2nd AGA Post Graduate Course held in South Africa

Top 10 “Take Home” points to bring back to your patients

‘Best of the 2013 AGA Spring Post Graduate Course’ held at the DDW Orlando, Florida
Brennan M.R. Spiegel, MD, MSHS  
Professor of Medicine VA  
Greater Los Angeles Healthcare System

Dr Spiegel is Professor of Medicine in the Division of Digestive Diseases, UCLA School of Medicine, and in the Division of Gastroenterology, VA Greater Los Angeles Health Care System. He is the Section Chief for Outcomes Research at the UCLA Divisions of Digestive Diseases, adjunct faculty in the Department of Health Services, UCLA School of Public Health, and a member of the CURE Digestive Diseases Research Center. He is the Program Director for the UCLA Fellowship Program in Digestive Diseases. Dr Spiegel attended Tufts University where he majored in Philosophy and Community Health, and received his M.D. with Alpha Omega Alpha honors from New York Medical College.

He received training in internal medicine at Cedars-Sinai Medical Center in Los Angeles, completed a fellowship in Gastroenterology at UCLA, and completed advanced studies in Health Services Research at the UCLA School of Public Health, where he received a Master's Degree in Health Services. He received a Research Career Development Award through the Veteran Administration during which time he was trained in health services methodology.

Dr Spiegel's research focuses on acid-peptic disorders, colon cancer screening, gastrointestinal haemorrhage, diverticular diseases, and functional bowel disorders such as irritable bowel syndrome (IBS). His overall research is defining strategies that improve the quality and cost-effectiveness of care for patients with digestive diseases. To achieve this goal, Dr Spiegel conducts cost-effectiveness analyses, patient reported outcome (PRO) research, health related quality of life studies, meta-analyses, epidemiological studies, provider surveys, quality indicator developmental studies, and other "outcomes" research. Dr Spiegel's group is also developing new technological innovations to expand care outside of the provider visit.
Take home point 1

The heart is more important than the gut (sadly)

ASA+PPI vs. Placebo+PPI Following ASA-Induced ulcer bleed

30-day Rebleeding

- ASA+PPI (N=78): 10.3%
- Placebo+PPI (N=78): 5.4%

P = NS

2-Month all-cause mortality

- ASA+PPI (N=78): 1.3%
- Placebo+PPI (N=78): 12.9%

P < 0.05

Restrictive transfusion strategy improves survival in GI bleeding – target hemoglobin of 7-9g/dL

For pancreatic cysts, size is everything

Size > 3cm Trumps Everything

Mural Nodule 9.3x
PD Dilatation 7.3x
Main Duct IPMN 4.7x

Use baclofen to curb alcohol cravings in patients with EtOH cirrhosis

1. Runyonism
   “Use forever”

2. Runyonism
   “Keep ramping up the dose if you can”
Take home point 5

Management of C. difficile is now stratified by disease severity: apply risk score and treat accordingly

<table>
<thead>
<tr>
<th>CDI Severity</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild to moderate</td>
<td>Metronidazole 50 mg 3 times per day PO 10-14 days</td>
</tr>
<tr>
<td>Severe</td>
<td>Vancomycin 125 mg 4 times per day PO 10-14 days</td>
</tr>
<tr>
<td>Severe complicated</td>
<td>Vancomycin 500 mg 4 times per day PO or by nasogastric tube or enema plus Metronidazole 500 mg q 8 hrs iv 10-14 days</td>
</tr>
</tbody>
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*Note: Ileus, toxic megacolon, PMC, ascites, hemodynamic instability, SIRA, organ failure*
• **Derivation cohort** –
  263 CDI subject in Boston

• **Prediction score**
  1 for Age > 65 years
  1 for Creatinine >2 mg/dL
  1 for WBC >2 20,000 cells/μL

• **Validation cohort** –
  CDI subjects in Houston
  (n = 225) & Dublin (n = 150)

**Predictive accuracy** (in validation cohort)
Score of 0 or 1 versus 2 or 3

**Severe outcomes = CDI - related ICU admission, colectomy or death.**

![Graph with score and severe outcome percentages]

- **Score: 0**
  - 11%

- **Score: 1**
  - 17%

- **Score: 2**
  - 32%

- **Score: 3**
  - 61%

**Predictive accuracy**
72.5%
[95% CI: 67.5-76.9%]
Take home point 6

If you’re still using single dose bowel prep, it’s time to switch: split dose is far superior with second dose within 8 hours of procedure

### Meta-analysis: Single vs. Split Prep

<table>
<thead>
<tr>
<th>Study or Subgroup</th>
<th>Odds Ratio M-H, Fixed, 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdul-Baki et al</td>
<td>7.18 [3.61, 14.27]</td>
</tr>
<tr>
<td>Aoun et al</td>
<td>2.54 [1.23, 5.24]</td>
</tr>
<tr>
<td>Marmo et al</td>
<td>3.48 [2.33, 5.22]</td>
</tr>
<tr>
<td>Park SS et al</td>
<td>3.13 [1.59, 6.17]</td>
</tr>
<tr>
<td>Total (95% CI)</td>
<td>3.70 [2.79, 4.91]</td>
</tr>
<tr>
<td>Total events</td>
<td></td>
</tr>
</tbody>
</table>
Reduces Discontinuations by 47%
Reduces nausea by 45%
Increases willingness to repeat by 1.8 times
Think of FGID Patients in a Biopsychosocial Context

**GI physical symptoms**
- GI pain
- Gas/bloat
- Altered defecation
- Foregut symptoms

**GI emotions**
- Visceral and general anxiety
- Depression
- Devitalization

**GI cognitions**
- Locus of control
- Catastrophizing
- Anticipatory concerns
- Embarrassment/stigma

**GI distress**

Consider early referral for cognitive behavioral therapy in FGID patients – remember that NNT between 2-3 for these therapies.
Take home point 8

Use evidence-based decision aids to help make IBD therapeutic decisions

Example BRIDGe Output

**RECOMMENDATIONS**

**INAPPROPRIATE**

The RAND panel felt that for this patient scenario, the use of immunomodulators was inappropriate (expected or potential health risks outweighed anticipated health benefits). Therefore, the recommendation is for anti-TNF monotherapy.

The recommendation is based on the following:

- **Patient group**
  - Patients on concomitant immunomodulator (at any dose) and biologic for at least 6 months

- **Disease extent**
  - More than 15 cm ileal involvement and/or upper tract/mid-small bowel involvement and/or more than right-sided colonic involvement

- **Perianal involvement**
  - Active or previous fissure, fistula, or anal stricture

- **Age**
  - Age 25 years or younger

- **Gender**
  - Male

- **Disease duration**
  - Disease duration of greater than 2 years (since diagnosis)

- **Surgery history**
  - 1 extensive (>15 cm ileal) resection, or more than 1 resection

www.BRIDGeIBD.com
Take home point 9

For 3-8 mm polyps, cold snare is quicker than hot snare and has fewer complications

Take home point 10

All patients treated with thiopurines require annual dermatological examination, sun block, and hats. Also consider for anti-TNF monotherapy
This meeting has been made possible by an educational grant from AstraZeneca.

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