)
- **With ursodiol, liver transplant free survival:**
  - 85% at 10 years
  - 66% at 20 years

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Obeticholic Acid

- Ligand for the farnesoid X receptor (bile acid homeostasis)
- Approved 2015
  - Inadequate response to ursodiol (alk phos > 2x ULN)
  - Or Side effects to ursodiol
- Does not improve survival or disease related symptoms
- Side effect pruritus
- Studies did not do liver biopsies …

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Primary Sclerosing Cholangitis

- Likely immune mediated
- Chronic, cholestatic liver disease
- Unclear incidence: 1 / 100,000 person years

Inflammation and fibrosis of intrahepatic and extrahepatic bile ducts

Multifocal bile duct strictures

Cirrhosis / Portal Hypertension

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PSC Natural History

- 10 year survival of 65% in PSC
  - Large individual variation
- **Mayo Risk Score**
  - Age, bilirubin, AST, albumin
  - History of variceal bleeding
- **Other important factors**
  - Age, intrahepatic / extrahepatic involvement
  - Dominant strictures

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PSC Symptoms

- **Variable**
  - RUQ pain
  - Fatigue
  - Pruritus
  - Weight loss
  - Cholangitis
- **Exam**
  - Hepatomegaly
  - Splenomegaly
  - Jaundice
- **Most Asymptomatic**
  - Incidental
  - Abnormal cholestatic liver tests
- **~70% have IBD (Ulcerative colitis > Crohn's)**
  - But only some with IBD have PSC

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PSC Diagnosis

- **Cholestatic liver tests**
  - ↑Alkaline phosphatase
  - (Normal does not exclude)
  - AST/ALT > 2-3x ULN
- **Autoantibodies**
  - Not helpful
- **Imaging (MRCP)**
  - > 80% sens; > 87 specific
  - Multifocal strictures / segmental dilation - *"beaded pattern"*
- **Liver biopsy not necessary**

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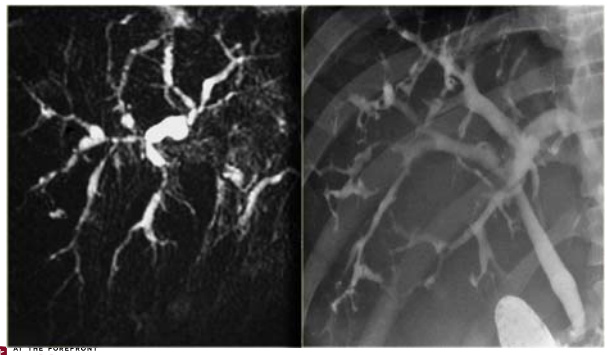

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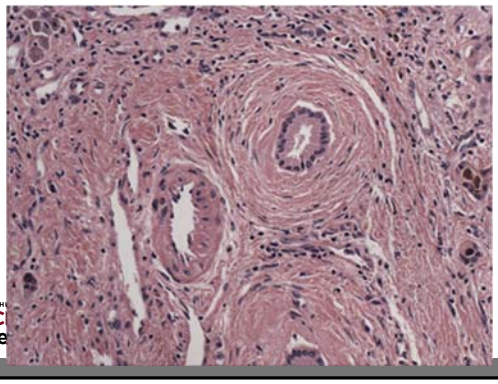
- **"Onion skinning" / Periductal fibrosis**



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PSC Liver Biposy

- **Small duct PSC**
  - Variant
  - Cholestatic features (elevated alk phos)
  - Normal cholangiogram
  - Histological features
- **PSC / Autoimmune Hepatitis Overlap syndrome**
  - Elevated AST / ALT (disproportionate to alk phos)
  - +ANA, + anti smooth muscle AB
  - +IgG4
  - Kids / young adults)

IBD & PSC

- **UC + PSC = ↑ risk of colorectal cancer / dysplasia**
  - OR 4.8 (CI 3.6-6.4) compared to patients with UC only
  - Younger (19 yrs vs 29 yrs)
- Surveillance colonoscopy q1-2 years in patients with IBD
- **Factoids**
  - IBD can present after liver transplantation for PSC
  - PSC can present after colectomy for UC

PSC Complications

- *Portal Hypertension / Cirrhosis*
- Dominant strictures
- Bacterial cholangitis
- Metabolic Bone Disease (hepatic osteo-dystrophy)
- Vitamin Deficiencies
- Malignancy
  - Cholangiocarcinoma
  - Gallbladder
  - Hepatocellular (if cirrhotic)

PSC Treatment

- **Controversial**
- **Ursodiol**
  - Not FDA approved
  - Low dose ursodiol → 13-15mg/kg/day
  - Goal is to lower alkaline phosphatase to 1.5x ULN
  - Can improve biochemical and histology
  - No difference in death, liver transplant, and progression
- **High dose ursodiol (28-30mg/kg)**
  - Increased risk of death / liver transplant

PSC Liver Transplant

- **MELD doesn't do justice to PSC patients**
- **Indications (deceased or living donor)**
  - Complications of portal hypertension
  - Impaired quality of life
  - Chronic liver failure
  - MELD Exception points
    - Intractable pruritus
    - Recurrent bacterial cholangitis
    - Cholangiocarcinoma
- **Successful**

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Leadership in 2021 and Beyond

Sunanda Kane, MD

Leadership in 2021 and Beyond

Sunanda Kane MD MSPH FACG FACP AGAF FASGE
Professor of Medicine
Mayo Clinic Rochester

Disclosures

- Consultant to: Gilead, TechLab, Pfizer
- Consultant to: United Health Group, Kinetix Health
- Section Editor: IBD section of UptoDate

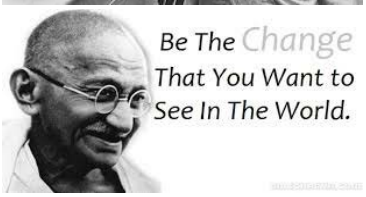
Topics for Discussion

- What does a good leader look like?
- Why is good leadership so important now?
- How do you become a good leader?
- What have I learned along the way on my journey to being a leader?

Some are Born into their Position

For Some It's the Right Circumstances

For Some it Was an Ideology



And Some are Elected

Leadership in Medicine

- A leader in health care today should be able to:
  - clearly articulate rationale and goals for change
  - cast a clear vision of how such change will improve patient and community care
  - motivate people to engage in the needed change

Historically

- Current leaders in academic medical centers ill prepared to lead, but influenced and chose the new generation of leaders
- Most health system leaders over 50 years were chosen to lead because of productivity, published research, solid clinical skills, or because they were great educators
- Most however never received formal leadership training, but instead learned by observing role models who were accomplished in areas of expertise, but not formally trained themselves

Why Physicians are Set Up to Fail at Effective Leadership

- Medical education typically produces practitioners working solo; however, modern management of patients and institutions requires teams
- Physician training is full of examples of absence of team building:
  - the experience of long and hierarchical training with extended subordination (internship, residency, fellowship)
  - evaluations based on individual performance (licensure, in-service, and board certification examinations)
  - extrapolated leadership (extended clinical authority to other areas, such as entering first in an elevator at the hospital)
  - training based on "deficit thinking" (always trying to find and solve the problem yourself)

What is a Good Leader?

- Similar to other industries, a leader should be honest, forward-looking, inspirational, and competent
  - Forward-looking means having a sense of direction and a concern for the future of the organization and community
  - Inspiring means to share the genuine enthusiasm, excitement, and energy about the future
  - Being competent refers to track record and ability to get things done

Stoller J. *Acad Med* 2013; 88:12-15.

Yes, But What Else?

- A high state of mindfulness
  - Being mindful of others may reduce distortion and more accurately interpret thoughts and perspectives
  - One should be aware of their emotional state and be emotionally mature and self-motivated
  - Self-motivation is something current leaders already have, but few have cultivated the other two
- Emotional empathy
  - The effective 21st century leader will not only be bright and able to generate wonderful ideas, but also will be able to go 3 levels down and:
    - broadly understand what the person at the third level is doing
    - will know the barriers faced by that third-level employee
    - try to remove barriers to achieve organizational progress

Emotional Intelligence

- James Stoller, Executive Director of Physician Leadership Development and Chairman, Education Institute Cleveland Clinic:
- "several characteristics of emotional intelligence seem especially important for effective leadership"
  - having a service orientation
  - being collaborative and adaptable
  - being an agent for change
  - having vision and initiative
  - developing others

Stoller J. *J Med Prac Manage* 2007; 22:237-242.

Leadership Capabilities at Mayo

- Inspire values
  - If you don't have this, all else will fail. No one will follow.
- Engaging Others
  - This is not the WHAT you do but the HOW you do it
  - Having diverse network helps with pattern recognition and solutions
- Bold and Forward Thinking
  - Where are you looking to anticipate change?
  - Are you courageous enough to abandon the past?
  - Looking forward works by shaping the future not reacting to it
- Driving results

Leadership and Burnout

- Leaders have a key effect on wellbeing and professional fulfillment of those they lead
- We evaluate and develop solutions and trained to think critically and derive decision based on evidence
- Participatory management style is typically most effective for physicians

Shanafelt T *Mayo Clin Proc* 2017; 92:129-146.

Personal and Professional Repercussions of Physician Burnout

*Physician leaders can impact all aspects of Professional burnout

Shanafelt, T. *Mayo Clin Proc* 2017; 92:129-146.

Leadership and Burnout

- Recent evidence suggests that the leadership behaviors of the physician supervisor play a critical role in the well-being of the physicians they lead
- A study of over 2800 physicians at Mayo Clinic showed that each 1-point increase in the leadership score (60-point scale) of a physician's immediate supervisor (division/department chair) associated with:
  - 3.3% decrease in the likelihood of burnout ($P < .001$)
  - 9.0% increase in satisfaction ($P < .001$) for individual physicians
- After adjusting for other factors, 11% of variation in burnout and 47% in satisfaction between work units explained by the aggregate leadership rating of the work unit supervisor as assessed by their physician reports

Shanafelt T *Mayo Clin Proc* 2015; 90:432-440.

Leadership and Burnout

- Evidence suggests physicians who spend at least 20% of their professional effort focused on the dimension of work they find most meaningful are at dramatically lower risk for burnout
- This suggests that physicians will spend 80% of their time doing what leadership needs them to do provided that they are spending at least 20% of their time in the professional activity that motivates them
- To harness this principle, leaders must know what that 20% activity is for each of their physicians
- In reality, few leaders seek such information, nor can most articulate in a granular way what is most meaningful to them when first asked
- Represents a missed opportunity for individual physicians and leaders to work together to foster engagement, professional development, and professional fulfillment

Shanafelt T *Arch Intern Med* 2009; 169:990-995.

Leadership and Burnout

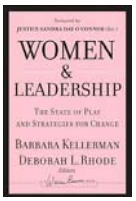
- Providing individual physicians with tools for self-calibration, resources to promote self-care, and training in skills that promote resilience are 3 tangible ways that leaders can help individuals care for themselves
- Individual physicians do not accurately calibrate their personal level of well-being/distress and providing them objective information on how their well-being compares with that of physicians nationally helps promote behavior change
- Resources should be comprehensive and address work-life integration, exercise/fitness, sleep habits, diet, personal financial health, relationships, hobbies, preventive medical care
- Physicians who take better care of their own health have been found to provide more optimal counseling and screening practices to their patients; this suggests that encouraging these behaviors in physicians may have a double benefit

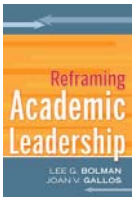
Shanafelt T *Ann Surg* 2014; 259:82-88.

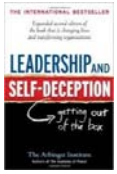
Assess Your Leadership Skills

- Am I comfortable attracting attention?
- Am I able to successfully self-reflect?
- Do I know who to call for professional counsel?
- Do I present my ideas in a convincing manner?
- Do others call me for insights and knowledge?
- Do I engage others in the dialogue? Do I invite their ideas and perspective?
- Do I articulate a vision that others want to rally around?

Can you Learn from a Book?







Formula for Success

- 70% work experience
- 20% feedback and relationships (networking, mentoring, coaching)
- 10% formal training

How I Did It: Tip 1

- With work experience, OWN IT
  - When asked to do something, bring 100%
  - Meet--or better yet--beat the deadline
  - Credibility is what gets you to the table (but what are you going to do next)?

How I Did It: Tip 2

- ASK
  - Get feedback!
  - Women Don't Ask
  - Calderwood GIE 2016; 83:730-33
    - Compared with men, women were significantly less likely to have had previous ASGE service (28% vs 42%)
    - For ASGE committee appointments, it appears that women who make requests are successful in receiving these appointments

How I Did It: Tip 3

- Get formal training
  - Public speaking
    - Opportunities all around you
  - Leadership
    - Many business schools and now medical schools offer courses in person or online
      - Mayo Clinic, University of Kentucky, Medical College of Wisconsin, Cleveland Clinic, Harvard

The Three Most Underused Phrases

1. Thank you
   - In a position of authority you likely have no idea how meaningful it is for your team to hear
   - You know how much you like to hear it
   - Use it judiciously so that it counts

Underused Phrases cont'd

2. I'm Sorry
   - It is ok to be human and make mistakes
   - Own up to them as they are bound to happen
   - Buys you credibility
   - Mean it and explain why

Underused Phrases cont'd

3. What do *you* think?
   - We often don't ask around the table for opinions, expect people to speak up
   - Empowers team members
   - Signifies engagement, trust and respect

African Proverb

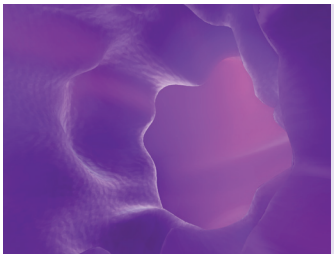
- If you think being small is insignificant, try spending the night in a tent with a few mosquitoes

Effective Leadership

- Keep team informed
- Ask for ideas and suggestions
- Facilitate professional development of others
- Recognize aspect of work most personally rewarding for each of member of the cohort
- Provide opportunities for those to gain experience and successfully engage in the work
- Acknowledge individual contributions and achievements

What I Have Learned

- Be noble
- Be genuine
- Inspire others
- Listen, engage, develop, then “lead”
- A good leader lets you fail but does not let you be a failure



HASHTAGS, HANDLES AND HEALTHCARE:

Social Media for GI Practice, Education & Career Development

Facebook: Ladies of the Gut

Nundhini Thukkani, MD

Ladies of the Gut

NUNDHINI THUKKANI, MD

13 MARCH 2021

Beginnings…

- Created 20 January 2016
- Based on a larger group of physician mothers
- Welcomes:
  - Female/female identifying
  - MD/DO/MBBS and other equivalent degrees
  - Pediatric and adult gastroenterologists & hepatologists (fellows welcome)
  - GI/Hep specialized pathologists

Impetus behind LOTG

Clinical conundrums

Network

Shared experiences

Members

- Currently 1,095 members
- Diversity of practices
  - Academics
  - Solo practitioner
  - Hospital based
  - Private practice
  - Locums
- Mainly North American, other countries represented (and welcome!)
- "self- throttled" membership to prevent explosive growth

Principles of LOTG

- No industry sponsorship
- No formal associations with GI/hep societies
- Laissez-faire admin (me) to allow for free (respectful) dialogue
- Use of platform for advocacy

Unexpected returns

COMMUNITY

ADVOCACY

'CME'

TRIAL AND ERROR

CLINICAL QUERIES

UC help:

40 yo m w UC w SEVERE disease, recurrent severe anemia.
On IFX with low mid cycle levels and no ATI.

Next steps?

CLINICAL QUERIES

Hepatic steatosis on imaging, labs normal, NFS indeterminant, FIB-4 negative, +metabolic syndrome.

Fibroscan or not?

CLINICAL QUERIES

Is NAUSEA a primary GI diagnosis? Once you feel like you complete the WHOLE work up—what do you do?

Send back to referring? Neuro?

Endoscopy: Shared wisdom

'In the moment advice'

Tools of the trade

'Next step' advice

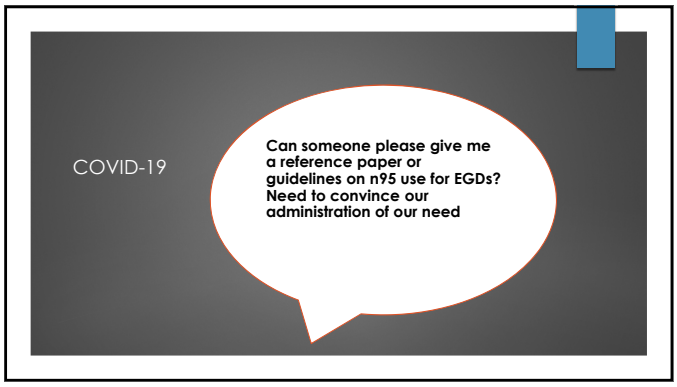
Pathology expertise

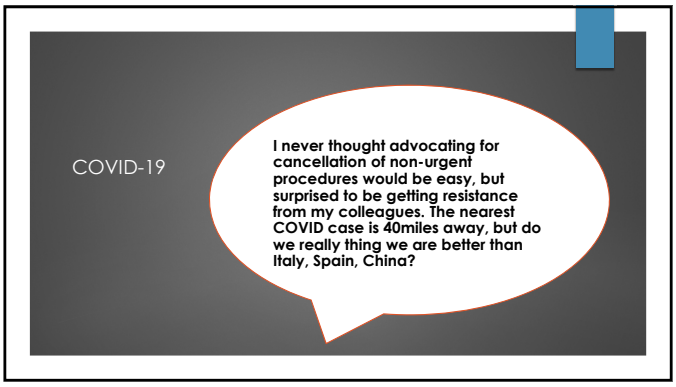
CLINICAL QUERIES

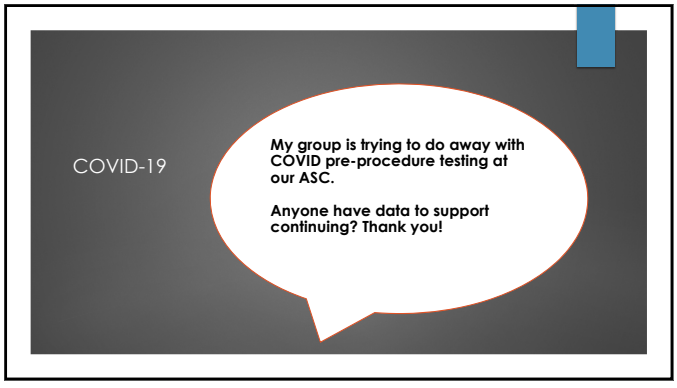
Anyone recommending self guided hypnosis for IBS patients?

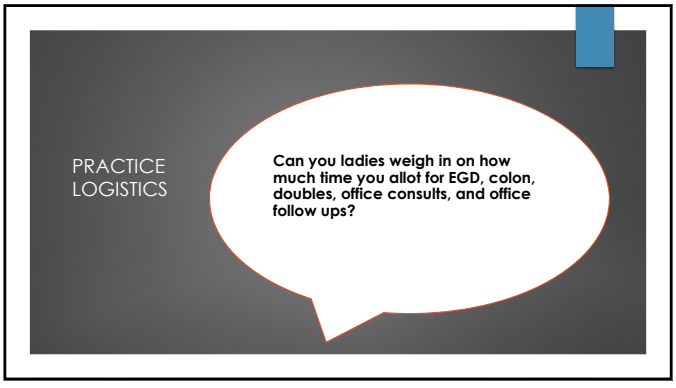
COVID-19

If (or when) COVID explodes, do you anticipate cancelling office visits or elective procedures? Has anyone started strategic planning? Will telehealth be billable? What are other countries doing?
Time to start considering the previously unlikely scenarios…


COVID-19
Can someone please give me a reference paper or guidelines on n95 use for EGDs? Need to convince our administration of our need


COVID-19
I never thought advocating for cancellation of non-urgent procedures would be easy, but surprised to be getting resistance from my colleagues. The nearest COVID case is 40miles away, but do we really thing we are better than Italy, Spain, China?


COVID-19
My group is trying to do away with COVID pre-procedure testing at our ASC.
Anyone have data to support continuing? Thank you!


PRACTICE LOGISTICS
Can you ladies weigh in on how much time you allot for EGD, colon, doubles, office consults, and office follow ups?

PRACTICE LOGISTICS

Does anyone have direct-to-procedure/open access colonoscopy guidelines that you provide your referring PCPs? Our current ones our out of date and causing a lot of problems

JOB LOGISITICS

For those of you part time, what influenced this decision?

How do you divide your days? Call?

JOB LOGISITICS

Wrist pain with endoscopy!

How do you deal with this?

CONTINUITY OF CARE

Anyone down in Chicago who would like to take care of my lovely Crohn's patient who is relocating? On biologics. Would love her to establish care with LOTG

REAL LIFE LOGISITICS

Just found out I am pregnant.
I am worried about how to break this to my partners.

REAL LIFE LOGISITICS

Anyone else dream about leaving medicine?

Shared resources

PRESENTATIONS

LETTERS (INSURANCE)

GUIDELINES/PROTOCOLS

MEETINGS/ CONFERENCES

LOTG Forward

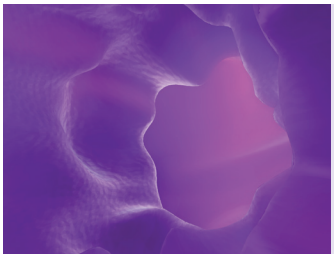
1. Continue "self throttled" growth
2. Allow LOTG to determine future directions, engagement
3. Continue to function independent of sponsorship
4. Work with GI/Hep societies
5. Continue to explore alternative platforms that would ensure ease of access, engagement

Join us!

- Message me directly on Facebook :

@Nundhini Thukkani

- Know a member? Ask her to add you and message me to approve your membership



HASHTAGS, HANDLES AND HEALTHCARE:

Social Media for GI Practice, Education & Career Development

Twitter: @MondayNightIBD and More

Aline Charabaty, MD

JOHNS HOPKINS MEDICINE

Harnessing the Power of Social Media: Medical Education, Networking and Career Advancement

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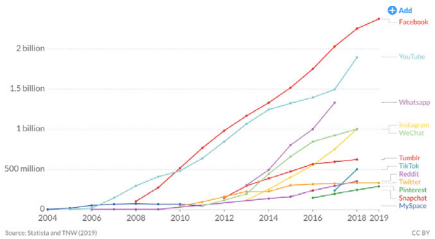
Assistant Clinical Director of the GI Division
Johns Hopkins School of Medicine
Director of the IBD Center
Johns Hopkins-Sibley Memorial Hospital
Washington DC

@DCharabaty
@MondayNightIBD
DrAlineCharabaty

Social Media: Monthly users in US

JOHNS HOPKINS MEDICINE

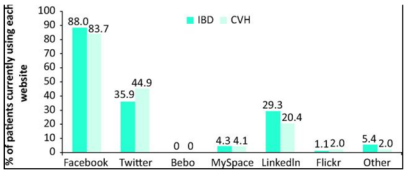


US platforms (monthly use)

73% use YouTube
69% Facebook
37% Instagram
28% Pinterest
27% LinkedIn
22% Twitter
24% Snapchat

Social Media: Where our Patients are

JOHNS HOPKINS MEDICINE



85% IBD pts would like some interaction with HCProfessionals on SoMe

Timms C et al. Clin Med April 2014

Social Media: Where Physicians are ?

JOHNS HOPKINS MEDICINE

- MD recognizing social media as a core component of
  - Patient care
  - Broader access to patients
  - Combating health misinformation
- GI conferences, Journals, Institutions encouraging SoMe presence
- Impact of COVID19: shifting MedEd and Networking to virtual and SoMe

Why are you not on Social Media (SoMe)

- Don't see the point/ utility
- Not sure how to proceed / which platform/ how to optimize my presence
- Not sure what to talk about
- Concerned about time commitment / privacy
- Concerned about negative feedback

So Many #SoMe So Little Time !

AGE

- LinkedIn
- Facebook, Closed safe space groups
- Instagram
- YouTube
- Twitter
- TikTok
- Snapchat

- Goals: SoMe consumer or Content producer
- Material: text, images, videos, topics
- Audience
- Time dedicated to SoMe : Posts, interactions

Find the right SoMe for YOU
Your goals
Your personality
Your interests
Your audience
Open vs closed space

Social Media for MDs: What's in a Tweet?

Because fewer patients are being seen and reduced numbers of procedures are being performed as a result of the pandemic, our industry partners in gastroenterology may see reductions in revenue. Some companies have noted plans for significant reductions in educational funding for 2020. This funding reduction will likely impact the development of locoregional courses and other educational events. Since these course often provide trainees with greater insight into a breadth of endoscopic procedures, it is hoped that industry may participate in the process of organizing novel educational resources such as video demonstrations that could be used in lieu of in-person training courses. Industry can potentially collaborate with societies in efforts like the newly announced ASGE [redacted] and [redacted], where fellows can engage with experts in endoscopy in a virtual setting. Likewise, trainees are encouraged to supplement their education by using social media platforms like Twitter to engage in regularly scheduled chats such as #MondayNightIBD (@MondayNightIBD) and #ScopingSundays (@ScopingSundays).

7. Implications of COVID-19 for future national and regional conferences

News Feature | Published: 09 December 2019

How Twitter is changing medical research

Nicole Wetsman

Nature Medicine **26**, 11–13(2020) | Cite this

Journal of Graduate Medical Education

More Than Likes and Tweets: Creating Social Media Portfolios for Academic Promotion and Tenure

Daniel Cabrera, Bryan S. Vartabedian, Robert J. Spinner, Barbara L. Jordan, Lee A. Aase and Farris K. Timimi

#SoMe Tips-Twips- and Etiquette

(how to get started and use #)

Tips

- Choose your handle wisely
- Bio: Who you are, Your interests
- Focus on few #Topics
- Diversify your twitter circle
- Tweet with a purpose

Etiquette

- Be kind, generous, respectful & honest
- Learn from others & share your wisdom
- Amplify & empower the voice of others
  - Share, RT colleagues, societies events
  - @Tag = give credit to other's work
- Engage with people
  - Participate in conversation
  - Promote your followers
- Keep it professional
  - But have a little bit of fun

How to #StrikeAPost: Post with Intention

What are your goals ?

- Educate
  - Professionals
  - Patients – Fight misinformation
  - Potential to access national and global expertise
- Advocate
  - Profession
  - Women in medicine
  - Patient
- Networking and Professional / Personal development
  - Empower, Amplify and Engage : Your and other's work / posts
  - Build a diverse portfolio of clinicians, advocates, GI societies, experts, people you are interested in listening to
  - Find your tribe
  - Create opportunities : Career opportunities, Research collaboration but also opportunity to mentor and sponsor
- Create your Brand

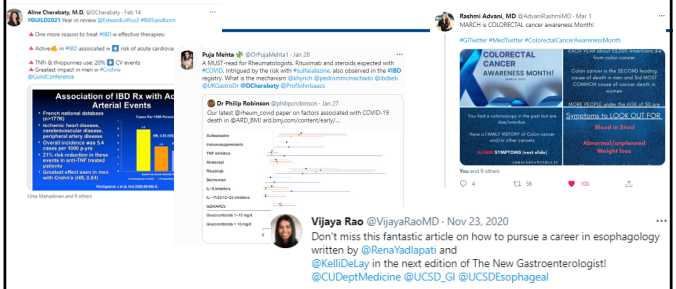
Why is Personal Branding so Important

- You are not (only) your institution/organization
  - People want to know who you are , your values
- There is more to you than your MD degree
  - There is more impact you want / can make outside the office and endo suite
  - Your voice help others find their voice – Empower Women in GI - Representation matters
- Your brand goes with you with career change
  - It's the new CV, accessible and visible to all

Educate #MedEd

- Share / RT quality content
  - Journal articles
  - Highlight from conference
  - Thread / Tweetorial
- Promote your work /colleagues' work
  - Publications
  - Talks
- Engage
  - Comment, raise questions, start a discussion
  - Link to articles, infographic
  - Language: clinicians and patients

#MedEd: Educate, Learn, Amplify, Promote & Engage

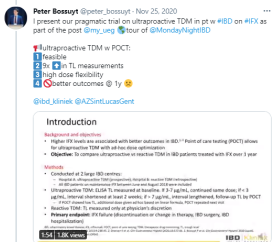


Vijaya Rao @VijayaRaoMD · Nov 23, 2020

Don't miss this fantastic article on how to pursue a career in esophagology written by @RenaYadlapati and @KelliDeLay in the next edition of The New Gastroenterologist! @CUDeptMedicine @UCSD_GI @UCSDEsophageal

mdedge.com/gihepnews/arti...

Global #MedEd

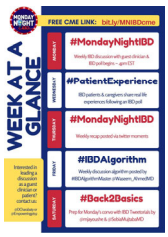


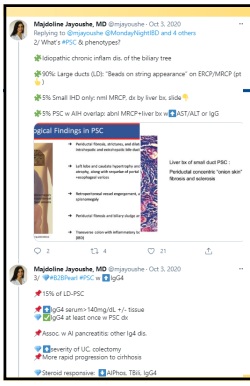
Structured #MedEd

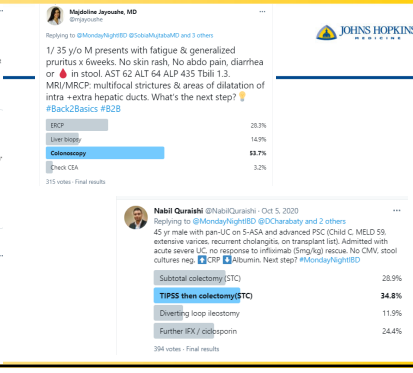
What Is @MondayNightIBD?

Inclusive #IBDEd Platform

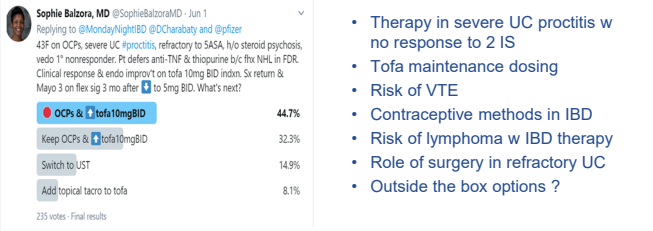
- "Real life" Clinical vignette, Poll & discussion led by an IBD clinician
- MultiDisciplinary & global discussion
- CME credit 1 AMA
- #Back2Basics
- Live Twitter based webinars
- Best of IBD
- Insights into #PatientExperience



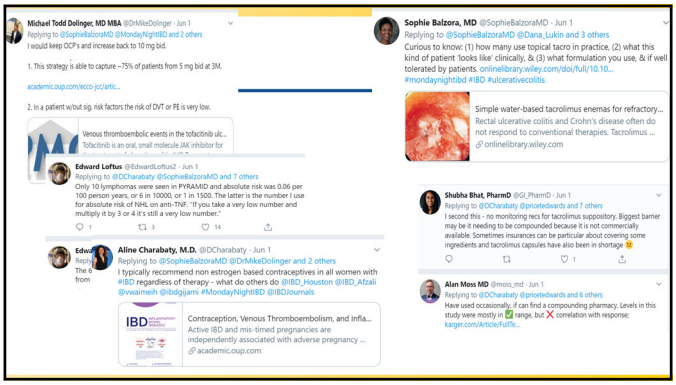




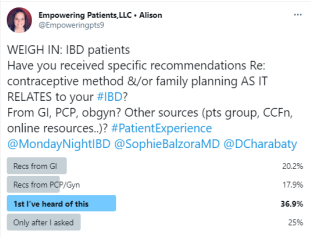
#IBDPoll Results & #IBDAlgorithm

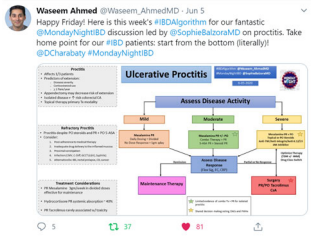


- Therapy in severe UC proctitis w no response to 2 IS
- Tofa maintenance dosing
- Risk of VTE
- Contraceptive methods in IBD
- Risk of lymphoma w IBD therapy
- Role of surgery in refractory UC
- Outside the box options ?

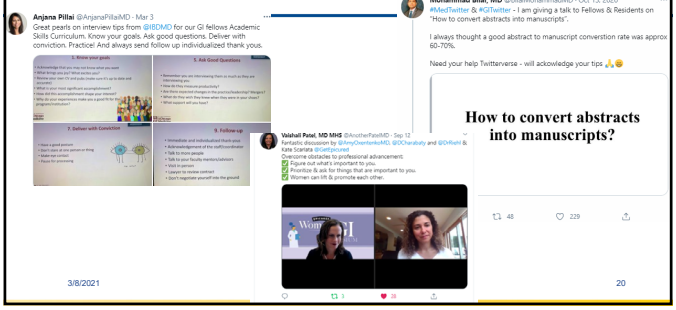


#PatientExperience & #IBDAlgorithm





#MedEd beyond medical info



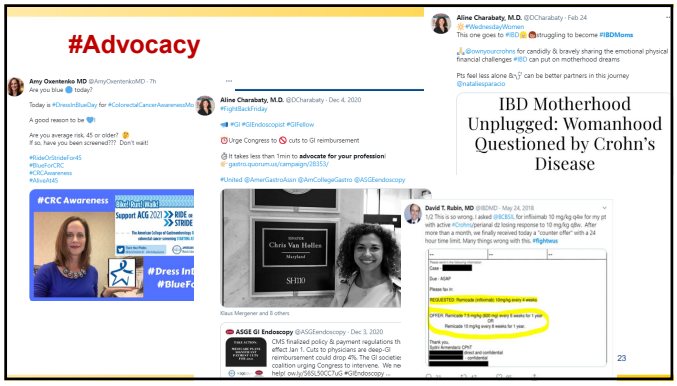
Self-Promotion ? YES !!

21

#Advocacy #SheforShe

22

#Advocacy



23

#Advocacy
Stay in our Lane? Make it our Lane ?

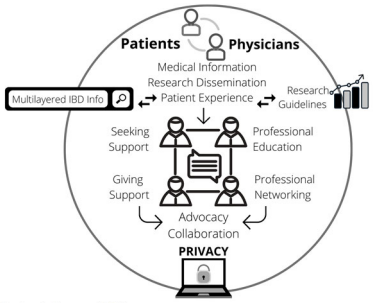
- Social justice
- Health equity
- COVID19 & Vaccine mis-information
- Healthy eating
- Burn out /system failures

24

Life Beyond Medicine

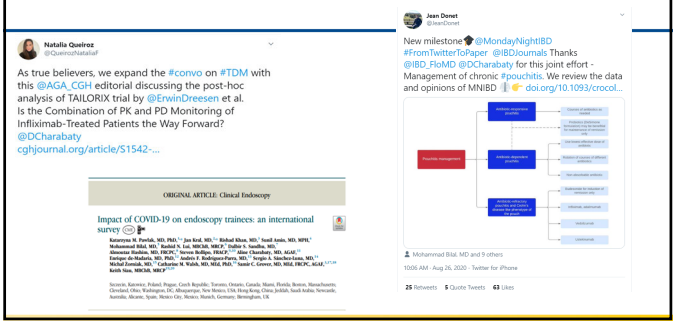
Show who you are and have a little bit of fun

Network



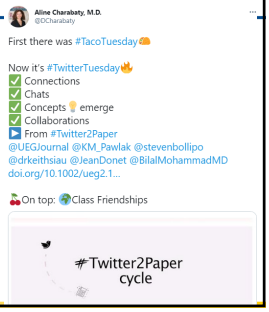
Ahmed Ahmed W, Taft T and Charabaty A. Gastroenterol 2021 in press

#SoMe Collaborations and Research



Reversing the cycle

- All original articles published in GIE from 2000 to 2016 were reviewed.
- Multivariable linear regression to assess for independent predictors of higher **citation rates over time**.
- Largest independent predictor of article citation was whether an article was **tweeted** (odds ratio [OR], 14.2; 95% confidence interval [CI], 8.93-22.45)



From #Twitter2Paper & Back

Aline Charabaty, M.D.
@DCharabaty

Being a endoscopist goes beyond technical skills

It requires @stevenbollipo #Scopemanship!
✅Communication
✅Compassion
✅Teamwork
✅Empowering pts+endo team
✅Situational awareness
✅Decision making
✅Leadership
✅Role modeling
@BilalMohammadMD @drkeithsiau @AmerGastroAssn

Steven Bollipo @stevenbollipo · Aug 14
How to introduce Scopemanship into your training program gastrojournal.org/article/S0016-... #Scopemanship @BilalMohammadMD @drkeithsiau @DCharabaty @AGA_Gastro

3:57 AM · Aug 14, 2020 · Twitter for iPhone

View Tweet activity

52 Retweets 9 Quote Tweets 139 Likes

Enrik Aguila @enrikke · Aug 14
#Scopemanship is the heart of what we do. It is when our passion meets our purpose. It is a call for a relentless desire to do greater things and do things extraordinarily. Thank you very much for this wonderful piece! ❤️
@stevenbollipo @BilalMohammadMD @drkeithsiau @DCharabaty

Seb @ibdseb · Aug 15
Great work : The art of endoscopy 👍
Feel some make scoping too regimental with🏛️numerous,duplicated checklists based on limited evidence from ivory towers & followers. This paper is a welcome & useful document 🔥 @stevenbollipo @DCharabaty @drkeithsiau @BilalMohammadMD .

Jami Kinnucan MD @ibdgijami · Aug 17
Great paper in @AmerGastroAssn @AGA_Gastro on #scopemanship

@APrabhuMD added to our Endoscopy high yield reading list!

👏 @BilalMohammadMD @stevenbollipo @DCharabaty @drkeithsiau

Bollipo S, Bilal M, Sisu K, Charabaty A. Gastroenterology. 2020; 159(5)

Concrete results of SoMe Networking

JOHNS HOPKINS MEDICINE

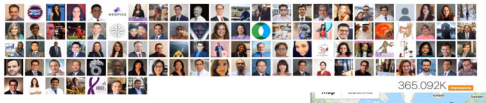
Scholarship activities
- Papers
- Invited talks
- Editorial boards
- GI Societies Committees

And Beyond
- Opportunity to mentor and sponsor younger GI
- Engaged in activity of interest: Women in medicine, diversity and health equity, healthy living
- Coping with COVID
- Finding my tribe beyond the confines of my physical location

Thank you !

JOHNS HOPKINS MEDICINE

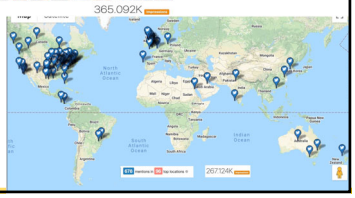
#MondayNightIBD Participants



Tell us where you are in your career

IBD Specialist	35.6%
General GI	24.4%
GI Fellow/trainee/Nurse	29.3%
Non-GI clinician	10.7%

225 votes · Final results



ExtraSlides

JOHNS HOPKINS MEDICINE

Aline Charabaty, M.D.
@DCharabaty
Replying to @DCharabaty
2/ Beyond #MedBikini , there are so many issues that #WomenInMedicine need to shed light on and address together:
🔺Equal pay
🔺Equal academic opportunities
🔺Equal negotiating powers
🔺Equal representation & voices in leadership roles
@Gur
9:02 AM
View
4 Retwe
Aline Charabaty, M.D. @DCharabaty · Dec 24, 2019
On this #ChristmasEve when I haven't started my gifts shopping yet 🤦‍♀️, my daughter and I gave each other the most precious gift #GiftOfTime and went for a run together #Running #HealthyLiving #MedBullying #MerryChristmas #FamilyFun #TisTheSeasonToGiveLoveNotStuff
Aline Charabaty, M.D. @DCharab
4/ Beyond #MedBikini, #WomenIn
🔺Eliminate women & minorities f
🔺Stand up to & Eliminate micro a
minorities and LGBTQ physicians face
@arghavan_salles @CarvalhoP_MD @SophiaBatoraMD @drfolamay
Aline Charabaty, M.D. @DCharabaty · Mar 1
#ColorectalCancerAwarenessMonth
🔪Get screened if age > 45, earlier if you are at high risk!
🚫Delay health prevention until "🦠 pandemic is over"
🚫Ignore pain, 🩸in stool, change ⛰️ anemia
👍Prevention & early detection save lives
#ScreenMoreFearLess #DontFeelBlueWear
AGA and 9 others
Rashmi Advani, MD @AdvaniRashmi
MARCH is COLORECTA
#ColorectalCancerAwa
Show this thread
My first podcast: talking about our Women Leaders in Medici program and the support we are getting from The Physicians Foundation and The Wellness, Equity and Leadership program the American Hospital Association. #np
soundcloud.com/advancinghealt...
#MondayNightIBD
Our #ThursdayThanks
🏆@ericbenchimol for leading the convo &
🏆#PediGI #PediIBD #GI #IBD Patients & caregivers #MondayNightIBD
🏆@snehadave98 leading #PatientExperience
🏆@bowelsounds team for 🎙️ podcast
🏆#Back2Basics team
Optimize the transition from pedi
Aline Charabaty, M.D.
@charabaty
A day of #telemedicine &counting my blessings
• 🐶keeping me company
•My letting me in their 🏠
•Pls asking me how I'm holding up & offering handsree 🤗
• 🐦through the window
ing is bringing us closer together in
together #NotTodayCOVID
Aline Charabaty, M.D. @DCharabaty · Sep 7, 2020
#MondayMorningRun
I run to keep my heart 💪
I run to clear my mind 🧠
I run to feel good wearing 👠
I run to stay emotionally 🧘‍♀️
But most of all .... I run to eat 😃
A fresh warm baguette 🥖is my 🏆 today 💃
What's your favorite workout?
What's your favorite post w/out treat?

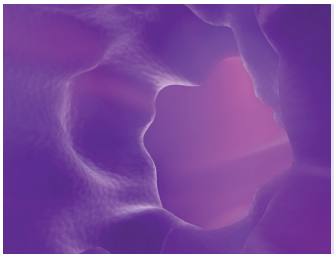
Closing Remarks

Helen Te, MD

Sponsor Support

- Abbvie
- Bausch Health
- Exact Sciences
- Gilead
- Janssen
- Boston Scientific
- Medtronic
- Takeda

AT THE FOREFRONT
UChicago Medicine



SPECIALTY CENTERS

UNIVERSITY OF CHICAGO MEDICINE DIGESTIVE DISEASE CENTER

The Digestive Diseases Center at the University of Chicago Medicine is a collaborative, multidisciplinary network of physicians, researchers and allied health professionals who share a legacy of innovation and a common purpose: to improve the lives of patients who suffer from digestive diseases. The Digestive Diseases Center comprises 15 areas of clinical and research strengths at the University of Chicago Medicine.

CELIAC DISEASE CENTER

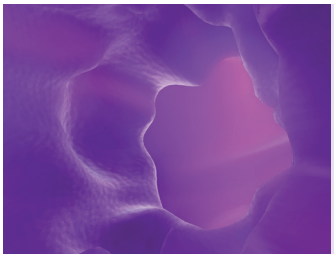
The University of Chicago Medicine's Celiac Disease Center is an internationally recognized center of excellence providing comprehensive patient and professional education, expert diagnosis and treatment for both children and adults, groundbreaking bench and clinical research, and active leadership in advocacy efforts. Our mission is to cure celiac disease. As we focus on research towards a cure, we also strive to raise awareness and diagnosis rates through education and advocacy.

CENTER FOR COLON AND RECTAL DISEASES

The University of Chicago Medicine has a rich tradition of national leadership and innovation in the surgical management of complex colorectal disease, especially inflammatory bowel disease, and sphincter-saving approaches to rectal cancer. Our team, as part of the Digestive Diseases Center, continues to build on this heritage in the treatment of a wide range of challenging colon, rectal and anal diseases, including pelvic floor disorders and perianal disease. We are recognized experts in the surgical treatment of these diseases, and when appropriate, use some of today's most advanced, leading-edge surgical techniques. In fact, more than half of colorectal surgeries we perform are done using minimally invasive techniques. Our collaborative team approach—including physician assistants, medical assistants, nurses and nurse practitioners, as well as highly experienced enterostomal and wound care nurses—has a profound effect on patient outcomes. Our combined expertise ensures that each patient receives the care he or she needs to thrive after surgery.

CENTER FOR ENDOSCOPIC RESEARCH AND THERAPEUTICS (CERT)

CERT offers patients, and their referring physicians, the benefits of endoscopic expertise as well as a comprehensive approach to patient care. Our resources—from cutting-edge technology to physicians, advanced practice nurses and scheduling staff—are exclusively dedicated to serving CERT patients. Our state-of-the-art endoscopy suite, located in the Center for Care and Discovery, offers the most advanced complement of technologies in the region. We use these technologies to diagnose and/or treat a wide variety of complex gastrointestinal disorders, including esophageal and pancreatic cancers, large colon polyps, pancreatic and bile duct stones, pancreatitis and Barrett's esophagus.



SPECIALTY CENTERS

CENTER FOR ENDOSCOPIC TREATMENT OF OBESITY

At the University of Chicago Medicine, we partner with our patients who are struggling with weight and provide them with a nonsurgical program that uses endoscopic therapies as a powerful tool to facilitate or enhance weight loss. Though it is not a cure for obesity, when used properly, endoscopic interventions can provide an effective way to achieve sustained weight loss, with patients averaging between eight percent to nearly 20 percent of their total body weight. As the only program in Chicago currently offering endoscopic sleeve gastroplasty, we provide patients with the latest treatments for nonsurgical weight loss. In addition to performing a wide variety of procedures to best meet our patients' needs, we also offer patients access to clinical trials, enabling them to benefit from novel treatment solutions not yet widely available on the market.

CENTER FOR ESOPHAGEAL DISEASES

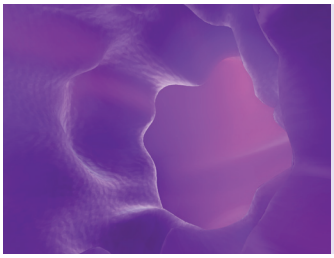
The Center for Esophageal Diseases is one of the few centers in the U.S. dedicated solely to the diagnosis and treatment of esophageal disease. We bring together nationally and internationally recognized clinicians and researchers in a variety of related disciplines to provide patients with advanced options, resources and a level of experience and innovation available at only a handful of leading medical centers in the world. Our approach is both personalized and multidisciplinary, and our outcomes are considered a model for outstanding patient care.

CENTER FOR LIVER DISEASES

For more than 20 years, the University of Chicago Center for Liver Diseases has helped set the standard of care for the management of many liver diseases, including hepatitis C, which has now reached the pinnacle of its therapy. We also have helped shape the therapeutic journey toward a cure for chronic hepatitis B. Today, we are helping to find an effective treatment for nonalcoholic fatty liver disease, and we are studying various biologic markers for the diagnosis and potential treatment targets of liver cancer. Our experienced team of hepatologists, mid-level providers and specialty nurses work with patients very closely to deliver personalized medicine that addresses each patient's needs. We have a multidisciplinary team of hepatologists, diagnostic radiologists, oncologists, and hepatobiliary and liver transplant surgeons who provide unparalleled comprehensive care for primary liver cancer in our Liver Tumor Clinic, where many challenging cases are often given new hope. We also take a collaborative approach to the management of fatty liver disease in our Metabolic Liver Clinic by working closely with an endocrinologist and dietitian, and Centers for Endoscopic and Surgical Treatment of Obesity to provide the most innovative, comprehensive treatments. Our liver transplant program is renowned nationally and worldwide. It is the oldest in the Midwest, and fourth oldest in the nation. Our program has the lowest waitlist mortality in Illinois - that is, patients on our waitlist have the lowest chance of dying before they receive a liver transplant. We also have excellent graft and patient survival rates. Our center also ranks at the top nationally in multi-organ transplant procedures. In terms of both volume and experience, we have performed the greatest number of combined liver, heart and kidney transplants, and are fourth in combined liver and heart transplants in the country.

CENTER FOR GASTROINTESTINAL ONCOLOGY

The Center for Gastrointestinal Oncology brings together experts from two of the University of Chicago Medicine's nationally recognized programs: cancer and gastroenterology. Both are consistently ranked among the top in the nation, and include physicians who are internationally recognized for their expertise. Our approach to diagnosis and treatment is multidisciplinary and consensus-based, so that patients—including those with rare or complex disease—benefit from collaborative problem solving among specialists in medical, surgical, and radiation oncology, general surgery and gastroenterology. Whenever possible, we offer minimally invasive, including robotic procedures for GI tumor biopsy and resection. Our team includes internationally renowned GI specialists and physicians who are pioneers in the use and development of endoscopy—including the use of probe-based confocal laser endomicroscopy. Our patients receive access to revolutionary clinical trials, offering the next generation of treatment to hose with gastrointestinal cancer. Through innovative surgical and radiation techniques, investigational and established medicines and novel molecular targeted therapies, our physicians offer patients the highest chances of success against a wide variety of cancers.



WOMEN IN DIGESTIVE DISEASES: UPDATES IN 2021

University of Chicago | A Virtual Event

March 13, 2021

SPECIALTY CENTERS

CENTER FOR SMALL BOWEL DISEASE AND NUTRITION

The Small Bowel Disease and Nutrition Program includes comprehensive management of small bowel bleeding, short bowel syndrome/intestinal failure, celiac disease and obesity. We were one of the first in the United States to perform double balloon enteroscopy for the treatment of small bowel bleeding, to use radiologic expertise in small bowel imaging, and to perform minimally invasive small bowel surgery. The center is uniquely staffed by a multidisciplinary nutrition support team to diagnose and manage short bowel syndrome/intestinal failure, diarrhea/malabsorption syndromes, and patients with feeding difficulties. The nutrition team, established in 1980, provides expert administration of parenteral and enteral nutrition in the inpatient and outpatient setting. Our obesity management program is unique in its focus on nutrition education by a certified physician-chef. In addition to the education and treatments provided to our patients, we also are actively researching novel therapies in the treatment of celiac disease, short bowel syndrome and other intestinal disorders.

CENTER FOR THE SURGICAL TREATMENT OF OBESITY

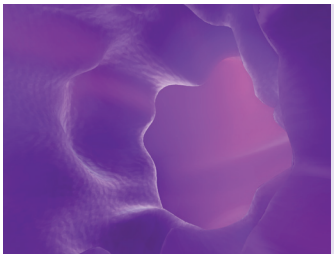
Obesity is a multifaceted disease with many causes and treatments. Our program provides individualized, patient-centric, compassionate and truly multidisciplinary care to help those with severe obesity achieve the best health outcomes possible. We make our recommendations based on the individual circumstances of our patients, so that they may be successful in attaining their desired or needed health goals. Our physicians work side-by-side with our dietitians and psychologists in the clinic—both pre- and post-operatively—and are committed to lifelong follow up with our patients. We are the only center in the region that individualizes recommendations and performs all four surgical options for the treatment of obesity. Our expertise in the treatment of super obesity (BMI >50) has garnered numerous invitations to present and demonstrate our approach and outcomes at local, regional, national and international conferences. We are the regionally recognized referral center for complications and other suboptimal outcomes following procedures performed at other institutions, and we routinely serve as educational hosts for visiting surgeons, dietitians and program managers as they initiate the incorporation of more advanced procedures and techniques into their practices.

GASTROINTESTINAL CANCER RISK AND PREVENTION CLINIC

The Gastrointestinal Cancer Risk and Prevention Clinic offers personalized and precision medicine for patients at increased risk for or survivors of gastrointestinal malignancies. As gastroenterologists, genetic counselors, oncologists, and surgeons. we work together in a multidisciplinary collaborative team to provide state-of-the art cancer risk assessment, genetic testing, management of hereditary syndromes, and cancer prevention strategies, such as control of inflammation in colitis.

GENERAL GASTROENTEROLOGY

The Center for General Gastroenterology provides comprehensive and innovative endoscopic and medical treatment for a variety of digestive disorders. Our physicians have experience and expertise in managing conditions such as heartburn and gastroesophageal reflux disease, acid-peptic disorders, colorectal cancer screening, occult and overt gastrointestinal bleeding, gastrointestinal infections and functional bowel diseases. Our general gastroenterologists are involved in robust clinical research programs including optimizing outcomes of patients hospitalized with upper and lower gastrointestinal bleeding, and improving quality of colorectal cancer screening.



SPECIALTY CENTERS

INFLAMMATORY BOWEL DISEASE CENTER

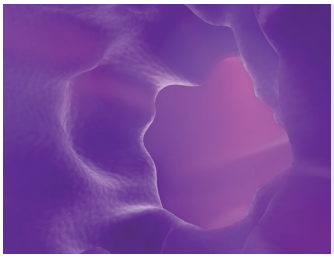
The Inflammatory Bowel Disease Center is committed to providing the highest caliber of care to patients who suffer from Crohn's disease, ulcerative colitis and related conditions. Outstanding patient care is at the center of everything we do, from providing state-of-the-art medical therapies and nutritional counseling, to using minimally invasive approaches for complex surgeries to decrease pain, scarring and recovery times, outstanding patient care is at the center of everything we do. In order to best serve our patients, we conduct ongoing medical research to advance our understanding of these conditions. We also deliver unique and highly relevant educational programs for patients and professionals. As one of only a limited number of research centers in the country testing new IBD treatments, we can offer a variety of clinical trial therapies—the most advanced treatments available—at the earliest possible time in patients' care. Every patient benefits from the expertise of our world-renowned clinicians and researchers, whose multidisciplinary, collaborative approach extends from patient care to advancing the science of medicine.

PANCREATIC DISEASE CENTER

Diseases of the pancreas require comprehensive care from a multidisciplinary and integrated team of experts. Our pancreatic disease team includes recognized leaders in specialties from gastroenterology to interventional radiology and pain management, and extends to include nutritionists, nurses and genetic counselors. Together, we offer unparalleled expertise in diagnosing and treating all types of pancreatic conditions, including severe acute and chronic pancreatitis, complications from pancreatitis, pancreatic pseudocyst and walled-off necrosis, treatment of large pancreatic duct stones using extracorporeal shock wave lithotripsy, pancreatic cystic lesions, genetic conditions that affect the pancreas including CFTR, PRSS1, CTRC and SPINK; and autoimmune pancreatitis, among others. IN conjunction with the Center for Endoscopic Research and Therapeutics, we are leaders in the use of minimally invasive, per-oral techniques for complex conditions that might otherwise require major surgery. We are also leaders in early detection in patients who are at high risk of developing pancreatic cancer. Our physician-scientists are involved in several multicenter research trials examining novel genetic links to pancreatitis and pancreatic cancer, new medications that improve outcomes after total pancreatectomy and islet autocell transplantation, and treatment outcomes after transmural treatment of walled-off necrosis, a complication from severe pancreatitis.

BASIC AND TRANSLATIONAL RESEARCH

At the heart of the Digestive Diseases Center lies basic and translational research, the latter defined as the application of basic knowledge to clinical practice. In this regard, our program is uniquely and intimately connected with the clinicians and clinical research programs at the University of Chicago Medicine. Within the Digestive Diseases Research Core Center (DDRCC), we focus on providing the best patient care by building a better understanding of gastrointestinal diseases in order to improve diagnosis, treatment and outcomes. Our research programs are supported by investigator-initiated grants of nearly $10 million per year from the NIH, Crohn's and Colitis Foundation of America, Castro-Intestinal Research Foundation of Chicago, Broad Medication Research Program, and other sources of extramural and philanthropic funds. The DDRCC promotes collaborative, multidisciplinary development of research and technology, and is one of only 17 such centers in the U.S. Our support of GI research has led to the discovery of the first IBD gene (NOD2), new understanding of the causes and management of celiac disease, insights into the role of gut microbes in complex immune disorders, and elucidation of the genetic and dietary mechanisms causing colon cancer. We are internationally renowned for our work on the gut microbiome, mucosal immunology, host-microbe interactions and cancer. Strong interactions and collaborations with Argonne National Laboratory and the Marine Biological Laboratory at Woods Hole (both affiliate research institutions of the University of Chicago) complement and extend



SPECIALTY CENTERS

our reach, as does our participation in SHARE, a consortium of seven research institutions whose pooled patient databases and other resources permit studies that otherwise could not be conducted by a single institution.

CLINICAL RESEARCH

At the University of Chicago Medicine, clinicians, patients and researchers participate in and benefit from a rigorously research-based approach to patient care. Year after year, we conduct or participate in more clinical trials than any other hospital in Illinois, offering patients and the physicians who refer them access to the most promising treatments and new standards of care. New ideas and new information shape our daily practice of medicine. They deepen our understanding of health and disease and amplify our ability to develop better treatments for all medical conditions, from the simplest to the most complex. Within the Digestive Diseases Center, a database of material pertaining to more than 5,000 patients, is the vital infrastructure for clinical trials of conventional and novel medical therapies intended to diagnose and treat a wide range of digestive diseases. In hepatology, we are currently conducting research in the areas of liver transplantation, fatty liver disease and other inflammatory liver disorders. Our research in nutrition is studying the impact of lactose intolerance in minority health outcomes, as well as obesity and celiac disease. Other studies are examining the optimization of colorectal cancer screening for average and high-risk patients, the effect of genetic counseling and the possibilities of chemoprevention. We are currently leading more than 200 research studies on human subjects with digestive diseases. This includes more than 20 IBD-related clinical trials, such as an NIH-supported human microbiome study that seeks to understand the role of intestinal microbes in the development of IBD. Whether working independently or as part of the multicenter research teams, we are asking—and answering—the questions that will lead to more effective treatments, better practice and better patient outcomes for healthcare professionals across the country and around the world.

CONTACT US

GI Physician Connect for referral assistance, patient appointments or consultations
1-844-UC GI DOC
1-844-824-4362

UCM Physician Connect for referrals
1-800-824-2282

UCM Transfer Connect for inpatient transfers
1-855-834-4782

AT THE FOREFRONT
UChicago Medicine
Digestive Diseases Center

You are invited to participate in our live, monthly Case Discussion Roundtable series, featuring clinical updates, case presentations, and Q & A with UChicago Digestive Diseases Center faculty. Meetings are held live, via Zoom.

Digestive Diseases Center Case Discussion Roundtables

4:30 to 5:30 PM Central Time

- Participate FREE
- Earn CME credit
- Join via any device

INFLAMMATORY BOWEL DISEASE
First Tuesdays

MARCH 2, 2021
Joel Pekow, MD
Update in the Management of Pyoderma Gangrenosum

APRIL 6, 2021
Christopher Weber, MD, PhD
Pathology and IBD Treatment

MAY 4, 2021
TBD

JUNE 8, 2021
Russell D. Cohen, MD/
David T. Rubin, MD
Updates from Digestive Diseases Conferences, 2021

LIVER
Third Thursdays

MARCH 16, 2021
Talia Baker, MD

APRIL 20, 2021
Andrew Aronsohn, MD

MAY 18, 2021
Anjana Pillai, MD

JUNE 15, 2021
Andrew Aronsohn, MD

OBESITY AND NUTRITION
Fourth Tuesdays

MARCH 23, 2020
Edwin McDonald, IV, MD

APRIL 27, 2021
Omar Jamil, MD

MAY 25, 2021
Mustafa Hussain, MD

JUNE 16, 2021
Annie Guinane, RD

JULY 27, 2021
Alison L. Crawford, MD

Interested in attending or want to learn more? Simply email our team. Our telehealth coordinator will follow up promptly. Email **GITelehealth@medicine.bsd.uchicago.edu.**

University of Chicago Digestive Diseases Center

We provide care for all types of gastrointestinal conditions, from inflammatory bowel disease and liver disorders, to esophageal, pancreatic and bile duct diseases and all forms of gastrointestinal cancers. U.S. News & World Report ranks our digestive disorders program among the best in the nation. We have patient-centered programs for many common and rare GI disorders.

UPCOMING EVENTS

OCT **1-2** 2021	**ANNUAL UPDATES IN DIGESTIVE DISEASES MEETS ACING THE GI BOARD EXAM** Hybrid Event: **Virtual and In-person** Location: **David Rubenstein Forum, University of Chicago Campus** **1201 E. 60th St., Chicago** **Contact: amy2@uchicago.edu** for additional details.
MAR **26** 2022	**WOMEN IN DIGESTIVE DISEASES: AT THE FOREFRONT** Location: **TBD** **Contact: amy2@uchicago.edu** for additional details.

AT THE FOREFRONT
UChicago Medicine

WOMEN IN DIGESTIVE DISEASES: AT THE FOREFRONT

MARCH 13, 2021