ACG INSTITUTE RESEARCH GRANTS AND AWARDS 2022

EIGHT different award types; INCREASED Junior Faculty FUNDING;
NEW Health Equity Research Award; Med Resident and Student Awards

www.gi.org/research-awards

Grant System Opens: September 7, 2021

Deadline: December 3, 2021

Read the Grant Flyer, FAQs, or visit the webpage for the full RFAs.

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ACG INSTITUTE FOR CLINICAL RESEARCH AND EDUCATION

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Virtual Grand Rounds

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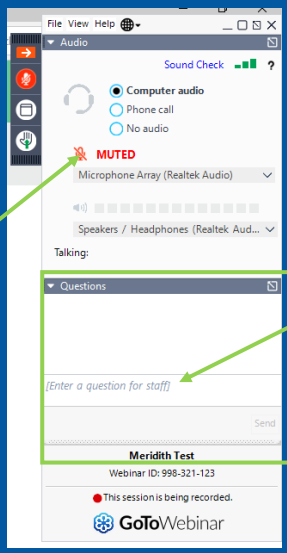
Participating in the Webinar



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.

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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.

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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.

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ACG Virtual Grand Rounds

Join us for upcoming Virtual Grand Rounds!

Week 38, 2021
So a traveler and their microbiome get onto a plane..: What's new in the world of travelers' diarrhea?
Mark S. Riddle, MD, DrPH, FISTM
September 30, 2021 at Noon Eastern

Week 39, 2021
ACG Clinical Guideline: Diagnosis and Management of Idiosyncratic Drug-Induced Liver Injury
Haripriya Maddur, MD
October 7, 2021 at Noon Eastern

Visit **gi.org/ACGVGR** to Register

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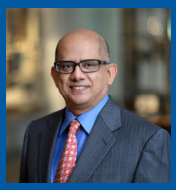
Disclosures:



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

Moderator:
Neha Mathur, MD
Dr. Mathur, faculty for this educational event, has no relevant financial relationship(s) with ineligible companies to disclose.

*All of the relevant financial relationships listed for these individuals have been mitigated

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Anorectal Disease for the Gastroenterologist

Waqar Qureshi, MD, FRCP, FACG
Professor
Baylor College of Medicine
Houston, Texas

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Commonly seen Anorectal Disease

- Hemorrhoids
- Anal fissures
- Pruritus
- Abscesses
- Fistulae
- Disorders of Defecation

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Hemorrhoids by the numbers

- 50% of Americans with symptomatic hemorrhoids by the age of 50.
- 10-20 million Americans have active hemorrhoids (4 – 5% prevalence rate).
- >$250 mil spent annually on OTC products.
- More than 120,000 hemorrhoidectomies per year. Many are unnecessary.
- 1.5 million colonoscopies are done each year. 15 – 20% reveal hemorrhoids as cause of bleeding

prepH

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Hemorrhoids

- Enlarged vascular cushions in the anal canal (connective tissue and A-V communications)
- left lateral, right anterior, and right posterior positions

Etiology

- Straining
- Constipation
- Prolonged lavatory sitting
- Pregnancy, ascites, liver cirrhosis, FH

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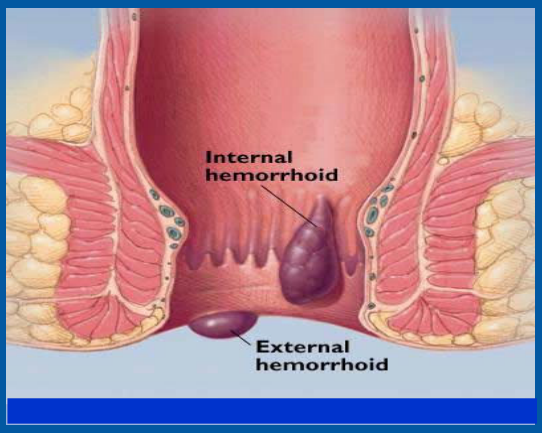
Classification

Dentate line



Golligher's classification

- 1° - Bleeding but no prolapse
- 2° - Prolapse reduces spontaneously
- 3° - prolapse requires manual reduction
- 4° - prolapse cannot be reduced manually

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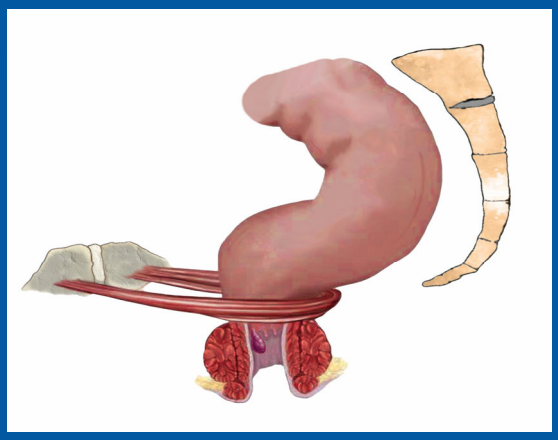
Office Management

Perform an Ano-rectal examination:

- Inspection
- DRE
- Anoscopy is quick and easy



Hemorrhoids don't hurt. Look for other causes

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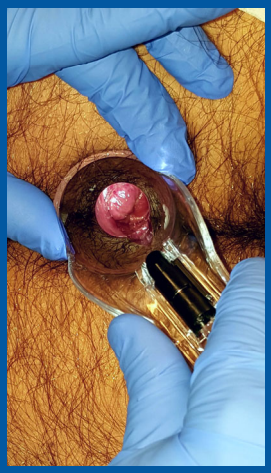

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Anal Cancer

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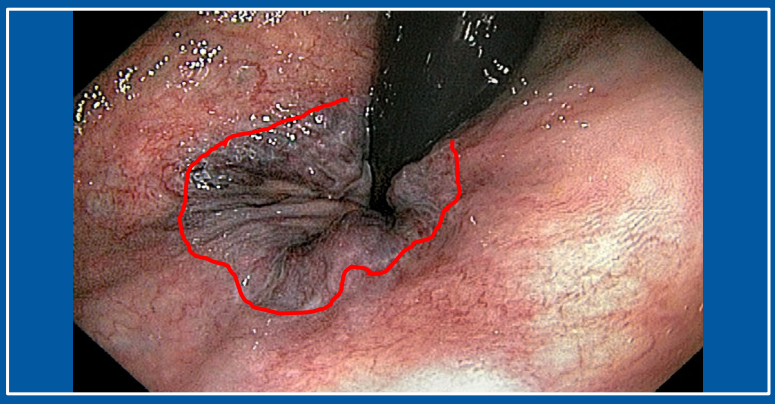

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Prolapsed, possibly thrombosed internal hemorrhoids

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Chronically thrombosed External Hemorrhoid

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Acutely prolapsed circumferential internal and external hemorrhoids

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Non-operative Treatment Options

- Rubber band ligation,
- Infrared photocoagulation,
- Bipolar diathermy,

- Injection sclerotherapy,
- Cryotherapy,

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Rubber Band Ligation

Rubber band ligation relies on the tight encirclement of redundant mucosa, connective tissue, and blood vessels in the Hemorrhoidal complex (at least 2 cm above the dentate line).

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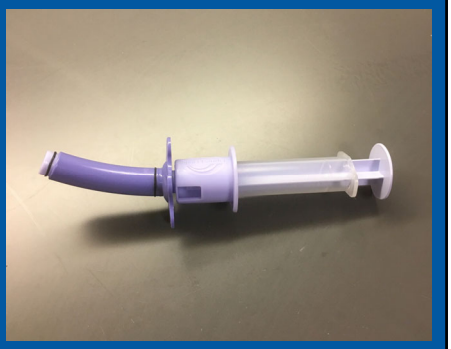
Banding devices



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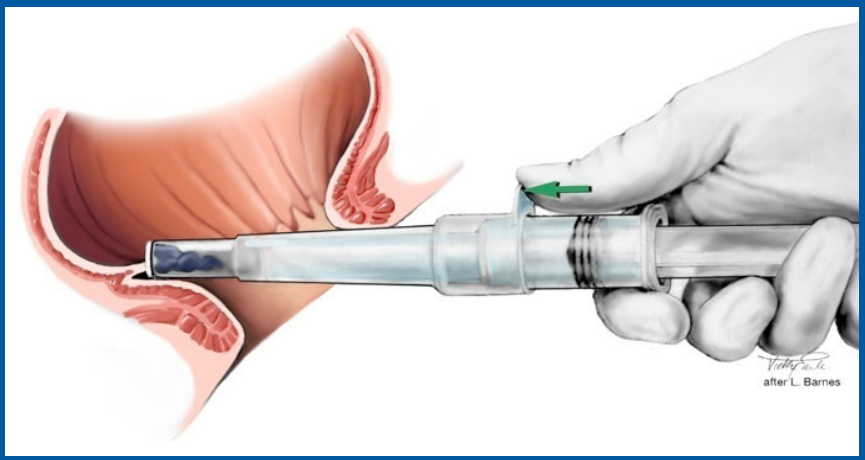
In Office Hemorrhoid Banding



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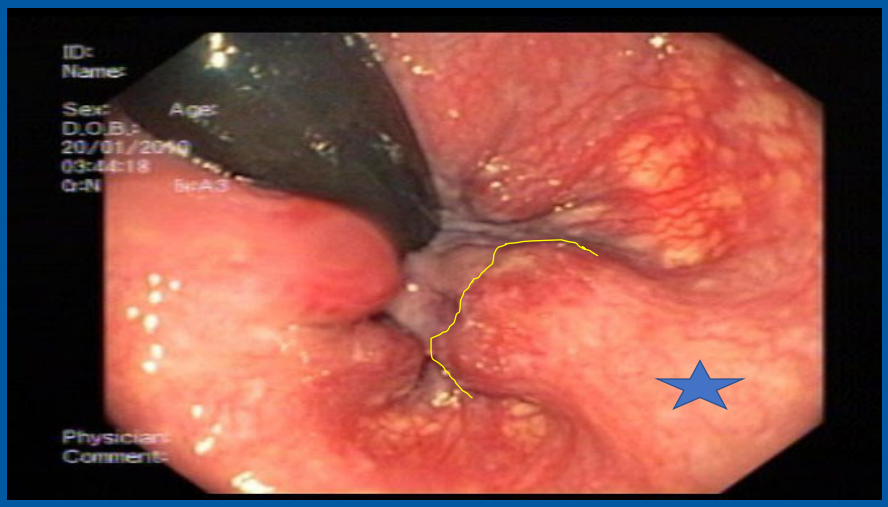

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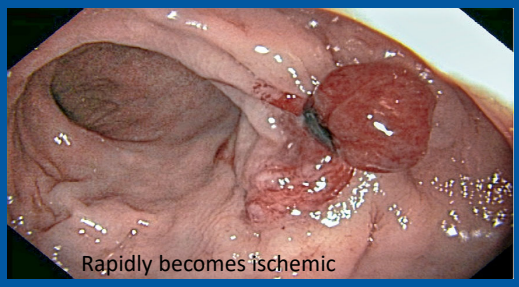
Rubber Band Ligation

Tissue sloughs



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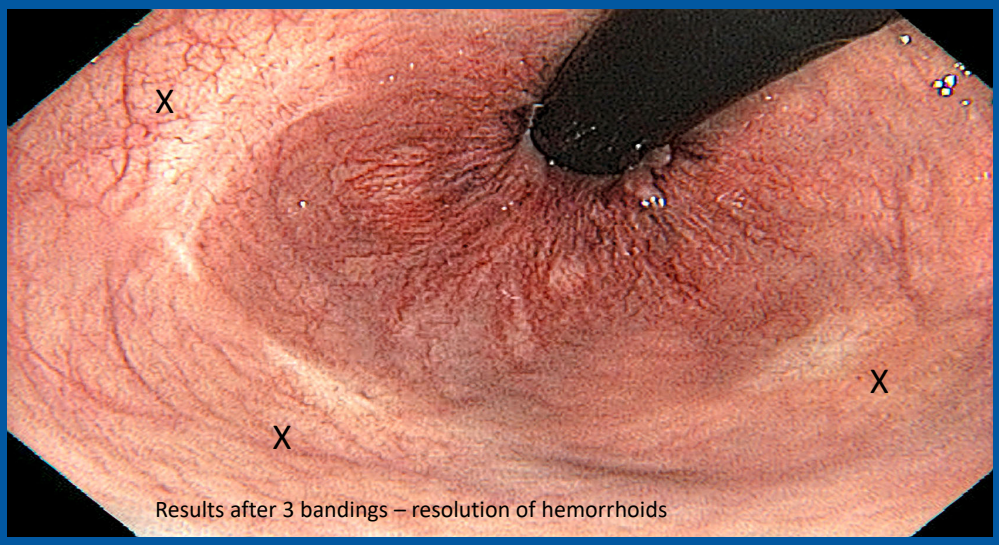

Photos courtesy of Neal Osborn, MD, MSc

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Rubber Band Ligation

Complications

- pain, reported in 5%–10% (managed with sitz baths and over-the-counter analgesics)
- abscess, urinary retention, band slippage, bleeding
- Necrotizing pelvic sepsis is a rare complication (severe pain, high fever and urinary retention)

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Pain After Banding

You have just applied a rubber band to an internal hemorrhoid and your patient begins to complain of 6/10 pain

Possibilities:

- You at at or below the dentate line (Remove band)
- You have more that just the mucosa entrapped within band

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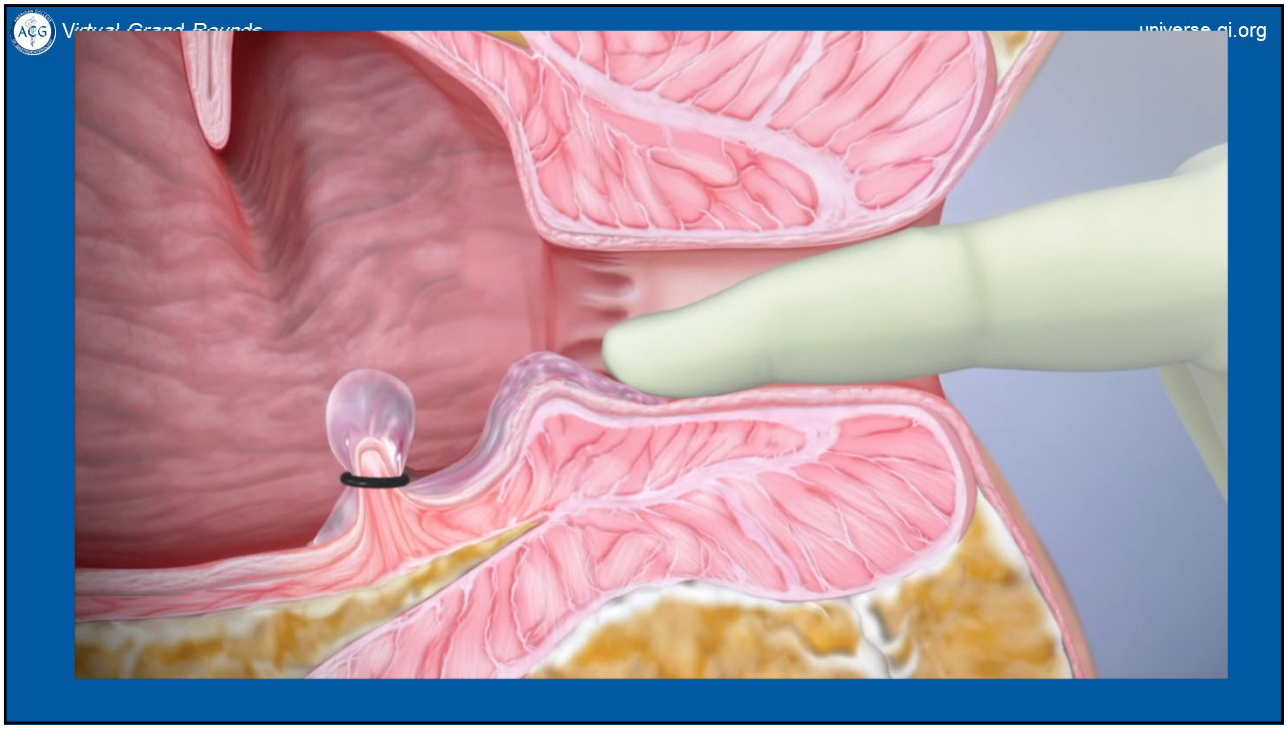

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Infrared Photocoagulation

- focuses energy from a tungsten-halogen lamp
- Probe tip must touch the hemorrhoidal tissue at its base
- 0.5- to 2-second pulses of energy are delivered
- Multiple hemorrhoids can be treated
- The depth of tissue injury is about 2.5 mm

Safer than banding in anticoag and pregnant patients

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Infrared Coagulation

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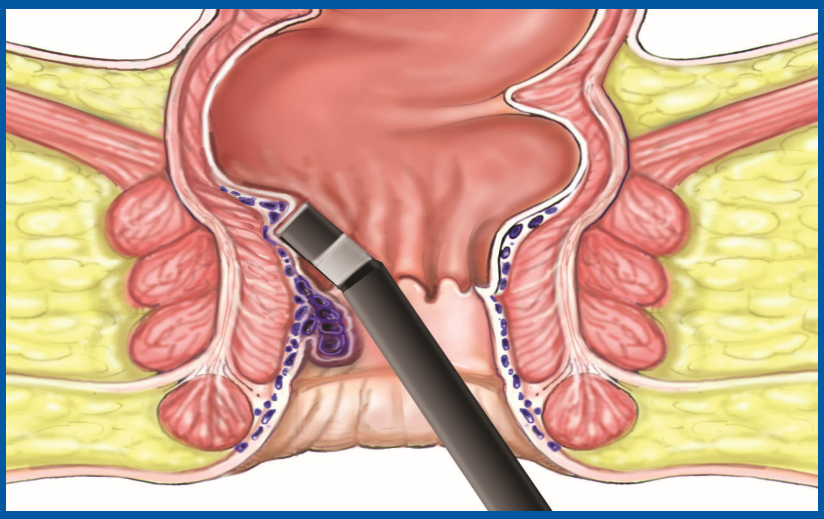
Infrared Coagulation



courtesy of Redfield corp NJ

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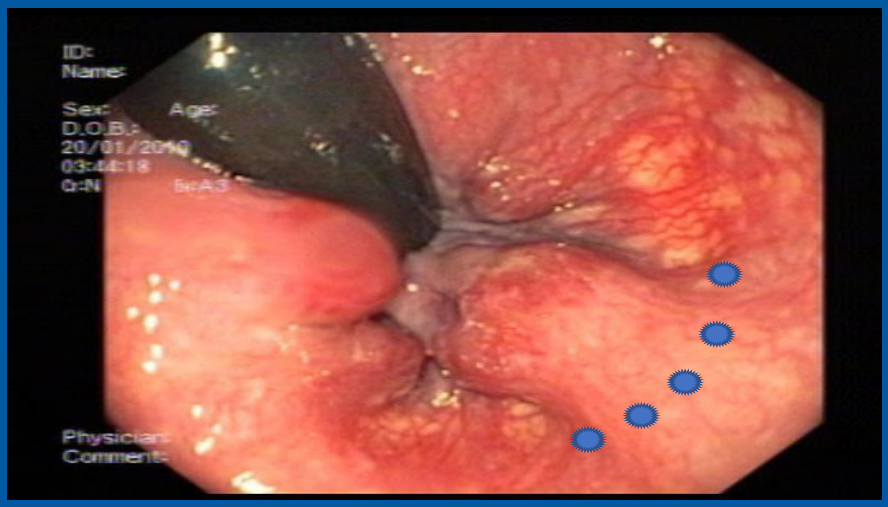

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Patient presents with acute onset pain

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Thrombosed External Hemorrhoid

- Acute rectal pain and mass.
- Associated with heavy lifting, straining, sitting, diarrhea.
- Anal sphincter spasm.
- Rx warm baths, stool softeners, Lidocaine ointment, analgesics, supine position, NTG, or calcium channel blocker ointment.
- Up to 50% will experience further hemorrhoid problems. After acute episode resolves proceed with banding.
- I & D best done within first 72 hrs.

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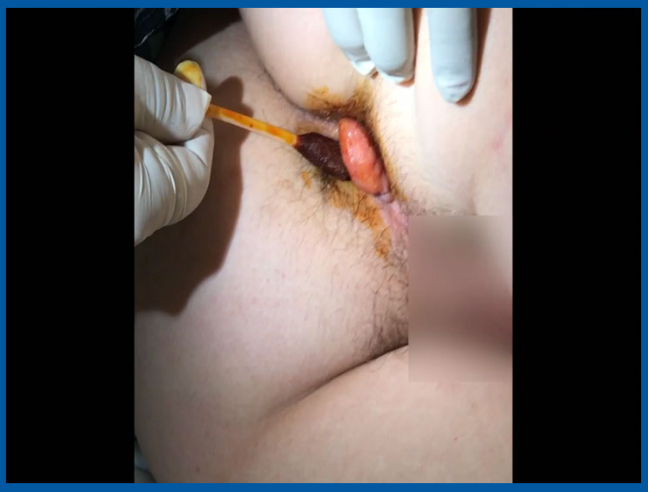

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Anal Fissures

- A linear tear in the anoderm caused by passage of hard stool, diarrhea, straining, sitting too long.
- Most often found in posterior midline, less commonly anterior midline.
- Ischemic component – poor blood supply to posterior midline, worsened by sphincter spasm.
- Deep fissures expose underlying internal sphincter.
- Sharp pain on BM
- Associated hemorrhoids are common.

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Anal Fissure

You will NOT see every anal fissure!

- Tenderness in midline (posterior >>>> anterior)
- Presence of inflammatory tissue or healing scar
- A "rough" area in posterior midline surrounded by smooth tissue
- Sentinel tag

If patients have multiple fissures including those not in midline, rule out other processes (Crohn's?, AIDS?)

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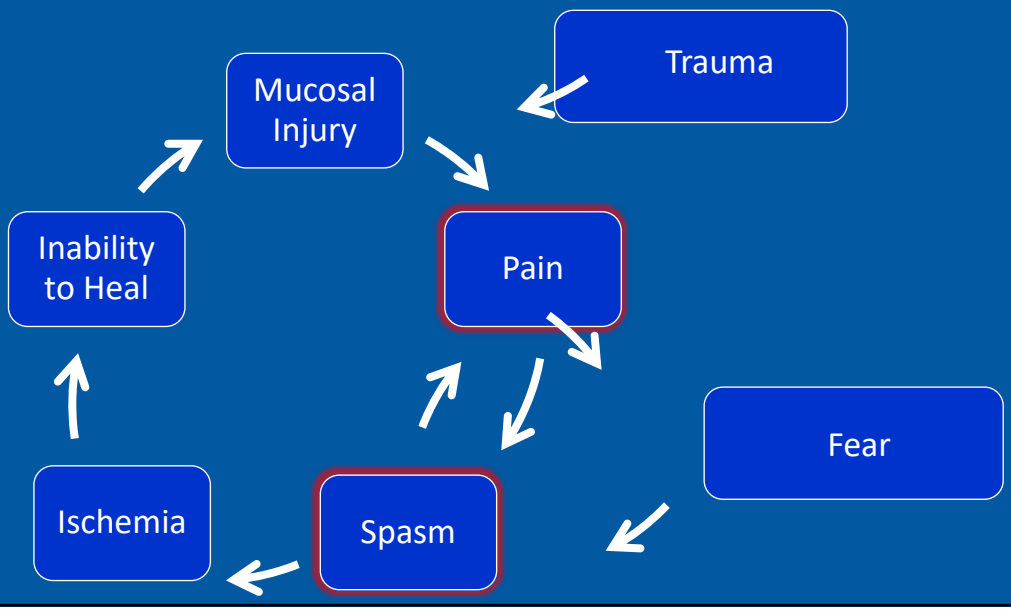
Pathophysiology



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Anal Fissure Rx

- Fiber (15 – 20 gm/day), increase fluid intake, limit time on commode, no straining, sitz baths.
- 2% Diltiazem or 0.5% Nifedipine with 5% lidocaine. Rx for 12weeks,
- NTG ointment, 0.125%. Rx for 12 weeks,
- Botox effective but expensive.
- Surgery is effective if medical therapy fails but has 2-4% incontinence rate.

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Medical Treatment Summary

Drug	Dose	Healing Rate	Safety	Recurrence Rate
Diltiazem	2-4%	67-89%	Lower incidence than NTG, well tolerated	11% or less
Nifedipine	0.2-0.5%	~95%	Lower incidence than NTG, well tolerated	~6%
NTG	0.4%	40-68%	Headache (5.9-56%); dose related and causes d/c in up to 20%	7.9-50%; dramatically higher than surgery

Poh et al. World J Gastroenterol 2010;2(7):231-241.
Perry et al. Dis Col Rectum 2010;53(8):1110-1115.
Perrotti et al. [illegible]
Katsinelos et al. Int J Colorectal Dis 2006;21:179-183.

Nifedipine 0.5% + Lidocaine 5%

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Pruritus Ani

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Pruritus Ani

- Contact dermatitis from soap, perfumes, dye in toilet paper, or hemorrhoid creams or wipes.
- Fungal infections
- Citrus fruits, grapes, tomatoes, spices, beer, milk, tea, or coffee may exacerbate condition.
- Laxatives, colpermin, and antibiotics may cause itch.
- Keep area clean and dry. Loose pants, cotton underwear. Balneol and clotrimazole or clotrimazole/betamethasone.
- Band hemorrhoids and treat fissure if present.

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Disorders of Defecation Can lead to Hemorrhoids, Fissures, Pruritus

- Severe Constipation NOT responding to laxatives
- Fecal Incontinence

- A well performed DRE will diagnosed rectal dyssynergia in over 80%.
- Confirm with Anorectal manometry.

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Rectal Dyssynergia

When to order Anorectal Manometry (ARM):

- Constipation or difficulties with defecation (In up to 20%).
- Fecal incontinence.
- To assess the result of surgery or biofeedback.
- Work up of anal rectal pain.

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Summary:

- Perform an ANO-rectal examination (Inspection, DRE, Anoscopy) to properly evaluate patient.
- In-office treatment of hemorrhoids safe and effective. Very few patients need surgical intervention.
- You don't always see anal fissures – make this a clinical diagnosis.
- Hemorrhoids don't hurt. Look for other causes
- Disorders of defecation can contribute to hemorrhoids/fissures
- Know when to order anorectal manometry

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Further Reading

Qureshi WA. Office management of hemorrhoids. Am J Gastroenterol. 2018 Jun;113(6):795-798.

Qureshi, WA. How I do it, Anal Fissures. Am J Gastroenterol. 2020 Mar;115(3):315-316.

Qureshi WA: Anorectal disease: a clinical reference. Slack incorp 2019. Textbook.

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"THE END"

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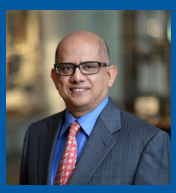
Questions?



Speaker:
Waqar Qureshi, MD, FACG

Moderator:
Neha Mathur, MD

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