



ACG INSTITUTE RESEARCH GRANTS AND AWARDS 2021



SEVEN different award types; INCREASED Junior Faculty FUNDING;
NEW Mid-Career Bridge Funding; Med Resident and Student Awards

www.gi.org/research-awards

Grant System Opens: September 8, 2020

Deadline: December 4, 2020

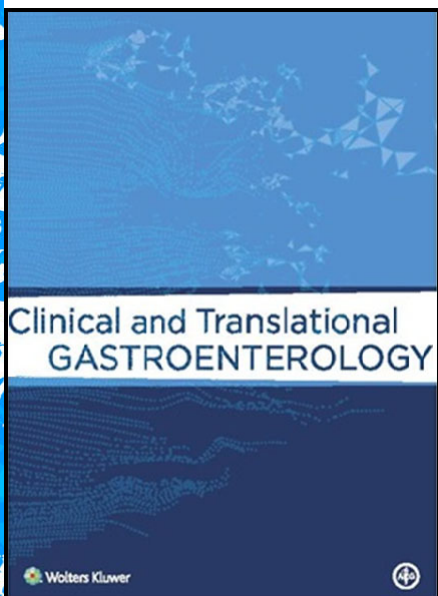
Read the [Grant Flyer](#), [FAQs](#), or visit the webpage for the RFAs.

Welcome to the Virtual Grand Rounds Waiting Room – The educational activity will begin promptly at 12 Noon Eastern.

1



AMERICAN COLLEGE OF
GASTROENTEROLOGY
Advancing Gastroenterology, Improving Patient Care



CTG Seeking Editor-in-Chief

CTG is seeking applicants for the position of Editor-in-Chief.

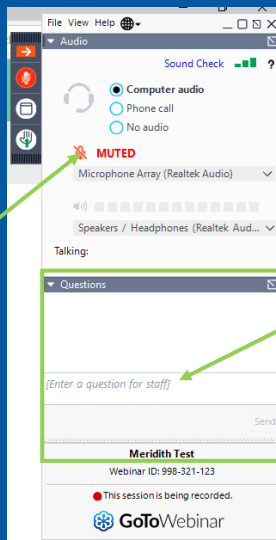
Applications are due December 1, 2020.

For more information contact
journals@gi.org

2

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.

3

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, 2020 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, 2021 for this activity.

4

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.

5

ACG Virtual Grand Rounds

Join us for upcoming Virtual Grand Rounds!



Week 33: Emotional Intelligence: Strategies for Improving Leadership in Medicine

Sara Ancello, DO; Divya Bhatt, MD; and Uchenna Agbim, MD
November 12, 2020 at Noon EDT



Week 34: ACG Clinical Guideline Chronic Pancreatitis

Timothy B. Gardner, MD, MS, FACG
November 19, 2020 at Noon EDT

Visit gi.org/ACGVGR to Register

6



Disclosures:

Douglas K. Rex, MD, MACG

*Consultant: Aries Pharmaceutical, Boston Scientific, Braintree Laboratories, Covidian/Medtronic, Endokey, GI Supply, Lumendi, Ltd., Medtronic, Norgine, Olympus Corporation
Research Support: EndoAid, Erbe USA Inc, Medivators, Olympus Corporation
Stockholder: Satisfai Health*



Brooks D. Cash, MD, FACG

Dr. Cash has no relevant financial relationships.

7

Managing Medical-Legal Risk in Colonoscopy: Rules for Success



Douglas K. Rex, MD, MACG

Indiana University Health

Indianapolis, IN

8

Common Medical-Legal Issues in Colonoscopy

- Most common
 - Interval Cancer
 - Splenic injury
 - Perforation
- Others
 - Bleeding
 - Wrong site surgery
 - Wrong surveillance intervals
 - Incorrect management of malignant polyp



Virtual Grand Rounds

9

Interval Cancer



Virtual Grand Rounds

10

- There's no video recording
- Or is there?
- Colonoscopies are poorly documented

11

Interval colon cancer malpractice cases

- Experts always say the same things
 - Plaintiff's expert: the exam was not careful to a degree that it was negligent
 - Defense expert: there is enormous evidence that colonoscopy is not perfectly effective at finding polyps even when it's performed carefully

12

The risk of an interval cancer:

- Determined by 2 factors:
 - ADR
 - Volume of procedures performed

Anatomy of an Interval Colon Cancer Malpractice Case

- Tumor
- Historical features
- Procedure
- Experts
- Doctor's general performance

Anatomy of an Interval Colon Cancer Malpractice Case

- Tumor
 - MSI
 - Poor differentiation
 - Signet ring cell formation
 - Shape (better if it's flat)

15

Anatomy of an Interval Colon Cancer Malpractice Case

- Historical features
 - Length of time since colonoscopy in question
 - Presence of persistent symptoms

16

Anatomy of an Interval Colon Cancer Malpractice Case

- Procedure (colonoscopy in question)
 - Withdrawal time
 - Documentation of cecal landmarks (including photography)
 - Documentation of bowel preparation (including photography)
 - Polypectomy techniques
 - Retroflexion and documentation



17

Anatomy of an Interval Colon Cancer Malpractice Case

- Expert opinion
 - You want the expert on the other side to say something that's easy to prove is wrong



18

Doctor's general performance

- Performance in deposition
- ADR
 - Was it measured at the time the colonoscopy was done?
 - If it wasn't measured can it be reconstructed?



Virtual Grand Rounds

19

Prep description

- Bowel prep scales for clinical trials
 - Aronchick – validated (E-G-F-P)
 - Ottawa – validated
 - Braintree – not validated (E-G-F-P)
- Bowel prep scales for clinical practice
 - Boston - validated
- Bowel prep scales that do both
 - Chicago - validated



Virtual Grand Rounds

20

Aronchick

- Excellent
- Good – large amount of clear fluid with > 90% of the mucosa seen
- Fair – some semi-solid debris with > 90 % of the mucosa seen
- Poor



Virtual Grand Rounds

21

In medical-legal actions

- “Fair” implies you didn’t see everything
- “Poor” says you clearly didn’t
- BBPS < 2 in any segment: inadequate
- Fair and poor imply you should repeat the exam at an early interval
 - Guidelines say ≤ 1 year
 - Photodocument the prep
- In a screening or surveillance exam – as soon as you decide you have to repeat the exam you should stop – get photos



Virtual Grand Rounds

22

Photography

- If prep was adequate have the photos reflect that
- If the prep was inadequate have the photos reflect that



Virtual Grand Rounds

23

Interval cancer cases

- Hard for a plaintiff to win if:
 - Adequate prep
 - Landmarks and photos present
 - WT adequate
 - ADR measured and adequate



Virtual Grand Rounds

24

Splenic injury



Virtual Grand Rounds

25

Splenic injury

- Best documented risk factor is female gender
- Other possible risk factors
 - Anticoagulation, intraabdominal surgery, COPD, propofol, splenomegaly
- Expert will opine: Splenic injury is *per se* evidence of negligence



Virtual Grand Rounds

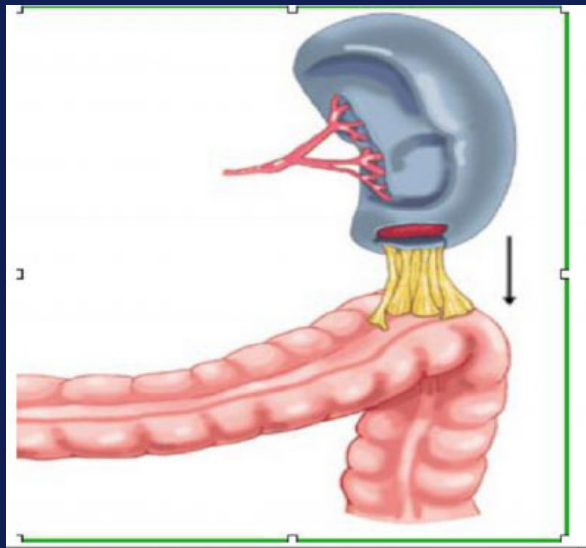
26

Remember the spleen!!!!

- No established rule to prevent it
- Rex rule: Be very careful with torque when the instrument tip is at or past the splenic flexure
- Diagnose early
 - Remember Kehr's sign
 - Use CT with IV contrast
- Remember IR for treatment if possible

27

Avoiding splenic injury



28

Perforation

29

Perforation types

- Diagnostic (rupture)
- Therapeutic
- Barotrauma

30

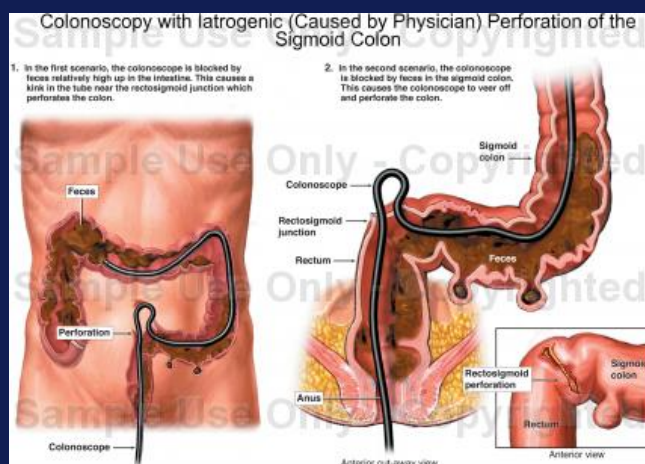
Avoiding diagnostic perforation

- Consider water immersion
- Flexible scope for fragile colon (pediatric scope or ultrathin/enteroscope)
 - Crohn's
 - Active IBD
 - Radiation
 - Chronic steroid use
 - Known severe diverticular disease
 - Multiple prior pelvic surgeries
 - Very elderly patients

31

Rule for preventing diagnostic perforation

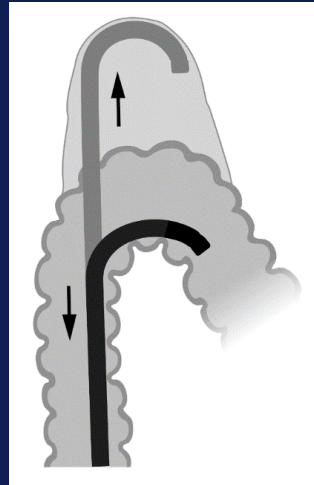
- Don't push against fixed resistance



32

Rules for preventing insertion injury

- Diagnostic perforation: don't push against fixed resistance



Use water in the fragile colon

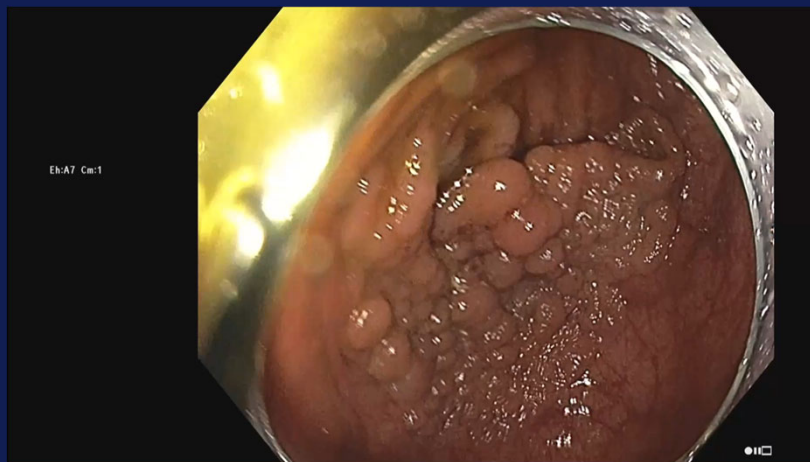
- Consider water in the fragile colon
 - Keeps sigmoid straighter (sigmoid is where the loops occur)

Avoiding therapeutic perforation

- EMR
 - Use snares of 15-20 mm size
 - Inject with a contrast agent
- Dilation
 - Don't overdilate
 - Don't dilate strictures longer than 4-5 cm
 - Don't dilate for endoscopic access alone

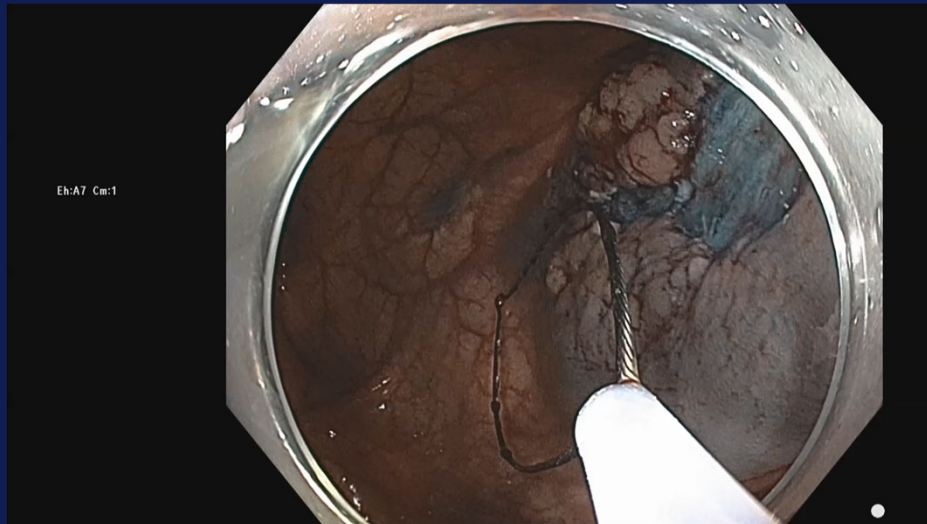
35

Safety during EMR



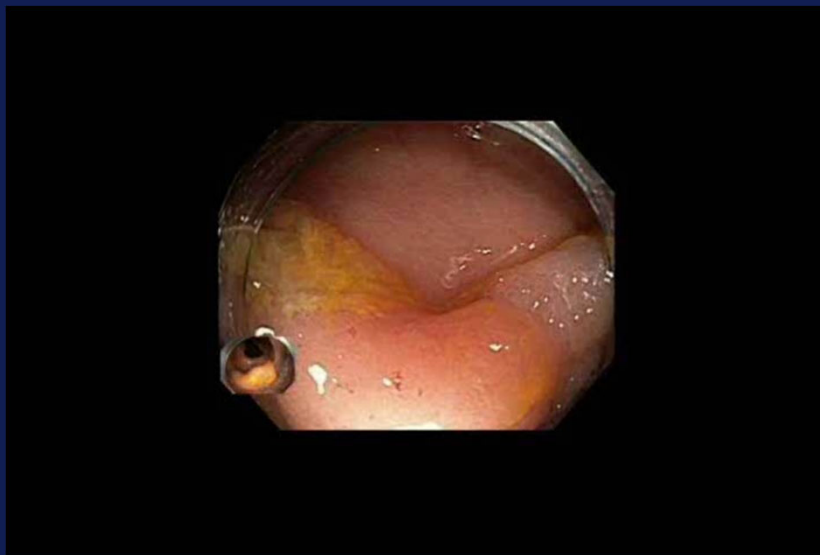
36

Contrast: Recognize Deep Mural Injury



37

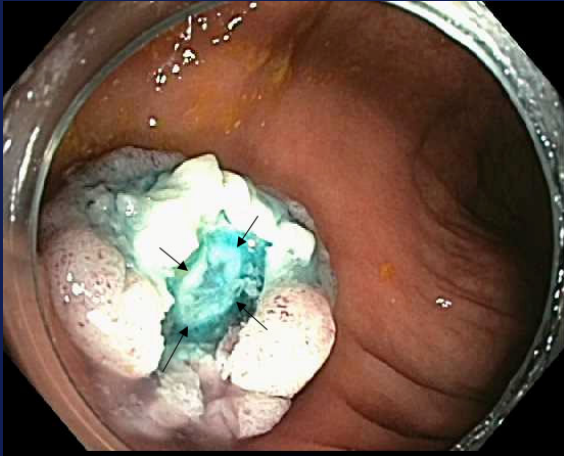
Identifying Muscle Injury



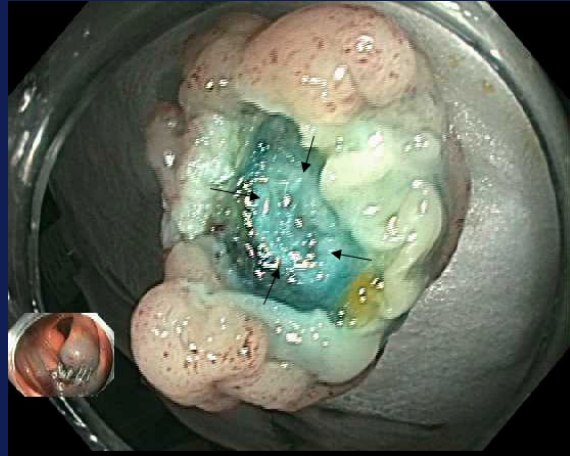
38

Target sign in the specimen

- In cecum



- On the table



39

From target to perforation



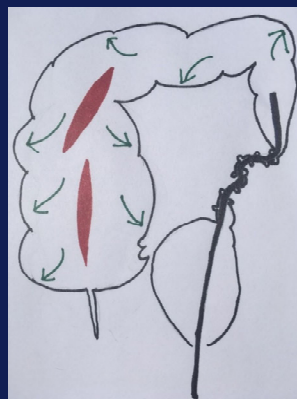
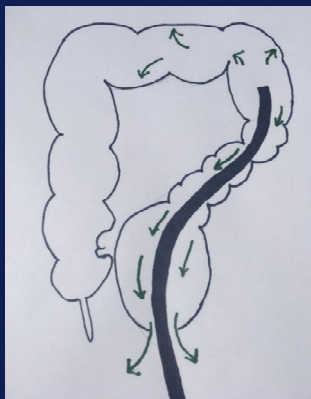
40

Avoiding barotrauma

- Convert to water in every complex sigmoid colon

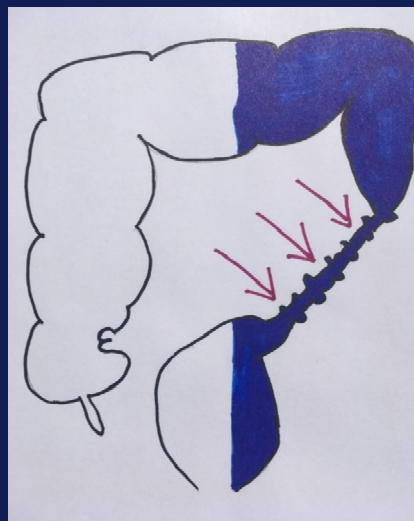
41

Water for prevention of barotrauma



42

Water for prevention of barotrauma



Virtual Grand Rounds

43

Wrong-site surgery



Virtual Grand Rounds

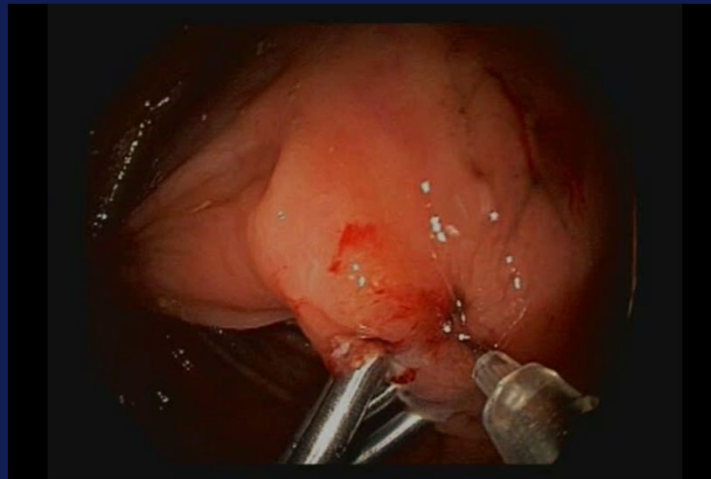
44

Tattooing

- Use a PPD technique
 - Approach tangentially
 - Lift the needle until it's visible in the sub-Q
- Get a sub-Q bleb then inject a lot
- Don't specify a specific segment unless you know it
- For cancers inject at distal end in 3-4 quadrants – for SPOT typically 10-15 cc
- Let surgeon know you'll come to the OR if they can't find the tattoo
- Make note if there are multiple tattoos

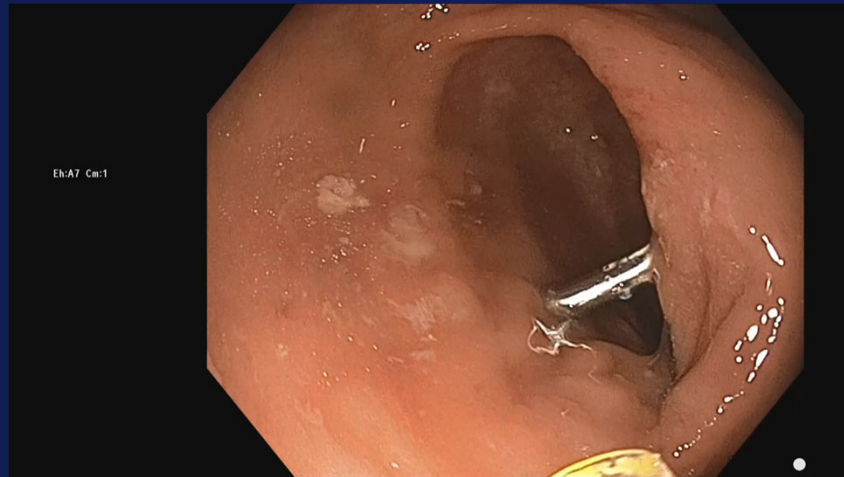
45

Direct injection method



46

Bleb method – step 1



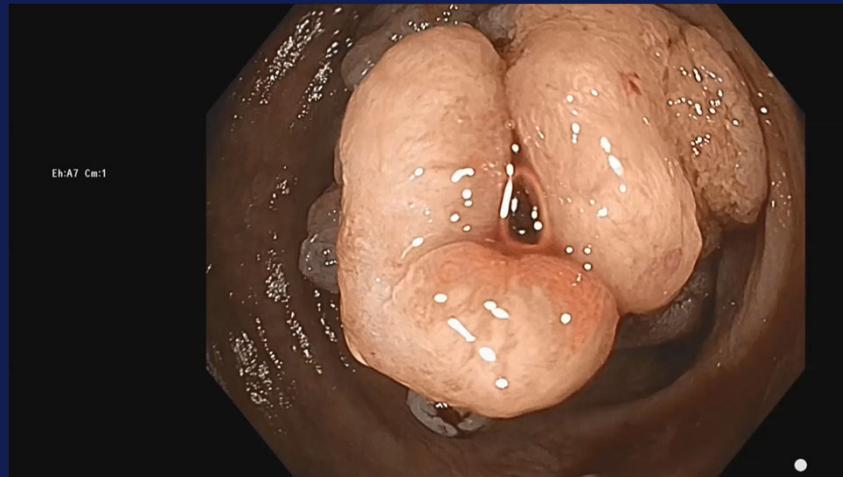
47

Bleb method – step 2



48

Bleb method



49

Avoiding wrong-site surgery

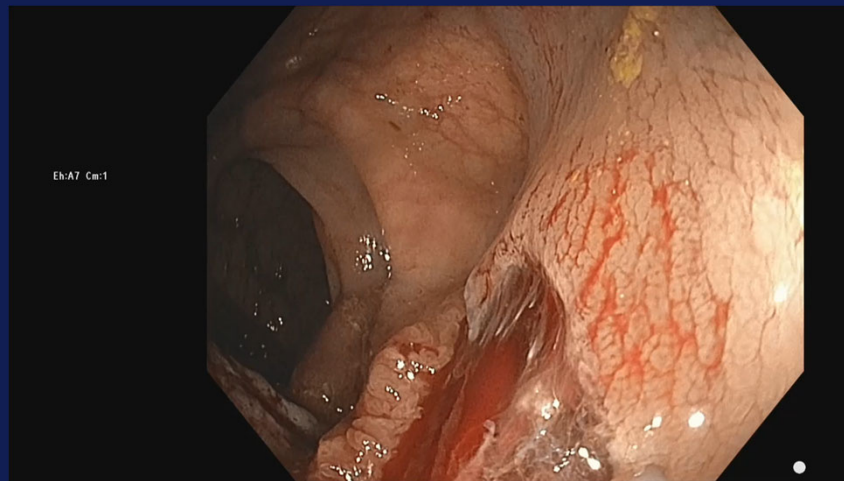
- Distal ascending to mid-sigmoid: be vague about location
- Tattoo distal end of tumor and say where tattoo is (distal)
- Put enough tattoo in for surgeon to see it
- Note other tattoos in the colon!
- Surgeon must find tattoo *in the colon wall*
- Make sure surgeon knows: "no tattoo=no resection"
 - Need intraoperative colonoscopy if tattoo can't be found

50

Bleeding

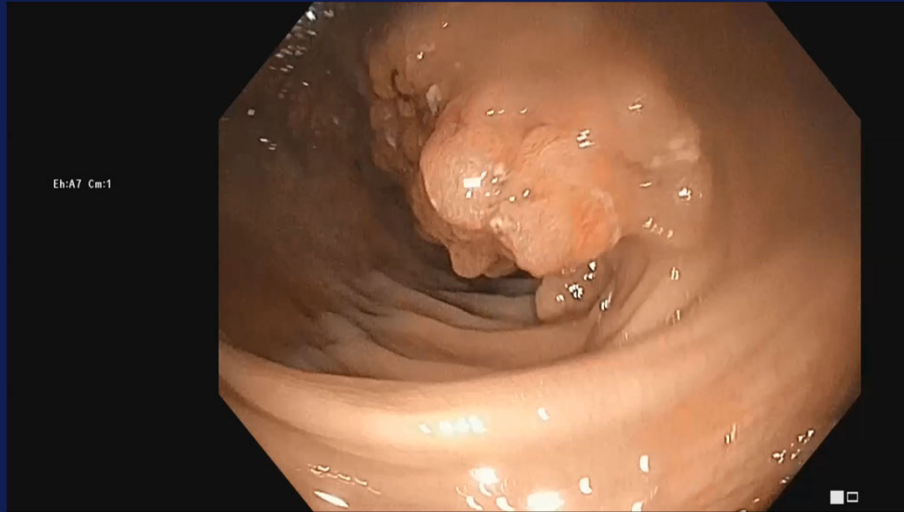
51

STSC for control of bleeding



52

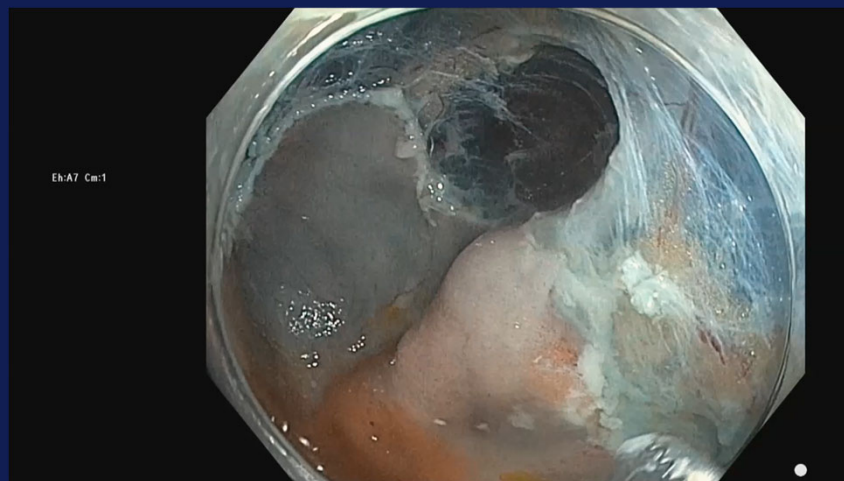
Control bleeding – coag graspers



Virtual Grand Rounds

53

Clip closure



Virtual Grand Rounds

54

Managing delayed hemorrhage

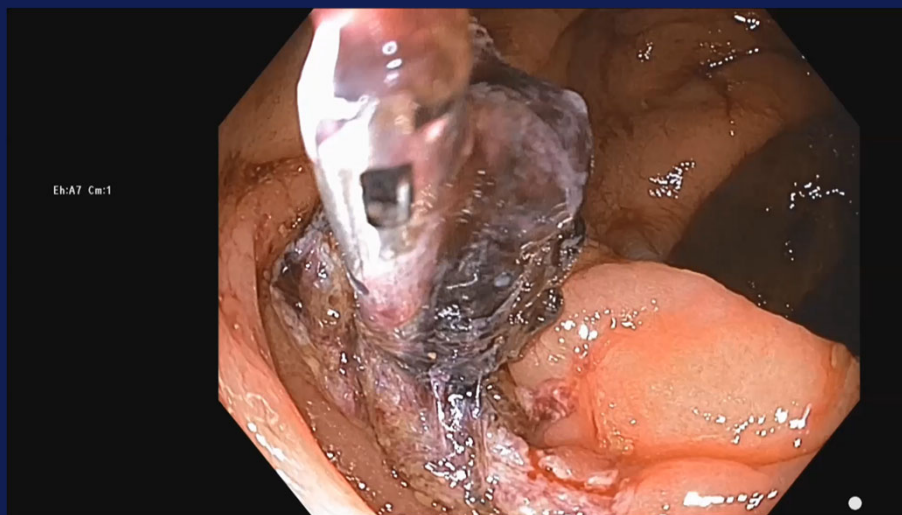
- Err on the side of going to the ED for evaluation
- Admit patients with ongoing bleeding
- If hematochezia consider urgent colonoscopy without bowel preparation
- If melena do bowel preparation
- If bleeding has stopped no mandate to scope but it may shorten hospitalization



Virtual Grand Rounds

55

Delayed hemorrhage



Virtual Grand Rounds

56

Aspirin

- ASGE: no need to stop it ever
- Our pre-procedure instructions: Do NOT stop aspirin if it was prescribed by a physician
- Post-procedure
 - Ok to not stop it for any procedure
 - Large EMRs: I stop it if there is no history of stroke, TIA, known vasculopathy



Virtual Grand Rounds

57

Non-aspirin anti-platelet agents; anti-coagulants

- Follow the guidelines
- Don't keep a written set of rules or policies that differs from the guidelines
- Don't allow nurses or schedulers to advise patients on management
- Defer decisions to the prescribing specialist (not the PCP)
 - There is medical-legal risk associated with both bleeding and thromboembolism



Virtual Grand Rounds

58

Incorrect intervals

- Don't exceed intervals recommended by MSTF
- Have a systematic method of following up pathology (and laboratory and radiographic) studies



Virtual Grand Rounds

59

Management of malignant polyps Unfavorable histologic criteria

Sessile malignant polyps

- Invasion depth > 1000 microns (en bloc resections only)
- Lymphovascular invasion
- Poor differentiations
- Tumor budding
- Close to resection line
- **Piecemeal resection***

Pedunculated malignant polyps

- Cancer closer than 2 mm to resection line
- Lymphovascular invasion
- Poor differentiation
- **Piecemeal resection***




Virtual Grand Rounds

60


Other issues

- Don't dilate asymptomatic strictures
- Don't treat asymptomatic radiation proctopathy
- Don't treat asymptomatic angiodysplasia
- Don't use hot forceps for polypectomy other than for avulsion

61


 Virtual Grand Rounds

universe.gi.org



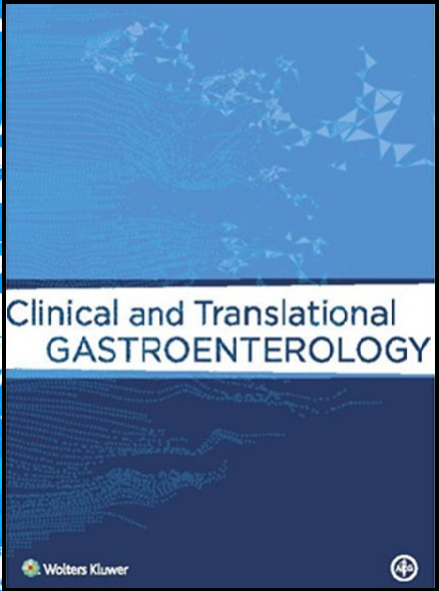
Questions?

Douglas K. Rex, MD, MACG



Brooks D. Cash, MD, FACG

62



CTG Seeking Editor-in-Chief

CTG is seeking applicants for the position of Editor-in-Chief.

Applications are due December 1, 2020.

For more information contact journals@gi.org

63

CONNECT AND COLLABORATE IN GI



ACG & CCF IBD Circle



ACG GI Circle
Connect and collaborate within GI



ACG Hepatology Circle



ACG Functional GI
Health and Nutrition Circle



ACG Women in GI Circle

ACG's Online Professional Networking Communities

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



64