ACG AWARDS

Nominate a Colleague by April 15th!

2022 Award Categories:
- New! NP/PA Award for Clinical Excellence
- Berk/Fise Clinical Achievement Award
- Community Service Award
- Distinguished Mentorship & Teaching Award
- Diversity, Equity & Inclusion Award
- International Leadership Award
- Master of the American College of Gastroenterology
- Samuel S. Weiss Award

Nominations for these awards will be presented at the College’s Annual Scientific Meeting in Charlotte, NC on October 22, 2022.

gi.org/about/awards

Special Edition ACG VRG April 11, 2022 8pm - 9pm EDT

ASSESSING HEREDITARY GI CANCER RISK EARLIER:
INSIGHTS FROM A GI PRACTICE

Register Now for April 11th Webinar
giod.co/Care0411
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, 2022** 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, 2023** 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 15
There will be No ACG Virtual Grand Rounds on April 14th due to Passover and Easter

Week 16
Practical Patient Education Tips and Strategies
Connie Arnold, PhD; Terry Davis, PhD; and James D. Morris, MD, FACG
April 21, 2022 at Noon Eastern and 8pm Eastern!

Visit gi.org/ACGVGR to Register
ACG SPECIAL Grand Rounds
Join us for upcoming Virtual Grand Rounds!

Special Edition ACG VRG April 11, 2022 8pm - 9pm EDT
THE POTENTIAL FOR EARLIER HEREDITARY GI CANCER DETECTION WITH INSIGHT FROM A GI PRACTICE

Jordan Ritchie, MD, FACG
Hindia Niazi, MD, MSc
Miro K. Weiss, MD

Register Now for April 11th Webinar
gi.com/Care411

Visit gi.org/ACGVGR to Register

Disclosures:

Laurie Keefer, PhD
AbbVie: Consultant
Takeda: Consultant
Eli Lilly: Consultant

Jill Deutsch, MD
GI Supply: Consultant

*All of the relevant financial relationships listed for these individuals have been mitigated
CAM and Psychological Therapies for Functional and Inflammatory Bowel Disease

Laurie Keefer, PhD
Professor of Medicine
Icahn School of Medicine at Mount Sinai

Jill Deutsch, MD
Assistant Professor of Medicine
Yale University

Case #1:

• 25yo Indian-American female with left sided colitis
• Diagnosed at Age 21, first flare presented with urgent, bloody stool, Mayo Score = 3, was advised to start on mesalamine but did not fill prescription, has not followed up with gastroenterologist
• Patient has not disclosed disease to anyone but her mother
• No prior history of mental health issues, describes self as “Type-A” personality
• Lives alone in NYC apartment, software engineer
• Has managed disease for past 4 years with low fiber/low residue diet, has lost ~30#, BMI now 17.
• Has occasional bloody stool and mucous “when stressed”
• Now reporting an increase in urgency and loose stool, occasional fecal incontinence since starting a new job
• Seeking gut-directed hypnotherapy to help with the impact of stress on her gastrointestinal tract
### Gut-Directed Hypnotherapy is Not Just Relaxation!

**Suggestions** | **Examples**
--- | ---
Regulating smooth muscle activity | “your bowels are beginning to function in all situations with a healthy, quiet, natural rhythm that is comfortable and soothing and hardly noticeable at all…”
Reduce impact of stress on GI system | “you feel inside like nothing can disturb your deep comfort...like nothing can upset you or cause you discomfort or pain…”
Reduce gut pain perception | “…sensations that used to be uncomfortable now increasingly feel just mild and soothing and do not bother you anymore.”
Increase patient’s sense of control over symptoms | “you can feel confident in your ability to keep strengthening your body’s natural resistance to stress and discomfort…”

Palsson O. *Eur Gastro Hep Rev.* 2010;6(1):42-46

---

- **Indications for Gut-directed hypnotherapy**
  - Brain-gut dysregulation and associated symptoms
    - IBS overlap
    - Abdominal Pain/Cramping
    - Urgency/Tenesmus
    - Bloating
    - Nausea/Vomiting
    - Constipation
    - Diarrhea
    - Dyspepsia/Early satiety
  - Maintenance of clinical remission in UC

• Is this patient appropriate for GDH?

Yes, GDH is appropriate because:
• Stress causes her symptoms
• Urgent diarrhea can respond to GDH
• Patient has a preference to use non-pharmacological therapies to treat UC

No, GDH is not appropriate because:
• She is not currently under care of gastroenterologist
• Mayo 3 at diagnosis, no treatment in past 4 years
• Patient following highly restricted diet with BMI <18.5
• Concerns about disease acceptance

How might one use gut-directed hypnotherapy in this case?

Case #2
• 42yo Chinese-American woman with diagnosis of IBS-C
• Constipation well-managed with PEG and Kiwi Fruit- has 1-2 bowel complete spontaneous bowel movements/day
• Continues to experience abdominal pain and bloating, especially after eating- limited response to peppermint oil
• Does not think that stress contributes to her symptoms
• History of generalized anxiety disorder, managed on citalopram
• Referred by gastroenterologist who she trusts for Cognitive-Behavior Therapy
• CBT is a theoretical orientation, not just a set of techniques
• Thoughts, behaviors and feelings are connected and modifiable
• Patients with GI symptoms develop patterns of thinking that might make sense, but are unhelpful or no longer useful
• CBT can retrain patients to think or act differently in response to symptoms
• Based on collaborative relationship between patient and therapist [not a lie on the couch experience]
• Can be highly personalized

**Case #3**

- A 19-year-old Puerto Rican man with newly diagnosed ulcerative proctitis (Mayo 2) with tenesmus, rectal bleeding, and frequent nocturnal stools seeks consultation
- He has lost 5lb since colonoscopy 4 weeks ago
- Studying to become a registered dietician
- Avidly practices and studies yoga
- Denies tobacco and alcohol use, but smoke marijuana at least 6 days per week
- He has read several blog posts about natural supplements to control inflammation and asks your opinion regarding the use of natural products to induce and maintain remission of disease
- What can you recommend?

---

**Figure 1. Clinical response and remission rate at study end point at week 4.**

**Figure 2. (A) Endoscopic response and remission rate at study end point at week 4. (B) Mean endoscopic rate at week 0 compared with week 4 in the 2 study groups.**
**Delta-9-tetrahydrocannabinol (THC):**
THC is most known for its effects on one’s mental state. It may alleviate nausea and chronic pain and improve appetite.

**Cannabidiol (CBD):**
Anti-inflammatory and immune modulating properties including reducing inflammation and treating insomnia, sleep apnea, spasticity, and pain.

**Extra Content: Practical Pearls & Resources**
Severe psychopathology, No insight into gut-brain interaction or overly focused on a “cure,” active substance abuse, needs case management services, cannot make time

Disordered eating, PTSD, personality factors affecting care, motivational deficiencies- determined by therapist comfort

Has been told s/he has DGBI, Has time to engage in behavior change program, Agrees coping could be improved, Experiences isolation, avoidance or distress around GI symptoms

<table>
<thead>
<tr>
<th>Resource</th>
<th>Website</th>
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<tr>
<td>Rome GastroPsych</td>
<td><a href="https://romeenglishpsych.org">https://romeenglishpsych.org</a></td>
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<tr>
<td>Psychology Today Therapist Finder</td>
<td><a href="https://www.psychologytoday.com/us/therapists">https://www.psychologytoday.com/us/therapists</a></td>
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<td>American Psychological Association</td>
<td><a href="https://locator.apa.org">https://locator.apa.org</a></td>
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<tr>
<td>National Register of Health Service Psychologists</td>
<td><a href="https://www.findpsychologist.org">https://www.findpsychologist.org</a></td>
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<tr>
<td>Association for Behavioral &amp; Cognitive Therapies</td>
<td><a href="http://www.findcbt.org">http://www.findcbt.org</a></td>
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<tr>
<td>National Eating Disorders Association</td>
<td><a href="https://map.nationaleatingdisorders.org">https://map.nationaleatingdisorders.org</a></td>
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Digital behavioral therapeutics for IBS based on scientifically studied protocols

<table>
<thead>
<tr>
<th>Cognitive-Behavior Therapy for IBS</th>
<th>Gut-directed hypnotherapy for IBS</th>
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<tbody>
<tr>
<td>Parallel (Mahana Therapeutics)*</td>
<td>Nerva (Monash University)</td>
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<tr>
<td>Zemedy (Bold Health)</td>
<td>Regulora (metaMe Health)</td>
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*FDA approval

Practice Pearl: GI Behavioral Prescription

Diaphragmatic Breathing

- Increases time in “Rest and Digest” mode/GI Efficiency
- Improved gastric accommodation after meals (Dyspepsia, Gastroparesis)
- Improve pressure gradient at lower esophageal sphincter (GERD, Rumination Syndrome)
- Decreases bowel urgency/cramping
- Decreases fear of incontinence/vomiting
- Decreases fear of passing stool when constipated
### Food Avoid Suitable

<table>
<thead>
<tr>
<th>Polyols</th>
<th>Fruits</th>
<th>Vegetables</th>
<th>Artificial sweeteners</th>
<th>Lactose</th>
<th>Non-dairy milk alternatives</th>
<th>Fructose/Sweeteners</th>
<th>Fructans Starches</th>
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<td>Dairy whey and high-lactose containing milks such as cow, goat, sheep, chocolate, buttermilk, and condensed milk, and whipped cream. Ice cream, cow’s milk-based yogurt, brie, cottage cheese, ricotta, and sour cream</td>
<td>Soy milk contains galactans and should be avoided as well, coconut milk, soy products, hummus, beans, and lentils</td>
<td>Honey, agave, apples, cherries, dates, guava, honeydew melon, lychee, mandarin oranges, mangoes, peaches, pears, persimmons, star fruit, canned fruit in natural juices, dried fruits and less ripe fruits, corn syrup, high fructose sweeteners, coconut milk, fruit pastes (i.e. chutney, plum sauce, barbeque sauce, ketchup), rose wine, port, and sherry</td>
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### Questions?

- **Laurie Keefer, PhD**
- **Jill Deutsch, MD**
The situation: Road trip with friends

THE THOUGHTS
I am worried that:
• I will have to stop along the way to use the bathroom.
• My friends will be inconvenienced by me.
• I will feel embarrassed if I have to ask the driver to pull over.
• If there is no place to pull off, I might have a bowel accident.

What is the realistic likelihood that:
• I will have to emergently stop along the way
• My friends will be upset
• I will have a bowel accident
• I wouldn’t be able to handle it

Would it be as bad as I think?
• My close friends like me for who I am
• How would I feel if this happened to someone I care about?
• Close calls are close calls for a reason
• Is it really worth making myself sick over?
Case #4

- 59-year-old Caucasian woman with well controlled GERD and depression who is being evaluated 9 weeks following recurrent C. difficile infections
- She reports change in bowel habits since completing a prolonged course of vancomycin for C. diff. Her bowel movements vary in frequency and consistency (3-4 times per day, Bristol types 5-7). Near daily lower abdominal discomfort alleviated by a BM
- Repeat C. diff testing has been negative
- Denies hematochezia
- Weight has been stable (BMI 21.5) over the past 8 weeks after resuming a regular diet
- You diagnose the patient with post-infection IBS
- Fearful of the prospect of needing another course of antibiotics and is wondering what she should or should not eat to help improve symptoms
- Asks about probiotics as she is leaving your office
YES, low FODMAP is appropriate because:

- Bloating/Distension
- Gas
- Abdominal pain
- Nausea
- Diarrhea
- Constipation

NO, low FODMAP is inappropriate because:

- Underweight, low BMI
- ARFID (avoidant restrictive food intake disorder)
- Vitamin and micronutrient deficiencies