March is COLORECTAL CANCER AWARENESS MONTH

Colorectal Cancer: You Can Prevent It.

New Patient Education Materials to Download
Participating in the Webinar

All attendees will be muted and will remain in Listen Only Mode.

Type your questions here so that the moderator can see them. Not all questions will be answered but we will get to as many as possible.

How to Receive CME and MOC Points

LIVE VIRTUAL GRAND ROUNDS WEBINAR

ACG will send a link to a CME & MOC evaluation to all attendees on the live webinar.

ABIM Board Certified physicians need to complete their MOC activities by December 31, 2021 in order for the MOC points to count toward any MOC requirements that are due by the end of the year. No MOC credit may be awarded after March 1, 2022 for this activity.
MOC QUESTION

If you plan to claim MOC Points for this activity, you will be asked to: Please list specific changes you will make in your practice as a result of the information you received from this activity.

Include specific strategies or changes that you plan to implement. THESE ANSWERS WILL BE REVIEWED.

ACG Virtual Grand Rounds

Join us for upcoming Virtual Grand Rounds!

Week 13, 2021
Healthcare Carbon Footprint: “Scope” of the Problem
Swapna Gayam, MD
April 1, 2021 at Noon Eastern

Week 14, 2021
Cystic Fibrosis – Navigating Gastrointestinal Complications
Christine Y. Hachem, MD, FACG
April 8, 2021 at Noon Eastern

Visit gi.org/ACGVGR to Register
SPECIAL EDITION – COVID-19 Vaccine Update

Speakers will explain the data behind the various vaccines, clinical recommendations, allergy and safety recommendations, and describe COVID-19 vaccine special issues in underrepresented minorities.

TUESDAY, MARCH 30th, 8-9:30 PM EDT

Faculty
- Freddy Caldera, DO, MS
- Francis A. Farraye, MD, Msc, MACG
- David T. Rubin, MD, FACC
- Pascale M. White, MD

Moderator
- ACG President David A. Greenwald, MD, FACG

Register & Learn More: gi.org/ACGVGR

TUNE IT UP: A CONCERT TO RAISE COLON CANCER AWARENESS

ACG Virtual Community Event in honor of March Colorectal Cancer Awareness Month

Wednesday, March 31st at 8 pm EDT

Hosted by Dr. Benjamin Levy and ACG Public Relations Committee

American College of Gastroenterology | gi.org/Concert
Disclosures:

**Speaker:**
David A. Greenwald, MD, FACG
Dr. Greenwald, faculty for this educational event, has no relevant financial relationship(s) with ineligible companies to disclose.

**Moderator:**
Aasma Shaukat, MD, MPH, FACG
Dr. Shaukat, faculty for this educational event, has no relevant financial relationship(s) with ineligible companies to disclose.

Colorectal Cancer Screening and Prevention in the US and Worldwide: Lessons from the Pandemic

David A. Greenwald, MD, FACG
President, American College of Gastroenterology
Director of Clinical Gastroenterology and Endoscopy
Mount Sinai Hospital
New York, NY

American College of Gastroenterology Virtual Grand Rounds
March 2021
Colorectal Cancer Screening in USA

*Initial Goal: 80% by 2018*

*Current Goal: 80% in Every Community*

It All Comes Down to This...

- Preventable
- Treatable
- Beatable
• Second most common diagnosed cancer in US
• Third overall in men and women respectively
• Second leading cause of cancer death in US

American Cancer Society, 2020

The Goal of Colorectal Cancer Screening is to Decrease Mortality

Sources: CDC’s National Program of Cancer Registries and National Cancer Institute’s Surveillance, Epidemiology, and End Results program.
*Rates are the number of cases per 100,000 persons and are age-adjusted to the 2000 U.S. standard population (19 age groups – Census P25–1130).
CDC data for 2010, accessed January 2021

Colorectal cancer screening: Up to Date in USA 2016

A. Percentage of respondents aged 50 to 75 who reported being up to date* with colorectal cancer screening, 2016

*Up to date = fecal occult blood test (FOBT) within 1 year, or sigmoidoscopy within 5 years with FOBT within 3 years, or colonoscopy within 10 years.
Colorectal Cancer Screening Rates in USA

BRFSS—Behavioral Risk Factor Surveillance System

Decreasing CRC Incidence and Mortality


Siegel et al. CA Cancer J Clin 2017; 67: 177–193
**National Colorectal Cancer Roundtable**

**CDC Initiative “80% by 2018”: Impact**

- **Goal:**
  - 80% of age-appropriate adults screened by 2018

- **Result:**
  - Reduction in colorectal cancer by 2030
    - >20% incidence
    - >33% mortality
    - Would prevent 277,000 new colon cancers between 2013-2030
    - Would prevent 203,000 deaths between 2013-2030


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**USPSTF CRC Screening 2016**

*Highlights*

- Menu of options
- Shared decision between patient and clinician
- Good evidence that screening works
- Screening is underutilized
  - 60%-67% of people up to date with CRC screening
- No direct comparison trials between screening strategies
  - Different evidence basis for each testing strategy
- Performance of a single test for detection of CRC is important
- In an ongoing screening program (i.e., FIT) sensitivity over time is important

*Update sent out for public comment late 2020, expected mid 2021*
### USPSTF CRC Screening 2016: Options

<table>
<thead>
<tr>
<th>Screening Method</th>
<th>Frequency</th>
<th>Evidence of Efficacy</th>
<th>Other Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stool-Based Tests</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>pFOBT</td>
<td>Every year</td>
<td>RCTs with mortality end points; high-sensitivity versions (e.g., Hemoccult SENS) have superior test performance characteristics than older tests (e.g., Hemoccult II)</td>
<td>Does not require bowel preparation, anesthesia, or transportation to and from the screening examination (test is performed at home)</td>
</tr>
<tr>
<td>FIT</td>
<td>Every year</td>
<td>Test characteristic studies: improved accuracy compared with pFOBT but can be done with a single specimen</td>
<td>Does not require bowel preparation, anesthesia, or transportation to and from the screening examination (test is performed at home)</td>
</tr>
<tr>
<td>FIT-DNA</td>
<td>Every 1 or 3 y(^e)</td>
<td>Test characteristic studies: specificity is lower than for FIT, resulting in more false-positive results, more diagnostic colonoscopies, and more associated adverse events per screening test</td>
<td>There is insufficient evidence about appropriate longitudinal follow-up of abnormal findings after a negative diagnostic colonoscopy; may potentially lead to overly intensive surveillance due to provider and patient concerns over the genetic component of the test</td>
</tr>
</tbody>
</table>

| Direct Visualization Tests | | | |
| Colonoscopy\(^d\) | Every 10 y | Prospective cohort study with mortality end point | Requires less frequent screening | Screening and diagnostic follow-up of positive findings can be performed during the same examination |
| CT colonography\(^e\) | Every 5 y | Test characteristic studies | There is insufficient evidence about the potential harms of associated extracolonic findings, which are common |
| Flexible sigmoidoscopy | Every 5 y | RCTs with mortality end points; modeling suggests it provides less benefit than when combined with FIT or compared with other strategies | Test availability has declined in the United States |

| Flexible sigmoidoscopy with FIT\(^f\) | Flexible sigmoidoscopy every 10 y plus FIT every year | RCT with mortality end point (subgroup analysis) | Test availability has declined in the United States; Potentially attractive option for patients who want endoscopic screening but want to limit exposure to colonoscopy |

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### USPSTF CRC Screening 2016

#### Recommendation Summary

<table>
<thead>
<tr>
<th>Population</th>
<th>Recommendation</th>
<th>Grade (What's This?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults aged 50 to 75 years</td>
<td>The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years. The risks and benefits of different screening methods vary. See the Clinical Considerations section and the Table for details about screening strategies.</td>
<td>A</td>
</tr>
<tr>
<td>Adults aged 76 to 85 years</td>
<td>The decision to screen for colorectal cancer in adults aged 76 to 85 years should be an individual one, taking into account the patient's overall health and prior screening history.</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>- Adults in this age group who have never been screened for colorectal cancer are more likely to benefit.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Screening would be most appropriate among adults who 1) are healthy enough to undergo treatment if colorectal cancer is detected and 2) do not have comorbid conditions that would significantly limit their life expectancy.</td>
<td></td>
</tr>
</tbody>
</table>
The ACS recommends that adults aged 45 y and older with an average risk of CRC undergo regular screening with either a high-sensitivity stool-based test or a structural (visual) examination, depending on patient preference and test availability.

- As a part of the screening process, all positive results on noncolonoscopy screening tests should be followed up with timely colonoscopy.
- The recommendation to begin screening at age 45 y is a qualified recommendation.
- The recommendation for regular screening in adults aged 50 y and older is a strong recommendation.
- The ACS recommends that average-risk adults in good health with a life expectancy of greater than 10 y continue CRC screening through the age of 75 y (qualified recommendation).
ACG Colorectal Cancer Screening Guidelines 2021

Recommend CRC screening in average risk individuals
- Between 50-75 (strong recommendation, moderate quality evidence)
- Between 45-49 (conditional recommendation)
- Screening beyond 75—individualized
- Primary modalities: Colonoscopy and FIT
- For those unwilling or unable to undergo FIT or colonoscopy:
  - Flexible sigmoidoscopy
  - Multitarget stool DNA testing
  - CT colonography
  - Colon capsule

ACG Colorectal Cancer Screening Guidelines 2021

- **One step screening**
  - Colonoscopy
- **Two step screening**
  - Stool based tests

- Intervals
  - FIT yearly
  - Colonoscopy every 10 years
  - Multitarget Stool DNA 3 years
  - Flex sig 5 years
  - CT colonography 5 years
  - Colon capsule 5 years
- Recommend against Septin 9
**Key Issue: Screening African Americans at Age 45**

**Disparities: Higher CRC Incidence and Mortality in African Americans**

For Black Americans compared to White Americans:
- 20% higher incidence of CRC
- 40% higher death rate

“Zip code more important than genetic code”

Williams et al., Committee on Minority Affairs and Cultural Diversity, American College of Gastroenterology. *Clinical and Translational Gastroenterology* 2016; 7(7):e185

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**Key Issue: Screening African Americans at Age 45**

**Disparities: Higher Incidence of Young CRC in African Americans**

![Graph showing age-adjusted CRC incidence rate by race and year for different populations.](image)

*Fig. 1* Age-adjusted CRC rate by race and year in different populations. Differences in age-adjusted CRC incidence rate (2000 US Standard Population) among young African Americans, non-Hispanic whites, and Asian-Pacific Islanders for the years 2000–2012


Multi-Society Recommendations Regarding African Americans (2017)

- Non-African American, average risk
  - Screening being at age 50
  - Strong recommendation
- African American
  - Screening should begin at age 45
  - Weak recommendation


Key Issue:
Start Screening at Age 45

Among adults younger than 55 years, there was a 51% increase in the incidence of CRC from 1994 to 2014 and an 11% increase in mortality from 2005 to 2015.

Key Issue:
Start Screening at Age 45

Age specific incidence is about the same for a 45 year old in 2015 as it was for a 50 year old in 1993, about 30 per 100,000

Key Issue:
Increasing Incidence of Early CRC: Why?

- Possible epidemiologic factors
  - Smoking
  - Obesity
  - Diet changes
  - Something “different” going on
- No formal guidelines or recommendations to date
- Concerning signs and symptoms should prompt evaluation
Key Issue: Effects of Smoking

- 20 pack-years of smoking
  - 2-3 fold increased risk of advanced adenoma

- 20% of all US CRC patients have a history of smoking
  - One of strongest predictors of CRC
  - Impact of quitting is as yet unclear
  - Risk may continue to be increased as long as 20 years after smoking cessation
  - Appears to be same risk as a first degree relative with CRC


Key Issue: Effect of Obesity
Colon Polyps and Cancer

- Overweight and obese status
  - Increases CRC risk by 1.5-2.8 fold

- For each unit increased BMI---3% increase in CRC risk

- For each 5 unit increase in BMI,--19% increase in adenoma risk

- Relative risk influenced by pattern of fat distribution important
  - Abdominal obesity > truncal obesity or BMI

(Gastroenterology 2012;142:762-9)
Key Issue: When to Stop Screening?

- Prevalence of adenomas increases with age in a linear fashion
- Incidence of CRC increases with age, but in a nonlinear fashion
- Separation of these 2 curves in elderly suggests:
  - More mutations
  - Advanced lesions more likely to convert to cancer
- Screening appropriate for previously unscreened elderly
- Colonoscopy better test than sigmoidoscopy
  - CRC shift into proximal colon with age
- Age becomes an increased risk factor for complications during procedures

*Individualize between patient and physician*

Gastroenterology 2016;150:103–113

Screening Options

American College of Gastroenterology
Colonoscopy

- Reduced incidence of CRC by 76-90%
- Impact on CRC incidence by clearing of polyps during colonoscopy
- Colon cancer incidence rates dropped by 30% from 2004-2014 (ACS 2014)
- Colon cancer mortality rate decreased 30% (ACS, 2013)

Winawer et al. NEJM 1993;329:1977-81
This-Evensen et al. Scand J Gastroenterol 1999;34:414-20

Polypectomy Reduces Death from CRC...

![Graph showing 53% reduction in cumulative colorectal cancer mortality](image)

Quality in Colonoscopy Paramount

- Adequate preparation
  - Adequate for polyp detection
- Cecal intubation rates
  - Benchmark is >95%
- Withdrawal time from cecum
  - 6 or 8 minutes
- Adenoma detection rates (benchmarks)
  - Males 30%
  - Females 20%

ACG, ASGE Quality Indicators, 2015

GIQuIC Colonoscopy Growth Rate
January 2012 - February 2021

American College of Gastroenterology
Colorectal Cancer Screening in NYC—Population Health

*C5: Citywide Colon Cancer Control Coalition*

- Convened by NYC Department of Health and Mental Hygiene (DOHMH) in March 2003
- Engaging multiple stakeholders
  - Health care professionals
  - Clinicians
  - Researchers
  - Administrators
  - Advocates

C5: Results

NYC Colonoscopy Screening Trends

Percentage ≥ 50 yrs Receiving Colonoscopy within last 10 years in NYC, 2003-2011

- Screened:
  - 2003: 828K
  - 2004: 1,055K
  - 2005: 1,067K
  - 2006: 1,193K
  - 2007: 1,252K
  - 2008: 1,399K
  - 2009: 1,428K
  - 2010: 1,599K

- Unscreened:
  - 2003: 1,163K
  - 2004: 973K
  - 2005: 870K
  - 2006: 814K
  - 2007: 785K
  - 2008: 739K
  - 2009: 722K
  - 2010: 696K
  - 2011: 758K
C5: Results
Racial/Ethnic Screening Disparities

Percentage ≥ 50 yrs Receiving Colonoscopy within last 10 years by Race/Ethnicity, 2003-2011

C5: Reducing Racial Disparities

Increased Screening Colonoscopy Rates and Reduced Racial Disparities in the New York Citywide Campaign: An Urban Model
ACG Virtual Grand Rounds

Initiatives in New York

American College of Gastroenterology
Colorectal Cancer Screening: The Future

- Focus on prevention and early detection
- Menu of options to choose
- Shared decision making
- High quality performance in all aspects of screening
- Colonoscopy and polypectomy remain the mainstay for therapy

Beyond 2018...additional campaigns
- Targeted messages at the unscreened
- Individualized approaches
- All combine to have colorectal cancer incidence and mortality continue to decrease
There are Many Ways to Screen for Colon Cancer....

Effect of COVID 19 Pandemic on Colonoscopy and Colorectal Cancer Screening

- Endoscopy services
- Outpatient services
- Training
- Vaccines and the Future
Where We Are Today

DAILY CONFIRMED NEW CASES (7-DAY MOVING AVERAGE)
Outbreak evolution for the current most affected countries

ACG Virtual Grand Rounds
universe.gi.org

COVID 19: The Beginning
A Novel Coronavirus from Patients with Pneumonia in China, 2019

December 31  WHO Informed
January 7    Virus Isolated
January 10-12 Full Genome Sequenced
January 11   Named 2019 nCoV
January 12   Genome Sequence Shared with WHO Databank
January 13   PCR Protocol Shared with WHO

Zhu N, et al, NEJM, Jan 2020
Endoscopic Volume: Markedly Reduced

- International survey of 250 centers
- 83% reduction in endoscopic volume across all continents
- Much of reduction due to shortage of PPE
- N95 use 70-91% (US), Europe (69%)
- UK—Procedure volume decreased to 12% of pre-COVID volume

Sravanthi Parasa, Nageshwar Reddy, Douglas O. Faigel, Alessandro Repici, Fabian Emura, Prateek Sharma,

Endoscopic Volume: Markedly Reduced

New York

[Graph showing endoscopic volume in New York pre-COVID and post-COVID]

England

[Graph showing endoscopic volume in England pre-COVID and post-COVID]


Impact of COVID 19 on GI Procedures and Cancers


Guidelines on Endoscopy During COVID Pandemic

US GI Societies Guidance on Endoscopic procedures in the pandemic, March 2020
Urgent/Emergent Procedures that May Not be Delayed

1. Upper and lower GI bleeding
2. Suspected GI bleeding
3. Dysphagia significantly impacting oral intake
4. Cholangitis or impeding cholangitis
5. Symptomatic pancreaticobiliary disease
6. Palliation of GI obstruction (UGI, LGI and pancreaticobiliary)
7. Patients with a time-sensitive diagnosis (evaluation/surveillance/treatment of premalignant or malignant conditions, staging malignancy prior to chemotherapy or surgery)
8. Cases where endoscopic procedure will urgently change management
9. Exceptional cases will require evaluation and approval by local leadership on a case by case basis

Elective Procedures that May be Delayed

1. Screening and surveillance colonoscopy in asymptomatic patients
2. Screening and surveillance for upper GI diseases in asymptomatic patients
3. Evaluation of non-urgent symptoms or disease states where procedure results will not imminently (within 4-6 weeks) change clinical management (e.g., EGD for non-alarm symptoms, EUS for intermediate risk pancreatic cysts)
4. Motility procedures - esophageal manometry, ambulatory pH testing, wireless motility capsule testing and anorectal manometry

Endoscopic Training

- Endoscopic training severely impacted by COVID
- Marked reduction in hands-on training
- Can that time be recovered?
- Extra training?
- Simulators
- Rise in virtual education
  - ASGE fireside chats
  - ACG Virtual Grand Rounds
Endoscopic Training Volume Reduced

Comparison of trainee-reported number of supervised procedures in the 30-day period before (PRE) and during COVID-19 (COVID)


Outpatient Gastroenterology Practice:

In Person Office Encounters: April vs. June

ACG practice survey, 2020
Outpatient Visits


Telemedicine

- Telemedicine became predominant
- Likely here to stay
- Technology issues
- Equity issues
Isolation and Fear

- Patients isolated from their families and loved ones
  - Dying alone
  - Technology to allow video visits
- Physicians isolated from their patients
  - Fear of COVID
  - PPE
  - Loss of touch
- Recognizing stress/anxiety for patients, staff, and MDs
  - Exacerbation of underlying anxiety and mental illness
  - Severe limitations on “usual” activity
- Increased depression, mental illness and suicide in health care workers

Colorectal Cancer Screening During COVID 19

Aligning statements

1. Colorectal cancer remains a public health priority
2. Colonoscopy remains safe
   - Identify those who should receive higher priority
3. During a time when colonoscopy may be limited, stool based testing is an option
4. Reigniting momentum and public health messaging will be key

NCCRT, A playbook for reigniting colorectal cancer screening, 2020
Impact of COVID-19 on GI Procedures and Cancers


COVID-19 and CRC Screening: Disparities

<table>
<thead>
<tr>
<th>Impacted area</th>
<th>Potential solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRC screening</td>
<td>• Encourage use of noninvasive screening modalities.</td>
</tr>
<tr>
<td></td>
<td>• Increase use of mailed FIT outreach programs.</td>
</tr>
<tr>
<td></td>
<td>• Establish safe protocols to pick up and return FIT kits.</td>
</tr>
<tr>
<td>Follow-up after abnormal FIT/fecal occult blood test screening</td>
<td>• Identify gastroenterologist partners to improve coordination of care.</td>
</tr>
<tr>
<td></td>
<td>• Prioritize patients with the earliest abnormal FIT results, highest quantitative FIT values, and/or the development of interval symptoms associated with CRC.</td>
</tr>
</tbody>
</table>

Community-based research

• Leverage the most accessible technology to sustain communication.
• Obtain a waiver of signature for minimal risk studies.
• Provide incentives where appropriate.

External factors

• Alert funding programs of changes in projected research.
• Develop contingency budgets for funded projects.

Engagement, advocacy, and policy

Community outreach and engagement

• Use existing platforms to provide COVID-19 information and offer aid programs.
• Extend CRC awareness events to year-round.
• Seek timely and innovative opportunities to serve medically underserved populations.

Advocacy and policy

• Shift advocacy events and policy campaigns to virtual platforms whenever possible.
• Use social media platforms, calls, and letters to connect with policymakers.

Marketing a Successful Return

- Don’t postpone regular care
- Resume routine health care
- There is a cost in health care quality to missing screening activities

Cancer Screening During the COVID-19 Pandemic.

At the onset of the COVID-19 pandemic, elective medical procedures, including cancer screening, were largely put on hold to prioritize urgent needs and reduce the risk of the spread of COVID-19 in healthcare settings. One consequence of this has been a substantial decline in cancer screening.

As states and other authorities re-open businesses and ease restrictions, many healthcare facilities are starting to offer elective procedures again, including cancer screening. Restarting cancer screening requires careful consideration of the risks and benefits of screening, along with ensuring safety for both patients and healthcare personnel.

Decisions about restarting screening depend on many factors, and they may not be the same for every person. They will likely vary by community while the pandemic continues.

Regular cancer screening is still important

Reassuring Patients

Mount Sinai Safety Hub

Your Safety in the New Normal
Throughout our community, conditions still need to be treated, procedures still need to be performed, and screenings still need to be scheduled to prevent disease. Your health is too important to put on hold.
131 million people have received at least one dose of a COVID-19 vaccine in US as of 3/24/2021
440 million people have received at least one dose of a COVID-19 vaccine worldwide as of 3/24/2021

Dear Colleagues,

As we write this, vaccinations against coronavirus are becoming available to combat COVID-19, and the FDA and CDC advisory panels have deemed these vaccines to be safe and highly effective.

Public health officials tell us that a successful vaccination program will require 75-90% of the U.S. population to be vaccinated. We know there is significant mistrust and vaccine hesitancy amongst the population.

As a community of gastroenterologists and other GI-related healthcare providers, we are well positioned to lead by example. For the vast majority of patients, the benefits of vaccination far outweigh the risks. While we each have our own personal choice about whether to be vaccinated, the decision we make will be followed closely by our colleagues, coworkers and, most importantly, our patients.

We urge you to share your decision to be vaccinated with others, and to have open discussions with your patients about this critically important topic. The availability of safe, COVID-19 vaccines is a historic opportunity that we need to seize promptly. —to help our patients and ourselves take advantage of the scientific breakthrough while, if applied widely, will help control COVID-19 pandemic.

American College of Gastroenterology
Vaccine Hesitancy

ACG Magazine, Volume 5, Number 1, Spring 2021

GI Society Collaboration

Joint GI Society Message: COVID-19 Clinical Insights for Our Community of Gastroenterologists and Gastroenterology Activities

Management of endoscopes, endoscope reprocessing, and storage areas during the COVID-19 Pandemic

- This document provides best practice recommendations with respect to endoscope handling, endoscope reprocessing, and storage area management during the COVID-19 pandemic.
- As more evidence becomes available, some of these suggestions may require subsequent updates.

Disinfection, Handling, and Endoscope Storage

Endocopy:

Urgent Congress to act now to protect our health care community during the COVID-19 pandemic

The coronavirus is impacting the entire health care community, including specialty physicians and researchers like us. There has been an outcry for more congressional support to protect health care professionals on the frontlines managing this deadly outbreak.
Leading the Public...

1 FACT/1 MYTH COVID-19 VACCINE INFORMATION
FROM THE AMERICAN COLLEGE OF GASTROENTEROLOGY

#1FACT1MYTH

FOR MORE INFO BIT.LV/ACG-COVIDVACCINE
#1FACT1MYTH #COVIDVACCINE #MYCOVIDVAX #COVID19

Raising Public Awareness...

Ask me about colorectal cancer screening.
ACG Virtual Grand Rounds

Raising Public Awareness

TUNE IT UP: A CONCERT TO RAISE COLON CANCER AWARENESS

Wednesday, March 21st at 8 pm EDT

gi.org/Concert
Impact of COVID 19 on Colonoscopy Practice and Colorectal Cancer Screening

Key Points
- The practice of gastroenterology and gastrointestinal endoscopy has changed dramatically in the past year
- Many of the changes are likely to persist
- Scientific breakthroughs have been rapid and profound
- The impact of COVID 19 on GI and endoscopy will not be fully known for a long time
- We are resilient and creative
- The value of connections, collaboration and comradery has never been more important
Questions

Speaker:
David A. Greenwald, MD, FACP

Moderator:
Aasma Shaukat, MD, MPH, FACP

CONNECT AND COLLABORATE IN GI

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LOGIN OR SIGN-UP NOW AT: acg-gi-circle.within3.com